HSC Public Health Agency

AGENDA

74th Meeting of the Public Health Agency board to be held on Thursday 19 March 2015, at 1:30pm, Conference Rooms, 12/22 Linenhall Street Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	1.30	Welcome and Apologies		Chair
2.	1.30	Declaration of Interests		Chair
3.	1.30	Minutes of the PHA board Meeting held on 19 February 2015		Chair
4.	1.35	Matters Arising		Chair
5.	1.35	Chair's Business		Chair
6.	1.40	Chief Executive's Business		Chief Executive
7.	1.45	Finance Update • PHA Financial Performance Report	**PHA/01/03/15 (for Noting)**	Mr Cummings
8.	1.55	Research and Health Intelligence sub-committee update		Dr Harbison
9.	2.05	Governance and Audit Committee Update • Minutes of 10 December 2014 meeting • Verbal briefing from Chair	**PHA/02/03/15 (for Noting)**	Mr Coulter
10.	2.15	Review of Standing Orders and Standing Financial Instructions	**PHA/03/03/15 (for Approval)**	Mr McClean / Mr Cummings
11.	2.25	Information Governance Strategy and Framework	**PHA/04/03/15 (for Noting)**	Mr McClean

12.	2.35	Policy on Appraisal for Medical Practitioners	**PHA/05/03/15 (for Noting)**	Dr Harper
13.	2.45	Board Governance Self-Assessment Tool	**PHA/06/03/15 (for Approval)**	Chair
14.	2.50	PHA Annual Business Plan 2015/16	**PHA/07/03/15 (for Approval)**	Mr McClean
15.	3.00	e-Health and Care Strategy for Northern Ireland	**PHA/08/03/15 (for Noting)**	Mr Donaghy
16.	3.30	Quality Improvement Biannual Report	**PHA/09/03/15 (for Noting)**	Mrs Cullen
17.	3.40	Any Other Business		

18. **Date, Time and Venue of Next Meeting**
    Thursday 21 May 2015
    1:30pm
    Fifth Floor Meeting Room
    12/22 Linenhall Street
    Belfast
    BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 73rd Meeting of the Public Health Agency board held on Thursday 19 February at 1:30pm, in Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mrs Julie Erskine	-	Acting Chair
Dr Eddie Rooney	-	Chief Executive
Mrs Pat Cullen	-	Director of Nursing and Allied Health Professionals
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mr Edmond McClean	-	Director of Operations
Councillor William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Dr Jeremy Harbison	-	Non-Executive Director
Mrs Miriam Karp	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

IN ATTENDANCE:

Mr Robert Graham	-	Secretariat

APOLOGIES:

Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Fionnuala McAndrew	-	Director of Social Services, HSCB
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

		Action
12/15	**Item 1 – Welcome and Apologies**	
12/15.1	The Chair welcomed everyone to the meeting and noted apologies from Mr Paul Cummings, Mrs Fionnuala McAndrew and Mrs Joanne McKissick.	
13/15	**Item 2 - Declaration of Interests**	
13/15.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

14/15	**Item 3 – Minutes of the PHA Board Meeting held on 22 January 2015**
14/15.1	The minutes of the previous meeting, held on 22 January 2015, were approved as an accurate record of the meeting.
15/15	**Item 4 – Matters Arising**
	7/15.6 Finance Report
15/15.1	The Chief Executive said that he had had an initial discussion with Mr McClean in regard to the inclusion of information from PEMS and the extent to which this might provide further insight to that already found in the Finance Report.
	8/15.9 Commissioning Plan 2015/16
15/15.2	The Chair circulated to members copies of correspondence that she had sent to, and the reply received from, Dr Ian Clements, Chairman of HSCB regarding the Commissioning Plan process for 2015/16.
16/15	**Item 5 – Chair's Business**
16/15.1	The Chair circulated to members a report of the meetings she had attended since the last meeting.
16/15.2	The Chair asked the Chief Executive to give an update to members following receipt of a query regarding the Donaldson Report.
16/15.3	The Chief Executive advised that, with regard to the Donaldson Report, DHSSPS had written to HSC Trusts seeking their response to the recommendations, but in his view, many of the recommendations had an effect on the core business of the PHA, therefore PHA would also be submitting a response.
16/15.4	Dr Harbison agreed that PHA should make a formal response as many of the recommendations relate to the core business of PHA. He added that there were comments made in the report relating to the interface between PHA and HSCB which, in terms of staffing, are left unresolved. Dr Rooney agreed that there were elements of the report which aren't helpful. Mr Mahaffy

	added that the PHA response should point out issues that were not picked up in the original report.
16/15.5	The Chair advised that she had received a query from Mr Mahaffy regarding a forthcoming DHSSPS review of Commissioning. The Chief Executive said that as part of that review PHA would take the opportunity to provide its views. He also agreed to write to HSCB to get its view on how the review would be taken forward.
16/15.6	Mr Coulter asked about the proposed duty of candour. Dr Harbison advised that the Minister has asked Departmental officials to draft primary legislation in this regard.
17/15	**Item 6 – Chief Executive's Business**
17/15.1	The Chief Executive advised members that he had attended the first meeting of the British Isles Healthcare Collaboration which was chaired by Sir Michael Marmot. He said that four areas had been identified for closer collaboration – early years and early intervention; social protection; workplace health and ageing.
17/15.2	The Chief Executive said that he had also met with Stephanie O'Keefe, the Regional Public Health Director of HSE.
18/15	**Item 7 – Finance Update** **PHA Financial Performance Report (PHA/01/02/15)**
18/15.1	In the absence of Mr Cummings, the Chair invited the Chief Executive to present the finance update. She assured members that she had met with Mr Simon Christie from HSCB to go through the report and had been satisfied that any of her queries had been satisfactorily resolved.
18/15.2	The Chief Executive highlighted two issues which related to demand-led services. He said that the expenditure regarding Lifeline was broadly within budget, but there remained an underspend in smoking cessation, which was likely due to the absence of a current advertising campaign, or an increase in the popularity of e-cigarettes.
18/15.3	The Chief Executive advised members that PHA had made provision for the non-receipt of £200k of funding from OFMDFM

	for Delivering Social Change initiatives, however, PHA had now been advised that this funding will be provided. The Chief Executive indicated that he, with finance colleagues, would view whether it was necessary to declare any of these funds to DHSSPS in order that the PHA meets its financial thresholds at the end of the financial year.
18/15.4	Members noted the Finance Report.
19/15	**Item 8 – Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 31 December 2014 (PHA/02/02/15)**
19/15.1	Mr McClean presented the performance management report for the period up to 31 December 2014. He advised that two of the targets no longer had a rating as one related to a report that had not yet been published, and the other was the responsibility of HSCB. He added that the rating for the implementation of the seasonal flu vaccination programme had moved to "amber", but he said that Northern Ireland still had the highest uptake in the UK.
19/15.2	Councillor Ashe noted that of the six pilot sites for the Building Shared Communities programme, five are in Belfast, and that in the future more of these should be moved out of Belfast.
19/15.3	Mrs Karp asked about health visiting services and noted that there will be a high dependency on all of the new graduate health visitors to take up posts. Mrs Cullen acknowledged that this would be the case over the next two years.
19/15.4	Mrs Cullen went on to say that there is an exercise being undertaken with regard to normative staffing levels and a report is due to be finalised by March 2015. She agreed to bring an update on this work to a future PHA Board meeting.
19/15.5	Members noted the Performance Management Report.
20/15	**Item 9 – Six Monthly Overview Report on Progress on the Implementation of RQIA Report Recommendations for the period ending 30 September 2014 (PHA/03/02/15)**

20/15.1	Dr Harper explained to members that there is a process in place whereby each RQIA review report is logged and a lead officer or group assigned to take forward any recommendations that are the responsibility of HSCB and/or PHA. She said that each report may contain up to 40 recommendations, therefore this report is designed to give an overview and to highlight any particular issues.
20/15.2	Dr Harper said that many of the updates are rated "amber". She advised that the implementation of recommendations relating to the Respiratory Framework was rated "red" as dedicated commissioning and administration support had not been identified, however this has now been arranged. With regard to the recommendations emanating from the unscheduled care reviews, Dr Harper said that this work is being led by DHSSPS.
20/15.3	Mr Coulter queried the reasons for bringing this report to the PHA Board. Dr Harper that due to PHA's role as a joint commissioner and making decisions regarding where investments are made, these recommendations show where there are currently gaps and challenges. The Chief Executive noted that many of the progress updates which are rated "green" are those which are PHA-led.
20/15.4	Members noted the update on the implementation of recommendations from RQIA reports.
21/15	**Item 10 – Update on Community Planning**
21/15.1	Mr McClean began his update on community planning by advising that a series of meetings with the new Council Chief Executives had been completed. He explained that the new Councils are operating in "shadow form" for their first 12 months and during that period, one of their main objectives is to develop their community plans. He added that PHA has been named as a statutory partner to support the community planning process.
21/15.2	Mr McClean said that he had envisaged that there would be a commonality of approach in the development of community plans but he outlined three different approaches which are taking place in three of the new Councils.
21/15.3	Mr McClean explained that there are some HR issues with

	Councils which require to be resolved. This relates to where PHA funding has been allocated to specific initiatives which has involved recruitment of staff by Councils and where Councils are seeking to relocate staff bases. He also explained that PHA cannot guarantee the funding over the longer term at this point, and that PHA will try to offer stability in 2015/16 with a more structured review in 2016/17 and beyond.
21/15.4	Councillor Ashe agreed that the money provided by PHA to Councils for projects should be utilised for projects. Mr Mahaffy asked if PHA could tell how much money is being spent in each of the Council areas. Mr McClean said that an exercise looking at this is being undertaken at the moment.
21/15.5	Members noted the update on Community Planning.
22/15	**Item 11 – Any Other Business**
22/15.1	Dr Harbison asked when PHA had been informed of the mismatch between the strains of flu being utilised in the flu vaccine and the flu strain that has been prevalent this year. Dr Harper said that PHA was only informed on the same day as the press release was issued. She noted that the strains used in the flu vaccine are determined eight months before the flu season, and that in this instance the virus had mutated.
22/15.2	The Chair advised members that if there were any updates on the financial situation for 2015/16, she would let members know immediately.
23/15	**Item 12 – Date and Time of Next Meeting** Date: Thursday 19 March 2015 Time: 1:30pm Venue: Conference Rooms 3+4 12/22 Linenhall Street Belfast BT2 8BS

Signed by Chair: _____

Date: _____

HSC Public Health Agency

PHA Board Report

January 2015

HSC Public Health Agency

January 2015

Summary Position

Income	***Page Reference***	**Annual £000s**	**Year to Date £000s**
Department Allocation*		100,877	79,399
Income from Other Sources		1,110	978
Total Income		101,987	80,377
Expenditure			
Non-Trust Programme	*2*	46,134	33,761
Trusts	*3*	34,738	28,949
PHA Administration (incl. BSO)	*4*	20,840	16,587
Total Expenditure		101,712	79,296
Surplus/(Deficit)		275	1,081

*Includes assumed allocations of £134k for Clinical Excellence Awards, £83k for a Nursing post and £354k from HSCB re Accommodation charges.

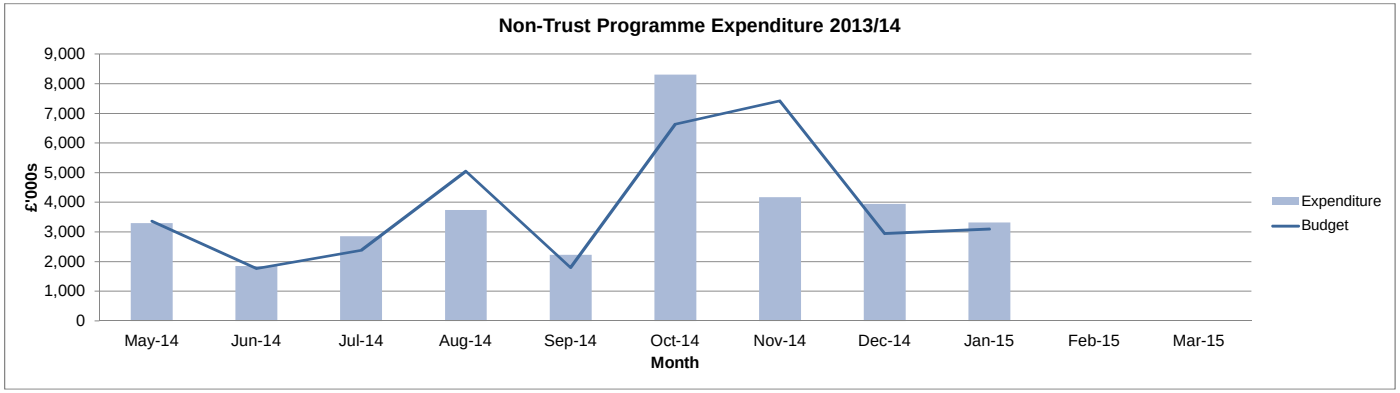
Position Synopsis:

Year to date the financial position shows a surplus of £1.1m against profiled budgets which relates to the non-Trust Programme budget underspend of £0.7m and Management and Administration budgets underspend of £0.4m.

Subsequent to covering the previously notified retraction (£1.5m) from the DHSSPS and the pressure relating to assumed income, there is approximately £0.4m remaining to be allocated by PHA. This position takes into account the Lifeline Contract which is currently projected to underspend by £70k.

Taking all known factors into account, the PHA is currently projecting a £275k surplus at the year end. This is largely due to a £200k allocation for Delivering Social Change being received from the DHSSPS in the current month, which PHA had previously been advised would not be allocated. The Agency are communicating with the DHSSPS regarding retraction of these funds as it had already committed internal funds to this initiative. The balance of £75k is within the breakeven tolerance level for PHA of 0.25%.

Non-Trust Programme Spend



	£'000s May-14	£'000s Jun-14	£'000s Jul-14	£'000s Aug-14	£'000s Sep-14	£'000s Oct-14	£'000s Nov-14	£'000s Dec-14	£'000s Jan-15	£'000s Feb-15	£'000s Mar-15	£'000s Total
Budget	3,368	1,769	2,389	5,051	1,804	6,639	7,432	2,944	3,092			34,487
Expenditure	3,299	1,858	2,865	3,744	2,231	8,313	4,174	3,950	3,326			33,761
2013-14 Expenditure for Comparison	*3,543*	*1,979*	*1,109*	*2,470*	*4,523*	*4,250*	*4,670*	*3,337*	*4,082*			*29,963*
Surplus/(Deficit)	69	(89)	(476)	1,307	(427)	(1,674)	3,258	(1,007)	(234)	0	0	727
Surplus/(Deficit) made up as follows:												
Health Improvement - Belfast LCG	87	2	(42)	283	22	(743)	423	37	(236)			(166)
Health Improvement - South East LCG	(137)	(158)	312	(271)	(302)	394	511	(102)	98			346
Health Improvement - North LCG	(88)	67	(305)	420	(43)	(451)	521	18	(304)			(166)
Health Improvement - South LCG	135	(54)	79	(90)	300	122	39	(251)	280			559
Health Improvement - West LCG	249	(146)	(200)	290	21	(505)	652	(193)	(195)			(27)
Health Improvement - Lifeline Contract	(137)	14	11	(36)	(12)	12	71	29	40			(8)
Health Improvement - Smoking Cessation	0	0	0	22	15	4	6	16	4			66
Health Protection	(60)	(12)	(482)	459	1	(18)	62	(164)	526			312
Service Development & Screening	115	65	38	(212)	(20)	3	98	8	(109)			(14)
Research & Development	29	(28)	71	707	(601)	(482)	683	(383)	(50)			(54)
Campaigns	(96)	17	(50)	(73)	16	(21)	115	52	(89)			(129)
Nursing & AHP	(3)	8	5	(6)	21	(29)	(2)	4	43			41
Health Improvement - Regional Projects	(25)	136	87	(186)	(4)	52	72	78	(243)			(32)
In year opportunities- held for Lifeline	0	0	0	0	159	(12)	7	(154)	0			0

Position Synopsis:

The current position shows an underspend of £0.7m at the end of January 2015, based on profiles shared by budget managers and the PEM system used by PHA to plan commitments. It is still anticipated that these budgets will breakeven at the end of the financial year and the Financial Management team continue to meet with Budget Managers to review budgets, profiles and assumptions regarding expenditure.

The total expenditure on non-Trust Programme to date is £33.8m, which represents 72% of the annual budget of £46.1m. This means 28% of the budget, or £13.2m, remains to be spent in February and March. This should be closely monitored to ensure the required expenditure in the last quarter is achieved.

HSC Public Health Agency

Revenue Resource Limits (RRLs) to Trusts

January 2015

	Initial Annual Budget (per revised SBAs) £'000s	Current Annual Budget £'000s	Variance £'000s
Western Trust	5,113	6,196	1,083
Northern Trust	6,129	7,365	1,236
Belfast Trust	11,178	12,019	841
South Eastern Trust	2,889	3,536	647
Southern Trust	4,595	5,490	895
NIMDTA	-	133	133
Funds identified to Trusts in Budget Paper but not yet allocated	4,751	-	(4,751)
Total	**34,655**	**34,738**	**83**

Main Reasons for Increase in Funding

The funds shown against specific Trusts have been notified via Service & Budget Agreements and additional adjustments have been made in year. PHA are expecting to fully utilise the funds which have not yet been allocated prior to the end of the financial year. There have been a number of minor retractions from Trusts in January which has reduced the budget by a net £0.1m.

HSC Public Health Agency

PHA Administration

January 2015

	Total Budget £'000's	Current Month Budget £'000's	Current Month Expenditure £'000's	Current Month Variance £'000's	Year to Date Budget £'000's	Year to Date Expenditure £'000's	Year to Date Variance £'000's
Salaries	17,887	1,521	1,468	53	14,642	14,226	416
Goods & Services	2,681	190	195	(6)	2,072	1,725	347
DHSSPS Retraction	(465)	(39)	0	(39)	(388)	0	(388)
Sub-Total Administration	20,103	1,673	1,663	8	16,327	15,952	375
BSO	737	120	122	(2)	614	635	(21)
Total Administration	**20,840**	**1,792**	**1,785**	**6**	**16,941**	**16,587**	**354**

Position Synopsis:

An overall management and administration surplus of £354k is reported at the end of January 2015 against the profiled budget (increase of £7k since December 2014). This is as a result of vacancies across the Agency and a number of allocations received late in the year for which the underlying pressure had been covered.

The DHSSPS retracted £465k from PHA's Management and Administration budget for 2014-15 during September 2014. This has been profiled and shown separately in the table above.

Prompt Payment Statistics

	January 2015 Value £'000	January 2015 Volume of Invoices	Cumulative position as at 31/1/15 £'000	Cumulative position as at 31/1/15 Volume of Invoices
Total bills paid (relating to Prompt Payment target)	2,347	676	25,648	7,294
Total bills paid on time (within 30 days or under other agreed terms)	2,178	577	23,916	6,445
Percentage of bills paid on time	**92.8%**	**85.4%**	**93.2%**	**88.4%**

The BSO has not yet been able to provide a comprehensive prompt payment report which is accurate for PHA, but the importance of providing this continues to be pressed at the BSO Customer Forum meetings. In the interim HSCB finance, on behalf of PHA, continue to generate a prompt payment report based on the audited method which was used to provide the Annual Accounts figures. This will ensure consistency of information reported to PHA on a monthly basis, while BSO work to produce a meaningful report.

PHA staff continue to work steadily on the finance systems to clear invoices promptly, with January performance falling slightly compared to the position reported in December. The January 30-day performance was 85.4% (90.2% December) by volume, and 92.8% (95.7% December) by value of all undisputed invoices paid within 30 days of receipt. This reduction in payment performance is attributed to continued efforts by Share Services Accounts Payable to clear older debt ahead of year end, and traditionally falls at this time of year due to the impact of statutory holidays. In addition, the overall 10 day performance is now 74.7% by volume for the year to date, which exceeds the 2014/15 10 day target of 50%

The cumulative month 10 position by volume of invoices (88.4%) and by value (93.2%) remains short of the 95% DHSSPS target.

HSC Public Health Agency

MINUTES

Minutes of the 27th Meeting of the Governance and Audit Committee held on Wednesday 10 December 2014, at 10 am, in the Public Health Agency Conference Rooms, 18 Ormeau Avenue, Belfast, BT2 8HS

Present:

Mr Brian Coulter	-	Chair
Mrs Miriam Karp	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director

In Attendance:

Mrs Julie Erskine	-	Acting Chair
Mr Edmond McClean	-	Director of Operations
Mr Paul Cummings	-	Director of Finance
Mr Simon Christie	-	AD Finance
Mr David Charles	-	Internal Audit
Ms Christine Hagan	-	ASM Chartered Accounts
Dr Janet Little	-	Consultant in Public Health (for item 10)
Mrs Cathy McAuley	-	Secretariat

Apologies

Alderman Paul Porter	-	Non-Executive Director
Miss Rosemary Taylor	-	AD Planning & Operational Services
Mr Mark Anderson	-	Sponsor Branch, DHSSPSNI

		Action
55/14	**Item 1 - Welcome and Apologies** The Chair welcomed everyone to the meeting and noted apologies. It was noted that there was no representative from the NI Audit Office present at today's meeting. The Chair welcomed Mrs Julie Erskine, Acting Chair of PHA to today's meeting and thanked Mrs Erskine for her contribution and support given as Chair to the GAC since 2009 and wished her success in her new role as Acting Chair. Mrs Erskine thanked the Chair for his kind words and indicated she wished to wish the committee well in its work. Mrs Erskine left the meeting at 10.10 am. The Chair welcomed Ms Christine Hagan, ASM Chartered Accountants to today's meeting and introductions followed. Ms Hagan advised that ASM were delighted to be appointed as external auditors and she was deputising today on behalf of Mr Brian Clerkin. Ms Hagan added that Mr Clerkin or she would be in attendance at future meetings. The Chair informed members that Dr Janet Little	

	would be in attendance for item 10.	
56/14	**Item 2 – Declaration of Interests** The Chair asked if anyone had any interests to declare relevant to any items on the agenda. None were declared.	
57/14	**Item 3 – Chair's Business** The Chair highlighted the HSC (F) 38-2014 circular issued by the DHSSPS dated 21 October 2014 re: Inclusion of complaints handling in Internal Audit programmes for action by Director of Finance and Head of Internal Audit of HSC bodies. Mr Charles advised the Chair that Internal Audit had acknowledged recognition of the HSC (F) 38-2014 circular and would build it into the 2015/16 programme.	
58/14	**Item 4 - Notes of previous Meeting – 11 June 2014** The minutes of the previous meeting, held on 8 October 2014, were approved subject to amendments; <u>42/7 paragraph 7</u> – to read "these *included four priority one recommendations made within the 2013/14 RTTCWG and these referred to the services provided to the PHA under the SLA which was held with BSO.* *The Chair added that all the recommendations made within the RTTCWG related to the new Shared Services environment and the operation of the new systems implemented under the Business Service Transformation Project (BSTP) in late 2012/13.* <u>42/16 paragraph 7</u> - to read additions *"in respect of BSTP were being agreed and would be included in the SLA in as service changes were implemented".*	Secretariat
59/14	**Item 5 – Matters Arising** <u>44/14 –- BSO Shared Services Centre</u> Mr Cummings advised that work continues with BSO colleagues regarding the efficiency of shared services.	
60/14	**Item 6.1 – Corporate Risk Register** Mr McClean presented the Corporate Risk Register as at September 2014 for noting and summarised the report. He said this quarter saw changes to the corporate risk register; • 1 risk had its risk rating reduced from high to medium (CR26) Lack of market testing for roll forward contracts • 1 risk had its risk rating increased from high to extreme (CR25) PHA Belfast Accommodation. **<u>CR25 PHA Belfast Accommodation</u>**	

The Chair advised that CR25 PHA Belfast Accommodation remains a concern to the board.

In response to this Mr McClean advised that the proposed move to new premises at 21 Linenhall Street, Belfast did not proceed as the lease was withdrawn by Savills (NI) Limited acting on behalf of the landlord before it was finalised.

He added that due to this recent development CR25 had therefore increased from high to extreme, as there was no alternative accommodation at the moment and pressures had increased due to maintenance issues which include water ingress in Alexander House and unacceptable density of staff in parts of Linenhall Street.

He added that an internal review of the current position and exploration of options the future for staff based at Linenhall Street was currently being carried out, but advised that this review was likely to be limited in terms of meaningful mitigation due to lack of space.

Mr McClean advised that PHA had been contacted by Asset Management, DHSSPS regarding PHA requirements as the Asset Management Unit are reviewing public bodies located in leased property assets in Belfast City Centre and are involved in the acquisition of a vacant office building in Belfast City Centre.

'Members reiterated concern about this 'third party' initiative which whilst welcome insofar as access to possible funding may arise is inherently risky due to limited input and lack of control by PHA executives. The associated escalation of risk was agreed.

CR26 Lack of market testing for roll forward contracts

Mrs Karp asked for clarity regarding robustness of the processes for ensuring clarity of monitoring and referenced the management of the Lifeline contract as an example.

Mr McClean responded to this by advising that management of this particular contract (Lifeline) remains a priority given demand management, clinical governance and accuracy issues and this was reflected in the corporate risk register as CR30.

He said the reported demand for this service had increased considerably and at a time exceeded the designated budget and requires on-going attention.

Mrs Karp acknowledged the costs for additional staff time and engagement in the management of this contract.

Mr Cummings advised that these comments would be taken into

	account in the business case at retendering stage. The Chair also acknowledged that this was a critical point and the GAC ask that these assurances are clearly reflected in the business case options. Members noted the corporate risk register.	
61/14	**Item 6.2 - Gifts and Hospitality Register** Mr McClean presented the Gifts and Hospitality Register for noting. Members noted the register.	
62/14	**Item 7 – Internal Audit Progress Report** Mr Charles presented the Internal Audit progress report to members for noting and advised that two reports had been issued in draft form and would brought to the next meeting. • Procurement and Contract Management • Management of Contracts with Voluntary and Community Sector Mr Charles gave a summary of the progress report and advised the Internal audit of performance management had received a satisfactory level of assurance and that three priority two weaknesses were identified and advised the committee that all recommendations had been accepted by management. The Chair referenced the timelines for adhering to deadlines of audit assignments. Mr Charles replied that internal audit did have agreed KPI's in place for adherence to timelines for the completion for reports, but regrettably these had not been met on this occasion as internal audit was reliant on responses from management. He added that both reports would be brought to the next meeting. Members noted the progress report subject to one amendment on page 4, management summary to read *"PHA Board"*.	D Charles
63/14	**Item 8 – Single Action Tender Register** Mr McClean presented the Single Action Tender Register for noting. Members noted the report.	
64/14	**Item 9.1 – Finance: Report to those charged with Governance Progress report** Mr Christie presented the progress report on the implementation of recommendations of the report to those charged with governance and summarised the report to members. He added since the last report the first meeting of the Shared Services Customer Forum for the PHA had been held and all issues identified on the RTTCWG had been raised with the managers of shared services for payroll, accounts payable and accounts	

receivable. He added the terms of reference (TOR) and membership for the customer forum had been agreed and that he would be the representative on behalf of the PHA. In conclusion he advised the first customer forum meeting had provided a positive platform for current issues to be shared between Shared Services and the PHA. Members noted the report.

65/15 **Item 10 – Policy on Appraisal for Medical Practitioners**

The Chair welcomed Dr Little to the meeting.

Dr Little gave members a brief outline of the policy guidance which included an introduction, aims and objectives. She added that the policy had the full support of the British Medical Association (BMA) and this policy would be brought to this committee on an annual basis for noting.

The Chair enquired the ownership of the policy and referenced a recently high profile case which had attracted media interest. Dr Little advised that failure to engage and participate in the 360 degree appraisal process would raise concern.

Discussion followed regarding the ownership of the policy and members agreed that whilst they are unable to change the guidance contained in the policy as it superseded DHSSPS circulars;

- TC8 11/01 Annual Appraisal for consutlants May 2001;
- TC8 1/2003 non-consultant career grade appraisal February 2003

it was agreed that the GAC would comment on the policy content and recommend it to the PHA Board.

Further Discussion took place regarding the robustness of the 360 degree appraisal system and how nominations for appraises were selected. GAC requested that they be made aware of any relevant comments which might be made by the RQIA in its role as part of the quality assuring of this Policy. The Chair thanked Dr Little for her very informative summary of the policy. Members noted the report and recommended it for noting to the PHA board.

66/14 **Item 11 - Date and time of next meeting**

Date: 19 February 2015
Time: 10.00am
Venue: Conference Rooms 3&4
2nd floor, 12-22 Linenhall Street
Belfast

HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

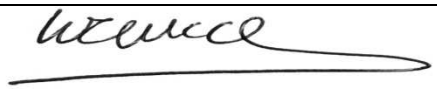
Date of Meeting	19 March 2015
Title of Paper	Review of Standing Orders and Standing Financial Instructions
Agenda Item	10
Reference	PHA/03/03/15

Summary

The PHA Standing Orders and Standing Financial Instructions are reviewed on an annual basis by HSCB Financial Governance on behalf of PHA and amendments made in response to updates in procedures or DHSSPS Circular guidance.

A cover sheet to summarise the changes made is included along with a full version of the PHA Standing Orders and Standing Financial Instructions highlighting where changes have been made.

A review of the Scheme of Delegated Authority (SoDA) is also normally undertaken as part of the Review, however as a comprehensive review of the SoDA was carried out in 2014, no further amendments are currently required. However, while the SoDA remains unchanged, the upper EU threshold has been amended in line with DHSSPS requirements and this will be updated annually. This is set at €200,000, which at March 2014 equates to £172,514.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This review was approved by AMT on 10 February and by the Governance and Audit Committee on 19 February.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	9 March 2015

PHA amendments to SO's Jan 2015

Overall
Some minor typographical and formatting errors have been changed.

Section 6.7
This has been updated to include reference to the DHSSPS gifts and hospitality circular guidance HSC(F) 49-2009.

Appendix 2 – Administrative Schemes of Delegation
Section 3.4.6 has been amended in accordance with DHSSPS circular guidance HSC(F) 43-2014 to reflect that the delegated limit for office accommodation leases has been removed.

The financial limits in Section 3.4.7 have been updated.

Section 3.4.8 has been amended to include reference to DHSSPS circular guidance HSC (F) 29-2014 regarding the dissemination of lessons learned from post project evaluations, following engagement of an external consultant.

Appendix 4 – Governance and Audit Committee Terms of Reference
In paragraph 1.5.1, a change has been made in relation to how long a Board member will hold office as a Governance and Audit Committee member.

An additional paragraph has been inserted regarding the five good practice principles as set out in the Audit and Risk Assurance Committee Handbook (NI), issued March 2014.

An additional task has been inserted in the terms of reference, "Advise the board on the strategic processes for risk, control and governance and the Governance Statement". Monitoring and reviewing the effectiveness of whistleblowing processes has also been added. Amendments are in line with the Audit and Risk Assurance Committee Handbook (NI).

PHA amendments to SFI's Jan 2015

Sections 2 – 21
Have been amended to include minor grammatical and syntax changes to improve layout and reader experience.

Section 8.10 (a)
Has been amended to refer to the revised circular guidance HSC(F) 49-2014, on assessment of value for money (VFM) for private finance initiatives.

Section 11.1.5
This executive pay section has been updated to reflect the updated DHSSPS circular reference HSC(F) 10/2014.

Section 11.3.3
The staff appointments section has been amended to include reference to current HMRC & DHSSPS guidance that staff employed directly, via an agency or in a self-employed capacity should be recruited via proper recruitment procedures and paid through payroll. No staff should be engaged via "off-payroll" arrangements.

Section 12.2.6(c)
This External consultancy section has been amended to include reference to DHSSPS circular guidance HSC(F) 29-2014 regarding the dissemination of lessons learned from post project evaluations, following engagement of an external consultant.

Section 14.3.3
Has been amended in accordance with DHSSPS circular guidance HSC(F) 43-2014 to reflect that the delegated limit for office accommodation leases has been removed.

Section 18
Gifts & hospitality section has been updated to include reference to the DHSSPS gifts & hospitality circular guidance HSS(F) 49/2009.

PUBLIC HEALTH AGENCY

STANDING FINANCIAL INSTRUCTIONS

Reviewed and Revised Jan 2015
AMT 10/2/15
GAC 19/2/15
Board Feb 19/2/2015

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SO No.8 – STANDING FINANCIAL INSTRUCTIONS

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Department of Health, Social Services & Public Safety (DHSSPS) under the provisions of Governance, Resources and Accounts Act (NI) 2001 and the Audit and Accountability (NI) Order 2003, the for the regulation of the conduct of the Public Health Agency (PHA) in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders (SOs) of the PHA.

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the PHA. They are designed to ensure that the PHA's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the board and the Scheme of Delegation adopted by the PHA.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the PHA and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance (ref para 1.2.6).

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance **must be sought before acting**. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the PHA's Standing Orders.

1.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 <u>Overriding Standing Financial Instructions</u>
If for any reason these Standing Financial Instructions are not complied with, full details and any justification for non-compliance along with the circumstances surrounding the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 Responsibilities and Delegation

1.2.1 The Board of the PHA (board)

The board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the board and employees as indicated in the Schemes of Delegation documents.

1.2.2 The PHA has resolved that certain powers and decisions may only be exercised by the board in formal session. These are set out in the 'Matters Reserved to the board' document within Standing Orders.

1.2.3 The PHA will delegate responsibility for the performance of its functions in accordance with Standing Orders and the Schemes of Delegation documents adopted by the PHA.

1.2.4 The Chief Executive and Director of Finance (ref para 1.2.6)

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the board, and as Accounting Officer, to the Minister for Health Social Services and Public Safety (HSSPS), for ensuring that the board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the PHA's activities; is responsible to the Chairman and the board for ensuring that its financial obligations and targets are met and has overall responsibility for the PHA's system of internal control.

1.2.5 It is a duty of the Chief Executive to ensure that Members of the board and employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.6 The Director of Finance

The PHA employs the services of the HSCB Finance Department to deliver Financial Management, Accounts and Financial Assurance services through the Director of Finance (ref para 1.2.4) of the Health and Social Care Board.

In this regard the Director of Finance of the HSCB acts as the Director of Finance of the PHA and will support and provide Financial Advice to the Chief Executive and the board of the PHA.

Within this document where the Director of Finance is noted this should be read as the Director of Finance of the HSCB, unless specifically stated otherwise,

The Director of Finance is responsible for:

(a) Implementing the PHA's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining and advising the PHA on an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that the PHA maintains sufficient records to show and explain the PHA's transactions, in order to disclose, with reasonable accuracy, the financial position of the PHA at any time; and

Without prejudice to any other functions of the PHA, and employees of the PHA, the duties of the Director of Finance include:

(a) the provision of financial advice to other members of the board and employees;

(b) the design, implementation and supervision of systems of internal financial control; and

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the PHA may require for the purpose of carrying out its statutory duties.

1.2.7 Business Services Organisation

The DHSSPS has directed that a range of transactional financial services will be outsourced and delivered by the Business Services Organisation (BSO) on behalf of the PHA namely:

(a) Banking Services (ref section 6);

(b) Payroll Services (ref section 11);

(c) Payment Services (ref section12); and

(d) Capital Asset Register (ref section 14).

Additionally Internal Audit, Procurement, Human Resources, Counter Fraud and Probity, Information Technology and Legal services are also delivered by the Business Services Organisation.

Where Financial services are delivered by the BSO the Director of Finance (ref para 1.2.6) will set out the arrangements within the PHA SLA with the BSO and monitor the delivery of these services on behalf of the PHA. With regard to other services provided by the BSO for the PHA the Director of Operations will set out the arrangements for these within the PHA SLA with the BSO and monitor the delivery of them.

1.2.8 PHA board Members, Members and Employees

All members of the board and employees, severally and collectively, are responsible for:

(a) the security of the property of the PHA;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Schemes of Delegation.

1.2.9 Contractors and their employees

Any contractor (e.g. General Practitioner) or employee of a contractor who is empowered by the PHA to commit the PHA to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.10 Miscellaneous

For all members of the board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the board and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders and the Cabinet Office's guidance on Codes of Practice for Public Bodies (FD/DFP 03/06), the agency shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit & Risk Committee Handbook (NI (March 2014) ~~(DAO (DFP) 07/07),~~ which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services and the adequacy of management response to audit findings;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the board;

(f) reviewing schedules of debtors/creditors balances over 6 months and £5,000 old and explanations/action plans;

(g) reviewing the information prepared to support the Assurance framework process prepared on behalf of the board and advising the board accordingly; and

(h) ensuring there is an effective Counter Fraud strategy in place/operation which is in line with DFP's guide "Managing the Risk of Fraud"

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the board. Exceptionally, the matter may need to be referred to the DHSSPS. (To the Director of Finance (ref para 1.2.6) in the first instance.) All incidents of fraud must be reported consistent with DHSSPS policy.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.1.4 The Governance and Audit Committee shall carry out the functions of an Audit Committee as set out above along with other functions in relation to Governance as set out in the Standing Orders.

2.2 **Director of Finance and Director of Operations**

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive;

(c) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(d) access at all reasonable times to any land, premises or members of the board or employee of the PHA;

(e) the production of any cash, stores or other property of the PHA under a member of the board or an employee's control; and

(f) explanations concerning any matter under investigation.

2.2.3 The Director of Operations is responsible for ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, excluding internal financial control.

2.2.4 Jointly the Director of Finance and the Director of Operations are responsible for:

(a) ensuring that the Internal Audit is adequate and meets the Public Sector Internal Audit Standards (PSIAS) in addition that it complies with circular HSS F 21/03 detailing Internal Audit arrangements between a sponsoring Department and its Non Departmental Public Bodies and circular HSS(F) 13/2007 on the model HPSS Financial Governance Documents.

(b) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the PHA board.

The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DHSSPS including for example compliance with control criteria and standards;
- major internal financial control weaknesses discovered;
- progress on the implementation of internal audit recommendations;
- progress against plan over the previous year;
- strategic audit plan covering the coming three years; and
- a detailed plan for the coming year.

2.3 **Role of Internal Audit**

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with and the financial effect of relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the PHA's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

- fraud and other offences;
- waste, extravagance, inefficient administration; and
- poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Framework statements in accordance with guidance from the DHSSPS.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately through the Director of Operations.

2.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the PHA.

2.3.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for Internal Audit shall be agreed between the Director of Finance (ref para 1.2.6), the Director of Operations, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards (PSIAS). The reporting system shall be reviewed at least every 3 years.

The reporting system for Internal Audit shall be as follows:

(a) An urgent interim report is to be made orally or in writing to alert management to the need to take immediate action to correct a serious weakness in performance or control or whether there are reasonable grounds for suspicion of malpractice;

(b) Interim reports may also be made where it is necessary to make a significant change in the scope of the assignment or where it is desirable to inform management of progress;

(c) At the end of the audit a meeting will be arranged between Internal Audit, Director of Operations and the appropriate Director/Manager from the area being audited to review the report. The Director of Finance (or nominated persons) will attend in all audits relating to finance;

(d) On completion of an audit a draft report will be sent by the Chief Internal Auditor to the Director of Finance, the Director of Operations and the Director/Manager with direct responsibility for the areas being audited and who has the authority to take action on audit recommendations;

(e) The Director or Manager who has authority to take action on the recommendations will draft an appropriate and acceptable management response to address or reject the recommendations in a timeline agreed initially with the Director of Operations;

(f) This management response will be sent to the Director of Operations for review and onward transmission to the Chief Internal Auditor to enable a final report to be issued;

(g) The final report will be issued to the Chief Executive, the Director of Finance the Director of Operations, the Assistant Director of Planning & Operational Services and the appropriate Director/ Manager in the area being audited;

(h) An action plan will be prepared and issued to all relevant parties. This action plan will include deadlines for action to be taken and review dates to ensure action has been taken. Action plans will be held on file for review and presentation to the audit committee; and

(i) The final internal audit reports with management responses must be submitted to the Audit Committee for consideration.

(j) Revised descriptors have been issued as per circular guidance (HSC(F)32/2013) ,which should be used to describe internal audit findings and when providing their overall opinion at Year-end. The descriptors are Substantial, Satisfactory, Limited and Unacceptable

2.4 External Audit

2.4.1 The Northern Ireland Comptroller and Auditor General is the appointed External Auditor of the PHA, who may outsource the External Audit programme to appropriately qualified private sector organisations. The External Auditor is paid for by the PHA. The Audit Committee must ensure a cost-efficient service.

2.4.2 If there are any problems relating to the service provided by an outsourced External Auditor, then this should be raised with the External Auditor and referred on to the NIAO if the issue cannot be resolved. The Director of Finance (ref para 1.2.6) will notify the board of any such instances.

2.4.3 Value for Money Audit work is directed by the nominated DHSSPS Senior Officer. The PHA shall be funded for 100% of each study done in the PHA and of any later work to follow-up completed studies.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the PHA Chief Executive and Director of Finance (ref para 1.2.6) shall monitor and ensure compliance with Directions issued by the DHSSPS Counter Fraud Policy Unit on fraud and corruption.

2.5.2 The Director of Finance of the HSCB shall nominate a Fraud Liaison Officer, as specified by the DHSSPS Counter Fraud Policy and Guidance, to provide specialist advice and support to the Chief Executive and Director of Operations of the PHA in fulfilling these duties.

2.5.3 The Fraud Liaison Officer of the HSCB shall periodically report to the PHA Director of Operations and shall work, on behalf of the PHA, with staff in the Counter Fraud and Regional Counter Fraud Unit at the BSO and the Regional Counter Fraud Policy Unit in accordance with the DHSSPS Counter Fraud Policy.

2.5.4 The Fraud Liaison Officer will provide written reports to the PHA's Governance and Audit Committee, on counter fraud work within and on behalf of the PHA.

2.6 Security Management

2.6.1 In line with his responsibilities, the PHA Chief Executive will monitor and ensure compliance with any Directions issued by the Minister on HSC security management.

3. RESOURCE LIMIT CONTROL

3.1 Resource Limit Control

3.1.1 The PHA is required by statutory provisions not to exceed Cash and Resource Limits, with a further requirement to declare all in-year easements to the DHSSPS. The Chief Executive has overall executive responsibility for the PHA's activities and is responsible to the PHA for ensuring that it stays within these limits and any in-year or cumulative deficits are eliminated.

3.1.2 The definition of use of resources is set out in RAB directions on use of resources which are available in the DHSSPS Finance Manual.

3.1.3 Any sums received on behalf of the Minister for HSSPS are treated as sums received by the PHA.

3.1.4 The Director of Finance (ref para 1.2.6) will:

(a) provide monthly reports in the form required by the DHSSPS;

(b) ensure money drawn from the DHSSPS against Cash limit, by the BSO on the PHA's behalf ,is required for approved expenditure only, and is drawn only at the time of need, follows best practice as set out in 'Cash Management in the NHS';

(c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the PHA to fulfill its statutory responsibility not to exceed its Annual Revenue and Capital Resource Limits and Cash limit; and

(d) be responsible for advising the Chief Executive on any operational financial risk for the register and ensure that the Chief Executive and Agency Management Team are advised of potential financial problems to ensure timely action is taken so that Departmental Expenditure limits are not breached.

3.1.5 The Agency Management Team shall ensure that adequate information is provided in a timely way to the Director of Finance (ref para 1.2.6) to enable reliable financial projections to be made, and necessary advice provided to the Chief Executive on any financial risk to the break-even position.

3.2 Promoting Financial Stability

3.2.1 The PHA has an obligation, with all other HSC Organisations, to contain expenditure within the resources available. Deficits should not be allowed to develop, and where they do threaten to arise, the PHA, as a commissioner, must, in partnership with the HSCB and providers, agree appropriate contingency and/or recovery arrangements are put in place.

3.2.2 The principles set out in circular HSS (F) 29/2000, "Promoting Financial Stability within HPSS Organisations" must be adhered to. In particular, no service developments should be initiated without the prior securing of recurrent funding from the DHSSPS

4. ALLOCATIONS, FINANCIAL STRATEGY, JOINT COMMISSIONING PLAN BUDGETS, BUDGETARY CONTROL AND MONITORING

4.1 Allocations

4.1.1 The Director of Operations will periodically review the basis and assumptions used for distributing allocations and ensure that these are reasonable and realistic and secure the PHA's entitlement to funds;

4.1.2 The Director of Finance will:

(a) prior to the start of each financial year submit to the PHA for approval a Financial Plan showing the total allocations received and their proposed distribution including any sums to be held in reserve;

(b) regularly update the PHA on significant changes to the initial allocation and the uses of such funds.

4.2 Preparation and Approval of Joint Commissioning Plans and Budgets

4.2.1 The Chief Executive of the Health and Social Care Board (HSCB) will compile a Joint Commissioning Plan in conjunction with the PHA which takes into account financial targets and forecast limits of available resources. The Joint Commissioning Plan will be presented to the boards of both the HSCB and the PHA by their respective Chief Executives for approval by both organisations before it is submitted to the DHSSPS. The Joint Commissioning Plan will contain:

(a) a statement of the significant assumptions on which the plan is based including a proposed deployment of resources across care programmes for the following period;

(b) details of major changes in workload, delivery of services and resources required to achieve the plan.

4.2.2 Prior to the start of the financial year the Director of Finance (ref para 1.2.6) will, on behalf of the Chief Executive, prepare and submit budgets for approval by the board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Joint Commissioning Plan;

(b) be in accordance with the PHA aims and objectives set out in its Corporate Strategy and Business Plans;

(c) accord with workload and manpower plans;

(d) be produced following discussion with other relevant HSC Organisations;

(e) be prepared within the limits of available funds; and

(f) identify potential risks.

4.2.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the board.

4.2.4 All Budget Holders must ensure that the necessary Business Case preparation and approvals, for expenditure decisions, have been obtained at Departmental level **before** committing to recurrent revenue expenditure in new service commissioning or to support any other proposed investment e.g. ICT. Failure to obtain the required approvals will mean that the expenditure has been incurred without the required authority and is a serious matter. Budget Holders should refer to the latest guidance on proportionate effort in respect of completing business cases (HSC (F) 46/2013) and the NI Guide on Expenditure Appraisal and Evaluation.

4.2.5 All HSC Organisations/providers and PHA budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.2.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets effectively.

4.3 Budgetary Delegating within the PHA

4.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement only within total Revenue or total Capital (non virement between revenue and capital);

(e) achievement of planned levels of service;

(f) the provision of regular reports; and

(g) processes for securing management approval, authorisation and performance reporting.

4.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the board.

4.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement. Where DHSSPS resources allocated for a particular purpose are not required or not required in full, for that purpose, they must be returned to the Department for potential redistribution.

4.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance (ref para 1.2.6).

4.3.5 All Budget Holders are required to regularly review all projected expenditure and identify to the Director of Finance on a timely basis, where inescapable expenditure has the potential to breach their delegated budget.

4.4 Budgetary Control and Reporting within the PHA

4.4.1 The Director of Finance (ref para 1.2.6) will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the board in a form approved by the board containing:

- income and expenditure to date showing trends and forecast year-end position;
- capital project spend and projected outturn against plan based on information received from the Director of Operations;
- explanations of any material variances from plan;
- details of any corrective action where
- Chief Executive's and Director of Finance's views of whether such actions are sufficient to correct the situation.

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of in-year budget transfers.

4.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the board or its delegated representative;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive and the Director of Finance, or his/her delegated representative, other than those provided for within the available resources and manpower establishment as approved by the board;

(d) Early indications of slippage against budget and projections is reported to the Director of Finance and the Director of Operations;

(e) Re-utilisation of slippage amounts must be within the Agency Management Team and PHA board approved areas (the Agency Management Team and board will discuss and agree priorities periodically and advise budget holders). This may mean that all slippage generated is returned to the centre for a corporate decision on deployment or return to the DHSSPS; and

(f) Attending such training identified as necessary by the Director of Finance

4.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Joint Commissioning Plan and a balanced budget.

4.5 Capital Expenditure

4.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in SFI 14 together with the provisions of the Capital Accounting Manual(Ref HSC (F) 63/2012)

4.6 Monitoring Returns

4.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance (ref para 1.2.6) on behalf of the PHA, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the DHSSPS and the Treasury, the PHA's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to the DHSSPS certified in accordance with current guidelines; and

(c) submit financial returns to the DHSSPS for each financial year in accordance with the timetable prescribed by the DHSSPS.

5.2 The PHA's annual accounts and annual report must be audited by an auditor appointed by the NIAO. The PHA's audited annual accounts and annual report must be presented to a public meeting and made available to the public after laying before the NI Assembly. . This document must comply with the DHSSPS' manual for Accounts.

6. BANK ACCOUNTS

6.1 General

6.1.1 The Director of Finance (ref para 1.2.6) is responsible for setting clarity of roles and responsibilities within the BSO SLA in respect of managing the PHA's banking arrangements, and for advising the PHA on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the DHSSPS.

6.1.2 The board shall approve the banking arrangements.

6.2 Banking Procedures

6.2.1 The Director of Finance (ref para 1.2.6) will prepare detailed instructions to advise the Business Services Organisation on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the PHA's accounts; and

(c) the limit to be applied to any overdraft.

6.2.2 The Director of Finance must advise the PHA's bankers in writing of the conditions under which each account will be operated.

6.3 Bank Accounts

6.3.1 The Director of Finance of the Business Services Organisation (BSO) is responsible for:

(a) bank accounts;

(b) establishing separate bank accounts for the PHA's non-public funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the board all arrangements made with the PHA's bankers for accounts to be overdrawn; and

(e) monitoring compliance with DHSSPS guidance on the level of cleared funds.

6.4 Tendering and Review

6.4.1 The Director of Finance will review the commercial banking arrangements of the PHA at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the PHA's commercial banking business, in co-operation with other HSC organisations. The PHA should avail of the regional banking contract, unless in exceptional circumstances.

6.4.2 Competitive tenders for HSC banking business should be sought at least every 5 years or extended period as agreed by the PHA. The results of the tendering exercise should be reported to the board.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Director of Finance of the Business Services Organisation is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including HSC transactions.

7.1.2 The Director of Finance of the Business Services Organisation is also responsible for ensuring that the BSO complies with the prompt banking of all monies received.

7.1.3 Performance against 7.1.1 and 7.1.2 will be monitored by the Director of Finance (ref para 1.2.6) and set out within the SLA with the BSO.

7.2 Fees and Charges

7.2.1 The Director of Finance (ref para 1.2.6) is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSSPS or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the DHSSPS's Commercial Sponsorship - Ethical standards in the HSC shall be followed.

7.2.2 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for ensuring the Business Services Organisation completes the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be advised to the Director of Finance (ref para 1.2.6) and be dealt with in accordance with losses procedures and guidance issued by DHSSPS Circular (HSC (F)50/2012

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance of the Business Services Organisation is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means either electronic or manual means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the PHA.

7.4.2 Public Funds shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance (ref para 1.2.6).

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the PHA is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the PHA from responsibility for any loss.

7.4.5 Any shortfall in cash, cheques or other negotiable instruments must be reported to the Director of Finance or Fraud Liaison Officier as soon as it is discovered.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the PHA shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 5.2.19 Suspension of Standing Orders is applied).

8.2 Northern Ireland Public Procurement Policy, EU Directives Governing Public Procurement and DHSSPS Mini-Code Guidance.

Northern Ireland Public Procurement Policy, Directives by the Council of the European Union and Guidance on procurement matters promulgated by the DHSSPS prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

8.3 Reverse e-Auctions

The PHA should follow extant guidance on the conduct of all tendering activity carried out through Reverse e-Auctions. For further guidance on Reverse e-Auctions refer to the PHA's Centre of Procurement Expertise (BSO PaLS).

8.4 Capital Investment Manual and other DHSSPS Guidance

The PHA shall comply as far as is practicable with the requirements of the DHSSPS "Capital Investment Manual", CONCODE and liaise with Health Estates department in respect of capital investment and estate and property transactions. In the case of external management consultancy contracts the PHA shall comply with DHSSPS guidance on the Use of Professional Services as set out in HSC (F) 25/2012 and HSC (F) 47/2012.

8.5 **Formal Competitive Tendering**

8.5.1 General Applicability

The PHA shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSSPS); and

(c) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and for disposals.

8.5.2 Health Care Services

Where the PHA elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8 and No. 9. In all cases the PHA must comply with the requirements of the Public Contract Regulations 2006 in respect of the disbursement of funds and/or grant aid to the voluntary sector and discharge its duties to ensure that such monies, where used for procurement purposes, comply with the relevant requirements of the Public Contracts Regulations 2006.

8.5.3 **Exceptions and instances where formal tendering need not be applied (HSC (F) 05/2012)**

It is always advised to review procedures on CONNECT and seek clarification with BSO PALs prior to placing an order however;

Formal publicly advertised tendering procedures **need not be applied** (ref Standing Orders Administrative Scheme of Delegation 3.4.7) where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£30,000**; or

(b) where the supply is proposed under special arrangements negotiated by the DHSSPS in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No.16;

8.5.4 Direct Award Contracts (DAC) encompassing Single Tender Actions / Waiving of Competition above £5,000

Guidance has been issued from DHSSPS in the form of circular HSC(F) 05/2012 stating that any proposal which will not be subject to competition must be forwarded to the PHA's Centre of Procurement Expertise (COPE), which is BSO PALs for goods and services,, for advice and agreement before it may be approved by the Chief Executive. This requirement is regardless of whether the actual purchasing is being conducted by PALs.

8.5.5 The case setting out why the Single Tender Action (DAC) is required must be presented by management to BSO PALs. After review PALs will provide a Red, Amber, Green (RAG) rating, this will then be considered by the Chief Executive for approval. It should be noted that procurement may not proceed until the Chief Executive has formally approved.

8.5.6 In addition this process also covers procurement with sole suppliers and contract extensions which are outside the options originally specified in the original contract.

8.5.7 Officers should liaise with the Director of Operations prior to procurement to ensure latest DFP and DHSSPS procurement guidance is compiled with.

8.5.8 Clear documented evidence must be retained and this should be forwarded to the Director of Operations or central retention, as well as reported to the Governance & Audit Committee.

8.5.9 The Regulatory Framework surrounding public procurement allows, in certain circumstances, single tender actions. Please refer to Public Contracts Regulations 2006 and amending regulations 2009 and 2011 circular HSC (F) 05/2012. The exceptions quoted are within a very few, narrowly defined parameters.

8.5.10 Please refer to the PHA's Standing Order's Administrative Schemes of Delegation 3.4.7 for financial limits and tendering requirements.

8.5.11 <u>List of Approved Firms</u>

The PHA shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Director of Operations it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 8.6.8 List of Approved Firms).

8.5.12 <u>Building and Engineering Construction Works</u>

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without DHSSPS approval.

8.5.13 <u>Items which subsequently breach thresholds after original approval</u>

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive (or appropriate delegated board Officer) and be recorded in an appropriate PHA record.

8.6 Contracting/Tendering Procedure

8.6.1 Invitation to Tender

(a) All invitations to tender shall clearly state the closing date and time for the receipt of tenders. As per DHSSPS circular guidance (HSC(F)62/2013) involvement of incumbent suppliers in the preparation of procurement competition should be carefully controlled and avoided where possible;

(b) All invitations to tender shall state that no tender will be accepted unless:

- submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the PHA (or the word "tender" followed by the subject to which it related) and be received before the closing date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

- that tender envelopes/packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

  OR

  Where and e-tendering system is in use shall not be accessible by any means until after the appointed date and time of closing and only then by appropriately authorised personnel.

(c) Every tender for goods, materials, services or disposals shall embody such of the HSC Standard Contract Conditions as are applicable; and

(d) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil

Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with DHSSPS guidance and, in minor respects, to cover special features of individual projects.

8.6.2 Receipt and safe custody of tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

OR

Where an e-tendering system is in use the electronic files shall be held in a secure electronic environment until time of opening has passed at which point the system shall release the files for access by appropriately authorised personnel.

8.6.3 Opening tenders and Register of tenders

The PHA would expect the Planning and Logistics Service (PALs) of the BSO would undertake the following on its behalf.

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department;

(b) Where services are to be provided by a Centre of Procurement Expertise (CoPE) it will be the responsibility of the CoPE to ensure that appropriate personnel from the CoPE are present at tender opening;

(c) The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the PHA's Schemes of Delegation;

(d) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender;

(e) The involvement of HSCB Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance (ref para

1.2.6) or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders;

(f) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The PHA's Company Secretary will count as a Director for the purposes of opening tenders;

(g) Every tender received shall be marked with the date of opening and initialed by those present at the opening;

(h) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations dispatched:

- the name of all firms/ individuals invited;
- the names of firms/ individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood; and

(i) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 17.6.5).

8.6.4 Admissibility

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive;

(b) Where only one tender is sought and/or received, the Chief Executive, Director of Finance (ref para 1.2.6) and the Director of Operations, shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the PHA.

8.6.5 Late Tenders

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer. Where services are to be provided by a Centre of Procurement Expertise (CoPE), a duly authorised CoPE officer will act as nominated officer;

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started. Where services are to be provided by a Centre of Procurement Expertise (CoPE), a duly authorised CoPE officer will act as nominated officer;

(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer. Where services are to be provided by a Centre of Procurement Expertise (CoPE), a duly authorised CoPE officer will act as nominated officer.

8.6.6 Acceptance of formal tenders (See overlap with SFI No. 8.7)

Prior to commencement of a tender process a group shall be constituted to evaluate and agree the award of contract. Nominees to the group shall be provided by the Chief Executive or his/her nominated officer and shall have the delegated authority to act on behalf of the PHA in respect of the award of contract.

(a) Prior to participation in an evaluation process those Officers participating in the evaluation will be required to complete a Declaration of Objectivity and Interests;

(b) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. Such discussions must be carried out by or with the knowledge and approval of the Procurement Officer responsible for management of the tender process;

(c) The lowest tender, if payment is to be made by the PHA, or the highest, if payment is to be received by the PHA, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- experience and qualifications of team members;
- understanding of client's needs;
- feasibility and credibility of proposed approach; and
    - ability to complete the project on time.
    - social considerations as per circular guidance HSC(F)60/2013

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(d) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the PHA and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or Director of Finance (ref para 1.2.6).

(e) The use of these procedures must demonstrate that the award of the contract was:

- not in excess of the going market rate / price current at the time the contract was awarded;
- that best value for money was achieved.

(f) All Tenders should be treated as confidential and should be retained for inspection.

8.6.7 Tender reports to the board of the PHA

Reports to the board will be made on an exceptional circumstance basis only.

8.6.8 List of approved firms (see SFI No. 8.5.5)

(a) Responsibility for maintaining list

BSO Procurement and Logistics service has been nominated by the Chief Executive to maintain lists of approved firms from who tenders

and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the PHA is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) Building and Engineering Construction Works

- Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

- Firms included on the approved list of tenderers shall comply with the N.I. Public Sector standard Equality Clause and ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

- Firms shall conform at least with the requirements of the Health and Safety at Work Act (N.I. Order) and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) Financial Standing and Technical Competence of Contractors

The Director of Finance (ref para 1.2.6), Director of Operations or the PHA's Centre of Procurement Expertise may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The lead care Director with responsibility for clinical and social care governance will make such enquiries as is felt appropriate to be satisfied as to their technical/professional/medical competence.

8.6.9 <u>Exceptions to using approved contractors</u>

If in the opinion of the Chief Executive and the Director of Operations, or the Director with lead responsibility for clinical governance or the PHA's Centre of Procurement Expertise, it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the

Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

8.7 **Quotations: Competitive and non-competitive**

8.7.1 **General Position on Quotations (Set out in detail in administrative schedule to the Standing Orders**Quotation's are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed the current levels contained within the DHSSPS Mini-code Guidance.

8.7.2 Competitive Quotations

(a) Quotations should be obtained in accordance with the DHSS&PS Mini-code based on specifications or terms of reference prepared by, or on behalf of, the PHA;

(b) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone (only for order value up to and including **£52,000**). Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record;

(c) All quotations should be treated as confidential and should be retained for inspection; and

(d) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the PHA, or the highest if payment is to be received by the PHA, then the choice made and the reasons why should be recorded in a permanent record and held as evidence by the approving officer.

Where quotations are obtained without formal competition being sought approval must be given by the Chief Executive or his/her appointed Officer.

8.7.3 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the PHA and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Operations, supported by the Director of Finance (ref para 1.2.6).

8.8 **Authorisation of Tenders and Competitive Quotations**

8.8.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the officers nominated in the Chief Executive's Scheme of Delegation at Appendix 1.

8.8.2 These levels of authorisation may be varied or changed and need to be read in conjunction with the board's Scheme of Delegation.

8.8.3 Formal authorisation must be put in writing. In the case of authorisation by the board this shall be recorded in their minutes.

8.8.4 Where the contract to be awarded is a multi-organisation or Regional Contract then the Chief Executive shall nominate in advance a PHA employee(s) to participate in the tender evaluation and adjudicate the contract on behalf of the Trust. In doing so the Chief Executive shall delegate authority to that officer(s) to award the contract on behalf of the PHA.

8.9 **Instances where formal competitive tendering or competitive quotation is not required**

Where competitive tendering or a competitive quotation is not required the PHA should adopt one of the following alternatives:

(a) the PHA shall use the BSO PALs / Centre of Procurement Expertise (COPE) for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented;

(b) If the PHA does not use the PALs / COPE - where tenders or quotations are not required because expenditure is below **£52,000,** the PHA shall procure goods and services in accordance with procurement procedures approved by the Director of Operations.

8.10 **Private Finance for capital procurement (see overlap with SFI No. 14.2)**

The PHA should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector (HSC (F)14/2013 49/2014;

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate DHSSPS for approval or treated as per current guidelines;

(c) The proposal must be specifically agreed by the board of the PHA; and

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.11 **Compliance requirements for all contracts**

The board may only enter into contracts on behalf of the PHA within the statutory powers delegated to it by the Minister for HSSPS and shall comply with:

(a) The PHA's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions including N.I. Procurement Policy and DHSS&PS Guidance;

(c) any relevant directions including the Capital Accounting Manual and guidance on the Procurement and Management of Consultants;

(d) such of the HSC Standard Contract Conditions as are applicable;

(e) contracts with HSC Trusts must be in a form compliant with appropriate DHSSPS guidance;

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and

(g) In all contracts made by the Trust, the board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the PHA.

8.12 **Agency Personnel (also refer to 11.3 on staff appointments)**

The Chief Executive shall nominate officers with relevant delegated budgetary authority to enter into contracts of employment with agency staff for temporary cover.

These engagements should follow the process set out by the Director of Human Resources (BSO) and unless a Single Tender Action is approved in advance by the Chief Executive, be within the terms of the current contract,(please also refer to SFI 11.3 regarding appointments prior to engaging staff).

8.13 **Healthcare Services Agreements**

Service agreements with HSC providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community

Care Act 1990 and administered by the PHA. Service agreements are not contracts in law and are not enforceable by the courts. However, a contract with an NHS Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with the joint commissioning plan approved by the board.

8.14 **Disposals**

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the PHA;

(c) items to be disposed of with an estimated sale value of less than £20,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

(e) land or buildings concerning which DHSSPS guidance has been issued but subject to compliance with such guidance.

8.15 **In-house Services**

8.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The PHA may also determine from time to time that in-house services should be market tested by competitive tendering.

8.15.2 In all cases where the board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

8.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.15.4 The evaluation team shall make recommendations to the board.

8.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the PHA.

9. HSC SERVICE AGREEMENTS FOR PROVISION OF SERVICES (See overlap with SFI No. 8.13 and 12.3)

9.1 Service Level Agreements (SLAs) for internal HSC agreements or Contracts with 3rd Party organisations

9.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the PHA enters into suitable agreements or contracts (Service Level Agreements SLA's) with service providers for the provision of Health and social care services.

All agreements or contracts should aim to implement the agreed priorities contained within the Joint Commissioning Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience, improving the Health and Wellbeing of the population and reducing inequalities . In discharging this responsibility, the Chief Executive should take into account:

(a) promotion of Health and Wellbeing improvements;

(b) promotion of the reduction of inequalities;

(c) the standards of service quality expected;

(d) the relevant service framework (if any);

(e) the provision of reliable information on cost and volume of services;

(f) the Performance Assessment Framework;

(g) that agreements and contracts build where appropriate on existing Joint Investment Plans; and

(h) that agreements and contracts are based on integrated care pathways.

9.2 Involving Partners and Jointly Managed Risk

A good SLA will result from a dialogue of clinicians, social workers, users, carers, public health professionals, AHPs and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the PHA works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA or Contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial

arrangements should reflect this. In this way the PHA can jointly manage risk with all interested parties. Due consideration, in all provider/purchaser arrangements, must be observed as the HSC moves toward a 'Patient/Client-led HSC'.

9.3 A 'Patient/Client-led HSC and 'Local Commissioning"

(Commissioning a Patient/Client-led HSC and Local Commissioning are being rolled out by the DHSSPS and full support and latest guidance may be accessed at http://www.dhssps.gov.uk).

9.4 Reports to board on SLAs and Contracts

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the board detailing actual and forecast expenditure against SLA 's and Contracts with the independent sector.

10. JOINT COMMISSIONING

10.1 Role of the PHA in Commissioning Health and Care Services

10.1.1 The PHA will work with the HSCB to jointly commission Health and Care services on behalf of the resident population. This will require the PHA to work in partnership with the HSCB, local HSC Trusts, users, carers and the voluntary sector to develop an annual Joint Commissioning Plan.

10.2 Role of the Chief Executive

10.2.1 The Chief Executive as the Accounting Officer has responsibility for ensuring Health and Care services are commissioned in accordance with the priorities agreed in the Joint Commissioning Plan. This will involve ensuring SLA s and contracts are put in place with the relevant providers, based upon integrated care pathways.

10.2.2 SLA s and Contracts will be the key means of delivering the objectives of the Priorities for Action and therefore they need to have a wider scope. The PHA Chief Executive will need to ensure that all SLA s and Contracts;

(a) Promote Health and Wellbeing improvements;

(b) Actively promote the reduction of inequalities;

(c) Where appropriate build on existing Joint Investment Plans;

(d) Meet the standards of service quality expected;

(e) Fit the relevant service framework (if any);

(f) Enable the provision of reliable information on cost and volume of services;

(g) Fit the Performance Assessment Framework;

(h) Are based upon cost-effective services; and

(i) Are based on integrated care pathways.

10.2.3 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the board detailing actual and forecast expenditure and activity for each SLA and Contract.

10.2.4 Where the PHA makes arrangements for the provision of services by non-NHS providers it is the Chief Executive, as the Accounting Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided.

10.2.5 The role and function of the PHA means that it will have a high proportion of contracts and grant arrangements with a large number of non HSC organisations. All such contracts and grant arrangements must comply with the PHA process and standard documentation for commissioning with non HSC organisations.

10.3 Role of Director of Finance (ref para 1.2.6)

10.3.1 A system of financial monitoring must be maintained by the Director of Finance to ensure the effective accounting of expenditure under the SLA s and Contracts. This should provide a suitable audit trail for all payments made under the agreements, but maintains patient confidentiality.

11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE PHA BOARD AND EMPLOYEES OF THE PHA

11.1 Remuneration and Terms of Service (see overlap with SO No. 5)

11.1.1 In accordance with Standing Orders the board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

11.1.2 The Committee will **(in areas not already specified by the Department**):

(a) advise the board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the PHA and other senior employees including:

- all aspects of salary (including any performance-related elements/bonuses);
- provisions for other benefits, including pensions and cars; and
- arrangements for termination of employment and other contractual terms.

(b) make such recommendations to the board on the remuneration and terms of service of officer members of the board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the PHA - having proper regard to the PHA's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members of and other senior employees; and

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

11.1.3 The Committee shall report in writing to the board the basis for its recommendations. The board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members in matters not already directed by the Department. Minutes of the board's meetings should record such decisions;

11.1.4 The board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by either Departmental direction or by the Committee; and

11.1.5 The PHA will pay allowances to the Chairman and non-executive members of the board in accordance with instructions issued by the Minister and in line with DHSSPS Circular guidance HSC(F)10/24..

11.2 **Funded Establishment**

11.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

11.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

11.2.3 The Finance Director will ensure that appropriate controls are in place to ensure the funded establishment is not exceeded without prior authority of the Chief Executive.

11.3 **Staff Appointments (also ref 8.12 Agency Staffing)**

11.3.1 No officer, Member of the board or PHA employee may engage new staff (either to vacancies or new posts), re-grade employees, or agree to changes in any aspect of remuneration, or hire agency staff (ref 8.12) either on a permanent or temporary basis:

(a) unless expressly authorised to do so by the Chief Executive or his/her nominated officer; and

(b) within the limit of their approved budget and funded establishment numbers as confirmed by the Director of Finance (ref para 1.2.6), who will review with reference to the overall Management and Administration budget set by the DHSSPS and staff establishment.

(c) The Director of Finance shall raise any issues regarding non-approval based on the terms set in 11.3.1 (b) with the Chief Executive.

(d) The introduction of electronic recruitment and approval processes shall not remove the requirements of 11.3.1 a – c.

11.3.2 The board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

11.3.3 In accordance with DHSSPS & HMRC guidance, staff will ensure that all individuals appointed to deliver services for PHA, regardless of type or duration of their appointment, are engaged using correct procedures. This covers staff directly recruited, employment agency appointments & other self-employed appointees, in accordance with DHSSPS circular reference HSC(F) 21/2014.

11.4 Processing Payroll

11.4.1 The Director of Finance of the Business Services Organisation is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications either manually or electronically;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

11.4.2 The Director of Finance (Ref para 1.2.6) will agree and ensure the issue of instructions by the BSO regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees & non-executive appointees (HSC(F)56/2013) and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash; and

(m) a system to ensure the recovery from those leaving the employment of the PHA of sums of money and property due by them to the PHA.

11.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting manual or electronic time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the instructions and in the form prescribed by the Director of Finance of the BSO; and

(c) submitting manual or electronic termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Operations must be informed immediately.

11.4.4 Regardless of the arrangements for providing the payroll service, the Director of Operations, supported by the Director of Finance (ref para 1.2.6)

of the HSCB, shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.4.5 Payroll processing performance will be monitored by the Director of Finance (ref para 1.2.6) and set out within the SLA with the BSO.

11.5 **Contracts of Employment**

The DHSSPS has directed that the processing of PHA payroll be outsourced to the Business Services Organisation.

11.5.1 The board shall delegate responsibility to a nominated BSO officer (HR Director) for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

The Director of Operations will ensure that there is an appropriate Service Level Agreement with the BSO and monitoring arrangements in place to ensure proper control systems are in place and operating effectively. This will provide the performance monitoring framework to be operated by the Director of Operations.

12. NON-PAY EXPENDITURE (Procurement and Programme)

12.1 **Delegation of Authority**

12.1.1 The board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

12.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place electronic requisitions for the supply of goods and services;

(b) the maximum level of each electronic requisition and the system for authorisation above that level.

12.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

12.2 **Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 8)**

12.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the PHA. In so doing, the advice of the PHA's Centre of Procurement Expertise (BSO PALs) shall be sought. Requisitions should be placed using the E-Procurement system

12.2.2 System of Payment and Payment Verification

The Director of Finance of the BSO shall be responsible for the prompt payment of accounts and claims once appropriately authorised by PHA officers. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with Public Sector Prompt Payment Policy.

12.2.3 The Director of Operations supported by the Director of Finance will through a Service Level Agreement and monitoring arrangements with the BSO:

(a) advise the board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

- An electronic approval framework for the electronic authorising of invoices and requisitions/orders.

A list of board members/employees (including specimens of their signatures) authorised to approve expenditure.

- Certification either manually or electronically that:

o goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work completed or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct; and

- the account is in order for payment.

- A timetable and system for submission to the BSO Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; and

- Instructions to employees regarding the handling and payment of accounts within the BSO Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 12.2.4 below.

12.2.4 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%) and the intention is not to circumvent cash limits;

(b) The appropriate officer member must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the PHA if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Operations will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into

account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered. This may impact on the ability of the Agency to deliver breakeven if the goods/services which are expected are not delivered by 31 March each financial year.

12.2.5 Official Orders

Official Orders either manual or electronic must:

(a) be consecutively numbered;

(b) be in a form approved by the PHA Director of Operations or the BSO Director of Operations on his behalf;

(c) state the PHA's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

12.2.6 Duties of Managers and Officers

Managers and officers acting for the PHA must ensure that they comply fully with the guidance and limits specified by the Director of Operations and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Operations in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with DHSSPS "guidance on the Use of Professional Services relating to the Engagement of External Consultants" (HSC(F) 25/2012 and HSC(F) 47/2012 and the sharing of lessons learned from post project evaluation following the use of consultancy HSC(F) 29/2014.~~;~~.

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

- isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; or

- conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with the Standing Order No 6 and the principles outlined in the PHA's policy on "Standards of Business Conduct for Staff and the Gifts and Hospitality Policy".

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Operations on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order via a requisition on the E-procurement system;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders must not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the PHA to a future uncompetitive purchase;

(j) changes to the list of members/employees and officers authorised to certify invoices are notified to the BSO;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Operations; and

(l) petty cash records are maintained in a form as determined by the Director of Finance of the BSO.

12.2.7 The Chief Executive and Director of Finance (ref para 1.2.6) shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and the Land transactions Handbook. The technical audit of these contracts shall be the responsibility of the relevant Director.

12.3 **Joint Finance Arrangements with HSC Organisations and Voluntary Bodies (see overlap with Standing Financial Instruction NO 9.1)**

12.3.1 Payments to HSC organisations and voluntary organisations **shall** comply with procedures laid down by the Director of Operations which shall be in accordance with DHSSPS guided best practice. See overlap with Standing Financial Instruction No 9.1)

12.4 **Grants and Service Level agreements with non-HSC organisations for Programme Expenditure**

12.4.1 Programme expenditure with non-HSC organisations for the provision of services to patients or clients shall, regardless of the source of funding, incorporate the principles set out in The Departmental Grants Manual, March 2005, issued by the DHSSPS.
(Please refer to www.DHSSPSNI.gov.uk)

12.4.2 The Manual aims to provide a guide to best practice in the management and administration of grant making. It is a procedures manual, setting out the basic accountability requirements for grant making and giving guidance on how these may be met in practice.

12.4.3 There are five main principles that apply to the management and administration of grant making. These are:

(a) **Regularity** - funds should be used for the authorised purpose;
(b) **Propriety** - funds should be distributed fairly, and free from undue influence;
(c) **Value for Money** - funds should be used in a manner that minimises costs, maximises outputs and always achieves intended outcomes
(d) **Proportionate Effort** - resources consumed in managing the risks to achieve and demonstrate regularity, propriety and value for money should be proportionate to the likelihood and impact of the risks materialising and losses occurring.
(e) **Clarity of responsibility and accountability** - within partnership working arrangements there should be clear documented lines of responsibility and accountability of each partner involved. Those who delegate responsibility should ensure that there are suitable means of monitoring performance.

12.4.4 All such expenditure/agreements must be consistent with the Joint Commissioning Plan approved by the PHA at the outset of the year; approval of grants should be in line with the PHA's Scheme of Delegation.

12.4.5 The first payment should only be made on receipt of confirmation from the Organisation that the project is to commence within 6 weeks.

12.4.6 Subsequent payments must only be released upon receipt of satisfactory performance monitoring information.

12.4.7 All payments must be advised to BSO Finance department on a Programme Expenditure Authorisation (PEA) form authorised in accordance with the Scheme of Delegated Authority.

12.4.8 If performance monitoring is not satisfactory the PHA's 'Escalation Policy' should be referred to for action to be taken.

12.4.9 Any end of year non-delivery of services and resultant underspends must be promptly notified to the Finance department.

12.5 HSC Organisations

12.5.1 HSC organisations will normally be advised of approved increases to their budget via increases in Revenue Resource Limits. PHA staff will complete and authorise, in line with the Scheme of Delegated Authority, a Programme Expenditure Authorisation (PEA) form and forward to HSCB Finance Department for processing.

13. HSC FINANCIAL GUIDANCE

13.1.1 The Director of Operations should ensure that members of the board are aware of the extant finance guidance issued by DHSS&PS, (i.e. directions which the PHA must follow regarding resource and capital allocation and funding to HSC organisations.) and that this direction and guidance is followed by the PHA.

14. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

14.1 Capital Investment

14.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all revenue consequences, including capital charges; and

(d) is required to seek Department approval for:

- All capital projects with expenditure of £50k and above (in accordance with the Capital Investment Manual and DHSSPS Circular HSS(F)13/06 and DAO(DFP) 06/05); and

- All ICT projects with expenditure of £250k and above.

14.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case commensurate to the level of investment and in line with the guidance contained within the *Capital Investment Manual* is produced setting out:

- an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
- the involvement of appropriate PHA personnel and external agencies;
- appropriate project management and control arrangements;

(b) that the Director of Finance or nominated Deputy has certified professionally to the costs and revenue consequences detailed in the business case;

(c) that all approvals for capital expenditure are in line with the PHA's Scheme of delegated authority;

(d) that Departmental approval is obtained for projects costing more than the PHA's delegated limit for capital schemes currently £50k; and

(e) schemes requiring Departmental approval are re-submitted to the Department for re-consideration if any of the conditions specified in the Capital Investment Manual apply.

14.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Land Transactions Handbook.

14.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

14.1.5 The Director of Operations agrees procedures with the Director of Finance for the regular reporting of expenditure and commitment against authorised expenditure, these procedures shall be issued within the PHA as appropriate.

14.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 8.5); and

(c) approval to accept a successful tender (see overlap with SFI No. 8.6).

The Chief Executive will issue a Scheme of delegation for capital investment management in accordance with the Land Transactions Handbook and the PHA's Standing Orders.

14.1.7 The Director of Operations, in conjunction with the Director of Finance (ref para 1.2.6) of the HSCB, shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuations for accounting purposes. These procedures shall fully take into account the current delegated limits for capital schemes (please refer to the PHA Standing Orders Administrative of Delegation 3.4.6).

14.2 **Private Finance (see overlap with SFI No. 8.10)**

14.2.1 The PHA should normally test for PFI when considering capital procurement. When the PHA proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Operations, supported by the Director of Finance (ref para 1.2.6) shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the DHSSPS or in line with any current guidelines; and

(c) The proposal must be specifically agreed by the board.

14.3 **HSC Organisations - Capital Proposals**

14.3.1 The PHA is required to confirm that it supports relevant capital investment proposals from other HSC organisations at Strategic Context stage, above certain delegated limits. It must also state that it is prepared to remit its share of any revenue resource consequences resulting from the scheme.

14.3.2 Circular HSS(PDD)4/95 directs that the Capital Accounting Manual (CAM) for Northern Ireland published(HSC (F) 63/2012) is to be implemented.

14.3.3 HSC organisations are required to obtain Departmental approval when costs are expected to exceed the following delegated limits or in accordance with Circular HSC(F) 43-2014 where the delegated limit for office accommodation leases has been removed:

(a) All capital projects with expenditure of £500k and above (in accordance with the Capital Accounting Manual (HSC (F) 63/2012 and DHSSPS Circular HSS(F)13/06 and DAO(DFP) 06/05);

(b) All IM and IT projects with expenditure of £250k and above.

14.3.4 The circular states that *"… the commitment of Commissioners must be secured from Strategic Context stage, before much of the detailed planning work is undertaken, and re-affirmed throughout the process".*

14.3.5 The Capital Accounting Manual requires confirmation of Commissioner support at each phase of the Business Case:

(a) the Strategic Context (SC);

(b) Outline Business Case (OBC); and

(c) Full Business Case (FBC).

Approval shall be in line with the PHA's Standing Orders Scheme of Delegation 3.4.6

14.3.6 Consideration of HSC organisations capital proposals is to be undertaken by a Capital Investment Core Group consisting of officers from PHA and Finance enlarged as necessary to give consideration from both the care/treatment and business/finance perspectives.

14.3.7 Further guidance is provided in SOC Paper 166/95 dated 22 August 1995. The requirement for all potential schemes to be tested for viability of private financing shall be particularly noted. The provisions of the Capital Investment Manual are to be followed in all cases above the delegated limits for HSC organisations.

14.4 Asset Registers

14.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance (ref para 1.2.6) concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

14.4.2 The Director of Finance of the BSO, on behalf of the PHA, shall maintain an asset register recording fixed assets on behalf of the PHA. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the DHSSPS.

14.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

14.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Attention is drawn to the recent guidance on limiting the holdings of land & buildings to the minimum required for the performance of present and clearly foreseen responsibilities HSC(F) 40/2013.

14.4.5 The Director of Finance (ref para 1.2.6) shall reconcile balances on fixed assets accounts in ledgers against balances on fixed asset registers and will monitor the BSO delivery of the Fixed Asset register and associated services.

14.4.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual (HSC (F) 63/2012) issued by the DHSSPS.

14.4.7 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual issued by the DHSSPS.

14.5 Security of Assets

14.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

14.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance (ref para 1.2.6). This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Operations.

14.5.4 Whilst each employee and officer has a responsibility for the security of property of the PHA, it is the responsibility of board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to HPSS property as may be determined by the board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.5.5 Any damage to the PHA's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by board members and employees in accordance with the procedure for reporting losses.

14.5.6 Where practical, assets should be marked as PHA property.

15. STORES AND RECEIPT OF GOODS

15.1 General Position

15.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take; and

(c) valued at the lower of cost and net realizable value.

15.2 Control of Stores, Stocktaking, Condemnations and Disposal

15.2.1 Subject to the responsibility of the Director of Operations for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance (ref para 1.2.6).

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the

designated manager/officer. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Director of Operations shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Director of Operations in conjunction with the Director of Finance (ref para 1.2.6) of the HSCB and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Operations.

15.2.6 The designated Manager/officer shall be responsible for a system approved by the Director of Operations for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Operations any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 16 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by Centres of Procurement Expertise (COPE) / HPSS Service Providers

15.3.1 For goods supplied via COPE (BSO PALs) central warehouses, the Chief Executive shall identify those authorised electronically to requisition and accept goods from the store.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 Disposals and Condemnations

16.1.1 Procedures

The Director of Operations supported by the Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a PHA asset, the Head of Department or authorised deputy will determine and advise the Director of Finance via the Director of Operations of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Operations;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Operations.

16.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Operations who will advise the Director of Finance (ref para 1.2.6) and take the appropriate action.

16.1.5 Heads of Department will be responsible for ensuring that all data held on assets for disposal are dealt with appropriately and securely.

16.2 Losses and Special Payments

16.2.1 Procedures

The Director of Finance (ref para 1.2.6) must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments, in line with the requirements of Circular HSC(F) 50/2012.

16.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Chief Executive and the Director of Operations, who will in turn inform the Director of Finance (ref para 1.2.6).

Where a criminal offence is suspected, the Director of Operations must immediately inform the police if theft or arson is involved. In cases of suspected fraud and corruption the officer should consult the PHA's Fraud Response Plan for further advice.

The Director of Operations, via the Fraud Liaison Service provided by the Director of Finance (HSCB), must notify the Counter Fraud and probity Service (CFPS, BSO), DHSS&PS Counter Fraud Policy Unit and the External Auditor of all frauds or thefts.

16.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Operations must immediately notify:

(a) the board;

(b) the Director of Finance; and

(c) the External Auditor.

16.2.4 Within limits delegated to it by the DHSSPS, the board shall approve the writing-off of losses (Ref HSC (F) 50/2012).

16.2.5 The Director of Operations with the support of the Director of Finance (ref para 1.2.6) shall be authorised to take any necessary steps to safeguard the PHA's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Director of Operations should consider whether any insurance claim can be made.

16.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the DHSSPS.

16.2.9 All losses and special payments must be reported to the Governance & Audit Committee at least once per annum.

17. INFORMATION TECHNOLOGY

17.1 Responsibilities and duties of the Director of Operations

The Director of Operations is responsible for the security of the computerised data of the PHA and shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the PHA's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.2 The Director of Finance (ref para 1.2.6) is responsible for the accuracy of financial data and shall ensure that new financial systems and amendments to current financial systems have been developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by

another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.1.3 The Director of Operations shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our PHA that we make publicly available.

17.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

17.2.1 In the case of computer systems which are proposed General Applications all responsible directors and employees will send to the Director of Operations:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the HSC, or from another public sector organisation, the operational requirement; and

(c) a supporting business case.

17.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation (e.g. HSCB or BSO) or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation (e.g. BSO) or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

17.4 Risk Assessment

The Director responsible for ICT shall ensure that risks to the PHA arising from the use of IT are effectively identified and considered and appropriate

action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 **Requirements for Computer Systems which have an impact on corporate financial systems**

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists; and

(c) such computer audit reviews as are considered necessary are being carried out.

18. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 12.2.6 (d))

The Director of Operations shall ensure that all staff are made aware of the PHA policy on acceptance of gifts and other benefits in kind by staff available on CONNECT. This policy follows the guidance contained in DHSSPS circular guidance on gifts and hospitality, HSS(F) 49/2009 ~~the Human Resource Code of Conduct which details the Standards of Business Conduct for HSCNI staff in the circular HSS (Gen1)1/95HSS (Gen1)1/95~~ and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

19. PAYMENTS TO INDEPENDENT CONTRACTORS

19.1 **Role of the PHA**

The PHA will approve additions to, and deletions from, approved lists of contractors, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received shall be dealt with equitably, within any time limits laid down in the contractor's HPSS terms and conditions of service.

19.2 **Duties of the Chief Executive**

The Chief Executive shall:

(a) ensure that lists of all contractors, for which the PHA is responsible, are maintained in an up to date condition;

(b) ensure that systems are in place to deal with applications, resignations, inspection of premises, etc, within the appropriate contractor's terms and conditions of service.

19.3 **Duties of the Director of Operations**

The Director of Operations shall:

(a) ensure that contractors who are included on a PHA approved list receive payments;

(b) maintain a system of payments such that all valid contractors' claims are paid promptly and correctly, and are supported by the appropriate documentation and signatures in accordance with the late payment of commercial debt regulations (HSC(F)52/2013) ;

(c) ensure that regular independent verification of claims is undertaken, to confirm that:

- rules have been correctly and consistently applied;
- overpayments are detected (or preferably prevented) and recovery initiated in accordance with HSC(F)50/2012 circular, Guidance on Losses and Special Payments, Appendix B “Recovery of Overpayments;
- suspicions of possible fraud are identified and subsequently dealt with in line with DHSSPS Directions on the management of fraud and corruption.

(d) ensure that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and

(e) ensure that a prompt response is made to any query raised by the Business Services Organisation, Counter Fraud and Probity Service regarding claims from contractors submitted directly to them.

20. RETENTION OF RECORDS

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with DHSSPS guidelines, Good Management, Good Records.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with DHSSPS guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

21. RISK MANAGEMENT AND INSURANCE

21.1 Programme of Risk Management

The Chief Executive shall ensure that the PHA has a programme of risk management, in accordance with current DHSSPS assurance framework requirements, which must be approved and monitored by the board.

The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering, among all levels of staff, a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical and social care audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current DHSSPS guidance.

21.2 Insurance arrangements with commercial insurers

21.2.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when HSC organisations may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) HSC organisations may enter commercial arrangements for **insuring motor vehicles** owned by the PHA including insuring third party liability arising from their use;

(b) where the PHA is involved with a consortium in a **Private Finance Initiative** contract and the other consortium members require that commercial insurance arrangements are entered into; and

(c) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the PHA for an HPSS purpose the activity may be covered in the risk pool. In any case of doubt concerning a PHA's powers to enter into commercial insurance arrangements the Finance Director should consult the DHSSPS.

Public Health Agency

STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

February 2015

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STANDING ORDERS

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APPENDICES

Foreword

The proper running of the Regional Agency for Public Health and Social Well-being (elsewhere referred to as the Public Health Agency, PHA or the Agency) requires Standing Orders (SOs) and Schedules to address in particular:

- Powers reserved to the Agency Board; and
- Powers delegated by the Agency Board

The Standing Orders' reserved and delegated powers and Standing Financial Instructions provide a comprehensive business framework for the Agency.

These documents fulfil the dual role of protecting the Agency's interests (ensuring, for example, that all transactions maximise the benefit to the Agency) and those of staff carrying out their work on behalf of the Agency.

All Executive Directors, Non-Executive Directors and all members of staff shall be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions required to comply fully with the regulations.

The Agency is committed to conducting its business and its meetings as publicly and openly as possible. It is intended that people shall be able to know about the services provided by the Agency and, particularly, be able to contribute to discussion about the Agency's priorities and actions.

The Agency is required to comply with all existing legislation, Department of Health, Social Services and Public Safety (DHSSPS) Framework Document, Management Statement/Financial Memorandum, Circulars and Regulations in so far as they impact upon the Agency's functions, activities and conduct.

The PHA's original Standing Orders and Standing Financial Instructions were approved by the Agency board at its meeting on 1 April 2009 and were subsequently forwarded to the Department of Health, Social Services and Public Safety (DHSSPS).

These current Standing Orders and Standing Financial Instructions were approved by the Agency board on 19 February 2015.

_____	_____
Chairperson	**Chief Executive**

Dated:

1. Introduction - Contents

1. Introduction

1.1 Statutory Framework

The Agency is a statutory body, which came into existence on 1 April 2009.

The Headquarters Office of the Agency is at 12-22 Linenhall Street, Belfast, BT2 8BS.

The Agency is governed by Statutory Instruments: HPSS (NI) Order 1972 (SI 1972/1265 NI14), the HPSS (NI) Order 1991 (SI 1991/194 NI1), the Audit and Accountability (NI) Order 2003 and the Health and Social Care (Reform) Act (Northern Ireland) 2009. Their provisions are incorporated in these Standing Orders.

As a statutory body, the Agency has specific powers to act as a regulator, to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Minister responsible for Health, Social Services and Public Safety.

1.2 Functions of the Agency

The PHA, incorporates and builds on the work previously carried out by the Health Promotion Agency, the former Health and Social Servcies Boards and the Research and Development office of the former Centrals Services Agency. Its primary functions can be summarised under three headings:

- **Improvement in health and social well-being** – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland;
- **Health protection** – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies;

- **Service development** – working with the HSCB with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with the HSCB, the PHA has an important role to play in providing professional leadership to the HSC.

In exercise of these functions, the PHA also has a general responsibility for promoting improved partnership between the HSC sector and local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social well-being and for anticipating the new opportunities offered by community planning.

The PHA acts as a corporate host for the Safeguarding Board for Northern Ireland (SBNI), supporting the SBNI by securing HR, financial and other corporate support functions. The SBNI and its objectives and functions of safeguarding and promoting the welfare of children in NI are entirely separate from that of the PHA. The PHA is accountable to the Department for the discharge of its corporate host obligations to SBNI but is not accountable for how the SBNI discharges its own statutory objectives and functions. A Memorandum of Understanding is in place which sets out in detail the respective obligations of the PHA and the SBNI.

1.3 Health and Social Care Frameworks (Ministerial Codes and Guidance)

In addition to the statutory requirements, the Minister, through the Department of Health, Social Services and Public Safety (DHSSPS), issues instructions and guidance. Where appropriate these are incorporated within the Agency's Standing Orders or other corporate governance documentation. Principal examples are as follows:

The DHSSPS produced the **Framework Document** (September 2011) meeting the requirement of The Health and Social Care (Reform) Act (NI) 2009, Section 5(1). The Framework Document sets out, in relation to each health and social care 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 arrangement for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC bodies.

The **Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies** (April 2011), was issued by the DHSSPS under cover of letter dated 18 July 2012. The Code of Accountability requires the board of the Agency to:

- Specify its requirements in terms of the accurate and timely financial and other information required to allow the board to discharge its responsibilities;
- Be clear what decisions and information are appropriate to the board and draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions to secure compliance with the board's wishes;
- Establish performance and quality targets that maintain the effective use of resources and provide value for money;
- Ensure the proper management arrangements are in place for the delegation of programmes of work and for performance against programmes to be monitored and senior executives held to account;
- Establish audit and remuneration committees on the basis of formally agreed terms of reference which set out the membership of the committee, the limit of their powers, and the arrangements for reporting back to the main board; and
- Act within statutory, financial and other constraints.

The **Code of Conduct** draws attention to the requirement for public service values to be at the heart of Health and Social Care (HSC) in Northern Ireland. High standards of corporate and personal conduct are essential. Moreover, as the HSC is publically funded, it is accountable to the Northern Ireland Assembly for the services provided and for the effective and economical use of taxpayers'

money. It also sets out measures to deal with possible conflicts of interest of board members.

The **Code of Practice on Openness** in the HPSS sets out the requirements for public access to information on the HPSS and for the conduct of board meetings. The Agency is required to ensure appropriate compliance with the Freedom of Information Act (2000).

1.4 Financial and Performance Framework

The **Management Statement** establishes the framework agreed with the DHSSPS within which the Public Health Agency operates. The associated **Financial Memorandum** sets out in detail certain aspects of the financial provisions which the PHA observes.

The Management Statement/Financial Memorandum (MS/FM) will be reviewed by the DHSSPS at least every 5 years.

A copy of the MS/FM will be given to all newly appointed PHA board members and senior executive staff on appointment. Additionally the MS/FM will be tabled for information of board members at least annually at a full meeting of the PHA board. Amendments made to the MS/FM will also be brought to the attention of the full PHA board on a timely basis.

The PHA's performance framework is determined by the DHSSPS in the light of its wider strategic aims and of current Public Service Agreement (PSA) objectives and targets. The PHA's key targets, standards and actions are defined by the DHSSPS within the Commissioning Directions and other priorities approved by the Minister. The DHSSPS also determines, by direction, the format and broad content of the Commissioning Plan, which is to be drawn up by the HSCB in accordance with section 8 of the Health and Social Care (Reform) Act (NI) 2009 ie in consultation with the PHA, having due regard for any advice or information provided by the Agency, and published only with its approval. The Commissioning Plan explains how the PHA will meet each of the targets, standards and actions for which it is deemed by the DHSSPS to have sole or lead responsibility. The document will also set out the PHA's contribution to the commissioning process through its professional expertise.

Consistent with the timetable for Northern Ireland Executive Budgets, the PHA will submit annually to the DHSSPS a draft of the Corporate Plan covering up to 3 years ahead; the first year of the Corporate Plan, amplified as necessary, shall form the Annual Business Plan. Plans will be subject to DHSSPS approval. The Corporate/Business Plan shall be published by the PHA and made available on its website (www.publichealth.hscni.net)

The PHA will comply in full with the control framework requirements set out in the MS/FM issued by the DHSSPS.

The PHA shall publish an annual report of its activities, including the required extracts from its audited accounts, after the end of each financial year in line with the timescales set out by the DHSSPS.

The PHA has a number of financial targets and policies within which it is obliged to operate. These are as follows:

- to break even on its Income and Expenditure Account year on year and to maintain its Net Current Assets;
- to maintain annual management and administration costs at or below limits set by the Department;
- to stay within its cash limit for the year;
- to promote financial stability in the HSC;
- to operate within the Resource Limits, both Capital and Revenue set by the Department; and
- to comply with the Confederation of British Industry "Better Payments Practice Code" and the Late Payment of Commercial Debts (No2) Regulations 2013 which advocates:

    - explaining payment procedures to suppliers;
    - agreeing payment terms at the outset and sticking to them;
    - paying bills in accordance with agreed terms, or as required by law;
    - telling suppliers without delay when an invoice is contested and settling quickly when a contested invoice gets a satisfactory response; and
    - payment to be made within agreed terms or 30 working days of the receipt of goods or valid invoice, failure to do

so may permit businesses to charge statutory interest on overdue payments.

1.5 Delegation of Powers

The Agency board is given powers as follows:

Subject to such directions as may be given by the Department of Health, Social Services and Public Safety, the Agency board may make arrangements for the exercise, on behalf of the Agency, of any of its functions by a Committee, sub-Committee or joint Committee, appointed by virtue of Standing Order 4.1, or by an officer of the Agency, in each case subject to such restrictions and conditions as the Agency board thinks fit.

Delegated Powers are covered in separate sections of this document entitled Powers Reserved to the Agency board (Standing Order 2) and Powers Delegated by the Agency board (Standing Order 3).

1.6 Interpretation

Save as permitted by law, at any meeting the Chairperson of the Agency board shall be the final authority on the interpretation of Standing Orders (on which he/she shall be advised by the Chief Executive and/or Secretary to the board.)

Any expression to which a meaning is given in the Health and Personal Social Services Orders of 1972 or 1991 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 shall have the same meaning in this interpretation and in addition:

"Accounting Officer" shall be the Chief Executive (as specified by the DHSSPS Permanent Secretary as Accounting Officer). She/he shall be responsible for ensuring the proper stewardship of public funds and assets.

"Agency or Public Health Agency (PHA)" means the Regional Agency for Public Health and Social Well-being

"board" shall mean the Chairperson, and Non-Executive (or non-officer) members of the Agency, appointed by the Minister with

responsibility for Health, Social Services and Public Safety and the Executive (or officer) members appointed by the PHA board.

"BSO" means Regional Business Services Organisation.

"Budget" means a resource, expressed in financial terms, approved by the board for the purpose of carrying out, for a specific period, any or all of the functions of the Agency.

"Budget holder" means the Director, Assistant Director or other named senior manager with delegated authority to manage finances for a specific area of the organisation.

"Chairperson" is the person appointed by the Minister to lead the Agency board and to ensure that it successfully discharges its responsibility for the Agency as a whole. The expression the 'Chairperson of the board' shall be deemed to include the member of the board deputising for the Chairperson if he/she is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Agency.

"Commissioning" is an 'end to end' process comprising assessment of need, prioritising need within available resources, building capacity of the population to improve their own health and wellbeing, engaging with stakeholders, securing – through service and budget agreements – the delivery of value for money services that meet standards and service frameworks for safe quality care: safeguarding the vulnerable and using investment, performance management and other initiatives to develop and reform services.

"Contracting and procurement" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Committee" shall mean a Committee created by the board either for its own good governance or by Departmental direction or by Legislation.

"Committee members" shall be persons formally appointed by the board to sit on or to chair specific Committees.

"**Co-opted member"** means a person who may be appointed by the board as necessary or expedient for the performance of the board's functions (without voting rights).

"Department" means the Department of Health, Social Services and Public Safety (DHSSPS). The term Department does appear as part of the title of other Government organisations and in these instances the title is given in full.

"Director" – there may be three categories - Executive Director means an officer member of the board, Non-Executive Director means a non-officer member of the board and the term Director may also be applied to a functional Director of the Organisation.

"Director of Finance" – means the Director of Finance for the HSCB, who also acts as the Director of Finance for the PHA.

"Head of Internal Audit" means the lead manager responsible for Internal Audit Provision and shall include external providers or agents of internal audit services

"HSC" refers to Health and Social Care (this was previously known as HPSS and references to HPSS relate to previously published documents).

"HSCB" means the Regional Health and Social Care Board.

"Legal advisors" means the properly qualified person(s) appointed by the board to provide legal services

"Local Commissioning Groups" (LCGs) means committees of the Regional Health and Social Care Board (HSCB) established to exercise such functions to the commissioning of health and social care as may be prescribed by the DHSSPS or HSCB.

"Member" shall mean non-executive Director (Non-Officer Member) or Executive Director (Officer Member) of the board, but excludes the Chairperson.

"Minister" means the Minister for Health, Social Services and Public Safety in the Northern Ireland Assembly

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-officer member" means a member of the board appointed under the Health and Social Care (Reform) Act (Northern Ireland) 2009.

"Officer" shall mean an employee of the Agency. In certain circumstances, an officer may include a person who is employed by another HSC organisation or by a Third Party contracted to or by the Organisation who carries out functions on behalf of the Organisation.

"Officer member" means a member of the board who is a member by virtue of or appointed under the Health and Social Care (Reform) Act (Northern Ireland) 2009.

"PCC" means the Patient and Client Council.

"Public" means any person who is not a board member or a member of staff servicing the board meeting and shall include any person with the status of observer.

"Secretary" means a person who is independent of the board's decision making process and who shall be appointed, by the board, to have responsibility for the administration of the board of the Agency.

"SFIs" is an abbreviation for Standing Financial Instructions.

"SOs" is an abbreviation for Standing Orders.

"**Sub-Committee"** means a committee of a committee created by the board.

"Vice-Chairperson" means a non-executive director who may be appointed by the board to take on the Chairperson's duties if the Chairperson is absent for any reason.

"Voting member" means the Chairperson, non-executive directors and officer members of the board

2. Powers Reserved to the Agency Board - Contents

2.1 Introduction

The matters reserved to the Board of each HSC Organisation are derived from the **Code of Conduct and Code of Accountability** (April 2011) issued by the Department 18 July 2012. The **Code of Conduct and Code of Accountability** applies to the board of the Agency created through the Health and Social Care (Reform) Act (Northern Ireland) 2009.

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

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

2.2 Composition of the board

In accordance with the Constitution Regulations, the composition of the board consists of 8 non-executive (non-officer) members and four officer members as well as representatives from the Health and

Social Care Board (Finance Director and Social Services Director) and the Patient Client Council. The composition of the board is set out in detail in **Section 5.1.3** which also describes members' roles.

2.3 Key Functions of the Agency board

The attached Schedule of Powers Reserved to the Agency board is sub-divided to correspond with the key functions specified above.

These matters are to be regarded as a guideline to the minimum requirement and shall not be interpreted so as to exclude any other issues which it might be appropriate, because of their exceptional nature, to bring to the board.

The Chairperson, in consultation with the Chief Executive, shall determine whether other issues out with the following schedules of reserved powers shall be brought to the board for consideration.

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.1
Establish Strategic Direction
To establish the *strategic direction* of the Agency within the policies and resources framework determined by the Department/Minister.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
A	Programme for Government	Approve response to consultation	*Within timescale set by Government for response	Director of Operations
B	Commissioning Plan	Approve annual Joint Commissioning Plan to achieve DHSSPS Commissioning Directions and advance PHA objectives	By 31 March each year or as soon as practicable thereafter within DHSSPS timescales	Director of Operations
C	Northern Ireland Budget proposals	Approve response to consultation	*Within timescale set by Government for response	Director of Operations
D	Agency Financial Plan	Approve recurrent expenditure proposals annually	By 31 March each year consistent with DHSSPS principles of 'Promoting Financial Stability'	Director of Finance
E	Departmental (DHSSPS) Strategic Proposals	Approve response to Departmental consultation proposals	As determined by consultative documents	Appropriate Executive Director

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.1
Establish Strategic Direction
To establish the *strategic direction* of the Agency within the policies resources framework determined by the Department/Minister.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
F	Other Departmental proposals which relate to Public Health and Social Well-Being	Approve response to consultative proposals	As determined by consultative documents	Appropriate Executive Director
G	Strategic plans and processes identified by the Agency on specific Public Health and Social Well-being issues	Approve the strategy and agree action plans and monitoring arrangements	As they arise	Appropriate Executive Director
H	Approval of New/Revised Agency Policy, as appropriate	Consider the implications of any proposals to introduce new or revised policy including the identification of any significant financial risk	Affordability within Department expenditure limits and other statutory controls	Appropriate Executive Director to identify all significant financial or other implications

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.2
Monitoring Performance
To oversee the delivery of planned results by *monitoring performance* against objectives and ensuring corrective action is taken as necessary.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
A	Ministerial Priorities and Objectives	Monitor performance against Ministerial priorities and objectives as set out in the Commissioning Plan Directions and ensure corrective action is taken.	Periodic reports as prescribed by the DHSSPS	Director of Operations and appropriate Executive Director
B	Service agreement performance	Monitor performance of providers against service agreements, ensure corrective action is taken and ensure appropriate action plans are pursued with providers	Monthly and quarterly reports supplemented by additional monitoring of specific issues on an as needs basis	Director of Operations and appropriate Executive Director
C	Monitoring the public health and social well-being of the population	To monitor trends and identify critical issues for Department	Annual/periodic as specified by Department	Director of Public Health
D	Staffing Levels	Monitor staffing levels and approve submission to Equality Commission.	Submission of three yearly returns	Chief Executive or Designated Director

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.2
Monitoring Performance
To oversee the delivery of planned results by *monitoring performance* against objectives and ensuring corrective action is taken as necessary.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
E	Section 75: Statutory Duties/ Responsibilities	Statement of the Agency's commitment to fulfilling its Section 75 statutory duties, including procedures for measuring performance	Schedule 9 N.I. Act 1998 Annual Report to Equality Commission by 31 August	Chief Executive/ Director of Operations
F	Complaints Monitoring	Monitor complaints handling and contribute to regional policy and approve annual report	Annual report	Director of Nursing and Allied Health Professions

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.3
Financial Stewardship
To ensure effective *financial stewardship* through value for money, financial control and financial planning and strategy.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
A	Financial Performance Framework	To ensure that the Agency achieves it financial performance targets	As determined by the Department	Chief Executive
B	Annual Financial Plan including Commissioning Plan and Commissioner costs	Approve plan within Departmental expenditure limits	By 31 March each year	Director of Finance
C	Monitoring	Consider monthly monitoring reports including: • Health improvement • Health protection • Screening • Commissioning input • Research and Development • PHA Management and Administration	Monthly	Director of Finance

2.3.3
Financial Stewardship
To ensure effective *financial stewardship* through value for money, financial control and financial planning and strategy.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
D D (i)	Agency Capital Expenditure & Disposal of Assets Agency Capital expenditure	Consider submissions & authorise expenditure	Expenditure proposals in excess of £50,000	Chief Executive
D (ii)	Disposal of Agency Assets	Consider submissions, approve decision and means of disposal	Net book value in excess of £50,000	Director of Operations
E (i)	Annual Accounts (and supporting financial excerpt in the Annual Report)	Approve for submission to Department and for inclusion in Annual Report	Recommended for approval by Governance and Audit Committee. To include detailed scrutiny of reconciliation to board approved Financial Plan	Chief Executive/Director of Finance
E (ii)	Report to those charged with Governance	Consider recommendations and approve requisite action plan and response to External Auditor	Each year following recommendation by Governance and Audit Committee	Director of Operations/Director of Finance
E (iii)	Fraud prevention and detection	Receive assurance from the Governance and Audit Committee	Annual report from Committee	Director of Finance/Director of Operations

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.4
Corporate Governance & Personal Behaviour and Conduct
To ensure that high standards of *corporate governance* and personal behaviour are maintained in the conduct of the business of the whole organisation.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
A	Schedule of Matters Reserved to the board	Approve new or revised versions	Following consideration & recommendation by Governance and Audit Committee	Chief Executive
B	Scheme of Delegation of Powers	Approve new or revised versions	Following consideration & recommendation by Governance and Audit Committee	Chief Executive
C	Standing Financial Instructions	Approve new or revised versions	Following consideration & recommendation by Governance and Audit Committee	Director of Operations/Director of Finance
D	Conduct of board Meetings	Approve new or revised versions	If/When required or revised	Chief Executive
E	Scheme of Delegation of Specific Statutory Functions.	Approve new or revised versions and submission to DHSSPS for approval	Within 3 months of new legislation being implemented.	Appropriate Executive Director

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.4
Corporate Governance & Personal Behaviour and Conduct
To ensure that high standards of *corporate governance* and personal behaviour are maintained in the conduct of the business of the whole organisation.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
F (i)	Assurances on Internal Control	Approval of a PHA Governance Framework, setting out the key components of governance within the PHA; Approval/adoption of the PHA Assurance Framework, which provides assurances on the effectiveness of the system of internal control	Recommended for approval by the Governance and Audit Committee	Chief Executive
F (ii)	Statements on Internal Control (Governance Statement and Mid Year Assurance Statement)	Confirms that a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding public funds and assets has been established and is in place	Recommended for approval by Governance and Audit Committee in time to meet Department reporting timetable	Chief Executive/Director of Operations

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.4
Corporate Governance & Personal Behaviour and Conduct
To ensure that high standards of *corporate governance* and personal behaviour are maintained in the conduct of the business of the whole organisation.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
G	PHA Corporate Plan	Production of a Corporate Plan covering up to three years ahead, with an annual business plan. Regular monitoring reports	Three yearly Annually	Chief Executive/Director of Operations
H	PHA board Committees	Approve establishment, terms of reference, membership & reporting arrangements of board Committees: • Governance and Audit Committee • Remuneration & Terms of Service Committee • Others as required or directed	Following recommendation for approval by Governance and Audit Committee & for submission to Department for final approval	Chair/Chief Executive

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.4
Corporate Governance & Personal Behaviour and Conduct
To ensure that high standards of *corporate governance* and personal behaviour are maintained in the conduct of the business of the whole organisation.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
I	PHA board sub-committees (defined as a committee of a committee)	Approve establishment, terms of reference, membership and reporting arrangements of board sub-committees	Section 8 of Health and Social care reform ad NI 2009	Chief Executive/Director of Operations
J	*Advisory and other Committees	There may be a range of committees to advise the board. These may be set up by statute or regulation but are not delegated a power reserved to the board	Appropriate advice notified to board	Appropriate Executive Director
K	Declaration of Chairperson and Members' Interests	board Members' Interests to be declared and recorded in minutes	Within 4 weeks of a change or addition; to be entered in Register available for scrutiny by public in Agency offices or at board meetings and on the PHA website	Board Members

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.4
Corporate Governance & Personal Behaviour and Conduct
To ensure that high standards of *corporate governance* and personal behaviour are maintained in the conduct of the business of the whole organisation.

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
L L (i)	Code of Conduct and Code of Accountability: Implementation of measures to ensure authorised officers behave with propriety, i.e. withdrawal from discussion where there is a potential perception of a conflict of interest	Approve measures to ensure that all Directors and staff are aware of the public service values which must underpin their conduct	**Code of conduct and code of accountability April 2011**	Chief Executive
L (ii)	Concerns of Staff & Others	Ensure arrangements are in place to guarantee that concerns expressed by staff & others are fully investigated & acted upon as appropriate and that all staff are treated with respect	**The Public Interest Disclosure (NI) Order 1998 (whistle blowing)**	Chief Executive

M	ALB Board Self-Assessment Tool	Review actions and agree Board self-assessment	**DHSSPS ALB Board Self-Assessment tool and guidance**	Board Members

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.5
Appoint, Appraise & Remunerate Senior Executives
To *appoint, appraise and remunerate senior executives*

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
A	Executive Director Appointments	Ensure that proper arrangements are in place for the composition of interview panels for the appointment of Executive Directors	Panel composition in accordance with Agency selection and recruitment policies	Chief Executive
B	Terms and Conditions	Scrutinise decisions of the Remuneration & Terms of Service Committee		Chairperson of board
C	Remuneration	Scrutinise decisions of the Remuneration & Terms of Service Committee for the total remuneration package of Executive Directors to assure compliance with Ministerial/Departmental direction	Annually In line with current approved terms including Salary review and Performance Related Pay arrangements Including any termination payments	Chairperson of board

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.6
Dialogue with Local Community
To ensure that there is *effective dialogue between the organisation and the local community* on its plans and performance and that these are responsive to the community's needs.'

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
A	board Meetings	To hold meetings in public	Monthly or as agreed by board. Only exceptional categories of items to be considered in a section of the meeting not open to the public	Chairperson
B	Meeting with Patient and Client Council (PCC)	To convene meeting with PCC	* Annually or to be determined	Chairperson
C	Consultation	Invite & receive views from the Public on proposals for strategic change	Consistent with Departmental guidance on consultation and processes	Appropriate Executive Director
D	Personal and public involvement; Requirement to introduce a consultation scheme	For submission to DHSSPS	Section 19 and 20 Health and Social care (reform) Act (NI) 2009	Director of Nursing and Allied Health Professions

2.3.6
Dialogue with Local Community
To ensure that there is *effective dialogue between the organisation and the local community* on its plans and performance and that these are responsive to the community's needs.'

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
E	Annual Report	Approve report	To be signed by Chairperson and Chief Executive & submitted to DHSSPS by due date	Chief Executive
F	Monitoring of Services	Ensure dissemination of service monitoring and other relevant reports to a cross section of interest groups and community organisations	Reports and follow up of specific issues on an as needs basis.	Chief Executive/other appropriate Executive Directors

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.7
Clinical and Social Care Governance and Risk Management
To ensure that the Agency has robust and effective arrangements in place for clinical and social care governance and risk management

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
A	PHA Corporate Risk Register	Approval of a fully functioning PHA Corporate Risk Register, which is supported by Directorate Risk Registers	Governance and Audit Committee reviews quarterly; PHA board reviews annually	Director of Operations/Appropriate Director

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.8 Additional Functions				
	ITEMS	**RESPONSIBILITY/TASK**	**CONTROLS**	**LEAD PERSON**
A	**Safety and Quality** Quality improvement plans and associated governance plans	Scrutinise Assessment and Approve Management Plans	Standing item on the board agenda	Director of Public Health/Medical Director and Director of Nursing and Allied Health Professionals, as appropriate
B	* **Statutory Responsibilities** All responsibilities placed upon the Agency board through statute for which a formal Scheme of Delegation is not in place. Including the following matters: • Public Health (Health Promotion/Health Improvement/Health Protection) • Supervision of Midwives	As defined in statute	As relevant to specified statutory responsibilities	Appropriate Executive Director Director of Public Health/Medical Director Director of Nursing and Allied Health Professionals

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

2.3.8 **Additional Functions**				
	ITEMS	**RESPONSIBILITY/TASK**	**CONTROLS**	**LEAD PERSON**
C	**Public Health** Annual Report	Scrutinise and receive for submission to DHSSPS	Annually	Director of Public Health/Medical Director
D	**Appointment of members to board committees**	Approval of appointment of members to board committees where such persons are not members of the Public Health Agency for onward submission to the Department of Health, Social Services and Public Safety for formal approval	Schedule 2 Section 7, Health and Social Care (Reform) Act (NI)	Director of Operations

3. Powers Delegated by the Agency Board - Contents

3.5.3 Authorisation & Approval of Non Payroll Expenditure

3.5.4 Authority to Initiate and Approve Cash Advances

3.1 Arrangements for Delegation by the Agency Board

3.1.1 Introduction

Subject to such directions as may be given by the DHSSPS, the PHA may make arrangements for the exercise, on behalf of the board, of any of its functions by a Committee, sub-Committee or joint Committee, appointed by virtue of SO 4 below or by an officer of the Agency board, or by another Officer, in each case subject to such restrictions and conditions as the board thinks fit.

The HPSS (NI) Order 1972 and the HPSS (NI) Orders 1991 and 1994 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 allow for functions of the board to be carried out on behalf of the board by other people and bodies, in the following ways:

- By a Committee or sub Committee or officer of the board or another HSC Board; and

- by a joint Committee or joint sub-Committee of the board and one or more other Boards.

Where functions are delegated: this means that although the carrying out of the function (i.e. day to day running) is delegated to another body, the Agency board retains the responsibility for the service.

The board of the Agency may also delegate statutory functions to HSC Trusts in accordance with the provisions of the HPSS (NI) Order 1994.

3.1.2 Urgent Decisions

Where decisions which would normally be taken by the board need to be taken between meetings, and it is not practicable to call a meeting of the board, the Chairperson, in consultation with the Chief Executive, shall be authorised to deal with the matter on behalf of the board. Such action shall be reported to board members via email/phone with a formal report delivered at the next meeting.

3.1.3 Delegation to Committees

The PHA shall, in accordance with Paragraph 7 of Schedule 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009, appoint a number of committees.

The PHA has established two Committees:

- Governance and Audit Committee; and
- Remuneration and Terms of Service Committee.

The terms of reference pertaining to each are set out in appendices 4 and 5 to the Standing Orders.

The Agency board may also establish other Committees or sub-Committees as appropriate, including a Joint Committee or a Joint sub-Committee between the PHA and the HSCB to facilitate inter-organisational working.

The board shall agree the delegation of executive powers to be exercised by committees, or sub-committees, or joint committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the board.

The board shall agree any amendment to the delegation of executive powers to be exercised by Committees, or sub-Committees, or joint-Committees, which it has formally constituted, as part of the annual review of Standing Orders, or as required.

3.1.4 Delegation to Officers

The Chief Executive shall exercise those functions of the board, which are not reserved to the board or delegated to a Committee, sub-Committee or joint-Committee, on behalf of the board. The Chief Executive shall determine which functions she/he shall perform personally and shall delegate to nominated officers the remaining functions for which she/he shall still retain accountability to the board.

The Chief Executive shall prepare a Scheme of Delegation identifying her/his proposals which shall be considered and approved by the board, subject to any amendment agreed during discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the board as indicated above.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the board of the Director of Operations, the

Director of Public Health/Medical Director, the Director of Nursing and Allied Health Professions or any other Officer to provide information and advise the board in accordance with statutory requirements. Outside these statutory requirements the roles of the Director of Operations, the Director of Public Health/Medical Director, the Director of Nursing and Allied Health Professions and all other Officers shall be accountable to the Chief Executive for operational matters.

The arrangements made by the board as set out in the Powers Reserved to the Agency board and Powers Delegated by the Agency board (SOs 2 & 3) shall have effect as if incorporated in these Standing Orders.

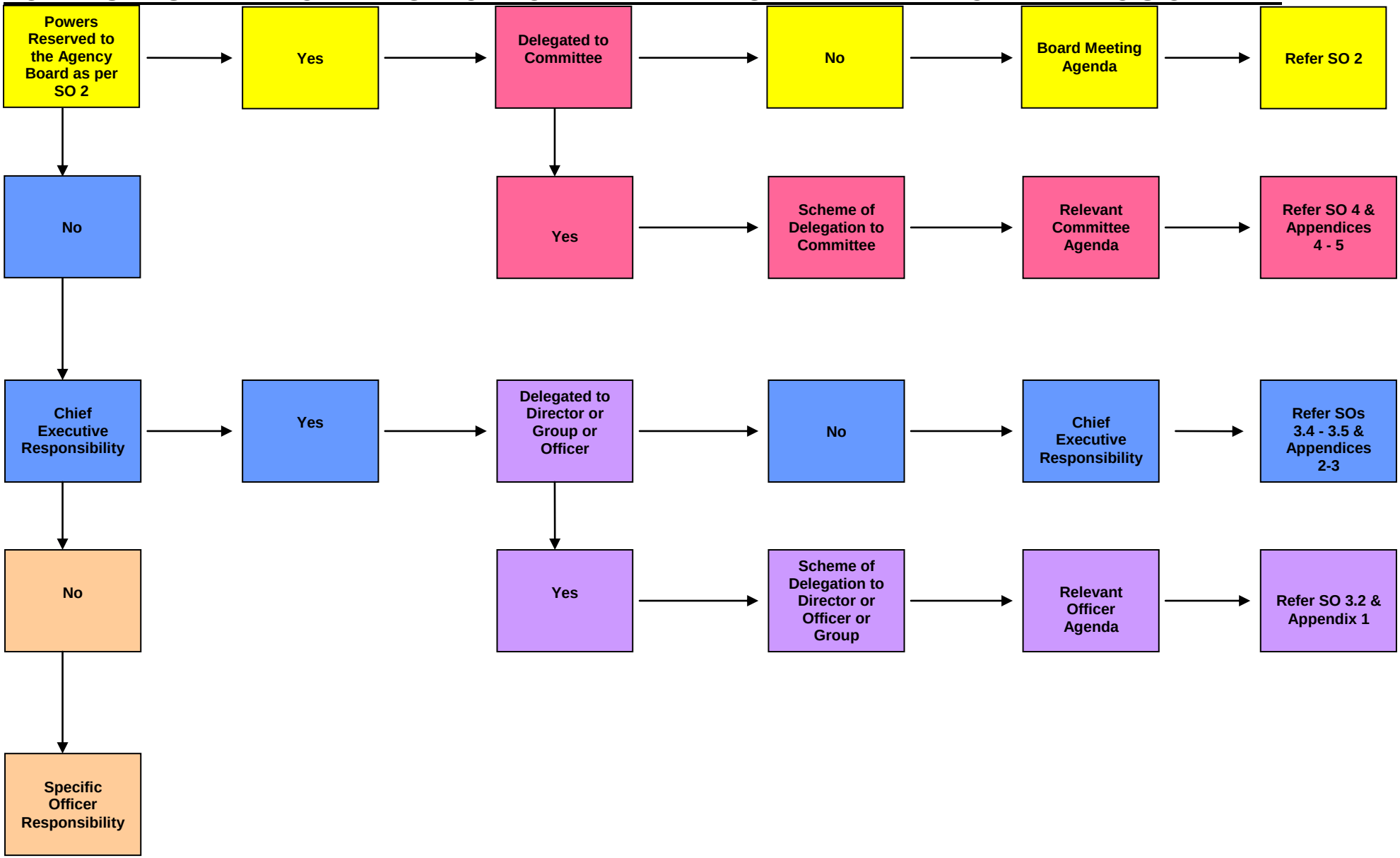
3.1.5 Decision Tree - Flowchart

The flowchart overleaf seeks to show the decision tree for the powers and responsibilities that are:

- Reserved to the Agency board;
- delegated by the Agency board to committees;
- exercised by the Chief Executive for which he/she is personally accountable to the Agency board;
- delegated by the Chief Executive to nominated officers; and
- specific Officer responsibility for example Director of Public Health/Medical Director.

Flowchart

POWERS RESERVED TO THE AGENCY BOARD AND DELEGATED BY THE BOARD - DECISION TREE



3.2 Chief Executive's Scheme of Delegation

The Chief Executive will delegate specific areas of the board's responsibility which are not reserved to the board and may be delegated to a Director, Group or Officer. The Chief Executive's Scheme of Delegation is set out in Appendix 1 and corresponds to the purple section of the Decision Tree Flowchart (SO 3.1.4).

3.3 Statutory Schemes of Delegation

None applicable to the Agency at this time.

3.4 Administrative Schemes of Delegation

3.4.1 Custody of Seal

The Common Seal of the Agency shall be kept by the Chief Executive (or Secretary) in a secure place.

3.4.2 Sealing of Documents

The Seal of the Agency shall not be fixed to any documents unless the sealing has been authorised by a resolution of the board or of a Committee, thereof or where the board has delegated its powers. Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Operations (or an officer nominated by her/him) and authorised and countersigned by the Chief Executive (or an officer nominated by her/him who shall not be within the originating directorate).

3.4.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. An application of the Common Seal shall be reported to the board at the next formal meeting. The report shall contain details of the seal number, the description of the document and date of sealing.

3.4.4 Signature of Documents

Where the signature of any document shall be a necessary step in legal proceedings involving the Agency, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the board shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers shall be authorised, by resolution of the board, to sign on behalf of the Agency any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the board or any Committee or sub-Committee thereof or where the board has delegated its powers on its behalf.

3.4.5 Delegation of Budgets for Agency Administration

Each year, on behalf of the Chief Executive, the Director of Operations will bring forward for AMT consideration and approval, a schedule of budgetary delegation to individual Directors of the Agency's budget for management and administration expenditure within the financial limits specified by DHSSPS.

3.4.6 Procedure for Delegating Power to Authorise & Approve Expenditure

Each year on behalf of the Chief Executive, the Director of Operations will bring forward for AMT consideration and approval, a schedule of delegated authority for authorisation and approval of specific expenditure by Director – nominated individuals and their associated authorisation and approval limits. Following approval these will be shared with the Director of Finance and the Business Services Organisation (BSO) to ensure only authorised individuals commit the Agency to expenditure within approved monetary limits.

3.4.7 Procedure for Quotations and Tendering

Procedures for tendering and contracting are set out in section 8 of the Standing Financial Instructions. The tendering and contracting for most services and supplies to the PHA will be undertaken by Procurement and Logistics Service (PALS) of the BSO in its role as a recognised centre of procurement expertise. Certain specified areas of procurement e.g. health improvement commissioning/procurement will be reserved to the

board/Chief Executive and delegated to nominated committees/officers of the PHA.

3.4.8 Use of Management Consultants

DHSSPS retains strict control over the use of Management Consultants and specifies the delegated limits within which the PHA may select and appoint consultants, using its tendering and contracting procedure. The PHA and its officers must comply with the most recent DHSSPS guidance, as set out in DHSSPS Circulars HSC(F) 25/2012 and HSC(F) 48/2012. In particular the DHSSPS must be advised of **ALL** proposals to use External Management Consultants in advance with **prior** approval from the Minister and/or DFP where the anticipated cost is £10,000 or above. Additionally, any proposal to use External Management Consultants which proposes a Single Tender Action / Direct Award Contract (any level of cost) must also have **prior** approval from the Permanent Secretary of the DHSSPS.

Further detail is set out in The Administrative Schemes of Delegation, Appendix 2 (section 3.4.8).

The Administrative Schemes of Delegation are set out in Appendix 2 and correspond to the blue section in the Decision Tree Flowchart (SO 3.1.4):

3.5 Financial Schemes of Delegation

The following Financial Schemes of Delegation are set out in Appendix 3 and correspond to the blue section in the Decision Tree Flowchart (SO 3.1.4):

3.5.1 Procedure for Delegation of Budgets;

3.5.2 Authorisation & Approval of Payroll Expenditure;

3.5.3 Authorisation & Approval of Non Payroll Expenditure; and

3.5.4 Authority to Initiate and Approve Cash Advances.

4. Agency board Committees - Contents

The arrangements for Powers Delegated to Committees on behalf of the board are outlined in the pink section of the Decision Tree Flowchart (SO 3.1.4).

4.1 Appointment of Committees

Subject to such directions as may be given by the Minister, the board may and, if directed by the Department, shall appoint Committees of the Agency board, or together with one or more other bodies appoint a Joint Committee consisting, in either case, wholly or partly of the Chairperson and members of the board or other bodies or wholly of persons who are not members of the board or other bodies in question.

A Committee or Joint Committee appointed under this Standing Order may, subject to such directions as may be given by the Minister, the board or other bodies, appoint sub-Committees consisting wholly or partly of members of the Committee or Joint Committee (whether or not they are members of the board or other bodies in question) or wholly of persons who are not members of the board or other bodies or the Committee of the board or other bodies in question.

The Standing Orders of the board, as far as they are applicable, shall apply, as appropriate, to meetings of any Committees established by the board.

Each Committee shall have such terms of reference and powers, membership and be subject to such reporting back arrangements as the board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

Where Committees are authorised to establish sub-Committees they may not delegate executive powers to the sub-Committee unless expressly authorised by the board.

The board shall approve the appointments to each of the Committees, which it has formally constituted. Where the board determines, and

regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the board as defined by the Minister. The board shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses.

Where the board is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Minister; and where such appointments are to operate independently of the board such appointment shall be made in accordance with the regulations laid down by the Minister.

See also SO 5.2.24 on Potential Conflicts of Interest.

4.2 Committees

Board Committees

Refer to:	**Appendix**
• Governance and Audit Committee	4
• Remuneration and Terms of Service Committee	5

Other board Committees may established as necessary

Sub Committees

* To be determined

Joint Committees

* To be determined

5. Conduct of Agency Board Business - Contents

5.1 Constitution and Remit of Agency

5.1.1 Constitution

All business shall be conducted in the name of the Agency.

All funds received in trust shall be held in the name of the Agency board as corporate trustee of the Agency.

5.1.2 Remit

The powers of the Agency established under statutory instruments shall be exercised by the Agency board meeting in public session except as otherwise provided for in SO 3.

The board shall define and regularly review the functions it exercises on behalf of the Minister.

The board has resolved that the board may only exercise certain powers and decisions in formal session. These powers and decisions are set out in 'Powers Reserved to the Agency board' SO 2.3.1-7 and have effect as if incorporated into the Standing Orders.

5.1.3 Composition of the Board

The Department of Health, Social Services and Public Safety determines the composition of the Agency board, which is currently as follows:

- A Chairperson appointed by the DHSSPS;
- a prescribed number of persons appointed by the DHSSPS;
- the chief officer of the PHA;
- such other officers of the PHA as may be prescribed;
- not more than a prescribed number of other officers of the PHA appointed by the Chairperson and the members specified the points above; and

- a prescribed number of members of district councils as appointed by the DHSSPS.

Except in so far as regulations otherwise provide, no person who is an officer of the PHA may be appointed as the Chairperson or by the DHSSPS. Regulations may provide that all or any of the persons appointed by the DHSSPS must fulfil prescribed conditions or hold posts of a prescribed description.

Details of board members are as follows:

The Chairperson

The role of the Chairperson is outlined in Appendix 7.

Non Officer Members

- 3 Non-Executive Directors (Non-specified);
- Non-Executive Director (Social Care);
- Non-Executive Director (Trade Union Representative); and
- 2 Non-Executive Directors (Local Government Representatives);

The Officer Members are

- Chief Executive;
- Director of Nursing and Allied Professions;
- Director of Operations;
- Director of Public Health/Medical Director; and
- Any other Officer who the Chief Executive determines should be a member of the Agency Management Team.

Others in Attendance at board meetings

The Director of Social Care & Children and the Director of Finance, both from HSCB or their deputies, will attend all Agency board meetings and have attendance and speaking rights.

A representative from the Patient and Client Council (PCC) will be in attendance.

5.1.4 The Agency Management Team comprises:

- Chief Executive;
- Director of Public Health/Medical Director;
- Director of Nursing/Allied Health Professionals;
- Director of Operations;
- Director of Social Care and Children, HSCB;
- Director of Finance, HSCB, and
- Any other Officer who the Chief Executive determines should be a member of the Agency Management Team.

Details of the role and remit of the AMT are outlined in Appendix 6.

5.2 Procedures for Meetings - Contents

5.2.1 Code of Practice on Openness
5.2.2 Open Board Meetings
5.2.3 Conduct of Meetings
5.2.4 Calling of Meetings
5.2.5 Setting Agenda
5.2.6 Petitions
5.2.7 Notice of Meetings
5.2.8 Notice of Motion
5.2.9 Deputations & Speaking Rights
5.2.10 Admission of the Public and media
5.2.11 Attendance of other HSC Organisation representatives
5.2.12 Chairperson of Meeting
5.2.13 Quorum
5.2.14 Record of attendance
5.2.15 Confidential Section of meetings
5.2.16 Motions
5.2.17 Voting
5.2.18 Joint Members
5.2.19 Suspension of Standing Orders
5.2.20 Minutes
5.2.21 Committee Minutes
5.2.22 Variation & Amendment of Standing Orders
5.2.23 Appointments
5.2.24 Potential Conflict of Interests

5.2.1 Code of Practice on Openness

The board shall pursue the aims of the **Code of Practice on Openness:**

'...to ensure that people may easily obtain an understanding of all services that are provided by the HSC and, particularly, changes to those services that may affect them or their families.'

The board shall accept the strong duty imposed on it by the Code to be positive in providing access to information; the presumption shall be in favour of openness and transparency in all its proceedings.

5.2.2 Open board Meetings

The Agency shall hold all its board meetings in public, although certain issues may be taken in a confidential section of the meeting.

A schedule of PHA public board meeting dates and venues will be posted on the Agency website (www.publichealth.hscni.net) for the financial year.

Public meetings shall be held in easily accessible venues across the region and at times when the public are able to attend. (**Code of Practice on Openness**; Annex A, para 3.1)

5.2.3 Conduct of Meetings

The meetings and proceedings of the board shall be conducted in accordance with these Standing Orders.

Proceedings shall be in accordance with section 54 (1) and (2) of the Health and Social Services Act (Northern Ireland) 2001 which provides that sections 23 to 27 of the Local Government Act (Northern Ireland) 1972 (c9) shall also apply. This is specified in the Guidance on Implementation of the **Code of Practice on Openness**, Annex A, para. 2.3.

The **Code of Practice on Openness** is not statutory, it does not set aside restrictions on disclosure, which are based in law and decisions shall rest on judgement and discretion. (See Guidance on the implementation of the **Code of Practice on Openness**, para 6.3).

5.2.4 Calling of Meetings

Ordinary meetings of the board shall normally take place monthly and be held at such times and places as the board may determine although, as good practice, some meetings may be held outside normal working hours to facilitate wider attendance by the general public. The board shall pay particular attention to the commitments within its Equality Scheme when calling meetings.

The Chairperson may call a meeting of the board for a special purpose (including in the event of an emergency) at any time.

The notice, agenda and papers for such a meeting shall be conveyed to members as far in advance of the meeting as the circumstances shall allow. Notice of meetings and agenda shall be posted on the Agency web site.

If requested by at least one third of the whole number of members, the Chairperson shall call a meeting of the board for a special purpose. If the Chairperson refuses to call a meeting or fails to do so within seven days after such a request, such one third or more members may forthwith call a meeting. In the case of a meeting called by members in default of the Chairperson, the notice shall be signed by those members and no other business, other than that specified in the notice shall be transacted at the meeting. Failure to service such a notice on more than three members of the board shall invalidate the meeting. A notice shall be presumed to have been served one day after posting.

5.2.5 Setting the Agenda

The board may determine or may be directed to ensure that certain matters shall appear on every agenda for a meeting of the board and shall be addressed prior to any other business being conducted. If so determined these matters shall be listed as an appendix to the Standing Orders.

A member desiring a matter to be included on an agenda shall normally make his/her request in writing to the Chairperson at least 14 clear days before the meeting. The request may include appropriate supporting information and a proposed motion. It may also note any grounds which would necessitate the item of business being dealt with in a confidential section of the meeting. Requests made less than 14 days before a

meeting may be included on the agenda at the discretion of the Chairperson.

The agenda and supporting papers shall be despatched to members 5 working days in advance of the meeting and certainly no later than three working days beforehand, except in cases of emergency.

5.2.6 Petitions

Where the board has received a petition of at least 100 signatures the Chairperson shall include the petition as an item for the agenda of the next meeting, providing it is appropriate for consideration by the board. The Chairperson shall advise the meeting of any petitions that are not granted and the grounds for refusal. However if the petition is deemed to be urgent the Chairperson may call a special meeting.

5.2.7 Notice of Meetings

Before each meeting of the board, a notice of the meeting, specifying the business proposed to be transacted at it, and any motions relating to it, and signed by the Chairperson or by an officer of the board authorised by the Chairperson to sign on his/her behalf shall be delivered to each member and posted on the PHA website at least five clear days before the meeting.

Absence of service of the notice on any member shall not affect the validity of a meeting. Failure to serve such a notice on more than three members shall invalidate the meeting. A notice shall be presumed to have been served one day after posting.

In the case of a meeting called by members in default of the Chairperson, those members shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

5.2.8 Notices of Motion

With reference to matters included in the notice of meetings, a member of the board may amend or propose a motion in writing at least 10 clear days before the meeting to the Chairperson. All notices so received, shall be inserted in the agenda for the meeting subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda.

5.2.9 Deputations and Speaking Rights

Deputations from any meeting, association, public body or an individual, in relation to a matter on the Agency board agenda, may be permitted to address a public meeting of the board provided notice of the intended deputation and a summary of the subject matter is given to the board at least two clear days prior to the meeting and provided that the Chairperson of the board is in agreement. The specified notice may be waived at the discretion of the Chairperson. In normal circumstances this facility shall be confined to the making of a short statement or presentation by no more than three members of the deputation and making a copy of the presentation available in advance (at least one clear day) of the meeting. The Chairperson shall determine the actual allotted time and if the deputation has sufficiently covered the issue.

5.2.10 Admission of the Public and Media

The PHA board shall undertake the necessary arrangements in order to encourage and facilitate the public at open board meetings. Reasonable facilities shall be made available to enable representatives of the press and broadcasting media to report the meetings.

The Chairperson shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press and broadcasting media, such as to ensure that the board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public shall be required to withdraw upon the board resolving as follows:

'That in the interests of public order the meeting adjourns for (the period to be specified) to enable the board to complete business without the presence of the public.'

Nothing in these Standing Orders shall require the board to allow members of the public or representatives of the press and broadcasting media to record proceedings in any manner whatsoever, other than in writing, or to make an oral report of proceedings as they take place from within the meeting, without prior agreement of the Chairperson.

5.2.11 Attendance of other HSC Organisation representatives

Officers representing the HSCB, HSC Trusts, the PCC and the BSO may attend and participate in meetings of the Agency board, with the agreement of the Chair.

5.2.12 Chairperson of Meeting

At any meeting of the board, the Chairperson, if present, shall preside. In the absence of the Chairperson the Vice Chairperson, if previously appointed, shall preside, if not previously appointed then such member (who is not also an officer of the board) as the Chairperson may nominate shall preside or if no such nomination has been made, such non executive member as those members present shall choose, shall preside.

If the Chairperson is absent temporarily on the grounds of a declared conflict of interest such non-executive member as the members shall choose shall preside.

5.2.13 Quorum

No decisions may be taken at a meeting unless at least one-third of the whole number of the Chairperson and voting members appointed, (including at least one non-officer member and one officer member) are present. Members may receive items for information, which are included on the agenda, providing this is also recorded in the minutes.

An officer in attendance for an officer member but without formal acting up status may not count towards the quorum. If the Chairperson or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he/she shall no longer count towards the quorum. If a quorum is then not available for the passing of a resolution on any matter, that matter may be discussed further but not voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting.

5.2.14 Record of Attendance

A record of the names of the Chairperson, and members present at the meeting shall be noted in the minutes. If necessary, the point at which they join, leave or resume their place at the meeting shall also be noted. The name of those ‘in attendance’ shall also be included along with the items for which they attended.

5.2.15 Confidential Section of Meetings

The board may by resolution exclude the public or representatives of the press or broadcasting media from a meeting (whether during the whole or part of the proceedings at the meeting) on one or more of the following grounds:

- By reason of the confidential nature of the business to be transacted at the meeting;
- when publicity would be prejudicial to the public interest; or
- for such special reasons as may be specified in the resolution being reasons arising from the exceptional nature of the business to be transacted or of the proceedings at the meeting.

5.2.16 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a member to move:

- An amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business (+);
- the appointment of an ad hoc Committee to deal with a specific item of business;
- that the motion be now put (+); or
- a motion resolving to exclude the public (including the press).

In the case of sub-paragraphs denoted by (+) above: to ensure objectivity, only a member who has not previously taken part in the debate may put motions.

No amendment to the motion shall be admitted if, in the opinion of the Chairperson of the meeting, the amendment negates the substance of the motion.

When an adjourned item of business is re-commenced or a meeting is reconvened, any provisions for deputations or speaking rights, not

previously undertaken or other arrangements shall be treated as though no interruption had occurred.

(a) Withdrawal of Motion or Amendments

The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the second and the consent of the Chairperson.

(b) Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) that has been passed within the preceding 6 calendar months, shall bear the signature of the member who gives it and also the signature of 4 other board members.

When any such motion has been disposed of by the board, it shall not be appropriate for any member other than the Chairperson to propose a motion to the same effect within 6 months; however the Chairperson may do so if he/she considers it appropriate.

(c) Chairperson's Ruling

Statements of members made at meetings of the board shall be relevant to the matter under discussion at the material time and the decision of the Chairperson of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

5.2.17 Voting

Every item or question at a meeting shall be determined by the Chairperson seeking the general assent of voting members or the expression of a wish to proceed to a vote. A vote shall be determined by the majority of the votes of the Chairperson of the meeting and members present and voting on the question; in the case of the number of votes for and against a motion being equal, the Chairperson of the meeting shall have a second or casting vote.

All questions put to the vote shall, at the discretion of the Chairperson of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the members present so request.

If at least one third of the members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each member present voted or abstained.

If a member so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the board to act up for an officer member during a period of incapacity or temporarily to fill an officer member vacancy, shall be entitled to exercise the voting rights of the officer member. An officer attending the board to represent an officer member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the officer member. An officer's status when attending a meeting shall be recorded in the minutes.

5.2.18 Joint Members

Where more than one person shares the office of a member of the board jointly:

- Either or both of those persons may attend or take part in meetings of the board;
- if both are present at a meeting they shall cast one vote if they agree;
- in the case of disagreement no vote shall be cast; and
- the presence of one or both of those persons shall count as the presence of one person for the purposes of a quorum.

5.2.19 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by the Department, one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the board are present, including one officer and one non-officer member, and that a majority of those present vote in favour of suspension.

A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairperson and members of the board.

No formal business may be transacted while Standing Orders are suspended.

The Governance and Audit Committee shall review every decision to suspend Standing Orders.

5.2.20 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where the person presiding at it shall sign them.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairperson considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

Minutes shall be circulated in accordance with members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public upon request as required by **Code of Practice on Openness** in the HPSS and the **Freedom of Information Act 2000**.

5.2.21 Committee Minutes

The minutes of all board Committee meetings shall be presented to the public board meeting immediately following the committee where they have been approved except where confidentiality needs to be expressly protected.

At the board meeting following the meeting of the committee, the committee Chairperson will give a verbal update of the meeting in the absence of the full minutes being available.

Where Committees meet infrequently, the draft minutes may be presented to the subsequent confidential meeting of the board for information only.

5.2.22 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- A notice of motion under the appropriate Standing Order has been given;
- at least two-thirds of the board members are present;
- no fewer than half the total of the board's non-officer members present vote in favour of amendment; and
- the variation proposed does not contravene a statutory provision or direction made by the Department.

5.2.23 Appointments

(a) Appointment of the Chairperson and Members, and Terms of Office

The legislative provisions governing the appointment of the Chairperson and members, and their terms of office, are contained in, Schedule 2, paragraphs 3-6, of the Health and Social Care (Reform) Act (Northern Ireland) 2009. Non-Executive appointments are made in accordance with the **Code of Practice**, issued by the Commissioner for Public Appointments for Northern Ireland.

(b) Appointment of Vice-Chairperson

Subject to the following, the Chairperson and members of the board may appoint one of their number, who is not also an officer member of the board, to be Vice-Chairperson, for such period, not exceeding the remainder of his/her term as a member of the board, as they may specify on appointing him/her.

Any member so appointed may at any time resign from the office of Vice-Chairperson by giving notice in writing to the Chairperson. The Chairperson and members may thereupon appoint another member as Vice-Chairperson in accordance with the provisions above.

If no Vice-Chairperson is available and the Chairperson is unable to conduct a board meeting, members shall appoint one from among the Non Executive members present to act as Chairperson for that meeting.

If no meeting is scheduled or the Chairperson is not available and the Chief Executive needs to take advice on an urgent matter, the Chief

Executive may obtain the agreement of non-executive members to appoint one of their number as Chairperson for this purpose.

Where the Chairperson of the board has passed away or has ceased to hold office, or where he/she has been unable to perform his/her duties as Chairperson owing to illness, absence from Northern Ireland or any other cause, the Vice-Chairperson, if previously appointed, shall act as Chairperson until a new Chairperson is appointed or the existing Chairperson resumes his/her duties, as the case may be. If not previously appointed the board may appoint one of their number, who is not also an officer member of the board, to be Chairperson, for such period. References to the Chairperson in these Standing Orders shall, so long as there is no Chairperson able to perform his/her duties, be taken to include references to the Vice-Chairperson.

(c) Joint Members

Where more than one person is appointed jointly to a post in the board which qualifies the holder for officer membership or in relation to which an officer member is to be appointed, those persons shall become appointed as an officer member jointly, and shall count for the purpose of Standing Orders as one person.

5.2.24 Potential Conflict of Interests

Subject to the following provisions of this Standing Order, if the Chairperson or a board member has any potential conflict of interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the board at which the contract or other matter is the subject of consideration, he/she shall, at the meeting, and as soon as practicable after its commencement, disclose the fact. It shall be disclosed in a manner that cannot be perceived to influence subsequent discussion or decision, and the member shall withdraw from the meeting while the consideration or discussion of the contract or other matter and the vote is being taken.

In **exceptional circumstances** the individual who has declared a potential conflict of interest may be permitted to remain for the discussion where their expertise is specifically required to inform the other members in their discussions. This expert advice shall be restricted to the giving of factual and objective information before withdrawing while the decision and vote is taken.

The DHSSPS may, subject to such conditions as it may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to be in the interests of the HSC that the disability shall be removed.

The board may exclude the Chairperson or a board member from a meeting of the board while any contract, proposed contract or other matter in which he / she has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chairperson or a board member shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chairperson or a board member shall be treated, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- He/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in any other matter under consideration; or

- he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in any other matter under consideration; and in the case of persons living together the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chairperson or a board member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

- of an interest of his as a person providing Family Health Services which cannot reasonably be regarded as an interest more substantial than that of others providing such of those services as he/she provides; or

- of an interest in any company, body or person with which he/she is connected as mentioned in Standing Orders above which is so

remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chairperson or a board member has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a Committee or Sub-Committee and to a Joint Committee as it applies to the board and applies to a member of any such Committee or Sub-Committee (whether or not he/she is also a member of the board) as it applies to a member of the board.

6. Code of Conduct and Code of Accountability – Contents

6.1 Introduction

The **Code of Conduct and Code of Accountability**, issued in July 2012, provides the basis on which the HSC bodies should seek to fulfil the duties and responsibilities conferred upon them by the DHSSPS

The Codes state that high standards of corporate and personal Conduct must be at the heart of the Health and Social Care Organisations.

Since Health and Social Care Organisations are publicly funded, they must be accountable to the Minister for Health, Social Services and Public Safety and ultimately to the Northern Ireland Assembly and the Public Accounts Committee, for the services they provide and for the effective and economical use of taxpayers' money.

6.2 Public Service Values – General Principles

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

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

The PHA is committed to these principles and all individuals are expected to adhere to them in the course of their work.

Those who work in the HSC have a duty to:

- Conduct business with probity;
- deal with patients, clients, carers, staff, residents and suppliers impartially and with respect;
- achieve value for money from public funds; and
- demonstrate high ethical standards of personal conduct.

The Chairperson, board members and all Agency employees/officers are required to accept the provisions of the **Code of Conduct and Code of Accountability** on appointment and to follow the principles set out herein.

The board must set a rigorous and visible example and shall be responsible for corporate standards of conduct and ensure acceptance and application of the Code. The Code shall inform and govern the decisions and personal conduct of the Chairperson, board members and all Agency employees/officers.

6.3 Openness and Public Responsibilities

The Code of Conduct advises that there should be a willingness to be open and to actively involve the public, patients, clients and staff as any need for change emerges. HSC business should also be conducted in a way that is socially responsible.

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

6.4 Public Service Values in Management

It is a long established principle that public sector bodies, which include the PHA, must be impartial, honest and open in the conduct of their business, and that their employees shall remain beyond suspicion. It is also an offence under the Public Bodies Corrupt Practices Act 1889 and Prevention of Corruption Acts 1906 and 1916 for an employee to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour or disfavour, in the handling of contracts.

In the **Code of Conduct** issued by the Department in July 2012, it was emphasized that public service values must be at the heart of the Health and Personal Social Services.

HSC organisations, including the PHA, are accountable to the Minister of Health, Social Services and Public Safety and ultimately to the Northern Ireland Assembly and the Public Accounts Committee for the services they provide and for the effective and economical use of taxpayer's money.

It is unacceptable for the board of any HSC organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. The Chairperson, board members and all staff have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible.

Proper stewardship of public monies requires value for money to be high on the agenda of the board at all times. Employment, procurement and accounting practices within the Agency must reflect the highest professional standards.

Individuals are expected to:

- ensure that the interests of patients and clients remain paramount at all times;
- be impartial and honest in the conduct of their official business; and

- use public funds entrusted to them to the best advantage of the service as a whole always ensuring value for money in the procurement of goods and services.

Public statements and reports issued by the Agency, or individuals within the Agency, shall be clear, comprehensive and balanced, and shall fully represent the facts. They shall also appropriately represent the corporate decisions of the Agency, or be explicit in being made in a personal capacity, where this is considered necessary.

Annual and all other key reports shall (on request) be made available to all individuals and groups in the community who have a legitimate interest in health and social care issues to allow full consideration by those wishing to attend public meetings on such issues.

6.5 Public Business and Private Gain

The **Code of Conduct** issued in July 2012 also outlined the principle that the Chairperson, board members and all staff shall act impartially and shall not be influenced by social or business relationships. No one shall use their public position to further their private interests.

It is the responsibility of all staff to ensure that they do not:

- Abuse their official position for personal gain or to benefit their family or friends or to benefit individual contractors; or
- seek to advantage or further private business or other interests in the course of their official duties.

Where there is a potential for private, voluntary or charitable interests to be material and relevant to board or HSC business, the relevant interest shall be declared and recorded in the board minutes and entered into a register, which is available to the public. This is set out in more detail in SO 6.11.

When a conflict of interest is established or perceived, the Chairperson, board member or member of staff shall withdraw and play no part in the relevant discussion or decision.

6.6 Counter Fraud Policy

The Agency is committed to maintaining an honest, open and well-intentioned atmosphere. It is therefore also committed to the elimination

of any fraud within or against the Agency, and to the rigorous investigation of any such cases.

The Agency has in place a Fraud Policy and Response plan, to give officers specific direction in dealing with cases of suspected fraud, theft, bribery or corruption. Advice may also be obtained from the Director of Operations and the Fraud Liaison Officer (FLO) role provided by the Department of Finance. The PHA's Fraud Liaison Officer (FLO) will ensure that all reporting requirements detailed in Circular HSC (F) 44/2011 are complied with.

The Agency wishes to encourage anyone with reasonable suspicions of fraud to report them. The PHA Whistleblowing Policy enables staff to raise concerns about issues of public interest either internally or externally at an early stage.

6.7 Gifts, Hospitality and Sponsorship

6.7.1 Providing and Receiving Hospitality

The use of public funds for hospitality and entertainment shall be carefully considered within the guidelines issued by the Department in circular HSS(F) 49/2009, and within Standing Financial Instruction 18.

6.7.2 Gifts and Hospitality

Token gifts (generally at Christmas) of very low intrinsic value such as diaries or calendars may be accepted from persons outside the Agency with whom staff have regular contact. At present a limit of £50 is used as a guide to identifying gifts of low intrinsic value but the nature or number of gifts may mean that items whose value is less than this may be considered inappropriate. The number of gifts accepted shall be limited within any financial period.

Apart from trivial/inexpensive seasonal gifts, such as diaries, no gift or hospitality of any kind from any source should be accepted by anyone involved in the procurement or monitoring of a contract. This will ensure that no criticism can be made regarding bias to a particular company or supplier and that the principles of the Bribery Act are complied with.

More expensive or substantial items, valued at £50 or more and gifts of lottery tickets, cash, gift vouchers or gift cheques, cannot on any account be accepted.

All gifts offered, even if they are declined/returned must be recorded in the central register.

If in doubt, staff shall decline the gift or consult their Line Manager/ Director before accepting it. Full details are contained within the Agency's Gifts and Hospitality Policy.

6.7.3 Sponsorship

Commercial sponsorship is not generally acceptable, as acceptance may be perceived as compromising the organisation's integrity.

Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses might be acceptable providing the employee seeks permission in advance and the Agency can be absolutely satisfied that its decision making processes are not compromised.

Members of the board must be satisfied that their acceptance of any commercial sponsorship could not compromise or be perceived to compromise future decisions.

Acceptance of commercial sponsorship of conferences, courses or other events run by the Agency may only be accepted if it can be demonstrated that:

- Promotional material of the sponsor does not unduly dominate the event;
- no particular product is being promoted or receiving an implicit endorsement by association with the Agency; and
- other commercial bodies have been given an equal opportunity to sponsor and be associated with a particular event or other such events over a period of time.

Any decisions regarding sponsorship are to be referred to the Agency Management Team in the case of Agency organized events. Decisions, together with all relevant information, shall be recorded in the minutes for future scrutiny.

A suitable contract shall be drawn up with the prospective sponsor, which sets out the Agency's requirements in line with this Standing Order.

6.7.4 Register(s) of Hospitality, Gifts and Sponsorship

All instances when hospitality, gifts (of less than £50 in value) and sponsorship are accepted or rejected by any Officer and Non-Officer members of the board and by members of staff shall be notified to the Chief Executive's Office with a record thereof. The basis of the decision to accept or reject shall be maintained in the Register and monitored within performance management arrangements set out in the PHA Gifts and Hospitality Policy (compliant with circulars FD (DFP) 19/09 and DAO (DFP) 10/06 revised as at 3 Sept 2009) and shall be made available for public inspection on request.

6.8 Declaration of Interests

The **Code of Conduct and Code of Accountability** requires the Chairperson and board Members to declare interests, which are relevant and material to the Agency on their appointment. All existing managers or budget-holders within the Agency, having delegated responsibility to commit or influence commitment of Public Funds, shall declare such interests on appointment.

Interests that shall be regarded as 'relevant and material' are:

- Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
- ownership or part-ownership of private companies, businesses or consultancies likely, or possibly seeking, to do business with the HSC;
- majority or controlling share holdings in organisations likely, or possibly seeking to do business with the HSC;
- a position of trust in a charity or voluntary organisation involving the field of health and social care;
- any connection with a HSC organisation, voluntary organisation or other organisation contracting (or seeking to contract) for HSC services, or applying for or receiving financial assistance from any NHS body; and
- any other commercial interest in the decision before the meeting.

At the time board members' interests are declared, they shall be recorded in the board minutes. Any changes in interests shall be declared at the board meeting following the change occurring and recorded in the minutes. Such minutes will be drawn to the attention of the board's internal and external auditors.

Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the HSC shall be published in the board's Annual Report. The information shall be kept up to date for inclusion in succeeding Annual Reports.

During the course of a board meeting, if a conflict of interest is established, the Member concerned shall, as soon as practicable after its commencement, disclose the fact. It shall be disclosed in a manner that cannot be perceived to influence subsequent discussion or decision. The member shall withdraw from the meeting and play no part in the relevant discussion or decision (see SO 5.2.24).

There is no requirement under the code, for members to declare 'relevant and material' interests as defined above, held by their spouses or partner. However, it is a requirement of the Constitution Regulations that in the case of married persons, or persons (whether of different sexes or not) living together as if married, the pecuniary interest of one partner shall, if known to the other, be deemed to be also an interest of the other and shall be so disclosed.

The principles of the Bribery Act 2011 must be borne in mind by all Agency officers in conducting business.

6.8.1 Register of Interests

The Chief Executive shall ensure that a Register of Interests is established to record formally declarations of interests of members (including associated and co-opted) and officers. In particular the Register shall include details of all directorships and other relevant and material interests, which have been declared by executive and non-executive board members, managers and budget-holders as defined above.

These details shall be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months shall be incorporated.

The Register shall be available to the public and the Chief Executive shall take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing.

If board members or relevant officers have any doubt about the relevance of an interest, this shall be discussed with the Chairperson, Chief Executive or Executive Director as appropriate

The general principle to be adopted is that if there is uncertainty regarding the need to disclose a particular interest then, in the interests of openness, disclosure shall be made.

6.9 Employee Relations

The Public Health Agency must comply with legislation and guidance from the DHSSPS, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to their staff and represent good value for taxpayers' money.

Appointments to Agency posts shall be made on the basis of merit and in line with all appropriate HR regulations.

The Agency Board shall ensure, through the Remuneration Committee, that executive board members' total remuneration can be justified as reasonable in the light of general practice in the public sector. All board members total remuneration from the organisation of which they are a member shall be published in the Annual Report.

6.10 Personal Liability of Board Members

The Code of Accountability sets out the personal liability of board members. Legal proceedings by a third party against individual board member are very exceptional. A board member may be personally liable if he or she makes a fraudulent or negligent statement which results in a loss to a third party; or may commit a breach of confidence under common law or a criminal offence under insider dealing legislation, if he or she misuses information gained through their position. However, the Department of Health, Social Services and Public Safety has indicated that individual board members who have acted honestly, reasonably, in good faith and without negligence will not have to meet out of their own personal resources any personal civil liability which is incurred in execution or purported execution of their board functions.

6.11 Staff Policies and Procedures

The Agency has a number of policies and procedures on a range of issues affecting staff and how they work within the Agency. Staff can access these from the policies and procedures sections of the PHA intranet site 'Connect' http://connect.publichealthagency.org/ , or directly from their Senior Officer.

The content of these policies has been consulted on with recognised staff side organisations and cover issues such as:

- Health and safety;
- equal opportunities;
- ICT security;
- HR policies (including attendance at courses/conferences, grievance, disciplinary, working well together, flexible working, special leave, drugs, alcohol and substance misuse) and
- Whistleblowing.

6.12 Staff Concerns

The Agency has in place a procedure for raising concerns about malpractice, patient safety, financial impropriety or any other serious risks that they consider to be in the public interest. The Agency Board promotes a culture of safety, built on openness and accountability. Staff are assured that it is safe and acceptable to speak up and that their concerns will be handled with sensitivity or respect for confidentiality. Full details can be found in the PHA Whistleblowing Policy.

7. POWERS AND DUTIES

The powers and duties of individuals within the Agency are generally set out in the relevant Job Descriptions and Contract of Employment. All individuals are expected to behave at all times in accordance with the Standing Orders.

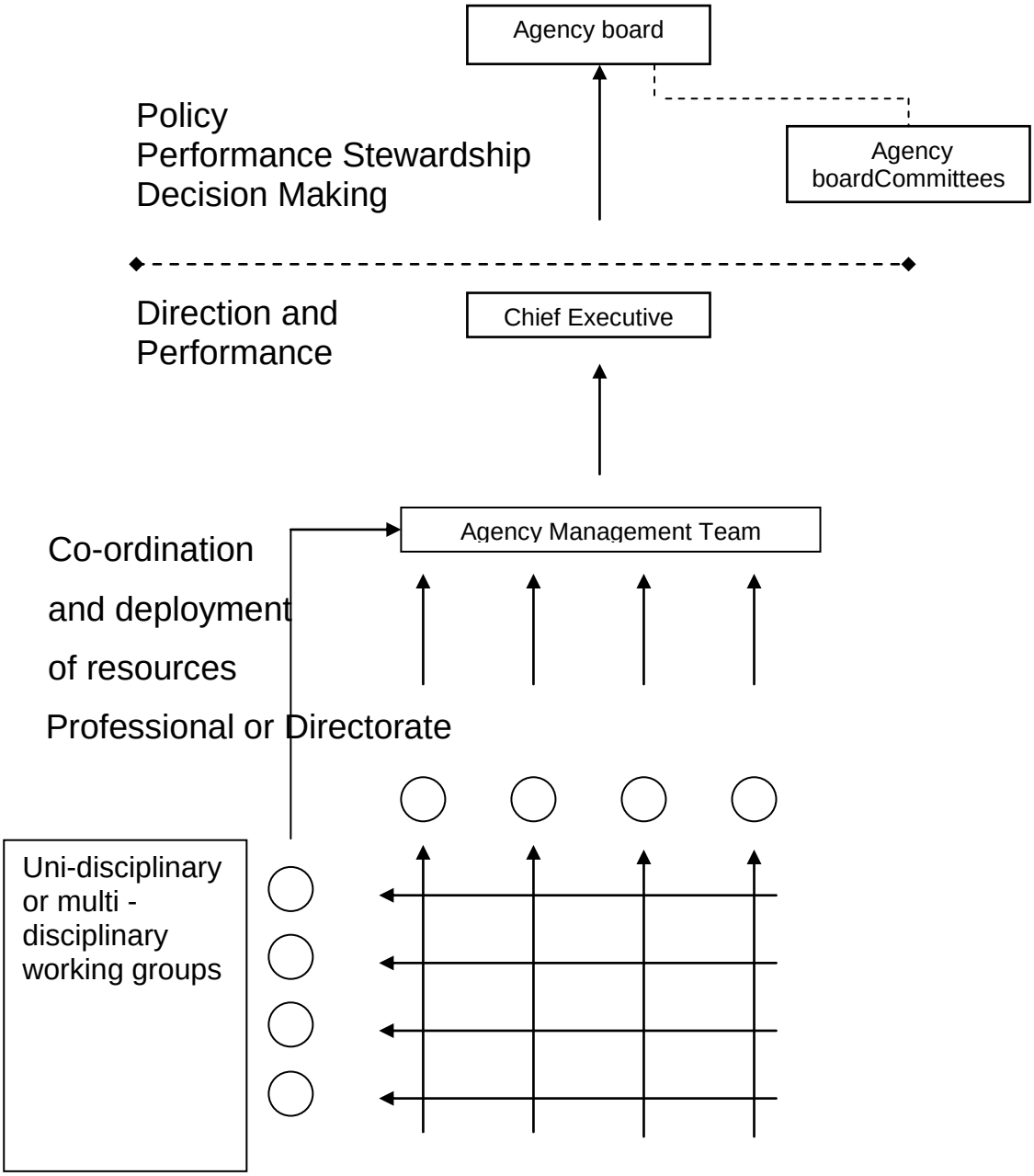
Those individuals who comprise the board, that is the Chairperson, Executive and Non Executive board members, shall pay regard to SO 2, which sets out the main functions of the board and those matters that are reserved to the board.

When acting in the capacity of a member of a board Committee, those individuals shall have regard to the appropriate Scheme of Delegation which sets out those matters which have been delegated by the board.

The Chief Executive, Executive Directors, Senior Managers and other staff shall have regard to any appropriate Scheme of Delegation either by the board or by the Chief Executive. This may delegate responsibility to the individual in a personal capacity or as a member of a working group or committee.

Individuals are accountable through their professional or directorate management structure as well as through any participation on a working group, committee or functional role. This accountability is to the Chief Executive through the Agency Management Team as illustrated in the following diagram.

*** Accountability Structures**



APPENDICES

Appendix 1	Chief Executive's Scheme of Delegation
Appendix 2	Administrative Schemes of Delegation
Appendix 3	Financial Schemes of Delegation
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Chief Executive's Scheme of Delegation **Appendix 1**

This Appendix Relates to Section 3.2 of STANDING ORDERS
CHIEF EXECUTIVE'S SCHEME OF DELEGATION

	ITEMS	RESPONSIBILITY	CONTROLS	DELEGATED TO
3.2.1	Corporate Operational Matters	Matters which impact on the corporate operational performance of the board	Timely submission required from appropriate lead Director or joint submission	Agency Management Team
3.2.2	Corporate Plan	An accessible statement of the Agency's purpose, values and goals; and key actions to be undertaken by the Agency to deliver	To be prepared annually in line with Government proposals	Agency Management Team
3.2.3	Multidisciplinary Planning and Commissioning and Monitoring proposals	Proposed matters which involve the planning and commissioning and monitoring of services including in year management of resources.	Proposals to be submitted for Agency Management Team approval and monitoring	Appropriate Planning or Commissioning Team or Programme lead

	ITEMS	RESPONSIBILITY	CONTROLS	DELEGATED TO
3.2.4	Lead and Manage Individual Directorates	The operational management of individual directorates including leadership and development	Responsive to corporate needs	Individual Executive Directors
3.2.5	Financial Performance of Directorate Operations	Monitoring of individual Directorate performance to achieve overall corporate targets set by the DHSSPS	Monthly reporting by Director of Finance to achieve overall targets	Agency Management Team
3.2.6	Control Assurance Standards and Risk Management	Ensure Agency-wide implementation and compliance with the requirements of Controls Assurance Standards	To be reported through the Governance & Audit Committee to the board	Director of Operations
3.2.7	Policy Approval Process to comply with Control Assurance Standards (CAS)	New policy proposals requiring approval in accordance with the CAS	Policies relating to internal management arrangements to be submitted to Agency Management Team for approval. All other policies have approval reserved to the board	Agency Management Team

Administrative Schemes of Delegation **Appendix 2**

This appendix refers to Sections 3.4.5 – 3.4.8 of the Standing Orders

Relates to Section 3.4 of STANDING ORDERS			
ADMINISTRATIVE SCHEMES OF DELEGATION **3.4.5 Delegation of Budgets for Agency Administration**			
ITEMS	**RESPONSIBILITY**	**CONTROLS**	**DELEGATED TO**
Authorisation and Approval of Non-Pay Expenditure for Agency Administration	The authorisation and approval of non-pay expenditure for Agency administration. Chief Executive further delegates these powers to Directors or nominated Officers within the budgets provided to them and the limits set out below. In turn, they may delegate them to named officers.	Within Limits set out below. The Director of Finance will bring forward annual budgets within which each Director must manage their annual expenditure.	Chief Executive/Directors or other nominated Budget Holders

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.6 Procedure for Delegating Power to Authorise and Approve Non-Pay Expenditure For Agency Administration

AUTHORITY TO INITIATE EXPENDITURE AND APPROVE PAYMENTS

Authority to initiate expenditure and to approve the payment of invoices is delegated to the Chief Executive who delegates it to Directors or nominated Officers. They in turn may delegate these powers to named officers in their directorates.

Each Director shall nominate appropriate officers and the Directorate of Operations will compile a comprehensive list. The list (including specimen signatures) will be copied to the BSO and HSCB (finance). A copy shall be retained in each directorate for reference. The list shall be amended as necessary and reviewed at least annually; a revised version will be distributed.

Expenditure in each specified category is only permitted within the budget provided for it.

The nominated officers shall observe the limits delegated to them on the list (see above), which shall not be exceeded without express approval of the Chief Executive. They must also note their responsibilities in authorising expenditure to be incurred by the Public Health Agency.

ROUTINE EXPENDITURE

Definition

This is expenditure on goods and services for which a budget is provided and which is usually initiated by requisition and repeated periodically. Examples would include office supplies and consumables together with the maintenance of equipment and other establishment costs.

Expenditure Limits

The delegated limits for accommodation leases was removed following Circular HSC(F) 43-2014.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.6 Procedure for Delegating Power to Authorise and Approve Non-Pay Expenditure For Agency Administration

NON-ROUTINE EXPENDITURE

Definition

This is expenditure which occurs on a once-only or occasional basis for which a budget may be provided. It may include books, periodicals, courses, travel, and equipment (costing less than £5,000).

Expenditure limits

As provided by the Scheme of Delegation within the budget or approved funding.

No Budget or Approved Funding:

If no budget or specifically approved funding exists for any such proposed expenditure, a Director or nominated Officer is to consult the Director of Finance to identify a possible source of funds. A submission may then be prepared for the Agency Management Team seeking the authorisation of the Chief Executive for the proposed expenditure and its funding.

Specific Items

Individual procedures applies to the:

- Use of External Management Consultants

(please refer to following sections for further information)

CAPITAL EXPENDITURE

Definition

Capital expenditure is defined in The HPSS Capital Accounting Manual.

The essential elements are that there is an asset capable of use for more than one year and that the expenditure exceeds £5,000.

Expenditure Limits

As provided by the Scheme of Delegation within the budget or approved funding.

Relates to Section 3.4 of STANDING ORDERS AND 8.7.2 WITHIN THE STANDING FINANCIAL INSTRUCTIONS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.7 Procedure for Quotations and Tendering of Non- Pay Expenditure For Agency Administration (unless order drawn from an existing tendered contract)

	Financial Limits	
	Order Value	Requirement
	Up to and including £5,000	May be placed without seeking quotation
	£5,000 - £10,000	**Process to be undertaken by the Contractor:** 4 formal written quotations in sealed envelope to be opened in presence of 2 BSO officers normally including the Admin Services Manager.
	£10,000 - £30,000	**Process to be undertaken by the Contractor:** 5 formal written quotations in sealed envelope to be opened in presence of 2 BSO officers normally including the Admin Services Manager.
	£30,000 - £EU Public Procure-ment Threshold*	**Process to be undertaken by the Contractor:** Publicly advertised tender competition (newspaper/website). Advice will be provided by PaLS as to the most cost effective procurement process on a case by case basis. The approach taken will be dependent on the nature of the contract and the BSO assessment of the skills of the FM provider to undertake the process. The tender process must be conducted in line with Procurement Guidance Note 05/12 (Procurement of Goods, Works and Services over £30,000 and below EU Thresholds)

	>£EU Public Procurement Threshold*	Should be EU advertised and EU Directives apply. To be undertaken by PaLS.

PLACING OF ORDERS

The advice of the Procurement and Logistics Service (PALs) of the Business Services Organisation should be sought in the case of any procurement queries in advance of contracting or ordering.

For orders falling within the financial limits above the Business Services Organisation (PALS) shall order under contracts already negotiated by tendering procedures OR shall advise on the tendering process on behalf of the requisitioning officer.

When selecting suppliers to be invited to submit a quotation or tender for procurements below £30,000, contracting authorities should provide opportunities for Small and Medium sized Enterprises (SMEs) to compete for business in line with Procurement Board's policy.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.7 Procedure for Quotations and Tendering of Non- Pay Expenditure For Agency Administration

For orders falling within the final two financial limits above Officers are advised to consult the Director of Finance. Reference shall also be made to current Procurement Guidance and Control notices and the Department's circular 'Contract Procedure Supplies'.

Requisitions should be placed by creating an "E-Procurement" requisition within the Finance, Procurement and Logistics System (FPL). Any Single Tender Award Contract i.e. those contracts awarded without competition must follow the agreed process set out in Standing Financial Instructions (Section 8) in advance of placing the "e-requisition". It should be noted that contracts of this type should only be approved by the Chief Executive.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

INTRODUCTION

DHSSPS Circular HSC (F) 25/2012, HSC (F) 48/2012 provides revised guidance on the use of professional services, covering the engagement of External Consultants by Health and Social Care organisations.

It applies to **all** contracts for External Management Consultancy projects and deals with the approval management and monitoring of such assignments.

Against this background the Agency has drawn up the following procedure to ensure compliance with this guidance and to enable the Agency's officers to carry out their delegated tasks with the assurance that they have achieved value for money, selected the best consultants for the job, followed the internal and external approval, Standing Orders and other procedures, managed the assignment in a professional manner and completed post review learning exercises.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

DELEGATION

The Agency requires that **all** proposed use of External Management Consultants **must** be submitted to the Chief Executive for authorisation, through the Director of Operations, **BEFORE** engaging or going out to tender. For payment of invoices after the initial approval process, and delivery of the project, the authorisation framework and thresholds shall be applied as set out for non-pay expenditure.

The nominated officer taking lead responsibility for the assignment shall complete relevant documentation (located on Connect and set out in HSC (F) 25/2012) and seek approval according to the summary below:

Annex A – Proposal Proforma
Annex B – Business Case
Annex C – Single Tender Action / Direct Award Contract
Annex D – Completion of Project
Annex E – Post Project Evaluation

These documents must be signed by the relevant Director and submitted to the Finance Department for review prior to authorisation by the Chief Executive. The approved forms must then be submitted to the DHSSPS in all instances.

Appropriate AMT members shall be consulted before making a decision on whether the relevant skills and expertise are available internally.

Detailed guidance and all documentation is available on Connect.

TENDERING

The use of External Management Consultancy is subject to the normal contract procedures as referred to

	in Standing Orders, Administrative/Financial Schemes of Delegation for Non-Pay Expenditure, see above.	

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

LIAISON WITH DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

The circular requires that the Department's Policy and Accountability Unit is notified **in all instances** where there is a case for External Consultants being employed. The Agency has decided that in all cases the notification shall be directed via the Finance Department who shall provide advice on the completion of forms and the notification to the DHSSPS.

The circular and associated supplements also require **the approval** of the Minister for Health, Social Services and Public Safety **before** going out to tender where the fees **are likely to exceed** £9,999 and DFP approval if greater than £75,000. As above, the Director of Finance shall advise on the referral process for approval and shall be the primary point of contact with the Department's Finance Policy and Accountability Unit (FPAU).

In addition, and in exceptional circumstances, if a single tender action (direct award contract without competition) is proposed for the External Consultancy project, the relevant Director must present the case to the Chief Executive who will decide whether the request may proceed to the Permanent Secretary (DHSSPS) for approval of the Single Tender Action, which must be prior to the approval of the Management Consultancy Project.

This is the case at all levels of proposed expenditure on External Management Consultancy with a proposal for a single tender action.

The Business Services Organisation (PALS) should be consulted in cases where a tender is deemed

necessary.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

ENGAGEMENT OF CONSULTANTS

The Agency's standard letter of contract shall be used. Where it is deemed necessary to depart from this, advice shall be sought from the Director of Operations.

MONITORING

The sponsoring directorate or steering Committee must appoint an officer to manage the External ~~Management~~ Consultancy project.

FEES AND EXPENSES

All expenditure **must** be approved according to the Scheme of Delegated Authority after the initial approval to proceed with the scheme by the Chief Executive, Director of Finance, DHSSPS, Minister or DFP as appropriate.

FINANCIAL MONITORING

The Director of Finance, with the support of the Director of Operations, is responsible for maintaining the records of expenditure on assignments completed and/or started during each year, which are required by the circular, and for submitting the quarterly and annual returns to the DHSSPS.

The nominated officer identified as being responsible for managing the project is responsible for advising the Director of Finance on expenditure on the project.

REPORT

The appointed officer and/or the steering Committee/project team shall promptly complete the Post Project Evaluation report recording the assessment of the consultant, which the circular requires. It shall then be forwarded to the Finance Department for onward submission to the DHSSPS. There is a requirement to disseminate lessons learnt from Post Project Evaluations as per Circular HSC(F)

	29-2014.	
Relates to Section 3.4 of STANDING ORDERS		
ADMINISTRATIVE SCHEMES OF DELEGATION **3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration**		
	RECORDS The monitoring officer shall set up a contract file which includes: • terms of reference/consultants brief; • evidence of DHSSPS notification and approval • evidence of notification to Trade Union, if applicable; • evaluation criteria; • copies of all the consultants proposals; • details of the short listing and final selection process; • the letter of contract and any variations; • records of payments; • implementation plans, and • project evaluation details. **CONSULTATION WITH STAFF** DHSSPS Circular HSC (F) 25/2012 requires that before commissioning any consultancy work on an efficiency assignment which may impact on the organisational structure and for staffing, the organisation should notify the relevant staff Association side. **EMPLOYMENT OF IT CONSULTANTS** In addition, the Information Management Group of the NHS HSS Executive has produced a guide on 'The Procurement and Management of Consultants within the NHS.' The Department has issued this as a model of good practice. Volume One focuses on the general issues of which senior management shall be aware and Volume Two on the practical details for a manager purchasing consultancy services.	

Any enquiries in connection with the above shall be addressed, in the first instance, to the Director of Operations.

Financial Schemes of Delegation Appendix 3

This appendix refers to Sections 3.5.1 – 3.5.4 of the Standing Orders

Relates to Section 3.5 of STANDING ORDERS **FINANCIAL SCHEMES OF DELEGATION** **3.5.1 Procedure for Delegation of Budgets**		
	The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and accompanied by a clear definition of: • The amount of the budget; • the purpose of each budget heading; • individual and group responsibilities; • Authority to exercise virement within total revenue or total capital; • achievement of planned levels of service; and • the provision of regular reports.	Standing Financial Instructions Section 5.3
	PRINCIPLES OF DELEGATION Control of a budget shall be set at a level at which budget management can be most effective. Whilst the Chief Executive retains overall responsibility for budgets, they may be delegated to Directors or nominated Officers who may, in turn, delegate the management of a budget to officers under their span of control. A list of the officers so authorised shall be forwarded to the Director of Operations and the Director of Finance.	

Relates to Section 3.5 of STANDING ORDERS

FINANCIAL SCHEMES OF DELEGATION
3.5.1 Procedure for Delegation of Budgets

GENERAL

All expenditure is to be included in the budgetary system and all items must be coded to a budget heading.

Where additional funding is required outside the budgetary framework for prospective expenditure the relevant Director or nominated Officer shall prepare a submission to the Agency Management Team.

TIMETABLE

The Director of Finance shall have discussions with designated holders in February and March of each year and submit proposed budgets to the Chief Executive for approval in March of each year. The delegation of budgets shall be arranged before 1 April each year.

VIREMENT

The rules governing virement are important. Virement powers cannot be unlimited as otherwise the initial budgetary decisions of the board could be nullified. Virement rules which are too restrictive, however, will not then allow the freedom to manage. The PHA board wishes to permit the optimum flexibility through virement, subject to its own priorities and plans. Virement is permissible except where expressly excluded as below:

- **No virement** between capital and revenue budgets is permitted except with the **written** permission of DHSSPS;
- **no virement** from a non-recurrent to a recurrent purpose is permitted;
- **no virement** is permissible between a programme budget and the PHA's Management and Administration budget without prior written authorisation from the Director of Finance, Chief Executive and DHSSPS;

- all non-recurrent virements must be agreed within a period of account and certainly no longer than one year;
- savings arising from PHA policy changes or from imposed cuts are not available to the budget holder;
- fortuitous savings are at the disposal of budget holders in the same way as planned savings (within the context of the above points), although the Chief Executive reserves the right to request all fortunitous savings to be made available for another planned purpose;
- where timing delays, such as the late delivery of capital equipment, mean that expenditure is not incurred in one period of account, then the 'savings' are not available for virement until the postponed expenditure in the following period of account has been committed; and
- If the proposed virement is between two budget holders, both must confirm their agreement to the Director of Finance in writing and the proposed virement must then be submitted to AMT to be approved by the Chief Executive.

OVERSPENDS AND UNDERSPENDS

The consent of the Chief Executive must be obtained before incurring any overspends which cannot be met by virement.

Any funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION **3.5.2 Authorisation & Approval Of Payroll Expenditure for Agency Administration**		
	AUTHORITY TO INITIATE AND APPROVE PAYROLL EXPENDITURE The power to authorise payroll expenditure is delegated to the Chief Executive as determined by the framework approved by the Remuneration and Terms of Service Committee on behalf of the board. The power to appoint a member of staff is delegated to members of the relevant interview panel provided that approval has been obtained from the Chief Executive to initiate the recruitment process. This applies to new posts or replacement staff for both permanent and temporary appointments. Additional payroll costs such as overtime payments are delegated to Directors and nominated Officers to authorise, providing they remain within the total funds for the individual budget concerned, and the approval levels delegated to these roles. The processing of supporting services will be outsourced to the Business Services Organisation managed through a Service Level Agreement mechanism.	
Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION (SO.4.5) **3.5.3 Authorisation and Approval of Non-Payroll Expenditure For Agency Administration**		
Financial Limits	The responsibility for the authorisation and approval of non-pay expenditure for Agency administration is delegated to the Chief Executive. The Chief Executive further delegates these powers to Directors and nominated Officers within the budgets provided to them and the limits set out below in line with the Scheme of Delegated Authority.	

	In turn, they may delegate them to named officers.	

Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION (SO.4.5) **3.5.3 Authorisation and Approval of Non-Payroll Expenditure For Agency Administration**		
Not required	**1. <u>Routine Revenue Expenditure</u>** – Within budget limits	
Limits may be Varied	**2. <u>Non-Routine Revenue Expenditure</u>** **(excluding use of external management consultants (3.4.8)** **within budget or ear-marked funds:** Please refer to the current Scheme of Delegated Authority for full details of all authorised limits. **No budget or ear-marked funds**: – submission to Agency Management Team **Use of Management Consultants** <u>Authorisation of proposed use</u>:	
Up to £9,999	– Chief Executive and notify Policy & Accountability Unit in advance	
£10,000 - £74,999	– Chief Executive plus authorisation of the Minister (DHSSPS) in advance.	
≥ £75,000	– Approvals as lower levels and DFP authorisation in advance	
Any amount	<u>Approval to pay</u>: As per the Scheme of Delegated Authority for Non-purchase order Administration costs. <u>Please note where a single tender action (direct award contract) is proposed for an External Consultancy project the Permanent secretary's advance approval must also be secured, this applies to ALL levels of expenditure.</u>	

Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION (SO.4.5) **3.5.3 Authorisation and Approval of Non-Payroll Expenditure For Agency Administration**		
	3. <u>Capital Expenditure</u> All capital expenditure is subject to appropriate business cases based on Green Book Guidance and the NI Guide to Expenditure Appraisal and Evaluation (DFP) (NIGEAE) Approval levels are as follows:	
<£50,000 >£50,000	– Chief Executive – PHA board	
	4. <u>Disposal of Agency Assets</u>	
<£50,000 >£50,000	– Chief Executive – PHA board	
Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION **3.5.4 Authority To Initiate And Approve Cash Advances To HSC Bodies**		
	FUNCTION **<u>CASH ADVANCES</u>** The responsibility for the authorisation and approval of Cash Advances to HSC Bodies is reserved to the Department of Health Social Services and Public Safety. The Department retains responsibility for the reconciliation of overall HSC cash draw and reported Income and Expenditure positions of individual HSC organisations in Northern Ireland. **<u>Limits of Authority</u>** There is no delegated authority, to the PHA from the Department for cash advances in any single financial year	

Appendix 4

GOVERNANCE AND AUDIT COMMITTEE - Contents

GOVERNANCE AND AUDIT COMMITTEE

1.0 REMIT AND CONSTITUTION

1.1 Introduction

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

1.1.1 The Code of Conduct and Code of Accountability originally issued in November 1994, updated and reissued in July 2012, specifies the requirement for HSC Bodies to establish an Audit Committee. It states that the audit committee supports the board and Accountable Officer with regard to their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. Circular HSS(PDD)8/94 set out detailed guidance on the establishment of audit committees. In addition a Departmental letter issued on 10 July 2009 provides for a representative of the DHSSPS to attend a Governance and Audit Committee once a year for the purposes of oversight of the Public Health Agency's systems. This follows on from the Public Accounts Committee's recommendations set out in their report in July 2008 entitled Good Governance – Effective Working Relationships between Departments and their Arm's Length Bodies.

1.1.2 Circular HSS (PPM) 6/2002 announced that the DHSSPS, in recognition of the importance of a sound system of risk management, had entered into a license agreement with Standards Australia for the use of their internationally recognised risk management standard AS/NZS 4360:1999 (now updated to 2004 model). The application of this internationally recognised approach to risk management would be seen as an important piece of evidence in support of a Statement of Internal Control.

1.1.3 The application of Controls Assurance standards within the HSC was announced in Circular HSS (PPM) 8/2002. This process would enable individual HSC organisations to provide evidence that they are doing their reasonable best to protect users, staff,

the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can discharge their responsibilities and provide assurances to the Department, the Assembly and the Public.

1.1.4 In January 2003 the DHSSPS issued guidance under Circular HSS (PPM) 10/2002, specific to clinical and social care governance. The guidance was to enable HSC organisations to formally begin the process of developing and implementing clinical and social care governance arrangements within their respective organisations and set a framework for action which highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

1.1.5 The circular also stipulated the requirement that this new guidance should be read in the context of previous guidance already issued on the implementation of a common system of risk management and the development of controls assurance standards for financial and organisational aspects of governance.

1.1.6 The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HSC Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care have been issued by DHSSPS. They will be used by the new Regulation, Quality Improvement Authority (RQIA) to assess the quality of care provided by the HSC.

1.1.7 The Audit and Risk Assurance Committee Handbook (NI), issued by the Department of Finance and Personnel (March 2014) sets out the five good practice principles (membership, independence, objectivity and understanding; skills; role of the audit and risk assurance committee; scope of work; communication and reporting) which Governance and Audit Committees should meet.

The board of the Agency have agreed the following process, which is reviewed in light of any subsequence guidance.

1.1.7 The Governance and Audit Committee will have an integrated governance approach encompassing financial governance, clinical and social care governance and organisational governance, all of which are underpinned by sound systems of risk management.

1.1.8 The Governance and Audit Committee will support the PHA board and Accounting Officer by reviewing the completeness of assurances to satisfy their needs and by reviewing the reliability and integrity of the assurances.

1.1.9 A designated senior manager shall serve as secretary to the Committee

1.2. Role

1.2.1 The board is responsible for:

- management of its activities in accordance with laws and regulations; and
- the establishment and maintenance of a system of internal control designed to give reasonable assurance that:

    - assets are safeguarded;
    - waste and inefficiency are avoided;
    - reliable financial information is produced; and
    - value for money is continuously sought.

1.2.2 The Committee assists the board in these functions by providing an independent and objective review of:

- All control systems;
- the information provided to the board;
- compliance with law, guidance and **Code of Conduct and Code of Accountability**; and
- Governance processes within the board.

The Committee is authorised by the board to investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times to inspect any books, records or documents including any e-mail records of the board. It can seek any information it requires from any employee and all employees are directed to

co-operate with any request made by the Committee. The only exception to this is patient identifiable data that is required to be kept confidential.

The Committee is authorised by the board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary subject to the board's procurement, budgetary and other requirements.

The Governance and Audit Committee may, by giving reasonable notice, require the attendance of any of the Officers or staff and auditors of the board at any meeting of the Committee.

1.2.3 The Committee shall give an assurance to the board of the Agency each year on the adequacy and effectiveness of the system of internal control in operation within the Agency.

1.2.4 The Chair of the Committee should report to the board on a regular basis on the work of the Committee.

1.3 Terms of Reference

The Terms of Reference will be reviewed at least annually by the PHA board and the Governance and Audit Committee to ensure that the work of the Committee is aligned with the business needs of the organisation.

1.3.1 The Committee shall undertake the following tasks:

- Review and recommend the board approve the Governance Framework, any associated implementation plan and the PHA Assurance Framework;
- review the monitoring reports of the Information Governance Steering Group;
- provide assurance to the board that governance is being appropriately managed in line with the Governance Framework;
- Advise the board on the strategic processes for risk, control and governance and the Governance Statement;
- review and approve the internal audit work plan prior to commencement of work;

- review verification reports and assurance reports from internal audit assignments and management's responses;
- monitor management's progress in meeting internal audit recommendations;
- prior to the external audit, discuss the audit plan with the auditor including the reliance to be placed on internal audit;
- review the external auditor's report to those charged with Governance and management's response;
- review the Annual Report and the Financial Statements prior to signature by the Accounting Officer;
- periodically obtain the views of the external and internal auditors on the work and effectiveness of the Governance and Audit Committee;
- seek annual assurance of the independence and effectiveness of the Agency's external and internal auditors;
- consider any report of the Public Accounts Committee or the Comptroller and Auditor General involving the Agency and review management's proposed response before presentation to the board;
- bring to the board's attention VFM studies that have been done elsewhere which might be relevant and review the work of the Agency in this area;
- review the Agency Officer responses and actions in respect of RQIA assessments and recommendations, where applicable;
- review Agency Officer responses and actions in respect of other regulatory and supervisory bodies;
- review and give particular attention to non-standardised issues of representation;
- give regular reports (both written and verbal) to the PHA board;
- provide an annual report to the PHA board timed to support preparation of the ~~Statement of Internal Control~~ Governance Statement; and
- Carry out an annual review of the committee in accordance with the NIAO audit committee self assessment checklist.

1.3.2 The responsibility for internal control rests with management. The Governance and Audit Committee shall review its scope and effectiveness.

1.3.3 The Governance and Audit Committee shall also:

- Review proposed changes to standing orders and standing financial instructions;
- examine the circumstances associated with each instance when standing orders are waived;
- review all proposed losses for write-off and compensation payments and make recommendations to the board;
- approve accounting policies and subsequent changes to them;
- monitor the implementation of the **Code of Conduct and Code of Accountability** thus offering assurance to the board of probity in the conduct of business; and
- monitor and review the effectiveness of the Agency's Counter Fraud programme and the whistle-blowing processes.

1.4 Composition of the Governance and Audit Committee

1.4.1 The Committee shall comprise a minimum of four Non-Executive Directors with a quorum of three. In exceptional circumstances, and only with the approval of the Chair, the quorum shall be two. A number of Lay Advisors may be appointed and shall attend meetings of the Committee and shall participate fully in the discussions but shall not be able to vote.

1.4.2 None of these Non-Executive Directors shall be the Chairperson of the board although he/she may be invited to attend meetings that are discussing issues pertinent to the whole Agency. Additionally, none of the Governance and Audit Committee members should be the chair of members of the remuneration committee.

1.4.3 The Director of Operations of the Agency, the internal and external auditors and the Lead Officer for Governance (Assistant Director Planning and Operational Services) may attend the Committee by invitation and others may also be required to attend as necessary.

1.4.4 Where possible, at least one member of the Committee shall have financial expertise and if possible, the remaining members shall include representation from clinical and social care backgrounds.

1.4.5 The Non-Executive members shall select a Chairperson of the Committee from among their number.

1.4.6 The Chairperson of the Committee will ensure open lines of communication with members of the Committee, the board, Head of Internal Audit and Head of External Audit.

1.4.7 The Governance and Audit Committee will annually review the skills base to check they have the necessary skills required for an effective committee.

1.5 Establishment of a Governance and Audit Committee

1.5.1 The Governance and Audit Committee is to be constituted as a Committee of the board with the authority to act with independence. The terms of reference of the Committee are to be approved by the board and recorded in the board minutes.

The members of the Committee shall be appointed by the board and shall hold office for three years. At any time any member of the Committee may resign or be removed by the board and shall cease to be a member of the Committee upon ceasing to be a board member. Any vacancy shall be filled promptly by the board.

1.5.2 Governance and Audit Committee meetings shall be conducted formally and minutes submitted to the board at its next meeting in accordance with section 5.2.21.

1.5.3 The Committee shall expect to meet at least four times per year. Agendas and briefing papers shall be prepared and circulated in sufficient time for members to give them due consideration.

1.5.4 As part of one of the meetings, members shall consider the internal and external audit plans and at another meeting, shall review the annual report of the External Auditor. There shall be an opportunity for the Committee to meet the External Auditor once a year without the Chairperson of board, the Executives and officers being present.

1.5.5 If the Committee is of the view that there is evidence of an ultra vires transaction or the committing of improper acts, the

Chairperson of the Governance and Audit Committee shall present the facts to a full meeting of the board. Exceptionally, the matter may need to be referred to the DHSSPS (to the Director of Financial Management in the first instance).

1.6 Relationship with Internal Audit

1.6.1 The Governance and Audit Committee must obtain the necessary information to assure the board that the systems of internal control are operating effectively and for this they shall rely on the work of Internal Audit together with the External Auditor and on the work of the Agency's Governance Officer Group.

1.6.2 The Governance and Audit Committee shall receive reports of findings on internal control. These reports shall form the basis of the Committee's conclusions and recommendations. The Director of Operations is responsible for the management of internal audit arrangements. The Committee shall participate in the selection process when an internal audit service provider is changed.

1.6.3 A nominated officer is responsible for securing an internal audit service. A direct reporting line, independent of the Chief Executive and other Executive Directors, shall be available to the Chair of the Governance and Audit Committee.

1.6.4 The Chair of the Governance and Audit Committee will meet annually with the head of Internal Audit.

1.7 Relationship with External Audit

1.7.1 The Governance and Audit Committee shall rely upon the certification of the accuracy, probity and legality of the Annual Accounts provided by the External Auditor, combined with the more detailed internal audit review of systems and procedures and other monitoring reports provided by officers, in discharging its responsibilities for ensuring sound internal control systems and accurate accounts and providing such assurances to the board.

1.7.2 The External Auditor shall provide an independent assessment of any major activity within his remit and a mechanism for

reporting the outcome of value for money or regularity studies. Non-Executive Directors shall raise any significant matters which cause them concern.

1.7.3 The Northern Ireland Comptroller and Auditor General is the appointed External Auditor. He may appoint independent companies as external auditor. The Governance & Audit Committee has a duty to ensure that an effective External Audit service is provided. Officers shall offer advice to the Committee in their annual assessment of the performance of the External Audit Service. The Committee shall also monitor the extent and scope of co-operation and joint planning between external and internal audit. Any problems shall be raised with the External Auditor.

1.7.4 The Chair of the Governance and Audit Committee will meet annually with the External Auditor.

2.0 CONDUCT OF BUSINESS

2.1 Attendance

2.1.1 Only the members of the Committee, the Lay Advisors and the nominated senior manager (who acts as secretary to the Committee), shall attend meetings as a matter of course together with appropriate administrative support staff.

2.1.2 The board's Chairperson and other Executive or Non-Executive board members may be invited to attend as required. The Lead Officer for Governance, the Director of Operations and the Director of Finance shall have a standing invitation to attend all meetings except the annual meeting with the External Auditor when it is stipulated that no Officers shall attend (see 2.1.3 below).

2.1.3 The External Auditor shall be invited to attend any meeting of the Committee. The Committee shall meet the External Auditor, without the presence of officers, once a year.

2.1.4 A nominated senior manager is responsible for securing the internal audit service for the Agency. He/she shall ensure the management respond promptly to Internal Audit reports and

shall monitor the performance of the Internal Audit Service on behalf of the Committee.

2.1.5 Any member of staff of the Agency may be required to attend a meeting of the Committee as necessary.

2.1.6 The Corporate Secretariat shall service the committee.

2.2 Agenda

2.2.1 Governance and Audit Committee meetings will include 'conflict of interest' as a standing item. In instances where there is a declaration of interest in any of the agenda items, members will be asked to leave the meeting while those items are being discussed. In instances where the conflict of interest is likely to be ongoing the member may be asked to stand down from the Governance and Audit Committee.

2.2.2 Items for 'Any Other Business' should formally be requested from the chair in advance of the meeting.

2.3 Frequency of Meetings

2.3.1 Routine meetings are to be held four times per year with a specific remit as the core of each meeting, although any appropriate matters may be considered at any meeting. Further meetings may be arranged at the discretion of the Chairperson as necessary. The Secretary to the Committee shall upon request of the Chair or any other member of the committee, or by the board's external auditors, call a meeting of the Committee, either by letter, e-mail, fax or telephone, giving at least three working days notice.

2.4 Complaints Matters

2.4.1 Complaints will be reviewed by the Governance and Audit

Appendix 5

REMUNERATION AND TERMS OF SERVICE COMMITTEE

Contents

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1.0 REMIT CONSTITUTION AND CONDUCT OF BUSINESS

1.1 Introduction

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

The Code of Conduct and Code of Accountability, set out in Circular HPSS PDD 8/94, updated and reissued in July 2012, require that a Remuneration and Terms of Service Committee be established.

1.2 Background

All staff with the exception of Director's on Senior Executive Contracts are on the Nationally agreed terms and conditions of service. The work of the Committee must take place within this context.

1.3 Role

The primary responsibility of the Remuneration and Terms of Service Committee is to advise the board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives subject to the direction of the Department of Health, Social Services and Public Safety.

The Committee is authorised by the board to investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times to inspect any books, records or documents including any e-mail records of the board. It can seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The only exception to this is patient identifiable data that is required to be kept confidential.

The Committee is authorised by the board to obtain outside legal or other independent advice and to secure the attendance of outsiders

with relevant experience and expertise if it considers this necessary subject to the board's procurement, budgetary and other requirements.

1.4 Terms of Reference

The main functions of the Committee are:

- To make recommendations to the board of the Agency on the total remuneration and terms of service package for officer members of the PHA board to ensure that they are fairly rewarded for their individual contribution to the organisation. This would include having proper regard to the organisation's circumstances and performance and to the provision of any arrangements established by the Department of Health, Social Services and Public Safety for such staff, where appropriate. The Remuneration and Terms of Service Committee shall also ensure that board Members' total remuneration can be justified as reasonable in accordance with departmental limits;
- to oversee the proper functioning of performance and appraisal systems;
- to oversee appropriate contractual arrangements for all staff. This would include a proper calculation and scrutiny of termination payments, taking account of such national and departmental guidance as is appropriate;
- to agree and monitor a remuneration strategy that reflects national agreements and Departmental policy; and
- to monitor the application of the remuneration strategy to ensure adherence to all equality legislation;

1.5 Relationship with and Reporting to the board of the Agency

The Committee shall report, in writing, to the board of the Agency the basis for its recommendations. The board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officers members in matters not already directed by the Department. Minutes of the board Meeting shall record such decisions.

1.6 Composition of the Remuneration and Terms of Service Committee

The Committee shall comprise the Agency Chairperson and at least two Non-Executive Directors. A quorum shall be two members. None of these members should be members of the audit committee.

The Chief Executive and other Senior Executives shall not be present for discussions about their own remuneration and terms of service. However, they can be invited to attend meetings of the Committee to discuss other staff's terms as required.

The Chief Executive, Director of Operations and a nominated HR Officer from the BSO shall provide advice and support to the Committee.

1.7 Establishment of a Remuneration and Terms of Service Committee

The Committee shall be constituted as a Committee of the board with the power to make decisions on behalf of the board of the Agency and where appropriate make recommendations to the board of the Agency. The Terms of Reference are to be approved by the board and recorded in the board minutes.

Committee meetings shall be conducted formally and minutes submitted to the board at its next meeting in accordance with the Policy set out in 5.2.21.

The Committee shall expect to meet at least two times per year. Agenda and briefing papers shall be prepared and circulated in sufficient time for members to give them due consideration.

2.0 CONDUCT OF BUSINESS

2.1 Attendance

2.1.1 Only the members of the Committee, the Chief Executive, the Director of Operations and a nominated HR Officer (from the BSO) shall attend meetings as a matter of course. Appropriate

administrative support staff shall be in attendance to record the business of the meetings.

2.1.2 Other Executive or Non-Executive board Members and Officers may be invited to attend as required. The Director of Operations shall have a standing invitation to attend all meetings.

2.1.3 A nominated HR officer (BSO) will be responsible for the implementation of remuneration and terms and conditions of service in the Agency. He/she shall deal with all matters affecting terms and conditions of service. He/she shall be present at every meeting.

2.1.5 Any member of staff of the PHA may be required to attend a meeting of the Committee, as necessary.

2.1.5 The Committee Chair shall request fuller explanatory Information in papers put before them, if there are any doubts or uncertainties and the issues discussed shall be summarised in the minutes.

2.2 Agenda

2.2.1 Remuneration Committee meetings will include 'conflict of interest' as a standing item. In instances where there is a declaration of interest in any of the agenda items, members will be asked to leave the meeting while those items are being discussed. In instances where the conflict of interest is likely to be ongoing the member may be asked to stand down from the Remuneration Committee.

2.3 Frequency of Meetings

2.3.1 Meetings should be held as least once every six months to review remuneration matters or deal with specific matters. Further meetings may be arranged at the discretion of the Chairperson, as necessary.

Appendix 6

AGENCY MANAGEMENT TEAM

Contents

1.0 Role

1.1 **The Agency Management Team (AMT) role can be summarized as:**

- Ensuring processes are in place to deliver key objectives and priorities;
- Ensuring coordination and oversight of budget plans and expenditure,
- Oversight of overall performance and outcomes in keeping with the strategic direction set by and decisions of the PHA board;
- Coordination of capacity and skills across Directorates, functions and with other bodies;
- Ensuring risks to the Agency, its work and assets are being managed and addressed satisfactorily; and considering and clearing papers for consideration by the board of the PHA.

1.2 In furtherance of this AMT will ensure proper consideration and approval of proposals such as those set out in development proposals, strategies, plans, business cases, evaluations, monitoring and investment/disinvestment proposals. This is particularly important where the PHA is the lead organization (albeit that the paper may also be of relevance to the HSCB/BSO or Trusts and may also subsequently be submitted to their senior management teams)

2.0 Attendance

2.1 The Agency Management Team comprises:

- Chief Executive;
- Director of Public Health/Medical Director;
- Director of Nursing/Allied Health Professionals;
- Director of Operations;
- Director of Social Care and Children, HSCB;
- Director of Finance, HSCB, and
- Any other Officer who the Chief Executive determines should be a member of the Agency Management Team.

The chief executive will chair AMT, with the Director of Operations deputising in his absence.

3.0 Frequency of Meetings

The AMT will normally meet on a weekly basis.

Appendix 7 – Role of Chairperson

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

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

- Formulating the board's strategy for discharging its duties;
- Ensuring that the board, in reaching decisions, takes proper account of guidance provided by the Department and other departmentally designated authorities;
- Ensuring that risk management is regularly and formally considered at board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;
- Encouraging high standards of propriety;
- Representing the views of the board to the general public;
- Ensuring that the board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual board members;
- Ensuring that all board members are fully briefed on the terms of their appointment, their duties, rights and responsibilities and assess, annually, the performance of individual board members.

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

HSC Public Health Agency

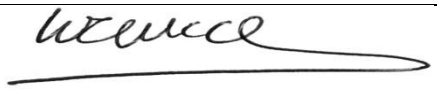
PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 March 2015
Title of Paper	Information Governance Strategy 2015 - 2019
Agenda Item	11
Reference	PHA/04/03/15

Summary

The PHA initially developed and approved its Information Governance Strategy in February 2012. The Strategy has now been revised and updated, and takes account of any revised guidance, including the new information management controls assurance standard, issued since 2012.

The Strategy sets out the framework to ensure that the PHA meets its obligations in respect of information governance. It will be supported by annual action plans, implementation of which will monitored by the Information Governance Steering Group with regular reports to the Governance and Audit Committee.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This Strategy was approved by the Information Governance Steering Group on 13 January, AMT on 27 January and by the Governance and Audit Committee on 19 February.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	9 March 2015

Information Governance

Strategy

Incorporating the

Information Governance Framework

2015 – 2019

Version	**1.7 Draft**
Approved by	
Date Approved	
Review Date	**March 2019**
Version	1.4
Approved by	IGSG & GAC & PHA board
Date Approved	13/2/12 & 16/2/12 &19/04/12

Table of Contents

1.0 Introduction

The Public Health Agency is heavily dependent on the information and records it holds. It recognizes that its records and information must be appropriately managed, handled and protected to serve its business needs and act openly while at the same time ensuring that personal and sensitive data is protected. It must also demonstrate compliance with all relevant legislation[1] as well as DHSSPS standards.

In recognising its public accountability the PHA will make every effort to ensure that information is efficiently managed and that appropriate policies, procedures and management accountability and structures provide a robust governance framework for information management. The framework will ensure that information is accessible while also ensuring the confidentiality of personal data (client and staff), and corporately sensitive information, through adopting robust security measures to protect that information from accidental loss, accidental disclosure or deliberate unauthorised disclosure.

2.0 Scope of Information Governance

The Information Governance Strategy sets out the framework to ensure that the PHA meets its obligations in respect of information governance; it will also be the vehicle for improving information governance in the PHA. The Strategy covers the 4 year period from 2015 to March 2019 and will be supported by annual Action Plans setting out how it will be implemented. The action plan will be monitored by the Information Governance Steering Group[2], chaired by the Senior Information Risk Owner (Director of Operations). Reports will be submitted to the PHA Governance and Audit Committee on a regular basis

[1] *Appendix 1 Legislation and Guidance*
[2] *Appendix 2 PHA Information Governance Steering Group (IGSG)*

3.0 Purpose

The general purpose of the Information Governance Strategy is to provide clear direction to the PHA in delivering the requirements of information governance and associated policies. The strategy will assist in establishing and maintaining a robust and effective Information Governance Framework[3] that allows PHA to fully discharge it strategic duties ensuring that overall corporate compliance is met both in relation to legal and statutory obligations and in meeting all relevant codes of practice.

The Information Governance Strategy cannot be seen in isolation as information is central to all areas of work in the PHA. Information Governance is also a key element of corporate and clinical governance. This strategy is, therefore, closely linked with other strategies to ensure integration with all aspects of the Agency's business activities.

4.0 Benefits

Benefits of a robust and fully implemented Information Governance strategy can be summarised as follows:

- Ensures that decisions are based on readily accessible high quality information
- Ensure that information is held and handled securely, and that personal and sensitive information is safeguarded;
- Reduce risks associated with poor and unregulated systems and processes
- Reduce data losses and the negative impact such losses have on corporate image
- Ensures that legal and other DHSSPS requirements are met
- Supports corporate governance and underpins the assurance framework and corporate risk register
- Ensures that information and information assets are managed in a coherent manner reducing duplication of effort and increasing availability.

[3] *Appendix 3 PHA Information Governance Management Framework*

5.0 Objectives

The key objectives of this Strategy are to ensure the effective management of Information Governance by:

- Complying with all legislation;
- Establishing, implementing and maintaining policies for the effective management of information;
- Recognising the need for an appropriate balance between openness and confidentiality in the management and use of information;
- Providing assurance that all information risks are identified, managed and where possible mitigated;
- Minimising the risk of breaches and inappropriate use of personal data;
- Ensuring that the public are effectively informed and know how to access their information and exercise their right of choice;
- Ensuring all PHA staff are sufficiently trained and enabled to follow and promote best practice in regard to the management of information;
- Achieving and improving compliance year on year with the DHSSPS led Information Management Controls Assurance Standard.

6.0 Information Governance Framework

The Information Governance Framework[4] is intended to pull together the various strands of policy and activity covered by 'Information Governance'. This is important as there are several policies[5] which impinge on Information Governance. It will enable PHA to set out and promote a culture of good practice around the processing of information and use of information systems throughout the organisation. That is, to ensure that information is handled to ethical and quality standards in a secure and confidential manner. The PHA requires all employees and Members to comply with the extant policies, procedures and guidelines which are in place to implement this framework.

[4] *Appendix 3 PHA Information Governance Management Framework*
[5] *Appendix 4 PHA Information Governance Policies*

6.1 Information Governance Policy Statement

A clear policy framework is critical to ensuring a coherent approach to Information Governance across all PHA functions and locations. This strategy is supported by a suite of information governance policies[6]. All Information Governance related policies will be reviewed and updated as necessary on a regular basis.

6.2 Roles, Responsibilities and Reporting Arrangements

- **Chief Executive –** The Chief Executive, as Accounting Officer, has responsibility for ensuring that the PHA complies with its statutory obligations and DHSSPS directives.

- **PHA Board –** is responsible for ensuring appropriate systems are in place to ensure effective Information Governance across all the services for which PHA are responsible. An Information Governance annual report will be presented to the PHA Board at least annually.

- **PHA Governance and Audit Committee (GAC) –** The GAC has responsibility for providing the PHA Board with an independent and objective review of governance processes and an assurance on the adequacy and effectiveness of the system of internal control within the PHA. It will formally review progress on the implementation of this Strategy and Action Plan on an annual basis.

- **PHA Agency Management Team -** AMT will receive updates on Information Governance matters on both a formal and informal basis via the Director of Operations who fulfils the role of Senior Information Risk Owner (SIRO) and Chair of the Information Governance Steering Group. The PDG will also report on matters relating to patient identifiable information where appropriate.

- **Information Governance Steering Group (IGSG)** - Consisting of representatives from all PHA Directorates the primary function of the IGSG will be to lead the development and implementation of the

[6] *Appendix 4 PHA Information Governance Policies*

Information Governance framework across the organisation. The Group will be chaired by the SIRO and will meet on a quarterly basis.

- **Senior Information Risk Owner (SIRO) -** The SIRO (Director of Operations) is the focus for the management of information risk at board level. The SIRO will advise the Accounting Officer on the Information Risk aspect of the Governance Statement and will own the overall information risk and risk assessment process.

- **The Personal Data Guardian (PDG)** - The PDG (Director of Public Health/Medical Director) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. The PDG is the 'conscience' of the organisation in respect of patient information, and will also promote a culture that respects and protects personal data. The PDG works closely with the SIRO and Information Asset Owners where appropriate, especially where information risk reviews are conducted for assets which comprise or contain patient/service user information.

- **Information Asset Owners (IAO's)** - The IAO's primary role will be to manage and address risks associated with the information assets within their function and to provide assurance to the SIRO on the management of those assets. Each PHA Assistant Director is the IAO for their function and also sit on the Information Governance Steering Group.

- **Deputy IAO's** – The Deputy IAO has responsibility delegated from the IAO to support them in the management of the information assets within their function

- **Assistant Director Planning and Operational Services (AD P&OS)** - The AD P&OS has responsibility delegated from the SIRO for ensuring that effective systems and processes are in place to address the information governance agenda.

- **Governance Manager -** The Governance Manager is operationally responsible for the day to day implementation of all aspects of Information Governance.

- **Records Management Working Group (RMWG)** – Chaired by the Assistant Director of Planning and Operational Services this Group will address the Records Management function within the PHA developing and implementing an effective system across all offices. Membership consists of representatives from each Directorate. Members will in turn cascade progress across all teams within their Directorate. The RMWG reports to the IGSG.

- **All Staff** - All staff have a responsibility to comply with this Strategy and all information governance policies and procedures.

6.3 Leadership

Effective leadership is essential to create and nurture a corporate culture conducive to effective Information Governance. A culture of both corporate and individual ownership and responsibility is essential when looking to effective compliance with all statues and codes of practice.

6.4 Supporting Staff

Clear accountability arrangements will ensure that staff are accountable for the work that they do and the information assets they process and manage. There should be an open and supportive environment in which errors, mistakes or concerns can be raised immediately with management, and corrective measures implemented swiftly and processes changed accordingly. This culture will further mitigate risks associated with the handling and processing of sensitive information, both corporate and personal in nature.

6.5 Communication

It is important to ensure that staff are aware of Information Governance issues, with updates as required. Effective and timely communication of Information Governance matters to all PHA staff is essential if the PHA is to meet the aims and objectives associated with this strategy. As well as ensuring compliance with this strategy and associated policies and

procedures, the wider Information Governance agenda within the Public Sector is a fast moving and quickly developing one, and it will be necessary to communicate new directives or initiatives to staff. Communicating matters to staff must be handled with care to ensure that the message is not lost amongst a wealth of material.

6.6 Training

It is also essential to ensure that all staff understand and have the knowledge and skills to put the Information Governance Strategy and associated policies and procedures into operational use. The PHA will ensure that appropriate training is developed and available to up-skill existing staff and new staff entering the service, this will include the use of the e-learning platform. All staff are required to undertake mandatory Information Governance training. The responsibility for ensuring that staff participate in these programmes rests with the relevant line managers with support from the Information Governance Steering Group. Members should also avail of relevant information governance awareness and training.

6.7 Implementation and Performance Monitoring

Performance will be monitored annually against a set of standards and targets in the form of the Information Management Controls Assurance Standards (CAS). Information Governance is also a specific element of the Governance Statement providing assurance in respect of information risk. The Information Governance Action Plan associated with this Strategy will also provide a mechanism by which progress can be monitored. The following reporting arrangements will apply:

- Quarterly progress reports on the Information Governance Action plan will be brought to the Information Governance Steering Group;
- Quarterly reports on progress against the Information Governance action plan will be brought to the Governance and Audit Committee;
- Reports to the Agency Management Team as required;
- An annual report will be brought to the PHA board.

7.0 Information Governance Action Plan

The Information Governance action plan will be updated on an annual basis and will be available on the PHA SharePoint portal.

8.0 Summary and Conclusion

Information Governance is a vital and integral part of the PHAs overall Governance programme. The implementation of the Information Governance Strategy and its subsequent policies, procedures, protocols and guidelines will ensure that the PHA has the appropriate framework in place to meet legislative and organisational requirements and it will drive the development and implementation of year on year improvement plans.

9.0 Equality and Human Rights Considerations

9.1 This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to them.

9.2 Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

9.3 This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

9.4 This policy will be included in the PHA's Register of Equality Screening Documentation and maintained for inspection whilst it remains in force.

9.5 This document can be made available on request in alternative formats and in other languages to meet the needs of those who are not fluent in English.

10.0 Review of Policy

10.1 The PHA is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

10.2 This policy will be reviewed by the Director of Operations on 1 April 2019, or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

Appendix 1

Legalisation and Guidance

There are a number of pieces of legislation and guidance which have a significant impact on records management. A selection of these is listed below.

Public Records Act (Northern Ireland) 1923

All HSC records are public records under the terms of the Public Records Act (Northern Ireland) 1923. Chief Executives and senior managers of all Health and Social Care organisations are personally accountable for records management within their organisation. They have a duty to make arrangements for the safekeeping and correct disposal (under the Disposal of Documents Order (Northern Ireland) 1925) of those records under the overall supervision of the Deputy Keeper of Public Records whose responsibility includes permanent preservation.

Data Protection Act 1998

The 1998 Data Protection Act places a statutory responsibility on the PHA to protect the personal data, which is hold. In relation to records management this means that the PHA must implement measures to:

- Maintain the accuracy of records held;
- Protect the security of personal data;
- Control access to the personal data; and
- Make arrangements for secure disposal once the record is no longer required.
-

Confidentiality and Data Protection Act

All HSC bodies and those carrying out functions on behalf of the HSC have a common law duty of confidence to patients/clients and a duty to maintain professional ethical standards of confidentiality. Everyone working for or with the HSC who records, handles, stores' or otherwise comes across personal information has a personal common law duty of confidence to patients/ clients and to his/her employer. The duty of confidence continues even after the death of the patient/client, or after an employee or contractor has left the HSC.

The Data Protection Act 1998 (DPA 1998), which replaced the earlier DPA 1984, extended its coverage to include both computer records and manual records of relevant filing systems. The Act, which applies to the whole of the United Kingdom, sets out requirements for the "processing" of personal data (i.e. meaning obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data).

A "data subject", namely, a living individual who is the subject of personal data, has a right of access to their personal data and, in certain circumstances, can have their data corrected or even deleted.

There are 8 basic data protection principles to be followed by anyone "processing" data, namely:

- Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless at least one of the conditions in Schedule 2 to the Data Protection Act 1998 is met, and, in the case of sensitive personal data, at least one of the conditions in Schedule 3 to the same Act is also met;
- Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes;
- Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed;
- Personal data shall be accurate and, where necessary, kept up to date;
- Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes;
- Personal data shall be processed in accordance with the rights of data subjects under this Act;
- Appropriate technical and PHA measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data;
- Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Schedules 2 and 3 to the Act set out conditions, respectively, for the processing of personal data and sensitive personal data.
The Information Commissioner, who has responsibility for the enforcement of this legislation, provides guidance on the application of the Act.

Further information on the Data Protection Act is available from the Information Commissioner at:
www.informationcommissioner.gov.uk

Freedom of Information Act 2000

The Freedom of Information Act 2000 creates a statutory right of access by the public to all records held by public bodies (with some exemptions). The Act makes provision for the Lord Chancellor to issue guidance on how records systems should be maintained in order to facilitate public access to information held. In particular S46 (1) states:

"The Lord Chancellor shall issue, and may from time to time revise, a code of practice providing guidance to relevant authorities as to the practice which it would, in his opinion, be desirable for them to follow in connection with the keeping, management and destruction of their records".

The Act was brought fully into force on 1 January 2005. The HSC has two main responsibilities under the Act. The HSC has to maintain its 'Publication Scheme'

(effectively a guide to the information which is publicly available) and staff have to deal with individual requests for information.

Anyone can make a request for information, although the request must be made in writing (including email) but an Environmental Information Regulation (EIR) request may be verbal. The request must contain details of name and address of the applicant and the information sought.
The HSC is obliged to produce information recorded both before and after the Act was passed. It is vital that records are held within a structured Records Management system in order to meet the HSC obligations under the Act. It should be noted that the responsibility for responding to information access requests lies with the authority that holds the information. The Act is intended to change the way in which public authorities do business, making them more accountable. The foreword to the Code of Practice on Records Management published by the Lord Chancellor under Section 46 of the Act states:

> *"Any freedom* of *information legislation is only* as *good* as *the quality* of *the records to which it provides* access".

This highlights the importance of good Records Management in the PHA.

Further information on the Freedom of Information Act is available from:
www.lco.gov.uk

Good Management, Good Records

These guidelines offer an overview of the key issues and solutions, and best practice for HSC teams to follow when preparing a records management strategy. It represents the joint DHSSPS and PRONI view of how records should be administered and sets the standard required of the HSC.
The Disposal Schedule has been approved by PRONI. It sets out minimum retention periods for HSC records of all types, except for GP medical records, and indicates which records are most likely to be appropriate for permanent preservation. It also explains the reasoning behind the determination of minimum retention periods, including legal requirements where relevant.

The Schedule does not replace the requirement for PHA to develop and agree their own disposal schedules with PRONI, however, it should form the basis for such schedules.

http://www.dhsspsni.gov.uk/index/gmgr.htm

Controls Assurance Standard

The Information Management Controls Assurance Standard sets out criteria by which the PHA can assess the degree to which it has in place a systematic and planned approach to the management of **all** records which ensures that, from the moment a record is created until its ultimate disposal, the PHA can control, both the quality and quantity of information it generates; can maintain that information in a manner that

effectively services its needs and those of its stakeholders; and can dispose of the information appropriately when it is no longer required.

The Data Protection Act 1998 supported by other access to information regimes such as the Freedom of Information Act 2000, the Environmental Information Regulations 2004 and the Access to Health Records (Northern Ireland) Order 1993 impacts significantly on the record keeping arrangements in public authorities.

Legislation, particularly The Data Protection Act 1998 supported by other access to information regimes such as the Freedom of Information Act 2000, the Environmental Information Regulations 2004 and the Access to Health Records (Northern Ireland) Order 1993 impacts significantly on the record keeping arrangements in public authorities.

ISO 15489 International Standard on Information and Documentation Records Management

The International Standard on managing recorded information, initially based on an earlier Australian standard, was adopted by ISO in 2001. The Standard acts as an enabler towards accreditation and renewal of IS09001 and other quality standards. It also provides a specification against which record management practices may themselves be audited.

There are a number of pieces of legislation and guidance which have a significant impact on records management.

Appendix 2

PHA INFORMATION GOVERNANCE STEERING GROUP (IGSG)

Terms of Reference

- Provide Quality Assurance, including advice and support, to Projects and Groups to ensure best practice in information governance in line with appropriate legislation
- Develop Strategic solutions to Common Information Governance problems
- Provide a forum to raise awareness and share experience and best practice in Information Governance
- Manage the work of Records Management Working Group
- Act as Directorate point of contact for Information Governance related issues such as Freedom of Information, Information Security and Data Protection etc.
- Ensure that the actions identified in the information governance action plan are taken forward.
- Share knowledge/experience.

Working Arrangements

- The Group will meet on a quarterly basis.
- The Group may from time to time call upon advisors e.g. ICT Security Manager
- The group will be chaired by the SIRO
- Governance Manager will provide the secretariat for the meeting.
- Agenda items should be submitted 5 days in advance of the meeting. The content and the agenda will be agreed with the Chair of the meeting prior to issue.
- Minutes of meeting will be produced and agreed with the chair prior to issue. These will be circulated as soon as possible after the meeting listing topics discussed, actions agreed and individuals responsible for undertaking those actions.
- The Group will review its TOR on an annual basis.

Reporting Arrangements

The Group will report to:

- AMT
- PHA Governance and Audit Committee

Membership List

SIRO Mr Ed McClean, Director of Operations – Chair

PDG Dr Carolyn Harper, Director of Public Health & Director of Public Health Research & Development
Deputy Dr Brid Farrell, Consultant, Service Development & Screening

Non-Executive Board Member Mr Brian Coulter

Planning and Corporate Services
IAO Ms Rosemary Taylor, Assistant Director
Deputy Mrs Joan Farley, Governance Manager

Communications and Knowledge Management
IAO Mr Stephen Wilson, Assistant Director
Deputy Ms Adele Graham, Senior Health Intelligence Manager

Nursing (AHP)
IAO Ms Pat Cullen, Executive Director of Nursing, Midwifery & AHPs
Deputy Ms Claire Buchner, Nurse Consultant, Centre for Connected Health & Social Care

Allied Health Professions and Personal and Public Involvement
IAO Ms Michelle Tennyson, Assistant Director
Deputy Ms Clare McGartland, AHP Consultant

Centre for Connected Health and Social Care
IAO Mr Eddie Ritson, Programme Director
Deputy Ms Penny Hobson Programme Manager

Health Protection
IAO Dr Lorraine Doherty, Assistant Director
Deputy Dr Neil Irvine, Consultant in Health Protection

Health and Social Wellbeing Improvement
IAO Ms Mary Black, Assistant Director
Deputy Mr Michael Owen, Health & Social Wellbeing Improvement Manager

Service Development and Screening
IAO Dr Janet Little, Assistant Director
Deputy *To be confirmed*

HSC Research and Development
IAO Dr Janice Bailie, Assistant Director HSC R&D
Deputy Dr Ruth Carroll, Programme Manager

Appendix 3 –PHA Information Governance Management Framework

INFORMATION GOVERNANCE MANAGEMENT FRAMEWORK		
Heading	**Requirement**	**PHA Structure**
Senior Roles	• IG Lead • Senior Information Risk Owner (SIRO) • Personal Data Guardian (PDG)	• The Chief Executive as Accountable Officer has overall accountability for IG and is required to provide assurance, that all risks to the PHA are effectively managed. • SIRO for the PHA is Director of Operations & Chair of the Information Governance Steering Group. • PDG for the PHA is Director of Public Health / Medical Director. • IAOs for the PHA are Assistant Directors within each Directorate
Policy	• Over-arching IG Policy • Data Protection Act 1998/Confidentiality Policy • Organisation Security Policy • Information Lifecycle Management (Records Management) Policy • Corporate Governance Policy	• Corporate Governance Framework • Information Governance Strategy Incorporating the Information Governance Framework • Information Governance Policy Statement • Data Protection/Confidentiality Policy • ICT Security Policy • Secure Mobile ICT Equip • Use of the Internet Policy • Use of Electronic Mail Policy • Use of ICT Equipment Policy • Records Management Policy • Freedom of Information Procedures
Key Governance Bodies	IG Board/Forum/Steering Group	• PHA Governance & Audit Committee • PHA Information Governance Steering Group • PHA Records Management Working Group
Resources	Details of key staff roles and dedicated budgets	• Assistant Director of Planning & Operational Services • Governance Manager x 1 • Governance Administrative Officer x 0.5
Governance Framework	Details of how responsibility and accountability for IG is cascaded	• All staff contracts include IG clauses • Staff responsibility set out in IG Strategy

	through the organisation.	• Contractors Confidentiality Agreement • Information Asset Register
Training & Guidance	• Staff Code of Conduct • Training for all staff • Organisation Security Policy • Training for specialist IG roles	• Code of Conduct • IG e-Learning Training mandatory for all staff • PHA ICT Security Policy • SIRO, PDG and IAO's training completed
Incident Management	Documented procedures and staff awareness	• PHA Risk Policy • Information Sharing Protocol • Guidance for reporting IG related incidents • Data Breach Incident Response Policy (including reporting mechanisms to GAC) • IG Leaflet • Incident Management Policy

Extract from IM CAS:
The Information Governance Management Framework may be described in a single one page standalone document or incorporated within an over-arching IG Policy or an IG Strategy and should provide a summary/overview of how an organisation is addressing the IG agenda

Appendix 4 – PHA Information Governance Policies & Guidance

Information Security leaflet and memo

Information governance: What you need to know

Records Management Strategy - 2011/12 to 2013/14

Records Management Policy

Records Management - Good Management Good Records

Protocol for the handling of requests for information made under the Freedom of Information Act/Data Protection Act

Freedom of Information internal review procedures

Data breach incident response policy

PHA ICT security policy documents and form

Procedure for provisioning new starts with access to IT services

Guidance on transferring hard copy personal information

Code of Practice on protecting the confidentiality of service user information

Data protection/Confidentiality policy document

Memorandum - Use of unencrypted USB storage devices on PHA computers

Guidance on the use of Digital Recorders

Application to enable camera facility on Blackberry

Application form to enable Bluetooth facility on Blackberry

Application form for provision of an encrypted USB memory stick

Safestick/SafeXS usage

Application form to enable access to removable media

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 March 2015
Title of Paper	Policy on Appraisal for Medical Practitioners
Agenda Item	12
Reference	PHA/05/03/15

Summary

The attached policy was approved and noted at the last Governance Committee and it was recommended it should go to the PHA Board for noting.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This policy was approved by the Governance and Audit Committee at its meeting on 10 December 2014.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Public Health
Date	9 March 2015

Policy on Appraisal

For Medical Practitioners

Version 8.0 (Final)

29 September 2014

CONTENTS

Appendices

DHSSPSNI Letter dated 14 February 2013 Re: Annual Appraisal for Consultants and Staff and Associate Specialist Medical Staff in HSC Trusts

DHSSPSNI Guidance on Appraisal for HSC Trust Employed Career Grade Medical Staff

HSCNI Medical Staff Appraisal Documentation

Bibliography

Policy on Appraisal for Medical Practitioners

1. Introduction

The legislation to introduce Medical Revalidation came into effect on 3 December 2012. Appraisal for medical practitioners is a requirement for each doctor and annual enhanced appraisal is required for the General Medical Council's (GMC) revalidation of the individual doctor.

This appraisal policy outlines the mechanisms in place to support annual appraisal of all medical practitioners employed by the Public Health Agency (PHA) and others for whom their Responsible Officer is the Director of Public Health/Medical Director. It encompasses the link between appraisal and the revalidation process, current guidelines on the types of supporting information that should be brought to appraisal, and the use of revised appraisal documentation, which was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in January 2013 (Appendices).

It outlines the internal organisational mechanisms in place to support, manage, resource and quality assure appraisal, continuous professional development and revalidation through training, appropriate documentation, monitoring and annual reporting through the Professional Development Group to the PHA Governance and Audit Committee and PHA Board.

The PHA has appointed the Director of Public Health/Medical Director as the Responsible Officer (RO).

The policy is to be read in conjunction with Guidance produced by the (DHSSPS), the GMC and the Faculty of Public Health (FPH).

2. Who this policy applies to

This policy applies to all consultant medical practitioners employed by the PHA and those to whom the Director of Public Health/Medical Director is RO. An annual appraisal is required for all medical practitioners (full time and part time) directly if not solely employed by the PHA.

Medical practitioners directly employed on a temporary, locum or on a sessional basis by the PHA or contracted to the PHA by an external agency for more than three months will be included in appraisal in line with DHSSPS guidance. Other medical practitioners may be affiliated to the PHA through their connection to the PHA Responsible Officer. Medical practitioners in training grades will undertake appraisal as part of their Annual Review of Competency Progression (ARCP). This will follow the agreed format as specified by the Northern Ireland Medical and Dental Agency (NIMDTA) and the Faculty of Public Health (FPH). The RO for all trainees is the Postgraduate Dean regardless of whether or not they are also engaged in other clinical work.

Where a medical practitioner is in the employ of more than one employer, only one appraisal should be carried out, normally by the lead employer, and should reflect the medical practitioner's total scope of practice ('whole practice appraisal'). The appraisee shall ensure that all employers are notified of the outcome of appraisal.

Any medical practitioner not in training grades but on the Northern Ireland Primary Care Performers List revalidates through the primary care route as outlined by the GMC, regardless of which organisation acts as lead employer and individual appraisal arrangements.

3. Definition of Appraisal

The DHSSPS has defined appraisal for doctors as:

> *"A professional process of constructive dialogue, in which the doctor being appraised has a formal, structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It should support doctors in their aim to deliver high quality care whilst ensuring they are practising within a safe and effective framework.*
>
> *It is a positive employer-led process to give doctors feedback in their performance, to chart their continuing progress and to identify development needs. It is a forward-looking process essential for the developmental and educational planning needs of an individual.*

It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance, aiming towards excellence. However, it can help to recognise, at an early stage, developing poor performance or ill health, which may be affecting practice."

4. Aims and Objectives of Appraisal

The aims and objectives of appraisal are to:

- ensure that each medical practitioner reflects on his or her practice with a trained appraiser based on evidence drawn from actual practice, which leads to the production of a Personal Development Plan (PDP);
- review regularly an individual's work and performance, utilising relevant and agreed comparative performance data from local, regional and national sources;
- optimise the use of skills and resources to contribute to the delivery of corporate and service priorities;
- review the medical practitioner's contribution to the PHA's quality and improvement agenda;
- identify and agree personal and professional development needs;
- identify the resources required to support the achievement of agreed objectives;
- ensure the annual appraisal process contributes to the requirements for GMC revalidation;
- support and inform the separate process of job planning for medical consultants.

5. Appraisal and Revalidation

The GMC has in place since 3 December 2012 a system of revalidation for its registrants. This change in medical regulation has been put in place to provide an assurance to patients and the public that doctors are keeping up-to-date and are fit to practise.

GMC registrants wishing to practise medicine have been issued with a licence to practise from the GMC. Renewal of this licence is subject to the process of revalidation whereby a senior doctor in a healthcare organisation, known as RO, makes a recommendation to

the GMC that those doctors, with whom the RO has a prescribed relationship, individually are practising to the standards defined by the GMC in *Good Medical Practice*.

In order to make this recommendation, the RO will review a range of information relating to the individual doctors. This information will come from the enhanced appraisal process which is the platform for reviewing the supporting information and completing a summary of how the individual demonstrates they are practicing to the standards of the GMC standards for *Good Medical Practice*.

The appraisal process and relevant documentation must form part of the induction of newly appointed consultants to PHA.

5.1 *Whole Practice Appraisal*

Revalidation will be based on **all** areas of a doctor's practice. Therefore the appraisal discussion should reflect this. Doctors are expected to bring supporting information in relation to all practice they undertake, including that in the independent sector. Further information on whole practice appraisal can be found on the GMC's website.

The GMC has identified the sources of supporting information and the frequency in a revalidation cycle with which they expect all doctors to provide these. This has been complemented by guidance provided by the Royal Academies, Colleges and Faculties.

Appraisal documentation for PHA medical staff is that developed for career grade doctors in Health and Social Care Trusts to reflect the GMC's *Framework for Appraisal and Revalidation*.

6. Appraisal and the Responsible Officer

It will **not** normally be the role of an RO to undertake appraisal for every doctor employed by the organisation to which they have been appointed. Rather, the RO must be able to demonstrate that all associated governance systems that support doctors are functioning effectively. In terms of appraisal, the RO must ensure that the appraisal system is consistently applied, appropriately monitored and of sufficient quality.

When the RO is asked to make a recommendation to the GMC on revalidation, participation in, and outcomes from appraisal will provide a key source of information upon which their recommendation will be based, alongside information obtained from other clinical and social care governance systems in their organisation. Guidance on the role of the RO has been developed and provides further information on this process.

The function of appraisal, therefore, remains supportive and developmental; it is not to be a one-off event but a continual process, an integral part of a learning culture and concurrently supports the RO in making a recommendation to the GMC.

7. Responsibilities of the PHA

The PHA, through the PHA Board, is ultimately responsible for ensuring that appropriate governance systems, including appraisal for doctors, are in place and implemented. The PHA is required to appoint an RO. The PHA has established a Professional Development Group which forms part of the Governance Framework for the PHA and will report annually to the Governance and Audit Committee, which forms part of the accountability framework for the PHA Board. This group will support medical revalidation amongst other professional development issues.

8. Responsibilities of the Chief Executive

The Chief Executive is accountable for ensuring that all doctors undergo an annual appraisal and that there are a sufficient number of appropriately trained appraisers available. The Chief Executive is accountable to the PHA Board for overseeing the appraisal process.

- ensuring that appraisals have been conducted for all doctors;
- ensuring there is a robust appraisal system in place which complies with regional and national guidelines;
- ensuring that the necessary links exist between the appraisal process and other PHA processes concerned with clinical governance, quality and risk management and the achievement of service priorities;
- ensuring that an annual report on appraisal is made to PHA Board;
- confirming to the Board that any issues arising out of the appraisals are being properly dealt with;

- ensuring that there are adequate resources available to support the process;
- ensuring that there is a system of quality assurance of the appraisal process in place.

The Chief Executive is responsible for ensuring that the necessary systems and arrangements are in place to meet the requirements identified by the GMC, the DHSSPS and Contracts of Employment.

9. Responsibilities of the DPH/Medical Director

The DPH/Medical Director is the RO for the PHA and is responsible for monitoring the quality of appraisals undertaken and, where appropriate, seeking external validation. This includes ensuring:

- that sufficient appraisers are recruited and trained (ideally appraisers should appraise no more than 10 doctors);
- that appraisal documentation is appropriate for recording, evaluating and acting on the appraisal process outcomes;
- the development of guidance and policies for appraisees and appraisers regarding governance;
- that appraisees and appraisers are supported in gathering information for appraisal;
- development of processes by which meaningful feedback from patients and colleagues can be obtained (multisource feedback).

The DPH/Medical Director shall carry delegated responsibility for establishing and maintaining a system of quality assurance of the appraisal process and for presenting an annual report to the Governance Committee and PHA Board on the process and operation of the appraisal process. The report shall highlight any general issues and actions arising out of the appraisal process. This information will be shared and discussed at the Consultant Staff Meetings. The Annual Report will not refer, explicitly or implicitly, to any individuals who have been appraised. Where the appraisal process identifies a collective or system wide issue this should be highlighted through the report.

The DPH/Medical Director shall be responsible for undertaking the appraisal of Assistant Directors. The DPH/Medical Director, in conjunction with appropriate Senior Staff, shall ensure that key issues arising from appraisal are addressed in the PHA and Public Health Department business plans.

The DPH/Medical Director will chair a regular Appraisal Review Meeting with Assistant Directors and other trained appraisers and feed into the staff development and regional CPD plans to:

- review appraisal systems;
- review progress of appraisal during the appraisal cycle;
- identify best practice, common themes and concerns arising from appraisal and
- approve the annual Appraisal Report for presentation to PHA Board.

The DPH/Medical Director will nominate an Assistant Director and consultant to lead on appraisal.

10. Responsibilities of the Lead Assistant Director for Appraisal and Revalidation

The Lead Assistant Director for appraisal and revalidation is required to have in place:

- an adequate number of trained appraisers;
- arrangements for a training update every three years for appraisers;
- arrangements for training for appraisees within each revalidation cycle;
- up-to-date appraisal training records;
- arrangements for multisource feedback;
- arrangements for the provision of relevant activity data to appraisees;
- arrangements to prepare the Annual Report for the RO's approval;
- arrangements for deputising for DPH/Medical Director as RO;
- contribute to quality assurance of the appraisal process.

11. Responsibilities of the Lead Consultant for Appraisal and Revalidation

The Lead Consultant for appraisal and revalidation is required to:

- organise training for appraisers and appraisees;
- ensure that arrangements are in place for multisource feedback;
- attend Confidence in Care Revalidation Delivery Board meetings;
- support the Professional Development Group reporting to PHA Governance and Audit Committee;
- provide annual revisions of the appraisal policy and other supporting documentation as required;
- prepare the Annual Report for consideration by the Assistant Director and then RO;
- contribute to quality assurance of the appraisal process.

12. Responsibilities of Assistant Directors

Assistant Directors are required to:

- ensure that medical practitioners are released to prepare for and participate in appraisal;
- encourage and facilitate medical practitioners to undertake development activities as identified in their PDP;
- ensure there are arrangements in place for all medical practitioners within the Directorate/service area to have an annual appraisal;
- ensure that adequate notice is given of appraisal;
- ensure that appraisees understand the documentation and information they need prior to the appraisal taking place;
- ensure an up-to-date register is kept of all appraisals undertaken within their Directorate/service area;
- ensure that copies of completed Appraisal Forms are retained for each doctor to provide support for revalidation;
- ensure that the DPH/Medical Director is provided with the completed appraisal documents of appraises;
- contribute to quality assurance of the appraisal process.

Records of appraisal should be retained in accordance with regional or national guidance.

At the end of the appraisal cycle the Assistant Director shall provide the DPH/Medical Director with an appraisal report, summarising the issues raised within their service area.

13. Responsibilities of all Appraisers

Appraisers are required to:

- be trained in appraisal and attend update training (at least once every three years);
- be up-to-date with relevant policies including Data Protection, Records Management and Equality Legislation;
- annually appraise those medical practitioners assigned to him/her in a manner consistent with the guidance issued by the PHA, DHSSPS, FPH and the GMC;
- base appraisal upon evidence presented by the appraisee and to ensure completion of whole scope of practice checklist;
- ensure that a PDP is agreed with the appraisee;
- review progress made against previous PDPs;
- record the appraisal interview on the appropriate forms;
- submit copies of the completed appraisal document to the DPH/Medical Director;
- agree with the appraisee, notification of any other employing bodies of the outcome of appraisal in accordance with available guidance;
- highlight promptly to the DPH/Medical Director any areas of concern resulting from an appraisal;
- collaborate with the DPH/Medical Director to prepare an appraisal report for the service area;
- contribute to quality assurance of the appraisal process.

14. Responsibilities of Appraisees

To facilitate the appraisal process and to ensure compliance with needs for revalidation, an appraisee is required to:

- arrange appraisal meeting in final quarter of each year (to ensure adequate time for revalidation)
- attend training in appraisal within each revalidation cycle;
- participate annually in appraisal;
- establish and maintain their appraisal folder ;

- retain appraisal information and a copy of relevant documentation including whole scope of practice checklist in accordance with regional or national guidance (or in the absence of guidance retain information for at least one completed revalidation cycle);
- use templates for reflective notes and others in the DHSSPS *Guidance on Appraisal*;
- prepare and submit their folder and completed documentation within required timescales and ensure all required elements to support revalidation are included;
- attend the appraisal interview and any relevant follow up;
- agree a Personal Development Programme;
- undertake the agreed PDP;
- contribute to quality assurance of the appraisal process

15. Confidentiality

The detail of discussions during the appraisal interview is confidential to appraisee and appraiser, except where concerns about fitness to practise or patient safety arise.

The Responsible Officer will have access to any documentation used during the appraisal process. In circumstances where access to this information is requested by other individuals, the doctor/dentist concerned will be informed and permission received before access is granted.

Both appraisee and appraiser will retain a copy of the appraisal documentation. These forms and all supporting documentation should be added to the appraisal folder of the consultant being appraised. The consultant will keep this.

16. Concerns arising during Appraisal

Issues or concerns may arise during appraisal. Many of these may be resolved through discussion or the provision of further information. If, as a result of the appraisal process, the appraiser believes that the activities of the appraisee are such as to fall short of acceptable professional practice, the appraisal process should be stopped and action taken. If the situation is remedied then the appraisal process can continue.

Where there is disagreement which cannot be resolved at the meeting, this should be recorded and a meeting between the

appraiser and appraisee will take place in the presence of the DPH/Medical Director to discuss the specific points of disagreement. A medical colleague from within the employing authority may accompany the doctor.

Where it becomes apparent during the appraisal process that there is a potentially serious performance issue which requires further discussion or examination, the matter must be referred by the appraiser immediately to the DPH/Medical Director to take appropriate action in keeping with DHSSPS guidance on *Maintaining High Professional Standards* (in draft).

17. Process of Appraisal

To date, this has been between January and March each year and will continue in this manner. The appraisal will be retrospective covering the most recent previous calendar year, starting at the end of the last appraisal period. For consultants, the separate but related process of job planning shall be prospective covering the future financial year starting in April.

18. Schedule of Appraisal

Each doctor is required to participate in appraisal annually. Appraisal will normally be carried out between January and March. Doctors in training may be required to participate more frequently or at other times as recommended by the appropriate training authority (NIMDTA).

The PHA has a responsibility to provide an opportunity for appraisal for each doctor in its employment. The requirement to participate in appraisal is a contractual obligation and rests with individual doctors.

- The appraisee will arrange a date for the appraisal with adequate notice, normally at least six weeks;
- The appraisee will prepare an up-to-date appraisal folder and portfolio of evidence covering the whole scope of his or her practice, including appraisal forms and submit it to the appraiser at least one week prior to the appraisal;
- The appraiser will document the appraisal interview on the appraisal forms, highlighting any significant issues or concerns;

- A PDP will be agreed at the appraisal, taking account of any significant issues or concerns;
- After the appraisal documentation has been typed, both appraisee and appraiser will sign it. All documentation should be signed off within 6 to 8 weeks;
- The appraiser will ensure that copies of appraisal documentation are submitted to the DPH/Medical Director;
- Appraisers from each division will collate annually an appraisal report to the DPH/Medical Director to inform the Annual Appraisal Report to the Governance and Audit Committee of PHA Board;
- The DPH/Medical Director on behalf of the Chief Executive Officer will present an Annual Appraisal Report to the PHA Board.

19. Multisource Feedback

PHA in line with the GMC revalidation schedule takes responsibility for triggering the multisource feedback process for every doctor prior to the final appraisal preceding their revalidation date. Colleague feedback (this should normally be within 12-15 months of the revalidation date & discussed as part of the final appraisal process immediately preceding revalidation.) It is the doctor's responsibility to select a list of respondents composed in line with existing guidance:

20-25 respondents selected as a minimum, broadly covering:

- 50/50 medical/non-medical
- 30/30/30 senior/peer/report
- 70-50/30-50 internal/external

A minimum response from 15 selected respondents is required to generate a report, the results of which will be discussed at appraisal or at an agreed date if that is more suitable. The appraisee will produce a reflective note on the multisource feedback process in the agreed format.

20. Documentation

Each medical practitioner is responsible for the maintenance of his or her own appraisal folder covering the practitioner's whole scope of practice. It is recommended that information is retained for at least a full revalidation cycle.

It is important that appraisal is carried out in a structured way, which is appropriate to the needs of the PHA, the medical practitioner and wider regulatory bodies. Appraisal forms must therefore conform to the standards set down by the DHSSPS. Templates in DHSSPS *Guidance for Appraisal* should be used and evidence should cover each of the GMC's four domains:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust.

The portfolio of evidence must be consistent with whole scope of practice and contain supporting information as set out in the GMC's *Supporting Information for Appraisal and Revalidation*:

- General information
- Keeping up to date
    - *CPD (in keeping with current FPH CPD policy)*
- Review of practice
    - *Quality improvement activity*
    - *Significant events including a statement where none have occurred*
- Feedback on professional practice,
    - *Colleague feedback*
    - *Patient and carer feedback (where appropriate)*
    - *Review of complaints and compliments including a statement where none have been received*

It is essential that the appraisal forms are supported by verifiable evidence under each of the core areas and relate to the medical practitioner's **total** practice, including health and probity declarations.

21. Quality Assurance

The DHSSPS and the GMC have highlighted the need for quality assurance of appraisal. A system of quality assurance of the appraisal process is being established and maintained. PHA's internal and external assurance framework for appraisal currently includes the following elements in line with GMC guidance for *Effective Governance to support Medical Revalidation*:

21.1 *There is corporate and organisation- wide commitment to creating an environment that fosters good professional practice*

The organisation has a Professional Development Group which reports to the PHA Governance and Audit Committee and the PHA Board.

All medical practitioners are supported through their job and PDPs to undertake adequate CPD in keeping with the FPH's requirements.

Staff are released and supported to attend internal and external courses and conferences as appropriate.

Annual completion of PDPs and CPD informs corporate staff training policy.

The PHA Board will receive the CEO's Annual Report on medical appraisal and revalidation.

The PHA is working with the Health and Social Care Board (HSCB) and has in place a number of processes including a Regional Complaints Board and a Regional Adverse Incident Board; and in addition there is a group established to ensure safety and quality alerts are disseminated and responded to appropriately by HSC services.

21.2 *Local governance mechanisms are in place and monitored*

PHA has moved to a new Human Resources system which includes modules on sickness absence. There is corporate monitoring of performance against appraisal targets. Doctors in training are subject to an annual review of competence and performance and subject to revalidation through NIMDTA.

Locum and temporary appointments are relatively rare events but would be subject to the same systems and processes as other employees.

All medical recruitment requires pre-employment health checks, references, qualifications and where relevant, Access NI checks prior to taking up post.

After period/s of sickness absence, a return to work interview will be undertaken in line with the PHA's *Attendance at Work Policy and Procedure* and a referral to Occupational Health will occur, where appropriate.

Where prolonged illness or other significant period of absence has occurred, appraisal will be rescheduled accordingly. This may lead to a deferral of revalidation.

Where there is prolonged absence of an appraiser, a deputy will be appointed and trained.

Quality improvement, case reviews and audit are undergoing development.

21.3 *Equality and diversity considerations are integrated into all of the organisation's medical revalidation policies and practices*

Like other PHA policies, this appraisal policy will be subject to the organisational Equality and Human Rights Screening process, which includes scrutiny by designated equality officers who provide training in this area available to all staff in line with organisational policy on equality and diversity.

A range of training programmes, policies and procedures are in place to ensure equality and diversity across the spectrum of Public Health practice.

There are regular equality monitoring reports from PHA to the Independent Equality Commission via the PHA Board.

The multisource feedback process is based on GMC guidance with minor modification to make relevant for public health.

21.4 *On-going compliance with regulatory requirements and standards creates an environment where professionals can flourish*

There are annual reports on training and regulation from the Assistant Director with responsibility for revalidation and appraisal to the PHA Board.

PHA has regional responsibility for the development delivery and monitoring of Personal and Public Involvement (PPI) across all HSC organisations including its own workings.

PHA collaborates with HSCB on taking into account patient views in developing, commissioning and delivering services.

Lay personnel participate in the Annual Review of Competency Progression of doctors in training. All recruitment panels are constituted in accordance with the Faculty of Public Health (FPH) Advisory and Appointments Committee guidance.

Medical professional activity data sources are under review and require further development; progress will be referenced in the annual report.

The DPH/Medical Director as RO receives completed appraisal documentation for each individual doctor on their list and provides feedback both to appraisers and appraisees.

Identity, qualifications, references and experience of doctors is ensured through the interview and recruitment process.

The conduct and performance of doctors including those in training, temporary and locum staff are monitored and issues arising addressed through regular individual meetings and the annual appraisal process.

21.5 ***Medical appraisal takes place in accordance with GMC guidance and organisational requirement***

PHA continues its representation and participation in DHSSPS Confidence in Care work. It has access to advice from the local GMC's Employment Liaison Officer.

Through its Faculty Advisor, it maintains close working relationships with its professional body, the FPH in the United Kingdom. Appraisers advise the RO when the annual cycle of appraisal is completed and is presented with all documentation, hence is in a

position to monitor progress, verify completion and account through the annual report on appraisal to the PHA Board.

The situation of non-appraisal rarely arises usually due to prolonged illness absence, but is addressed through rescheduling.

This appraisal policy will be circulated for comment and discussed at a consultant meeting open to all consultants. It will be subject to annual review and dissemination.

Training in appraisal is in place both for appraisers and appraisees and reporting on outcomes thereof forms part of the annual report on appraisal.

Further training needs are identified annually through appraisal outcomes reported by appraisers to the RO and fed back to the consultant with responsibility for appraisal and revalidation for inclusion in the appraisal training programme, e.g. in completion of appraisal documentation and use of the scope of practice checklist.

Appraisers are monitored through their own appraisal and peer review through learning sets and collation of staff training requirements into an annual staff development and training plan.

CPD is discussed in each appraisal and audited internally. There is an external assurance of individual CPD submissions to FPH (20% sample annually).

The Professional Development Group oversees the on-going development and delivery of the annual appraisal programme for doctors employed by PHA and reports annually within the existing PHA governance framework. Through it, the DPH/Medical Director holds to account those members of staff responsible for training in appraisal and revalidation processes and systems to ensure compliance with GMC guidance and organisational requirements outlined in this policy.

PHA endorses approved appraisal documentation based on GMC guidance, which reflects the GMC's *Good Medical Practice* and other relevant guidance referred to in this policy and its appendices.

The annual appraisal process is reviewed through individually and formally sought feedback from appraisees and appraisers and divisional reports to the DPH/Medical Director on individual concerns

and common themes emerging for staff training and development. These are discussed at consultant meetings and in the DPH Assistant Directors' appraisal learning set.

These quality assurance processes are subject to internal review via the Professional Development Group, the Governance and Audit Committee and the PHA Board.

The DPH/Medical Director invites RQIA to externally review and quality assure these arrangements to ensure they are up-to-date, proportionate and fit for purpose.

21.6 Review

This policy was approved on xx/xx/xxxx and is to be reviewed and updated annually in November.

Appendices

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

HUMAN RESOURCES DIRECTORATE
MEDICAL – TERMS & CONDITIONS

Chief Executive of each HSC Trust

For information:
Directors of Human Resources
Directors of Medical Services
Chief Executive of Public Health
HSCB Chief Executive
Dean, Head of School of Medicine, Dentistry and Biomedical Sciences, QUB
NIMDTA Chief Executive/Postgraduate Dean
RQIA Chief Executive
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Ref No: HSC (TC8) 1/2013
Date 14th February 2013

Dear Colleagues

Annual Appraisal for Consultants and Staff and Associate Specialist Medical Staff in HSC Trusts

Related document HSS (TC8) 8/2006

Superseded documents HSS (TC8) 3/01, HSS (TC8) 11/01 and HSS (TC8)1/2003

1. The attached guidance (Annex A) and associated documentation (Annex B) have been revised to reflect the developments in medical appraisal since its introduction in 2001, and to support the enhanced regulatory arrangements for licensed medical practitioners, revalidation, which commenced on 3 December 2012. The guidance and documentation have been agreed by the BMA and should be adopted for use in HSC Trusts with immediate effect.

2. A robust, quality assured appraisal system is integral to HSC Trusts fulfilling their statutory duty of quality.

3. The Department will review this guidance and associated documentation as required.

4. HSC employers should ensure that appraisal is completed for all doctors they employ or contract services from in accordance with terms and conditions of service. Employers should note that participation in an annual, quality assured appraisal process is a requirement for the revalidation of medical practitioners.

Background

With the coming into force of The General Medical Council (License to Practice and Revalidation) Regulations on 3 December 2012, the need for doctors to participate in annual

appraisal became a regulatory requirement in addition to the long standing contractual obligation within the HSC.

5. Since its introduction in 2001, Chief Executives have had accountability for the medical appraisal system within their organisations, its quality assurance and linkage to related clinical and social care governance processes within the organisation. In addition, they have been required to submit an annual report to the Trust Board on the appraisal process for doctors in the organisation.

6. The establishment of the responsible officer role by The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010, provided for the key linkage between appraisal and other quality assurance processes within organisations and the requirement for doctors to periodically demonstrate their continued fitness to practice through revalidation. Those regulations also placed an obligation on organisations to support The Responsible Officer in discharging their statutory role.

Action

7. HSC trusts should adopt the attached documentation into their current appraisal processes with immediate effect and on foot of the attached guidance review their current policies governing appraisal for doctors and the associated reporting and accountability arrangements.

Enquiries

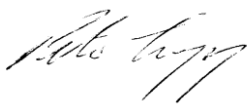
8. **Employees** should direct personal enquiries about the contents of this Circular to their Human Resources Department.

9. **Employers** should direct enquiries about the contents of this Circular to the above address or telephone 028 90 52 2344, e-mail p&e@dhsspsni.gov.uk

Further Copies

10. Copies of this Circular can be obtained from the Department's internet site at http://www.dhsspsni.gov.uk/index/hrd/guidance_circulars.htm

Yours sincerely



PETER GREGG

DEPUTY DIRECTOR OF HUMAN RESOURCES

Annex A

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

Department of Health, Social Services and Public Safety

Guidance on Appraisal for HSC Trust Employed Career Grade Medical Staff

January 2013

CONTENTS

Introduction & Background

1. The Guidance aims to define the key components of medical appraisal to ensure there is consistency in its application, whilst recognising that there will be a range of structures in place to support appraisal according to the needs of individual organisations, appraisal providers and appraisees.

2. It encompasses the link between appraisal and the revalidation process, current guidelines on the types of supporting information that should be brought to appraisal, and the use of revised appraisal documentation.

3. This Guidance supersedes the following Circulars:

(TC8) 11/01 Annual Appraisal for Consultants May 2001

(TC8) 1/2003 Non-Consultant Career Grade Appraisal February 2003

Purpose of Appraisal

4. Medical Appraisal can be defined as:

A positive process of constructive dialogue, in which the doctor being appraised has a formal, structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It should support doctors in their aim to deliver high quality care whilst ensuring they are practising within a safe and effective framework.

The aims and objectives of appraisal are to enable doctors and employers to:

- review regularly an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources
- optimise the use of skills and resources in seeking to achieve the delivery of service priorities
- consider the doctor's contribution to the quality and improvement of services and priorities delivered locally

- define personal and professional development needs and agree plans for these to be met
- identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met
- provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider HSC
- contribute to the governance requirements of the organisation
- utilise the annual appraisal process and associated documentation to contribute to the requirements of revalidation.

5. In addition to the above aims, medical appraisal should:

- be delivered by competent, trained appraisers
- be consistently applied
- be undertaken annually
- not be a one-off event but a continual process and an integral part of a learning culture
- relate to **all areas** of a doctor's practice

Accountability for Appraisal

6. The Chief Executive within an organisation is accountable for the appraisal process and must ensure that an annual report on appraisal is submitted to the Board of the employing authority. In addition to this, the Responsible Officer of an organisation has, as defined in legislation[1], responsibility for those governance arrangements within the organisation that support doctors in meeting the requirements of revalidation. Therefore, Responsible Officers will wish to assure themselves that the doctors with whom they have a prescribed relationship are participating in a quality assured appraisal scheme.

7. Medical appraisers should ensure that they are adhering to the standards required by their organisation and participate in available training opportunities to ensure they are maintaining and improving their skills.

[1] The Medical Profession (Responsible Officer) Regulations (Northern Ireland) 2010

8. Individual doctors have a responsibility to ensure they are meeting their contractual requirements[2] and must participate in annual appraisal, unless otherwise agreed by the Responsible Officer/Medical Director of their organisation. Organisations should have an agreed policy to address the issue of non-participation in appraisal.

Appraisal and Revalidation

9. The General Medical Council (GMC) implemented a system of revalidation for its registrants on 3rd December 2012. This change in medical regulation will provide an assurance to patients and the public that doctors are keeping up to date and are fit to practise. All registrants wishing to practise medicine have been issued with a licence to practise from the GMC. Renewal of this licence will be subject to the process of revalidation whereby a senior doctor in a healthcare organisation, known as a Responsible Officer, will make a recommendation to the GMC that those doctors with whom they have a prescribed relationship are practising to the standards defined by the GMC in *Good Medical Practice*[3].

10. In order to make this recommendation, the Responsible Officer will review a range of information relating to individual doctors. Rather than the addition of another process that has the potential to place an administrative burden on doctors, the appraisal process should be the platform for reviewing the supporting information required by the GMC for revalidation that demonstrates the doctor is practising to the standards set out in *Good Medical Practice*.

Appraisal and the Responsible Officer

11. It will not normally be the role of a Responsible officer to undertake appraisal for every doctor employed by the organisation to which they are appointed (although this may be the case where an organisation employs few doctors). Rather, the Responsible Officer must be able to demonstrate that all associated governance systems that support doctors are functioning effectively. In terms of appraisal, the

[2] http://www.dhsspsni.gov.uk/scu-consultantcontract.pdf

[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp

Responsible Officer must ensure that the appraisal system is appropriately monitored and is of sufficient quality.

12. The Responsible Officer should ensure that the governance processes that support appraisal are sufficiently robust through:

- Accountability and oversight
- Information sharing
- Processes for escalation of concerns arising from appraisal
- Processes to manage complaints in relation to appraisal.

13. When the Responsible Officer is asked to make a recommendation to the GMC on revalidation, participation in, and outcomes from, appraisal will provide a key source of information upon which their recommendation will be based, alongside information obtained from clinical and social care governance systems in their organisation. Guidance on the role of the Responsible Officer has been developed and provides further information on this process. [4]

14. The function of appraisal, therefore, remains supportive and developmental but concurrently supports the Responsible Officer in making a recommendation to the GMC on the fitness to practise of individual doctors.

Appraisal for Secondary Care Locum Doctors

15. Interim guidance was issued by DHSSPS on 27 October 2006 (Circular HSS (TC8) 8/2006) in relation to the appraisal of locums. In keeping with this guidance all HSC Trusts must make arrangements for the appraisal of locums. While the guidance suggests locum doctors employed continuously for six months should be appraised by the organisation, some HSC Trusts undertake appraisal for locum doctors employed for a minimum of three months. A key source of supporting information for appraisal for this group of doctors will be the exit report from the previous employer. Each HSC Trust should ensure an exit report is completed for locum doctors at the end of their employment period.

[4] http://www.dhsspsni.gov.uk/index/hss/confidence_in_care.htm

Whole Practice Appraisal

16. Revalidation will be based on all areas of a doctor's practice therefore the appraisal discussion should reflect this. Doctors are expected to bring supporting information in relation to all practice they undertake, including that in the independent sector. Further information on whole practice appraisal can be found on the GMC's website. [5]

Appraisal Documentation

17. Appraisal documentation is part of the overall process for appraisal and completion of documentation provides a written record of the discussion at the appraisal meeting and encourages consistency in approach. The documentation has been amended to reflect the revised *Good Medical Practice* framework and the requirements for revalidation. This revision also provided an opportunity to develop documentation that incorporated changes suggested by its users.

18. This Guidance document relates to medical appraisal for HSCNI Trust Career Grade staff only and is intended to support the completion of revised documentation for this staff group.

Who Undertakes the Appraisal?

19. A senior doctor on the medical register must undertake the appraisal. The Chief Executive[6] will nominate an appropriate doctor who is competent to undertake appraisal across the broad range of headings within the appraisal scheme. The Chief Executive must ensure that appraisers are properly trained and in a position to undertake this role. While the appraiser will generally be from the same specialty as the appraisee, this may, on occasion, not be possible. In this situation, the appraiser should ensure that they are familiar with the types of supporting information from the specialty of the appraisee. They may wish to seek advice from the relevant Medical Royal College or Faculty.

[5] http://www.gmc-uk.org/doctors/revalidation/revalidation_ebulletin_issue_2.asp
[6] This is often a delegated function by the Chief Executive in HSC organisations

20. The appraiser will be able to cover all aspects of clinical practice and matters relating to service delivery, and will be appointed as appropriate according to the organisational structure of the employer.

21. The appraisee can request an alternative appraiser if they are not content with the proposed appraiser nominated by the employer. This request should be submitted to the organisation's Responsible Officer, and should outline the reason why an alternative appraiser is required. Ultimately, the Chief Executive will be responsible for nominating suitable alternatives however this function is likely to be delegated to the Responsible Officer. The appraisee must accept one of these alternatives.

22. In some small organisations, it may not be possible to identify suitable appraisers to conduct elements of the appraisal, i.e. those in which specialist knowledge is essential. In these instances, two or more organisations might collaborate to ensure that an appraiser is available to conduct the appraisal process.

23. It is considered good practice that within a five year revalidation cycle, a doctor should have two appraisers with at least one appraisal being undertaken by a second appraiser. This promotes transparency and contributes to the quality assurance of the appraisal process.

Peer Review

24. If, during the appraisal, it becomes apparent that more detailed discussion and examination of any aspect would be helpful, either the appraiser or appraisee should be able to request an internal or external review. This should normally be completed within one month and a further meeting scheduled as soon as possible thereafter (but no longer than one month) to discuss this review and to complete the appraisal process.

Support for Appraisers

25. HSC Trusts should establish processes to support appraisers in their role so that appraisers can share learning and best practice to ensure the high quality of appraisal across an organisation.

Quality Assurance of Appraisal

26. HSC Trusts should implement quality assurance processes for their appraisals. The performance of appraisers in the appraiser role should be included in the appraiser's own appraisal.

27. The Regulation and Quality Improvement Authority (RQIA) will provide external quality assurance of the governance arrangements in HSC organisations including medical appraisal processes in both primary and secondary care.

28. An appraisee feedback proforma is included in **Appendix 2** of this guidance. Completion of this following the appraisal is optional but HSC organisations may consider use of these as part of the development of appraisal systems.

Preparing for Appraisal

29. Adequate time should be allocated for preparation and participation in appraisal and should include time required for quality assurance of the appraisal process. The appraisal discussion should be scheduled and take place in time free of interruptions.

Supporting Information

30. Each doctor is responsible for the collation of their appraisal folder or portfolio of supporting information that will inform the appraisal discussion, assist in the development of a personal development plan and will meet the GMC's requirements for revalidation. This supporting information should reflect all areas of the doctor's practice and, as such, this information will vary but it should be of sufficient quality to assure the appraiser that the doctor is meeting the requirements of *Good Medical Practice.* Employers should provide appropriate supporting information on the activity of their doctors to assist with the appraisal process.

31. The GMC have identified the following sources of supporting information they require for revalidation[7]:

- Continuing professional development
- Quality improvement activity
- Significant events
- Review of complaints and compliments.
- Feedback from colleagues
- Feedback from patients (where applicable)

32. The GMC acknowledge that not every doctor will have been involved in a significant event or received any complaints/compliments since their last appraisal. It is the demonstration of learning and any change of practice from both these supporting information requirements over a revalidation cycle that should be the focus rather than the number.

33. The appraisal discussion should assist to identify where a doctor has any gaps in supporting information that has the potential to impede revalidation and ensure this is addressed within the revalidation cycle at an early stage. Suggested sources of supporting information are provided in **Appendix 1** of this document and further discussed in paragraphs 47-51 of this Guidance.

34. Medical Royal Colleges have developed Guidance that describes how the GMC's core requirements relate to the broad range of medical specialties. Appraisers and appraisees may find this Guidance helpful in preparing for appraisal.

Reflection

35. In preparing for appraisal, both the appraisee and appraiser should have adequate time (ideally two weeks) to reflect on the supporting information and plan the key areas to be discussed at the appraisal. Doctors should consider what the information tells them about their practice and demonstrate to their appraiser any changes or modifications to their practice they intend to make as a result of

[7] http://www.gmc-uk.org/doctors/revalidation/supporting_information.asp

reviewing the information. Sample reflective templates are provided in Appendix 4 of this Guidance.

Personal Development Plan

36. As an outcome of appraisal, key development objectives for the following year and subsequent years should be set. These objectives may cover any aspect of appraisal such as personal development needs, training goals, and CPD. This plan should be reviewed periodically by the doctor and at the next appraisal to ensure the objectives have been met.

Addressing Performance Concerns

37. It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good practice, aiming towards excellence. Organisations and their Responsible Officer, through existing clinical governance systems, will continue to act promptly if issues are identified that may affect the quality of care a patient receives.

38. Appraisal may, however, help to recognise, at an early stage, developing poor performance or ill health, or other concerns which may be affecting practice. If, as a result of the appraisal process the appraiser believes the activities of the appraisee are such as to put patients at risk, the appraisal process should be stopped and action taken. Organisations should ensure their local appraisal policy identifies the processes to be undertaken to address performance issues that arise during appraisal, and be aware of the processes to address concerns in *Maintaining High Professional Standards*[8].

Appraisal for Doctor Undergoing Remediation/Rehabilitation/Fitness to Practise Proceedings

39. As a primarily supportive process, appraisal should continue as scheduled if a doctor is undergoing remediation, rehabilitation or fitness to practise proceedings.

[8] http://www.dhsspsni.gov.uk/hrd_suspensions_framework.pdf

The appraiser should be aware of any of the above, and of any conditions placed on the appraisee's practice.

Guidance on Completion of HSCNI Career Grade Appraisal Documentation

40. Appraisal documentation has been revised to reflect the GMC's *Framework for Appraisal and Revalidation*[9]. This framework is intended to encourage the appraisee to:

- Reflect on their practice and approach to medicine
- Reflect on the supporting information they have gathered and what that information demonstrates about their practice
- Identify areas of practice where they could make improvements or undertake further development
- Demonstrate that they are up to date and fit to practise.

41. The GMC do not require every type of supporting information to be extensively mapped to each domain and attribute of the Framework. The revised appraisal documentation is, however, based on the four domains to provide structure to the appraisal discussion and collation of supporting information.

42. The documentation comprises 7 Forms :

Form 1 - Background Details
Form 2 - Current Medical Activities
Form 3 - Supporting Information & Summary of Appraisal Discussion
Form 4 - Personal Development Plan
Form 5 – Health & Probity
Form 6 - Sign Off
Form 7 – Revalidation Progress

43. Guidance on completion of each section is detailed below.

[9] http://www.gmc-uk.org/GMP_framework_for_appraisal_and_revalidation.pdf_41326960.pdf

Form 1 – Background Details

44. The aim of this section is to provide basic background information and brief details of the appraisee's employment in the previous year. The appraisee can supplement this with any additional information they think helpful for example medical and specialist societies they belong to.

Form 2 – Current Medical Activities

45. The aim of this section is to provide the appraisee with an opportunity to describe their current posts in the HSC, other organisations or the independent healthcare sector. They should explain what their responsibilities are, where they work/practise and ensure they include all of their practice and work at all locations since their last appraisal.

46. As per paragraph 16, the appraisal should encompass **all** areas of practice. If the appraisee undertakes any other work outside the HSC, they will need to bring supporting information to the appraisal that evidences they are up to date and fit to practise in this area of work, as well as their work for the HSC. This may include, but is not limited to, work undertaken in the independent sector, medical work for business (e.g. insurance companies) and charities (e.g. hospice work), work undertaken as a sports doctor and work for panels, tribunals and government.

Form 3 – Supporting Information and Summary of Appraisal Discussion

47. The aim of this section is to allow the appraisee to list the supporting information they are bringing to appraisal and to document the discussion between the appraiser and appraisee that the information prompts. This discussion should include consideration of the information source and what it tells the appraiser

about the appraisee's medical practice. Any actions arising from the appraisal discussion should be documented here.

48. **Appendix 1** of this Guidance outlines suggested sources of supporting information and the appropriate Domain they may be tabled under. Due to the varied nature of medical practice, these are not prescriptive. A key component of the appraisal discussion will be consideration of the supporting information and which Domain it should be tabled under.

49. One type of supporting information may be applicable to one or more Domains of the GMP Framework. Reflection on supporting information may be included within a second Domain. For example, updating knowledge via CPD may lead to reflection on improving patient safety. Therefore CPD may be listed under Domain 1 (Knowledge, Skills and Performance) and reflection leading to improved safety and quality listed under Domain 2 (Safety and Quality).

50. The organisation and their appraisers may also wish to consider the use of data sets that they would expect doctors' working in a particular specialty to bring to appraisal and include this in their guidance for appraisees.

51. Preparing for appraisal will require the collation of a range of supporting information. Some data sources will be held by the appraisee and others will be provided by the employing organisation. Organisations should provide appropriate information to doctors to assist with their appraisal.

Form 4 – Personal Development Plan

52. In this section, the appraiser and appraisee should review progress against the previous years' personal development plan (PDP) and identify key development objectives for the year ahead. This will include actions identified during completion of Form 3 but may also include other development activity where this arises during the appraisal discussion. Any PDP outputs should be practical and achievable, ideally with defined outputs targeted against development needs.

53. The anticipated timescale within which the objectives will be met should be indicated. The appraiser should countersign the agreed PDP.

Form 5 – Health and Probity

54. The appraisee should read the statements that apply to health and probity and sign and date them. Any supplementary proformas for health and probity should form part of the supporting documentation.

55. The following are examples of areas which could form part of the discussion on probity; research conduct, conflicts of interest, contacts with pharmaceutical industry, and financial probity. This list is not exhaustive.

56. Any health issues which may affect the appraisee's work as a doctor should be discussed during the appraisal discussion and any action arising from this noted in Form 4. Due to potential confidentiality issues, specific details of a health complaint or probity issue should not be entered directly into Appraisal Forms 1-6 but recorded in the Forms contained in Appendix 3 of this Guidance and retained by the appraisee in their portfolio of supporting information.

Form 6- Sign Off

57. This section requires both the appraiser and appraisee to confirm that the documentation is an accurate record of the appraisal discussion, the supporting information presented and the agreed personal development plan.

58. If the appraisee has been unable to provide all the required elements of supporting information, or demonstrate their practice is meeting the requirements of the *GMP Framework*, the reason/s why should be recorded in this section.

59. This may be due to a period of absence from employment or other mitigating circumstances. The organisation's Responsible Officer may wish to reference this information to inform the revalidation recommendation process.

60. This Form also includes a checklist to ensure the required sections of the appraisal documentation have been completed. Each organisation will have a defined process to ensure the Responsible Officer is aware that the appraisal meeting has taken place and the appraiser should return the requested information to the appropriate source as soon as possible following the appraisal meeting.

Form 7- Revalidation Progress

61. This section provides an overview of progress towards meeting revalidation requirements. It should demonstrate annual participation in appraisal and that the appraiser has evidenced they have met the GMC and employer required supporting information elements.

62. It is envisaged that this summary will be a valuable source of information for the Responsible Officer to reference when required to make a revalidation recommendation to the GMC.

Appendix 1 Supporting Information Examples

63. This table provides examples of supporting information and suggested Domains these may be listed under. These examples are a guide to assist preparation for appraisal and to inform the appraisal discussion.

Appendix 2 Evaluation Proforma

64. There is an appraisee evaluation proforma, completion of which is optional but encouraged as it may inform the organisation's quality assurance processes and highlight areas where further training may be required.

Appendix 3 Health and Probity Forms

65. Health and probity forms are provided in Appendix 3. Specific details of a health complaint or probity issue should not be entered directly into Appraisal Forms 1-6 but recorded in these Forms and retained by the appraisee in their portfolio of supporting information.

Appendix 4 Reflective Templates

66. Reflective templates are provided in Appendix 4 that may be used to demonstrate reflection on supporting information

Appendix 1-Supporting Information

The table below provides examples of supporting information which may be appropriate to evidence each domain/attribute. These lists are not exhaustive and some items of information may be relevant to more than one Domain..[10] **Information is required in relation to all areas of practice.**

Domain	Suggested Evidence/Supporting Information
1 - Knowledge, Skills and Performance: Attribute: 1.1 Maintain your professional performance Attribute: 1.2 Apply knowledge and experience to practice Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.	• Job plan, workload records • Evidence of how educational activity may have affected service delivery outcomes • Information about teaching and training activities. Include any information in relation to delivering workshops and lectures, mentoring activities and tutorials undertaken. • Evidence of reflective practice • Evidence of CPD and audit activity • Research activity, including peer review / oversight of research activity • Relevant process and outcome data • Previous Form 4 and Personal Development Plan

[10] http://www.dhsspsni.gov.uk/cic-revalidation-report.pdf

2 - Safety and Quality: Attribute: 2.1 Contribute to and comply with systems to protect patients Attribute: 2.2 Respond to risks to safety Attribute: 2.3 Protect patients and colleagues from any risk posed by your health	• Evidence of any resource shortfalls which may have compromised outcomes • Up to date audit data including information on audit methodology and a record of how results of audit have resulted in changes to practice (if applicable) • Reflection on significant events/critical incidents/near misses • Records of how relevant medical guidelines have been reviewed by you and your team and how these have changed practice • Evidence of attendance at, and participation in, governance activity relevant to practice. • Evidence of risk management to include near misses and action taken to addresses/reduce risks • Evidence of registration with a GP, Statement of Health, vaccination records • Statement of satisfactory research practice • Records of training related to enhancing safety and quality of patient care • Analysis of, and reflection on, current practice

3 - Communication, Partnership and Teamwork Attribute: 3.1 Communicate effectively Attribute: 3.2 Work constructively with colleagues and delegate effectively Attribute: 3.3 Establish and maintain partnerships with patients	• Evidence of any team development activity • Description of the team you work within (medical and/or multidisciplinary) • Description of all activities in which you interact with other healthcare workers e.g. multidisciplinary meetings, working groups and committee work. • Analysis of trainee/medical student survey (where appropriate) • Patient and colleague feedback • Evidence of participation in multi-professional team meetings
4 - Maintaining Trust: Attribute:4.1 Show respect for patients Attribute:4.2 Treat patients and colleagues fairly and without discrimination Attribute:4.3 Act with honesty and integrity	• Statement of Probity and Health • Complaints • Compliments • Patient and colleague feedback.

GMC SUPPORTING INFORMATION REQUIREMENTS[11]
Personal Details
Scope of Work
Record of annual appraisals
Personal Development Plans and Review
Statement of probity
Statement of health
Continuing Professional Development
Quality Improvement Activity
Significant Events
Patient (where applicable) and Colleague Feedback
Review of complaints and compliments

** The GMC acknowledge that not every doctor will have been involved in a significant event or received any complaints/compliments since there last appraisal. It is the demonstration of learning and any change of practise from both these supporting information requirements over a revalidation cycle that should be the focus rather than the number.*

[11] GMC | Supporting information for appraisal and revalidation

Appendix 2- Evaluation Proforma (Optional)

Appraisee Feedback Questionnaire

1 Very poor / Strongly disagree	2 Poor / Disagree	3 Average / Neutral	4 Good / Agree	5 Very good / Strongly agree

The organisation's approach to appraisal	1	2	3	4	5
The organisation's appraisal system					

My appraiser's skills	1	2	3	4	5
The appraiser's preparation for the appraisal					
The appraiser's skill in conducting my appraisal					
The appraiser's ability to listen to me					
The appraiser was supportive					
The appraiser's feedback was constructive and helpful					
The appraiser helped me think about new areas for development					
Overall rating of my appraiser in their role as an appraiser					

The appraisal discussion	1	2	3	4	5
The appraiser reviewed progress against last year's development plan					
How challenging was the appraisal in making me think about my practice					
How useful was the appraisal in my professional development					
The PDP reflects my main priorities for development					
How useful was the appraisal in preparation for revalidation					
I have confidence in the confidentiality of the appraisal discussion					

The administration of appraisal	1	2	3	4	5
I had access to forms and materials for appraisal					
I was given adequate notice of the date of my appraisal					
I had access to the necessary supporting information					
I was satisfied with the process for appraiser allocation					
Overall rating of the administration supporting appraisal in the organisation					

How long the appraisal meeting take? _____ minutes.
How could the Appraisal Meeting have been improved?

Comments to help appraisers improve their skills;

Appendix 3- Health and Probity Forms for Supporting Information

You should complete these forms if there are issues that you intend to discuss with your appraiser relating to any health and probity issues. You should retain the competed Forms in your supporting information portfolio.

a. Health Declaration Proforma

The GMC acknowledges that medicine can be a demanding profession and that doctors who become ill deserve help and support. Doctors also have to recognise that illness can impair their judgement and performance and thus put patients and colleagues at risk (this is particularly so in the case of psychiatric conditions, drug and alcohol abuse). The GMC therefore encourages doctors to reflect on their own health, seek professional advice if necessary and consider whether, for health related reasons, they should modify their professional activities.

1. Do you have any illness or physical condition that has, since your last appraisal/revalidation*, resulted in your restricting or changing your professional activities?

   Yes / No

   If yes, please give details of the changes in your professional activities, which it is – or was – necessary for you to make:

   ……

   ……

   ……

2. Are you – or have you been since your last appraisal/revalidation been the subject of any proceedings under the GMC's Health Procedures or Health Committee or similar proceedings of other professional regulatory or licensing bodies within the UK or abroad?

   Yes / No

   If yes, please give details:

   ……

   ……

   ……

3. Are you currently or since your last appraisal/revalidation been subject to medical supervision, voluntary or otherwise, and/or any restrictions voluntary or otherwise, imposed by your employer or contractor resulting from any illness or physical condition within the UK or abroad?

Yes / No

If yes, please give details:

……

……

……

* If this is your first appraisal and you have not yet gone through the process of revalidation then please fill in the proforma answering the questions as they apply to you at the current time.

b. Probity Declaration Proforma

Convictions, findings against you and disciplinary action

1. Since your last appraisal/revalidation*, have you been convicted of a criminal offence either inside or outside the UK? Yes / No
   If yes, please give details:
   ……

   ……

   ……

2. Do you have any criminal proceedings pending against you inside or outside the UK? Yes / No
   If yes, please give details:
   ……

   ……

   ……

3. Since your last appraisal/revalidation, have you had any cases considered, heard and concluded against you by any of the following:

   a. The General Medical Council.
   b. Any Other professional regulatory or other professional licensing body within the UK.
   c. A professional regulatory or other professional licensing body outside the UK. Yes / No

   If yes, please give details

   ……

   ……

   ……

   ……

4. Are there any cases pending against you with any of the following organisations:-

   a. The General Medical Council.
   b. Any other professional regulatory or other professional licensing body with the UK.
   c. A professional regulatory or other professional licensing body outside the UK.

   Yes / No

   If yes, please give brief details:

   ……

   ……

……

……

5. Since your last appraisal/revalidation, have there been any disciplinary actions taken against you by your employer or your contractor – either in the UK or outside – that have been upheld?

   Yes / No

   If yes, please give brief details:

   ……

   ……

   ……

6. Since your last appraisal/revalidation, has your employment or contract ever been terminated or suspended – in the UK or abroad – on grounds relating to your fitness to practice (conduct, performance or health)?

   If yes, please give brief details:

   ……

   ……

   ……

* If this is your first appraisal and you have not yet gone through the process of revalidation then please fill in the proforma answering the questions as they apply to you at the current time.

Appendix 4 – Reflective Templates

Colleague feedback structured reflective template

Name of doctor: GMC No:
Date of exercise:
Feedback scheme used (specify if self- or locally-designed):
Number of colleagues giving feedback:
Name of person who collated and gave feedback:
Designation of person giving feedback: (e.g. Clinical Director, Professional Partner, Appraiser; Professional Facilitator)
Main outcomes of feedback Hints: Look at your positive outcomes, as well as learning needs:
What learning might I undertake? Hint: It may help to separate learning from changing your behaviour. So, rather than "I will show more respect to nursing colleagues", it might be more productive to undertake learning which develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.
Final outcome after discussion at appraisal: (Complete at appraisal, considering how your outcome will improve patient care)

Patient or client feedback structured reflective template

Name of doctor:	GMC No:
Date of survey:	
Type of survey:	

What issues can I identify from the exercise?

Hints: Look at your positive findings just as carefully as the most negative. Discuss and seek advice from colleagues both peer and senior, if possible. If you have difficulty identifying learning needs from the survey, be frank about this. Skills in interpreting such information can then be considered as your first learning need in this regard.

What actions will I undertake?

Hints: These might include: improving communication techniques, restructuring ward rounds to maximise dignity and privacy, negotiating changes to the consulting environment, developing skills with respect to specific cohorts of patients, learning more about how to learn from patient surveys (as above).

Final outcome after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

Significant event audit (SEA) structured reflective template

Name of doctor:	GMC No:
SEA Title:	
Date of incident:	
Description of events:	
What went well?	
What could have been done better?	
What changes have been agreed? Personally: For the team:	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)	

Please note that PHA uses a different SAE form contained in Appendix C.

Data collection/audit structured reflective template

Name of doctor:	GMC No:
Measurement/audit title:	Date of data collection/audit:
Reason for choice of measurement/audit:	
Audit findings:	
Learning outcome and changes made: New audit target:	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)	

Case review structured reflective template

Name of doctor:	GMC No:
Date of clinical event:	Patient Identifier:

Description of clinical event:

Hint: You may choose a single consultation at random, or you may prefer to choose a case in which you were involved over time. Either way, your involvement should have been significant. You should write from your personal perspective, and reflect on how your own professional behaviour can improve, not that of the organisation, or of others.

Reflections relating to Good Clinical Care:

Hints: This refers to the systems allowing effective care, and your place within them. Was all information to hand? Was there enough time for the consultation? Was the environment conducive to patient privacy and dignity? Were all required clinical facilities available? Were local guidelines available? What can I do to improve these factors?

Reflections relating to Maintaining Good Medical Practice

Hints: This refers to your level of knowledge. How do I judge my level of knowledge, or skill around this clinical topic? What unmet learning needs can I identify? How can I address them?

Reflections relating to Relationships with Patients

Hints: How well did I communicate with the patient? Did the patient feel respected? Did the patient have sufficient opportunity to tell their story? Did the patient feel a partner to the outcome of the consultation? How do I gauge these? What skills can I identify which will enhance these?

Reflections relating to Relationships with Colleagues

Hints: Did I take account of notes made by others prior to this event? Did I gather information appropriately from others? Did I make comprehensive, legible records for others who may see the patient subsequently? Did I appropriately respect the clinical approach of others, even if it differs from my own? What can I do to improve this area in the future?

Outcome: For completion at your appraisal:

Agreed potential learning needs for consideration for inclusion in your personal development plan, considering how your outcome will improve patient care.

Other roles structured reflective template

Name of doctor: GMC No:
Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, in the last year, these have brought the following benefits to my main clinical role:
They also brought the following drawbacks to my main clinical role:
I could consider the following actions, to maximise the benefits and minimise the drawbacks: Date of reflection:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)

Annex B

APPRAISAL DOCUMENTS

CONTENTS

FORM 1 - BACKGROUND DETAILS

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.*
- *The form includes an optional section for any additional information.*

1.1	Full name	
1.2	GMC Registered address (contact address if different)	
1.3	Main employer	
1.4	Main place of work	
1.5	Other employers/ places of work	
1.6	Date of primary medical qualification	
1.7	GMC registration number and type	
1.8	Start date of first substantive appointment in HSC as a trained doctor	
1.8	GMC Registration date and specialties	
1.9	Title of current post and date appointed	
1.10	For any specialist registration / qualification outside UK, please give date and specialty	
1.11	Please list any other specialties or sub-specialties in which you are registered	
1.12	Is your registration currently in question?	
1.13	Date of last revalidation (if applicable)	
1.14	Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	

ANY ADDITIONAL INFORMATION

FORM 2 - CURRENT MEDICAL ACTIVITIES

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.*
- *Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.*
- *You may wish to comment in addition on factors which affect the provision of good health care.*

2.1 Please give a short description of your work, including the different types of activity you undertake	
2.2 List your main sub-specialist skills and commitments / special interests	
2.3 Please give details of any emergency, on-call and out of hours responsibilities	
2.4 Please give details of out-patient work if applicable	
2.5 Details of any other clinical work	
2.6 In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	
2.7 List any non-clinical work that you undertake which relates to teaching	

2.7.1 List any non-clinical work that you undertake which relates to management	
2.7.2 List any non-clinical work that you undertake which relates to research	
2.7.3 List any work you undertake for regional, national or international organisations.	
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

DOMAIN 1 - Knowledge, Skills and Performance

Attribute: 1.1 Maintain your professional performance
Attribute: 1.2 Apply knowledge and experience to practice
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

	List of Supporting Information	Applicable Date
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Discussion

Actions Agreed

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients
Attribute: 2.2 Respond to risks to safety
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Discussion

Actions Agreed

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively
Attribute: 3.2 Work constructively with colleagues and delegate effectively
Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Discussion

Actions Agreed

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients
Attribute:4.2 Treat patients and colleagues fairly and without discrimination
Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Discussion

Actions Agreed

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan		
Development needs	**Actions agreed**	**Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?**

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	**Actions agreed**	**Target dates**

FORM 5- HEALTH AND PROBITY STATEMENTS

HEALTH DECLARATION

Professional Obligations
The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: ……. Date: ……

Name in capitals ……...

Regulatory and Voluntary Proceedings
Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: ……. Date: ……...

Name in capitals ……...

PROBITY DECLARATION

Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice (2006).*

Signature…… **Date** …….

Name in Capitals……..

Convictions, findings against you and disciplinary action

Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

If I have been subject to any of the above, I have discussed this with my appraiser.

Signature …….. **Date** …….

Name in Capitals ……..

FORM 6 - SIGN OFF

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			
Quality improvement activity			
Significant events review			
Review of complaints and compliments			
Feedback from colleagues	Year undertaken OR Planned Year:		
Feedback from patients (where applicable)	Year undertaken OR Planned Year:		

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	
Ensure the previous year's Personal Development Plan has been reviewed.	
Forward required Forms according to the organisation's appraisal policy.	

APPRAISAL COMPLETION

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

APPRAISEE

Signature of Appraisee: : _____ Date: _____

APPRAISER

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

CO-APPRAISER (if applicable)

Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____

GMC Number: _____ Organisation: _____

FORM 7- REVALIDATION PROGRESS

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 2

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years			
Feedback from patients (where applicable) 1 in 5 years			
Significant Events Review			
Review of complaints and compliments			
Continuing Professional Development			
Quality Improvement Review			

Bibliography

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5. Department of Health, Social Services and Public Safety. Maintaining High Professional Standards in the 21st Century. A framework for managing concerns about doctors and dentists in the HSC. December 2012 (draft).

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10. General Medical Council. Good Medical Practice. 2013.

11. General Medical Council. Ready for Revalidation: Make your connection. 2012.

12. General Medical Council. Ready for revalidation. How doctors can meet the GMC's requirements for revalidation in the first cycle. 2012.

13. General Medical Council. Effective governance to support medical revalidation. A handbook for boards and governing bodies. March 2013.

14. General Medical Council. Ready for Revalidation. Making revalidation recommendations: the GMC responsible officer protocol. Guide for responsible officers. December 2012.

15. HSC Leadership Centre. Online Colleague Feedback User Manual. Participant/ Facilitator Guide. September 2012.

16. Northern Ireland Medical and Dental Training Agency. NIMDTA Annual GP Appraisal for all General Practitioners. http://www.nimdta.gov.uk/general-practice/gp-appraisal/

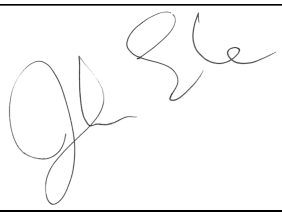
PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 March 2015
Title of Paper	Board Governance Self-Assessment Tool
Agenda Item	13
Reference	PHA/06/03/15

Summary

Following receipt of correspondence from Richard Pengelly on 18 November 2014, the PHA was required to complete the Board Governance Self-Assessment Tool.

The attached completed template is for approval by members for submission to DHSSPS.

Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Approval
Director's Signature	
Title	Chair
Date	9 March 2015

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

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by DHSSPS Sponsored Arms Length Bodies

Updated 28th October 2014

Contents

Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes (Good governance CIPFA). Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on DHSSPS sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health, Social Services and Public Safety (DHSSPS).

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment

It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

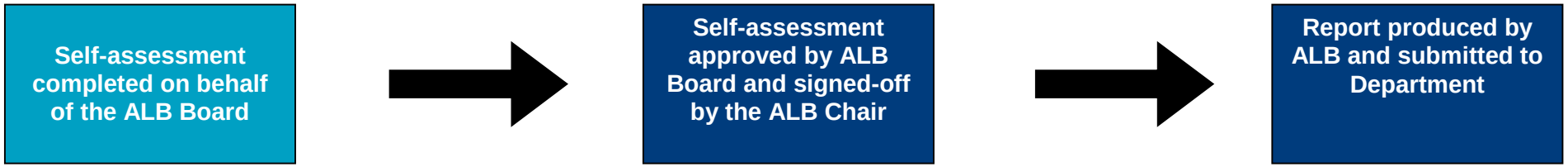
Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

Approval of the self-assessment by ALB Board and sign off by the Chair: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

Report produced: The ALB Board should provide a report back to Department's Central ALB Governance Unit (CAGU). This report should include the self-assessment ratings reached by the ALB Board and, where necessary, provide details on action plans on how they are going to comply with best practice.

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board and subsequently to the Department. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement. The Department may also wish to explore options at its disposal to ask for its own independent verification.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment (pg 10-37) using the electronic Submission Document (pg 39-60). The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they

have not adopted the practice or cannot adopt the practice. The Board should also complete the Summary of Results template (pg 61-62) which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete 3 mini case studies (pg 65-68) on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;
- Organisational culture change; and
- Organisational Strategy

The Board should use the electronic template provided and the case studies should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case studies. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
    - robust Action Plans in place that are on track to achieve good practice; or
    - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
    - Action Plans are not in place, not robust or not on track;
    - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
    - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g.

where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

The Report

The ALB will provide a summary report (see proforma) to the Department which will comprise of:

1. the self-assessment ratings reached by the ALB Board;
2. a brief description of the action plans that will be implemented to ensure compliance with Best Practice;
3. areas where the Board believes additional assurance is required; and
4. their feedback on the self-assessment and any suggested areas for improvement (e.g. identify specific criteria that need tweaked).

Replies to:

Central Arm's Length Bodies Governance Unit

Room D3

Castle Buildings

Stormont

BT4 3SQ

1. Board composition and commitment

1. Board composition and commitment overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size
2. Balance and calibre of Board members
3. Role of the Board
4. Committees of the Board
5. Board member commitment

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
1. The Chair and/or CE are currently interim or the position(s) vacant. 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). 3. The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	1. The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled. 2. The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities. 3. It is clear who on the Board is entitled to vote. 4. The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders. 5. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Standing Orders • Board Minutes • Job Descriptions • Biographical information on each member of the Board.

1. Board composition and commitment

1.2 Balance and calibre of Board members

Red Flag	Good Practice
1. There are no NEDs with a recent and relevant financial background. 2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. 3. The majority of Board members are in their first Board position. 4. The majority of Board members are new to the organisation (i.e. within their first 18 months). 5. The balance in numbers of Executives and Non Executives is incorrect. 6. There are insufficient numbers of Non Executives to be able to operate committees.	1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan. 2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors. 3. The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*. 4. There is at least one NED with a background specific to the business of the ALB. 5. Where appropriate, the Board includes people with relevant technical and professional expertise. 6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. 7. The majority of the Board are experienced Board members. 8. Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. 9. The Chair of the Board has previous non-executive experience. 10. At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Skills audit • Biographical information on each member of the Board

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit. 3. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 4. The Board takes collective responsibility for the performance of the ALB. 5. NEDs are independent of management. 6. The Chair has a positive relationship with the Minister and sponsor Department. 7. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 8. The Board operates as an effective team. 9. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 10. Board members respect confidentiality and sensitive information. 11. The Board governs, Executives manage. 12. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 13. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 14. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 15. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them. 16. The Board is aware of and annually approves a scheme of delegation to its committees.

	17. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme

1. Board composition and commitment

1.4 Committees of the Board

Red Flag	Good Practice
1. The Board notes the minutes of Committee meetings and reports, instead of discussing same. 2. Committee members do not receive performance management appraisals in relation to their Committee role. 3. There are no terms of reference for the Committee. 4. Non Executives are unaware of their differing roles between the Board and Committee. 5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team.	1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board. 2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees. 3. Schemes of delegation from the Board to the Committees are in place. 4. There are clear lines of reporting and accountability in respect of each Committee back to the Board. 5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle. 6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made. 7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees. 8. It is clearly documented who is responsible for reporting back to the Board.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Scheme of delegation • TOR • Board minutes • Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
1. There is a record of Board and Committee meetings not being quorate. 2. There is regular non-attendance by one or more Board members at Board or Committee meetings. 3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings). 4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved. 5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events. 2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time. 3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair. 4. Board meetings and Committee meetings are scheduled at least 6 months in advance.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record • Induction programme • Board member annual appraisals • Board Schedule

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Red Flag	Good Practice
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months. 2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years. 3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc). 4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months. 2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken. 3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. • The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation • The Board Scheme of Delegation/ Reservation of Powers

2. Board evaluation, development and learning

2.2 Whole Board development programme

Red Flag	Good Practice
1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members. 2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements. 2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities. 3. Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues. 4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: • The focus and balance of Board time; • The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; • How the Board responded to any service, financial or governance failures; • Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; • The robustness of the ALB's risk management processes; • The reliability, validity and comprehensiveness of information received by the Board. 5. Time is 'protected' for undertaking this programme and it is well attended. 6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.
Examples of evidence that could be submitted to support the Board's RAG rating.	• The Board Development Programme • Attendance record at the Board Development Programme

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
1. Board members have not attended the CIPFA "On Board" training course within 3 months of appointment. 2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable. 3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable. 4. NED appointment terms are not sufficiently staggered.	1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB. 2. Induction for Board members is conducted on a timely basis. 3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders. 4. Deputising arrangements for the Chair and CE have been formally documented. 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Succession plans • Induction programmes • Standing Order

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role. 3. Appraisals are perceived to be a 'tick box' exercise. 4. The Chair does not consider the differing roles of Board members and Committee members.	1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair 2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation. 3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary). 4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. 5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board • Personal Development Plans • Board member objectives • Evidence of attendance at training events and conferences • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

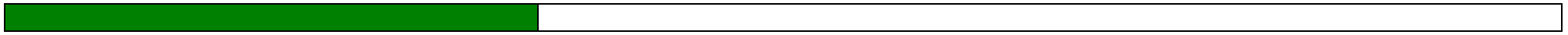
3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

Red Flag	Good Practice
1. Significant unplanned variances in performance have occurred. 2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner. 3. Finance and Quality reports are considered in isolation from one another. 4. The Board does not have an action log. 5. Key risks are not reported/escalated up to the Board.	1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept. 2. The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible. 3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made. 4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them. 5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Performance Report • Board Action Log • Example Board agendas and minutes highlighting committee discussions by the Board.



3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against efficiency and productivity plans. 2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans. 3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need. 4. The Board does not have a Board Assurance Framework (BAF).	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans. 2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service. 3. The Board receives information on all efficiency and productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Efficiency and Productivity plans • Reports to the Board on the plans • Post implementation reviews

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB. 3. The Board does not formally review progress towards delivering its strategies.	1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF). 2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan. 4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis. 5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CE report • Evidence of the Board reviewing lessons learnt in relation to enquiries • Outcomes of an external stakeholder mapping exercise • Corporate objectives and associated milestones and how these are monitored • Board Annual programme of work • BAF • Risk register

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured. 9. Board members can demonstrate that they understand the information presented to them,

	including how that information was collected and quality assured, and any limitations that this may impose. 10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Documented information requirements • Data quality assurance process • Evidence of challenge e.g. from Board minutes • Board meeting timetable • Process for submitting and issuing Board papers • In-month reports • Board papers • Data Quality updates

3. Board insight and foresight

3.5 Assurance and risk management

Red Flag	Good Practice
1. The Board does not receive assurance on the management of risks facing the ALB. 2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources. 3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic. 4. The Board has not reviewed the ALB's governance arrangements within the last two years.	1. The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board. 2. The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured. 3. The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc 4. The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services. 5. The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate. 6. An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Risk management policy and procedures • Risk register • Evidence of review of risks, e.g. Board minutes • Evidence of review of governance structures, e.g. Board minutes • Board Assurance Framework (BAF) • Clinical and Social care governance policy

4. Board engagement and involvement

4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months. 5. The Board has not overseen a system for receiving, acting on and reporting	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI Consultation Scheme • Complaints • Customer Survey • Regulatory and Review reports

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The ALBs latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). 3. There are significant unresolved quality issues. 4. There is a high turn over of staff. 5. Best practise is not shared within the ALB.	1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. 3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB. 5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Staff Survey • Grievance and disciplinary procedures • Whistle blowing procedures • Code of conduct for staff • Internal engagement or communications strategy/ plan.

4. Board engagement and involvement

4.3 Board profile and visibility

Red Flag	Good Practice
1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. 2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. 2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. 3. Board members attend and/or present at high profile events. 4. NEDs routinely meet stakeholders and service users. 5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made • Active participation at high-profile events • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings

5. Board Governance Self- Assessment Submission

Name of ALB – Public Health Agency

Date of Board Meeting at which Submission was discussed - 19 March 2014 (Date)

Approved by …….....(ALB Chair)

1. Board composition and commitment ALB Name – Public Health Agency Date – 23 Dec 2014

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	The size of the Board and the Board Committee structure is sufficient to ensure that there are processes in place to ensure that governance responsibilities are compliant with Standing Orders. At present, due to the Chair's term coming to an end, and a member acting as Chair a vacancy has arisen in our non-Executive positions. We also have 2 NED's whose terms expire in April 2015.	We are aware that advertisement and the application process has commenced and it is hoped that 1st April 2015 will see the appointment of a Chair and two new non-executive members.		
GP2 Green	The Board is content that it is provided with the appropriate guidance, support and advice to effectively discharge its responsibilities. This is done through its present membership and if required, others have been invited to attend to ensure informed decisions.			

GP3 Green	The process for voting, and who the voting members are is outlined in Standing Order 5.2.17. Members are aware of their responsibilities in this area from induction and through guidance from the chair.			
GP4 Green	The composition of the Board is set out in the Standing Orders and accords with the establishing legislation. The responsibility for appointing non-executive board members lies with the Public Appointments Unit for approval by the Minister, therefore ensuring that the composition is in accordance with legislation is outside the remit of PHA. Executive Board Members are in line with DHSSPS requirements. Membership of Board and committees complies with the terms of reference set out in the PHA Standing orders.			
GP5 Green	The non-executives on the Board have variation in terms of appointment. This can be evidenced in the letters of appointment, updated in relation to their second term. Terms of appointment are determined by the Minister			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		The Chair's term finished in November 2014 and while this has been discussed with both Sponsor Branch and PAU, the appointment process has not yet been completed. Therefore an existing NED is Acting Chair, resulting in board membership being reduced by one person. However, we understand that recruitment is proceeding and anticipate new Chair in place by April 2015 (subject to Ministerial approval). Additionally 2 NEDs' terms finish in April 2015. PAU is currently recruiting for these posts and again it is expected that they will be in place by April 2015.
RF2		
RF3		

1. Board composition and commitment ALB Name – Public Health Agency Date – 23 Dec 2014

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The current balance of skills, knowledge and experience amongst Board members is appropriate to effectively govern the PHA. Changes in membership may impact on this and there will be ongoing review led by the Chair.			
GP2 Green	The PHA board members have backgrounds from the public, private and voluntary sectors as well as local councillors. (biographical information on Board members in Annual Report). Members terms of appointment and renewal dates are staggered.			
GP3 Green	Non Executive Board members are appointed through the PAU, who have responsibility for complying with Section 75. Executive Board members are appointed through the HSC recruitment and selection processes which are compliant with Section 75. The Board understands its			

	responsibility in relation to Section 75 and regularly meets with Equality staff to ensure compliance of its statutory obligations and good practice.			
GP4 Green	Several non executive directors have a background related to health care/ health improvement. Non-executive backgrounds also include governace and financial management. (biographical information on Board members in Annual Report)			
GP5 Green	As per legislation, the board is constituted from local government and lay members. The Board includes people with relevant technical and professional expertise.			
GP6 Green	Yes, however, 2 members' terms expire in April 2015 and the Chair vacancy is also expected to be filled by April 2015. There is a balance between Executive and non-Executive members which ensures an excellent mix of skills and knowledge etc.		As noted position will also change in April 2016 and 2017	
GP7	Board members (both		Position may change in April 15	

Green	executive/non-executive) have served on boards for a number of years, some at the level of Chair. (biographical information on Board members in Annual Report)			
GP8 Green	The Acting Chair has held the position of Deputy Chair from June 2014. However, she was Chair of the Governance and Audit Committee from 2009. She has held a number of Chair positions and has extensive experience in leading large complex organisations.		Position may change in April 15	
GP9 Green	The Acting Chair has held a number of non-Executive and Executive positions at Board level for many years.		Position may change in April 15	
GP10 Amber	The Acting Chair has financial qualifications, however as Acting Chair she cannot hold any position on the Governance and Audit Committee. While GAC members have experience in considering financial statements and understanding financial governance, it is recognised that this could be strengthened. The Chair of GAC has recently		Position may change in April 15	

	completed recommend Governacne and Audit training. PAU were asked to recruit at least one of the new Board members with financial experience. It is anticipated new members will be in place early 2015/16.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment ALB Name – Public Health Agency Date – 23 Dec 2014

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The role and responsibility of the board is outlined within Standing Orders. Members will have a copy of Standing Orders as part of their induction. Standing Orders are reviewed annually and approved at Board meeting.			
GP2 Green	Ministerial policies and expectations are communicated to members, through Board meetings, workshops and the issue of papers. This is also included in the business planning and strategy processes which include full Board involvement.			
GP3 Green	There is a clear understanding of the role of Executive Officers and non-executive Board members as this is outlined in job descriptions and the scheme of delegation within Standing Orders.			

GP4 Green	The Board recognises fully its collective responsibility in relation to the performance of the PHA. This is outlined in Standing Orders, Management Statement / Financial Memorandum and in the induction process.			
GP5 Green	NEDs are totally independent of management but work with Executive Directors when required.			
GP6 Green	The previous Chair had a positive relationship with the Minister and sponsor department. The Acting Chair has met with the DHSSPS and Minister on a number of occasions to ensure a positive working relationship.		Ongoing in light of the acting position and the recruitment of a new chair	
GP7 Green	At Board and Committee meetings, NEDs regularly and constructively challenge members on the papers and verbal updates given. This can be seen in the minutes of the meetings.			
GP8 Green	The PHA Board works as an effective team.			
GP9 Green	The PHA board shares corporate responsibility for decisions taken and makes its decisions based on best			

	evidence available.			
GP10 Green	Board members are aware of which papers are brought to public sessions and which are brought to confidential sessions and the need to respect confidentiality and sensitive information.			
GP11 Green	Yes, Executive Directors have responsibility for operational management of the PHA, while the PHA board governs as set out in the PHA Standing Orders.			
GP12 Green	The Board members contribute openly and fully to deliberations and exercise a healthy challenge function.			
GP13 Green	The Chair acts as first port of call for any advice, help or support. If she is not able to provide the help herself, she will refer members on as appropriate.			
GP14 Green	The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision.			

GP15 Green	The PHA considers the needs of all its stakeholders and fully participates in partnership and public involvement to ensure excellent relationships.			
GP16 Green	The PHA Board clearly understands the scheme of delegation; it is brought to the Governance and Audit Committee and Board for review and approval annually.			
GP17 Green	The Board receives timely and robust post-evaluation documentation, when appropriate, in relation to major projects.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment ALB Name – Public Health Agency Date – 23 Dec 2014

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Terms of reference for board Committees are clear and specified in Standing Orders. They are systematically reviewed.			
GP2 Green	Tasks, functions and responsibilities are delegated to appropriate committees as per Standing Orders, but the members of Board in totality recognise that they carry the ultimate responsibility for the actions of Committees.			
GP3 Green	The scheme of delegation is outlined in Standing Orders.			
GP4 Green	There are clear lines of reporting and accountability in respect of each Committee with the Board receiving full minutes and a verbal update.			
GP5 Green	There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and			

	approved by the Governance and Audit Committee and also the board.			
GP6 Green	The Committee Chair provides a verbal update to the board at the meeting following the Committee meeting. This can be seen in the board minutes. Minutes of the committee meetings are brought to the next board meeting after their approval.			
GP7 Green	The Governance and Audit Committee has undertaken the Audit Committee Self-Assessment for a number of years taking action to address gaps. An annual GAC Report is included in the Annual Report.			
GP8 Green	The terms of reference for the Governance and Audit Committee and Remuneration Committee highlight who is responsible for reporting to Board. The terms of reference are included within Standing Orders.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

RF3		
RF4		
RF5		

1. Board composition and commitment ALB Name – Public Health Agency Date – 23 Dec 2014

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	An attendance record is maintained by the Secretariat. Attendance is generally very good for board and committee meetings.			
GP2 Green	Members' commitment is 5 days per month which is broken down as 1 day for board meeting, 1 day for committee meetings, 1 day for workshops, 1 day for reading papers and 1 day available for any other ad hoc events and launches.			
GP3 Green	Board members have all received a copy of the DHSSPS Code of Conduct and Code of Accountability. Compliance is included in the Chair's annual appraisal of NEDs.			
GP4 Green	An annual schedule of meetings is prepared and agreed with members in relation to Board meetings, workshops and strategic days.			

	Schedules are also in place for Governance and Audit and Remuneration Committees and other specific meetings such as Local Government committee, older people etc.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 23 Dec 2014

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board completed its second self-assessment in 2013/14. This was approved by the Board on 20 March 2014.	The PHA Board will continue to undertake the DHSSPS ALB Board self-assessment annually.		
GP2 Green	The PHA Board continues to review itself to ensure improvement and development. At a recent workshop a few changes have been made in relation to Board Business and reporting to the Board by the Chair and Chief Executive.	The PHA Board will continue to use the self-assessment and other tools as a basis for identifying further improvements / changes.		
GP3 Green	The Internal Audit assists the Board in relation to governance. Internal Audit audited the PHA Board Self-Assessment in 2013/14, providing satisfactory assurance. Learning from the audit has been incorporated into subsequent self assessments.			

	An annual meeting takes place between Governance and Audit Committee members with External and Internal Audit.			
GP4 Green	The Board workshop in September 2014 was facilitated by an external facilitator who provided constructive challenge to members. The Board held a workshop with staff in December 2014 as the second stage of engagement for the new Corporate Strategy. Two further sessions have been arranged.			
GP5 Green	The current self-assessment has covered those questions/areas included in the DHSSPS checklist, both 'hard' and 'soft' dimensions of effectiveness.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 23 Dec 2014

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	In addition to having an annual PHA board planning and review workshop, there have been regular topic specific workshops on key areas of PHA business.This model is continually under review by the Board to ensure it meets their needs.			
GP2 Green	The relationship between the Minister, Department and ALB board members is included in the Management Statement, which is brought to a board meeting annually. The Management Statement and Financial Memorandum was revised by DHSSPS in 2013/14, agreed by the Board and signed by the Chief Executive.	This will be included in the induction process for new members to ensure clear understanding of the role and function of all concerned. It would be beneficial for the new chair to meet the Minister asap after appointment		
GP3 Green	Reports on action plans to address governance issues arising from internal audit			

	reports or other significant control issues are reported to the GAC. GAC minutes are brought to the PHA board, and the Chair of the GAC also provides a verbal update to board members. The GAC also prepares an Annual Report.			
GP4 Green	The 2014/15 PHA workshop included time for members to consider the effectiveness of the Board and arrangements for the coming year.	This will be included each year as new members shall be joining over the next few years. This is good practice to ensure input/outcome is clearly understood by all members.		
GP5 Green	Time is set aside for PHA board planning / review and it is well attended by members.			
GP6 Green	Members are reminded annually at formal appraisal, but also throughout the year. They are given the opportunity to avail of relevant development opportunities.	The Board reflects annually on future potential development needs to ensure future needs / challenges as well as reflection on self-assessment.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 23 Dec 2014

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	All Board members have had induction and this includes attendance at the On Board training course. Specific induction is also provided for new members of the Governance and Audit Committee.	The Acting Chair is working on a new induction programme to ensure full compliance / understanding of Board responsibilities, roles, expectations, commitment to ensure new members are clear about their role etc. This will also include updating present members where appropriate.		
GP2 Green	Induction is undertaken as soon as possible after appointment.			
GP3 Green	At the induction, new members will receive a pack of relevant corporate and strategic documentation. They also have the opportunity to have 1:1 meetings with both the Chair, Chief Executive and Executive Directors. This also includes an overview of services provided by the PHA, the organisational structure. PHA values, objectives and key issues.	The Acting Chair is working on a new induction programme to ensure full compliance / understanding of Board responsibilities, roles, expectations, commitment to ensure new members are clear about their role etc.		

GP4 Amber	Deputising arrangements are specified within Standing Orders and noted in the Board minutes.	Deputising arrangements for the Chief Executive have been discussed at Remuneration Committee and should the need arise, appropriate action shall be taken. Deputising for the Chair will be seen as top priority once chair is appointed.		
GP5 Green	Appropriate action has been taken by the PHA. At present two members will be leaving in April 2015, and the PAU have been notified. The Acting Chair will liaise with PAU to ensure that these vacancies do not impact on the governance of the PHA.	The vacancies for Chair and members have been advertised and provisional dates for interviews have been sent by the PAU.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 23 Dec 2014

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Annual appraisals are carried out by the Chair / Acting Chair in line with the requirements of the PAU.	It is proposed by the Acting Chair that annual 1:1 meetings shall be held with members to ensure communication and any issues can be openly discussed. The Acting Chair operates an "open door" policy.		
GP2 Green	The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee.			
GP3 Green	The Chair receives an appraisal from a Deputy Secretary and this is signed off by the Permanent Secretary			
GP4 Green	As part of the appraisal system, this is clearly discussed and specified to ensure continuous development.			

GP5 Green	Board members appraisals allow members to highlight development needs.	It is proposed by the Acting Chair that annual 1:1 meetings shall be held with members to ensure communication and any issues can be openly discussed. The Acting Chair operates an “open door” policy.		
GP6 Green	This is covered through the appraisal system and PDPs, as well as through Director/Chief Execuitve away days. Relevant training/awareness is also built in where particular needs arise during the year.			
GP7 Green	Where appropriate, this is the case.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		This has not been part of the formal appraisal process currently required by DHSSPS.
RF2		
RF3		
RF4		

3. Board insight and foresight

ALB Name – Public Health Agency **Date – 23 Dec 2014**

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board receives regular financial and performance monitoring reports the layout of which has been shaped by the business needs of the Board and for ease of use by NEDs. This sets out • performance against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted, explained and mitigating actions identified • Issues regarding future performance are highlighted The PHA Corporate Strategy, Annual Business Plan including commissioning direction targets (evidence, board papers & internal audit report) set the parameters for performance reporting.	The PHA will continue to refine and develop its performance monitoring, in line with the Annual Business Plan for 2015/16. In light of budget issues, the Board will work closely with Executives and Finance to ensure objectives, targets etc. remain achievable.		
GP2	The board receives a quarterly			

Green	performance report outlining progress against objectives in the Business Plan. It also receives monthly financial report and updates on Commissioning Directions.			
GP3 Green	The Committee Chairs provide updates to the Board following each Committee meetings as specified in Standing Orders. The approved minutes of each Committee are brought to the Board for noting.			
GP4 Green	The Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee.			
GP5 Green	Actions are recorded in the minutes of board meetings against named officers and updates reported on at the following meeting.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments

RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name – Public Health Agency **Date – 23 Dec 2014**

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board is assured that there are robust processes for assessing risks and the potential knock on or impact these could have on the health and social care family.			
GP2	Not applicable			
GP3	Not applicable			
GP4	Not applicable			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight

ALB Name – Public Health Agency **Date – 23 Dec 2014**

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chief Executive presents a report at every Board meeting. This, if required, will cover areas such as the external environment, policy changes and any other areas as required.			
GP2 Green	The board considers the impact of any actions arising from findings as well as the learning outcomes to ensure continuous organisational improvement.			
GP3 Green	The Board actively contributes to the development of the Business Plan through its workshop and strategic days. When all parties / stakeholders etc. have been consulted with, it is brought to the Board for formal approval.			
GP4 Green	As GP3 above, and reports are brought to the board on a quarterly basis as outlined in section 3.1 (GP2). There is			

	also an Assurance Framework which outlines what reports are required to be brought to the board and a corporate calendar outlining when these will be brought to the board.			
GP5 Green	The Board's annual programme of work allows for time for the board to consider environmental and strategic risks, (including confidential board meetings, board workshops and board away day). Where relevant the Assurance Framework will be amended to include additional reporting, and or amendments brought back through Executive Directors for the Risk Register.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

3. Board insight and foresight ALB Name – Public Health Agency Date – 23 Dec 2014

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	A plan of Board and Committee meetings is set annually to ensure diary management, for example Board meetings are normally scheduled for the third Thursday of each month. Deadlines such as Annual Reports and Accounts and Governance Statements are also taken account of to ensure completion in a timely manner.			
GP2 Green	Board and Committee papers are issued at least one week in advance of the meeting to ensure adequate time for reading etc.			
GP3 Green	Board papers have a cover sheet which clearly outlines what decision is required of the Board i.e. noting or approval.	The layout of the sheet will be reviewed by the Acting Chair in early 2015.		
GP4 Green	Quarterly performance reports are brought to the board. If members wish to raise a specific item at a board			

	meeting, they can do so. The PHA has clearly defined procedures for bringing significant issues to the Board's attention outside the formal monthly meetings.			
GP5 Green	Board papers include the relevant information in respect of proposals or decisions that have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board.			
GP6 Green	The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data. Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers are brought to Board meetings. Also, the Governance and Audit Committee have the opportunity to challenge and question data provided. Internal and External Audit report consider data quality in relevant audits.			

GP7 Green	Board minutes clearly demonstrate where members have challenged and questioned information brought in relation to performance management and the grading of same.			
GP8 Green	The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops.			
GP9 Green	Board members can clearly demonstrate that they understand information presented and openly challenge the collection and presentation of same.			
GP10 Green	The PHA takes all steps to ensure that documentation presented to the Board complies with DHSSPS guidance where appropriate.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name – Public Health Agency **Date – 23 Dec 2014**

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has a clear strategy and policy and procedures in relation to risk management and emerging risks which have been approved by the GAC. These are regularly reviewed and are also supported by operational procedures. This clearly includes the level of risk, risk appetite and how risks escalate from directorate risk register to Corporate Risk Register, as well as reporting arrangements to GAC and PHA Board.			
GP2 Green	There is an Assurance Framework in place which outlines the key sources of assurances and how these will be reported to the board. The risk register is brought to the GAC each quarter, where it is scrutinised.			
GP3 Green	The Assurance Framework identifies a range of sources of assurance for the board, including internal and external			

	audit.			
GP4 Green	The Board regularly reviews/updates governance arrangements and practices against DHSSPS standards, good practice and good governance standards for public service.			
GP5 Green	Given the nature of the PHA functions it does not have a separate clinical and social care risk assessment and management. All types of risk are included in the Directorate and Corporate risk registersand are subject to systematic review.			
GP6 Green	The Director of Public Health is responsible for professional issues in respect of medical staff, and the Director of Nursing and AHP for nursing and AHP staff.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

4. Board engagement and involvement ALB Name – Public Health Agency Date – 23 Dec 2014

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has an approved PPI consultation scheme and has had service users present to the Board throughout the year.			
GP2 Green	A variety of methods are used across the PHA to engage with service users and the wider public. Board members attend at a range of activities/events/conferences of voluntary, community organisations as well as other HSC events. Chair and Chief Exeutive report at monthly board meetings in respect of events etc they have attended. Executive Directors will also have direct contact with a range of external stakeholders. The Board has identified two NED disability champions, who will be working with PHA officers and other stakeholders to ensure this agenda is taken			

	forward.			
GP3 Green	Individual programme staff engage with external stakeholders in respect of the various services they are commissioning. This information is used in the development of the PHA business plans.	An external engagement event has been organised for March 2015 to contribute to the next PHA Corporate Strategy. This will also be supported through social media.		
GP4 Green	The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA.			
GP5 Green	The PHA ensures that the learning from SAIs is disseminated and where appropriate influences the commissioning of services.			
GP6 Green	PHA Board / Agency has very constructive and effective relationships with a range of key stakeholders.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		

RF2		
RF3		
RF4		
RF5		

4. Board engagement and involvement ALB Name – Public Health Agency Date – 23 Dec 2014

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The organisation culture is reviewed by the Remuneration committee bi-annually and discussed at confidential session. Follow up actions in respect of organisational culture are discussed at committee/board. An annual staff event is held for all staff – Board members attend (most recently December 2014) Staff present on their work at board workshops. An Organisational Working Development Group has been established and is working through an Action Plan. The Emphasis Programme has been developed and launched as part of this. It includes a range of OD programmes. A working group reports to AMT with the Director of HR reporting to the Board.			

GP2 Green	Staff are involved in the development of corporate and directorate business plans at directorate/function level. This information is then fed through to the corporate business plan. An event for all staff was held in December 2014 to enable staff to input to the development of the new Corporate Strategy. In addition, an internal social media platform has been set up to continue the conversation.			
GP3 Green	This is communicated through Directors to their teams, and is the basis for appraisals.			
GP4 Green	The Board regularly thanks individuals and departments at Board meetings or other group functions, it acknowledges contributions and achievements as and when appropriate.			
GP5 Green	The PHA Board and Agency have clear values and behaviours that have been communicated to staff not only in internal meetings by management, but clearly in policies and procedures.			
GP6 Green	Staff are informed about major risks etc through a range of channels, including emails from			

	the Chief Executive, and through Chief Executive and Directorate briefings.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

4. Board engagement and involvement ALB Name – Public Health Agency Date – 23 Dec 2014

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Board members attend a range of events and launches across the PHA. Board workshops provide the opportunity for staff to present to board members and discuss programme areas in more depth and with a wider range of staff involved than would be possible at a formal board meeting.			
GP2 Green	Board members, and in particular the Acting Chair and Chief Executive attend a range of meetings and events with external stakeholders.			
GP3 Green	Board members regularly attend events which would include high profile events.			
GP4 Green	NEDs regularly meet stakeholders and service users through events / presentations etc.			

GP5 Green	The Board holds its meetings in public, and only has a small number of confidential sessions, with very specific, sensitive and/or urgent agendas. Board agendas and minutes are published on the PHA internet site.			
GP6 Green	Yes			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

Summary Results **ALB Name – Public Health Agency** **Date – 23 Dec 2014**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Amber	
1.2 Balance and calibre of Board members	Amber	Changes in membership and Chair position will be managed as required but will reqire a period of change and learning
1.3 Role of the Board	Green	
1.4 Committees of the Board	Green	
1.5 Board member commitment	Green	

2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation	Green	
2.2 Whole Board development programme	Green	
2.3 Board induction, succession and contingency planning	Green	
2.4 Board member appraisal and personal development	Green	

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting	Green	
3.2 Efficiency and Productivity	Green	

3.3 Environmental and strategic focus	Green	
3.4 Quality of Board papers and timeliness of information	Green	
3.5 Assurance and risk management	Green	

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders	Green	
4.2 Internal stakeholders	Green	
4.3 Board profile and visibility	Green	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes
5.1		
5.2		
5.3		

Areas where additional training/guidance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers recent case studies in the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the Trust. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB Name.....Date.....

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	Title:
Brief description of issue	
Outline Board's understanding of the issue and how it arrived at this	
Outline the challenge/scrutiny process involved	
Outline how the issue was resolved	
Summarise the key learning points	
Summarise the key improvements made to the governance arrangements directly as a result of above	

6. Board impact case studies ALB Name – Public Health Agency Date – 13 Jan 2015

6.2 Case Study 2

Organisational Culture Change	Title: Safety, Quality and Patient Experience
Brief description of area of focus	PHA Board assurances in relation to safety, quality and patient experience.
Outline reasons/ rationale for why the Board wanted to focus on this area	In light of the Francis Report, the PHA Board wished to receive more detailed information and more regular updates in relation to safety, quality and patient experience. The Board requested a specific confidential session relating solely to Serious Adverse Incidents (SAIs) which would give members an overview of the SAI process and assurances regarding how learning is disseminated and implemented.
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	The Board received a detailed briefing on SAIs at its meeting in February 2014. This included an overview of the process and members were shown examples of learning letters and newsletter to help explain how learning is disseminated. A six-monthly report on SAIs is brought to the Board. The Board has also received updates on the 10,000 Voices project which looks at patient experience. Furthermore, the Board has had the opportunity to hear first hand from service users on their experience, and has also heard from users whose lives have been changed thanks to their participation in programmes that PHA funds e.g. FNP, MARA, CLARE and some PPI initiatives.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	The Board will continue to receive regular updates on SAIs and it is hoped that more patient experience stories will be shared with the Board.

6. Board impact case studies ALB Name.....Date.....

6.3 Case Study 3

Organisational strategy	Title:
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	

HSC Public Health Agency

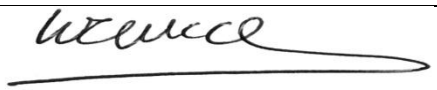
PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 March 2015
Title of Paper	PHA Annual Business Plan 2015-16
Agenda Item	14
Reference	PHA/07/03/15

Summary

The PHA is required to develop an Annual Business Plan, as specified in the Management Statement and in line with DHSSPS requirements. The draft Annual Business Plan has been developed with input from all Directorates. It takes account of the draft Commissioning Directions, and while no DHSSPS Requirements document was received for 2015/16, the initial draft has been shared with Sponsor Branch, and comments have been addressed as applicable.

In line with the DHSSPS extended timeline for approval of Annual Business Plans the revised final draft was approved by AMT on 3rd March 2015.
The PHA Board are asked to consider, and approve, this final draft PHA Annual Business Plan 2015/16 for submission to the DHSSPS.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The Business Plan was approved by AMT on 3 March.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	9 March 2015

ANNUAL BUSINESS PLAN

HSC Public Health Agency

2015–2016

Approved by the **PHA Board xxxxxx**

Approved by DHSSPS xxxxxx

Purpose, vision and values

During 2015/16 the PHA will continue to work and be guided by our purpose, vision and values.

Our purpose

To protect and improve the health and social wellbeing of the people of Northern Ireland and to reduce health inequalities through strong partnerships with individuals, communities and key public, private and voluntary organisations.

Our vision

That all people in Northern Ireland can achieve their full health and wellbeing potential.

Our values

- Improving the health and social wellbeing of the community we serve will be at the heart of everything we do.
- In conducting our business, we will act with openness and honesty, treating all with dignity and respect.
- We will work in partnership to improve the quality of life of those we serve.
- We will value and develop our staff and strive for excellence in all we do.

Contents

Introduction

The Public Health Agency (PHA) *Annual Business Plan 2015–2016* details how we will make best use of our resources to achieve our core goals, as set out in our *Corporate Strategy 2011–2015*. These are:

- Protecting health
- Improving health and wellbeing and tackling health inequalities
- Improving the quality of health and social care services
- Improving early detection of illness

It also details how we plan to improve how we work by:

- Using evidence, fostering innovation and reform
- Developing our staff and ensuring effective processes

This plan focuses on significant new initiatives for 2015/16, incorporating Departmental requirements, and is not intended to cover every aspect of the PHA's planned work.

It will provide a basis for staff objectives and training and is a core accountability tool for the Department of Health, Social Services and Public Safety (DHSSPS).

Strategic context

The PHA has been in operation since April 2009 and over this time we have moved from establishment, to consolidating our position, developing our work and its impact, as well as strengthening the partnerships and links we have with communities, groups and organisations.

There have been significant developments in recent years in terms of interventions and programmes to improve and protect health and well-being, reducing health inequalities, as well as in modernising and developing the range and quality of care services. This provides no basis for complacency as there are, for example, currently 4,000 premature deaths per year and 61,000 potential years of life lost through preventable illnesses. Loss to the local economy as a result of obesity alone is estimated at over £400 million, with 61% of the population being either overweight or obese and the impact of the misuse of alcohol on the health and social care system is estimated at some £250 million.

We recognise that reducing health inequalities is also central to ensuring economic and social progress. Reducing entrenched health inequalities is not something that the PHA alone can achieve, nor will it be easily measured on an annual basis. Accordingly working effectively with communities, organisations and groups is at the heart of what we do. The new strategic Public Health framework "Making Life Better", published in 2014 provides a renewed drive and direction for working better together, including with other Departments and public Agencies on the root causes of health inequalities.

The PHA, like all other HSC organisations and the wider public sector, faces financial challenges as we enter 2015/16. The NI public budget is constrained and tough choices will have to be made. This will have implications on how we do our business, as we take steps to work within a reduced management and administration budget. It will also impact on how we use our budget to achieve our core goals. The PHA will however continue to closely monitor and review its expenditure to ensure that it is used to maximum effect to help improve the health and wellbeing of the people of Northern Ireland and maintain the safety and quality of the services we commission.

Our last Annual Business Plan (2014/15) contained approximately 85 targets including those set for it in the DHSSPS Commissioning Plan Directions and Departmental Objectives. These targets covered every facet of our work with the vast majority, *78%,* completed on time and a further *18%* on track for completion, albeit slightly delayed. These stretching targets reflected areas identified as having the biggest potential impact on improving levels of health and social wellbeing, protecting the health of the community, and ensuring patients continue to receive high quality and safe treatment and care services.

In planning our work for 2015/16 the PHA must take account of the regulatory and strategic environment in which we operate, including:

- Programme for Government 2011–2015
- 'Making Life Better'
- DHSSPS policy priorities
- Partnership working
- Personal and public involvement

Our actions will therefore reflect these. We will also seek to embed prevention and early intervention across the services we commission and, where appropriate, in relevant sections of the HSCB/PHA commissioning plan.

Programme for Government 2011–2015

Through the Programme for Government (PfG) 2011–2015, the fundamental importance of reducing health inequalities and improving long-term public health was recognised by a commitment to invest an additional £10m in public health initiatives over the lifetime of the programme. Specifically PFG set out the importance of tackling obesity. During 2014/15 the PHA continued to invest the additional budget in key public health areas, including specific programmes to tackle obesity, as set out in the 2014/15 Annual Business Plan.

The PHA also continued to work with the HSCB and other Health and Social Care (HSC) bodies during 2014/15 to achieve other relevant PfG targets, including those relating to chronic condition management, measures aimed at improving safeguarding for children and vulnerable adults, improving outcomes and access to new treatments and services, as well as reconfiguring, reforming and modernising the delivery of HSC services to improve the quality of patient care.

As the life of the current NI Executive has been extended for a further year, these PFG targets will also remain for a further year. The PHA will continue to work to address the priorities set out in the PFG 2011-15.

Making Life Better

A key priority for 2015/16 is the implementation of 'Making Life Better – A Whole System Strategic Framework for Public Health 2013-2023', which sets out an updated strategic direction for public health for the next ten years. The PHA has a lead role in the implementation of 'Making Life Better', working with DHSSPS and other partners through existing and recently established structures. The PHA established and chairs the Regional Project Board for Public Health which is comprised of Chief Officers of relevant statutory agencies including representation from health and social care, local government, community and voluntary sector and the private sector and reports to the All Departments Officials Group (ADOG). The Project Board will also be informed by and will support local partnerships with an initial focus on strengthening collaboration and co-ordination to deliver on the following strategic priorities across sectors at regional and local levels:

- Caring Connected Communities
- Active Travel/Space and Place
- Neighbourhood Renewal

Other DHSSPS policy priorities

During 2015/16, the PHA will also have joint responsibility with the Health and Social Care Board (HSCB) for the implementation of Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland. The goals of the strategy are the delivery of high quality services and for Northern Ireland to be recognised locally and internationally as a leader for excellence in health and social care.

We will also continue to work with the HSCB to implement Transforming Your Care: A Review of Health and Social Care, published by the Minister in December 2011.

Partnership working

The PHA has a statutory responsibility to work closely with partners in the community, the voluntary sector, health and social care, local government and the statutory sector. We will continue to do this in 2015/16, building on and consolidating relationships.

Much of our partnership working will continue to be through providing funding and professional leadership to implement specific programmes and initiatives. In other instances it will be through influencing and shaping the priorities, processes and budgets of partners to improve longer-term health outcomes.

We will continue to work closely and build on our relationships with local government, as they transition through significant reform, working collaboratively with the newly established councils to develop shared approaches and arrangements for improving and protecting our communities' health.

Personal and public involvement

Personal and Public Involvement (PPI) is a term used to describe the active and meaningful involvement of service users, carers and the public in the commissioning, design, delivery and evaluation of health and social care services.

PPI is a statutory responsibility for HSC organisations. It is also an integral component of the drive to achieve improvements in safety, quality and effectiveness, helping to ensure that services are truly person centred.

In keeping with our PPI strategy and action plan, "Valuing People, Valuing their Participation", the PHA will continue to work to embed PPI into the culture and practice of the organisation. The PHA also has regional leadership responsibilities for PPI across the HSC system. This includes:

- Leading the implementation of PPI policy across HSC;
- Ensuring Trusts meet their PPI responsibilities;
- Chairing the Regional HSC PPI Forum;
- Sharing of PPI best practice and promoting consistency of approach;
- Establishment of robust PPI monitoring arrangements;
- Raising awareness of and understanding PPI through capacity building and commissioning of training.

Beyond 2015

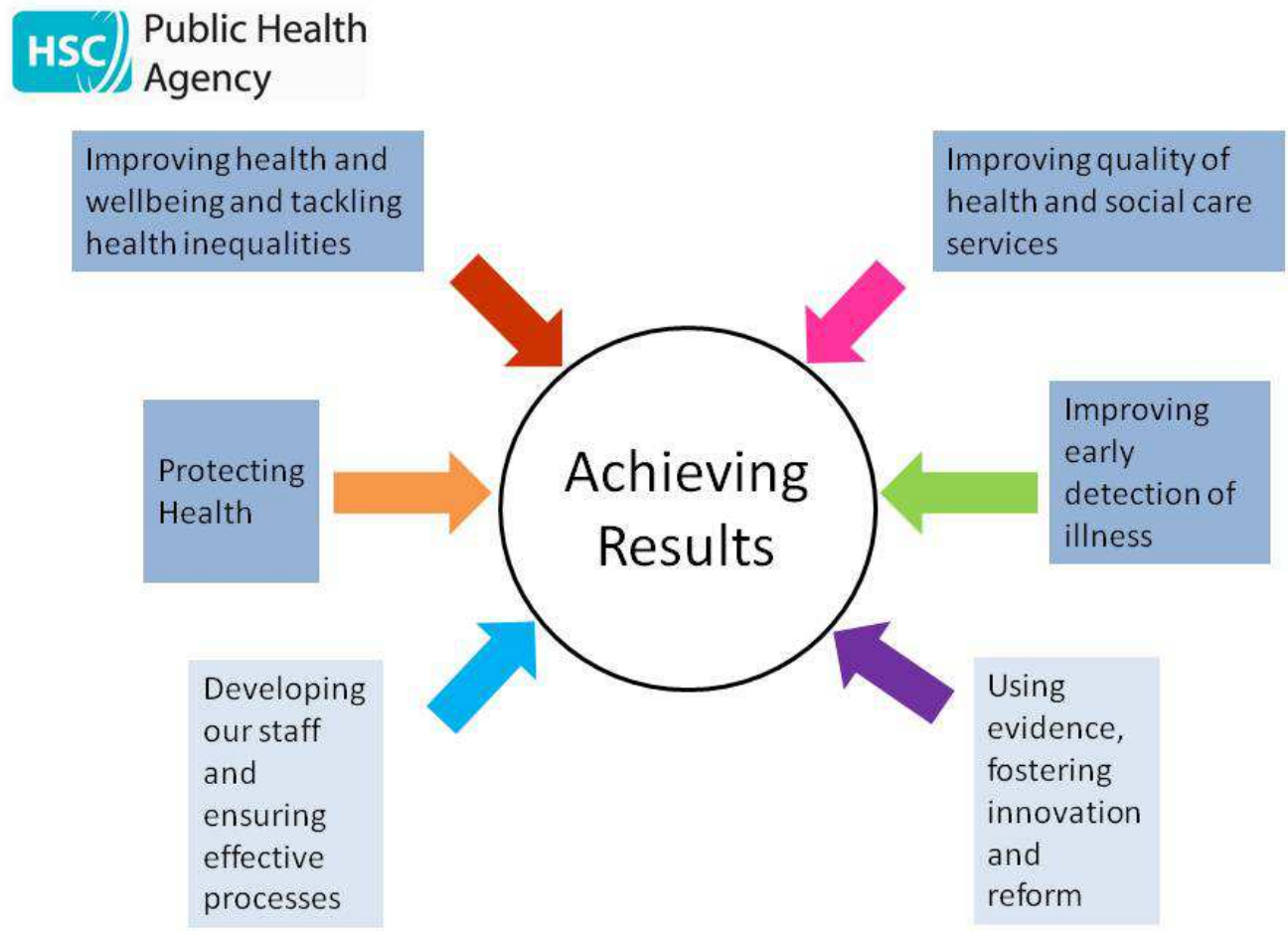
As set out in the PHA Annual Business Plan for 2014/15 the PHA commenced work in 2014 to develop a new corporate strategy, including both external and internal engagement. While our existing Corporate Strategy 2011 – 2015 will be extended for a further year (reflecting the extension of the NI Executive) covering this Annual Business Plan for 2015/16, the development of our new Corporate Strategy will be a key priority for the coming year. The new Corporate Strategy will be based on what we learn from listening to our partners, stakeholders and staff, scanning the future environment as well as reflecting our statutory responsibilities.

2015/16 will also see further changes to the PHA board. Mary McMahon our inaugural Chair completed her term in November 2014, with Julie Erskine taking on the role of Acting Chair until our new Chair is appointed in 2015. As well as a new Chair, two Non-Executive Directors (Jeremy Harbison and Miriam Karp) will also complete their terms in April 2015, with two new Non-Executive Directors to be appointed.

The forthcoming year will be a challenging one as we work within the budget constraints and reductions. This will have implications for what we do and how we do it. However we remain committed to working to achieve improvements in the health and wellbeing of the population of Northern Ireland, making best use of our resources to do so in 2015/16 as well as plan for the future.

Our work in 2015/16

In 2015/16 we will continue to focus on our six core areas of work, as illustrated in the diagram below:



The following sections of this business plan break each of these areas down into key actions to be led by specific PHA executive directors, recognizing that many of them will involve input and work across several Directorates.

Reports on the progress against each of these actions will be submitted on a regular basis to the PHA board. This will be supplemented by in-depth reporting on progress on specific issues as summarised in Appendix 1.

More detailed implementation plans for key actions will be presented to and considered by the PHA board. These will form the basis of monitoring and reporting of progress and achievements.

Following the introductory narrative in the following sections of this Plan, a table is presented setting out Key Actions to be taken forward in 2015/16.

Protecting health

The Health Protection Service within the PHA is responsible for the prevention and control of communicable disease and environmental hazards and provides the acute response function to major issues in these areas, such as outbreaks of infectious disease. The PHA Health Protection Duty Room, located in Linenhall Street at PHA headquarters, is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases.

The Health Protection Service has a number of work programmes in key areas with regional consultant leads for each area. These include healthcare associated infections, immunisation, health protection emergency preparedness, gastrointestinal infections, sexually transmitted infections, influenza, and tuberculosis. Immunisation programmes are one of the most successful public health programmes in existence, protecting the population of Northern Ireland against serious diseases. It is thus important that we sustain our work to maintain high rates of immunisation uptake here. The need to tackle the problem of increasing resistance of microbes to our arsenal of antimicrobial treatments is acknowledged as a global public health priority. More work is needed in this area across the HSC sector and in partnership with a range of external stakeholders.

During 2015/16, the PHA will continue to lead and provide the acute health protection response to incidents, outbreaks and the wide range of issues reported to the Health Protection Duty Room. We will ensure our protocols are fully up to date and further strengthen our service through continuous learning and development.

Priority actions for 2015/16 are:

- take forward work on antimicrobial resistance surveillance, within available resources;
- continue to extend flu immunisation programmes to children in the age groups identified in DHSSPS guidance;
- take forward the delivery of existing and new immunisation programmes and maintain high immunisation uptake targets across all programmes;
- ensure PHA is fully prepared to respond effectively to a range of health protection threats, including Ebola Virus Disease.

Key actions for 2015/16

	Action	Lead director	Timescale for completion
1.	Work with the HSC Trusts to secure a further reduction of x% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and in-patient episodes of MRSA bloodstream infection.	Medical Director/Director of Public Health	31st March 2016
2.	Update, test and refine PHA plans in relation to emergency preparedness.	Medical Director/Director of Public Health	31st March 2016
3.	During 2015/16 have emergency response plans in place to respond to a case of Ebola Virus Disease (EVD) in Northern Ireland.	Medical Director/Director of Public Health	31st March 2016
4	To scope the feasibility of introducing a surveillance system for AMR in Northern Ireland and to bring NI in line with the rest of the UK.	Medical Director/Director of Public Health	31st March 2016
5	Deliver a programme of training for the HSC on infectious diseases outbreak response and management.	Medical Director/Director of Public Health	31st March 2016
6	During 2015/16 extend the seasonal flu immunisation programme to include all pre-school children aged 2 and over and all primary school children and years 8, 9 and 10 post primary school and achieve a 75% uptake for this group of school children.	Medical Director/Director of Public Health	31st March 2016
7	Continue and enhance proactive communications of health protection issues, including vaccination, hand hygiene, observance days, etc.	Director of Operations	On-going throughout 2015/16

Improving health and wellbeing and tackling health inequalities

Our work to improve health and wellbeing and to reduce health inequalities across the population, including with particular communities and groups known to be at increased risk of poorer health, reflects four key objectives:

- to give every child the best start in life;
- to ensure a decent standard of living for all;
- to build sustainable communities;
- to make healthier choices easier.

During 2015/16 the PHA will advance these objectives through implementation of Making Life Better, the new public health framework for Northern Ireland, which seeks to ensure strengthened collaboration across society, improve health and wellbeing and reduce inequalities. We will also seek to strengthen our joint working with the eleven new councils and ensure close alignment with community planning processes to improve health and wellbeing.

The PHA will continue to progress the early years intervention agenda, in particular through the workstreams of the Early Intervention Transformation Programme, sponsored by a consortium including Government departments. We will continue to work with communities and organisations to reduce some of the structural barriers to health, aiming to reduce poverty and improve employability, social and economic development. We will work to ensure the active engagement of communities wherever possible.

In addition, we will focus on a number of specific public health issues:

- breastfeeding;
- obesity prevention;
- tobacco control;
- alcohol and drugs;
- sexual health;
- skin cancer;
- home accidents;
- mental health and wellbeing;
- suicide prevention;
- child health promotion.

Other important areas for action in 2015/16 include working with local government to embed Making Life Better themes and values into plans for regeneration and community development. Work will also be expanded to support Active Travel, engaging with a wide range of partners including the Department for Regional Development.

We will also be taking forward a programme to support the active engagement of older people to improve their health and wellbeing and building 'caring communities'. Four key areas of action will include: promoting active citizenship and positive ageing environments; improving access to and uptake of health and wellbeing programmes; supporting local approaches to include older people in issues that affect their health and wellbeing; and promoting befriending and support for older people and their carers.

A significant area of work this year will be the procurement of services including mental health promotion and suicide prevention as well as alcohol and drug misuse. Preparation for this has included extensive engagement with community and voluntary sector partners in developing agreed standards for services. These processes aim to secure the best possible outcomes for the public.

Work will also continue during 2015/16, with the HSCB and others as appropriate, to ensure that the e-health and care strategy is implemented and reflects the objectives of the PHA and 'Making Life Better'.

Improving health and wellbeing and tackling health inequalities Key actions for 2015/16

	Action	Lead director	Timescale for completion
	Giving Every Child the Best Start – Theme 1 Making Life Better		
1.	Implement Phase One of Early Intervention Transformation Programme in relation to universal midwifery, health visiting and pre-school services (Work stream one).	Director of Nursing/AHP	31st March 2016
2.	Implement Phase One of the Early Intervention service and family support hubs. (Work stream two)	Medical Director/Director of Public Health	31st March 2016
3.	Lead the expansion of Family Nurse Partnership to two further Trusts (funding permitting)	Director of Nursing/AHP	On-going throughout 2015/16
4.	Implement the regional Infant Mental Health plan and commission training to HSC and early years workforce.	Medical Director/Director of Public Health	31st March 2016
5.	Implement the Action Plan for the Breastfeeding Strategy for Northern Ireland.	Medical Director/Director of Public Health	31st March 2016
	Equipped Throughout Life – Theme 2 Making Life Better		
6.	Provide strategic leadership and co-ordinate the Regional Learning Disability Health Care & Improvement Steering Group on behalf of PHA & HSCB ensuring that good practice is promoted and health inequalities are identified and addressed in this area, and that services are responsive and make adequate adaptation to meet the health care needs of people with a learning disability.	Director of Nursing/AHP Medical Director/ Director of Public Health	31st March 2016
	Empowering Healthy Living – Theme 3 Making Life Better		
7.	Continue and enhance proactive communications on health improvement to reflect PHA programmes, campaigns, observance days and partnerships.	Director of Operations	On-going throughout 2015/16
8.	Ensure Trusts continue to deliver Telehealth and Telecare services including through the Telemonitoring NI contract, to targets set by the PHA.	Programme Director CCHSC	31st March 2016
9.	Embed the new drug and alcohol services tendered under the New Strategic Direction on Alcohol and Drugs (NSDAD) 2011-16 and the PHA/HSCB Drug and Alcohol Commissioning Framework 2013-16.	Medical Director/ Director of Public Health	31st March 2016

10.	Implement the Tobacco Control Implementation Plan including Brief Intervention Training, smoking cessation services, enforcement control and Public Information.	Medical Director/ Director of Public Health	31st March 2016
11.	Support and lead multi-agency partnerships to oversee regional and local delivery of Protect Life and Mental and Emotional Wellbeing strategies such as the regional Bamford structures and local Protecting Life Implementation Groups' Action Plans.	Medical Director/ Director of Public Health	31st March 2016
12.	Implement the obesity prevention action plan including: weight management programmes for children, adults, and pregnant women; development of a common regional Physical Activity Referral programme; implementation of Active Travel programme in schools; implementation of Active Travel Plan Belfast and public information and awareness.	Medical Director/ Director of Public Health	31st March 2016
13.	Take forward recommendations of the RQIA 'Review of specialist Sexual Health services in Northern Ireland' in partnership with DHSSPSNI, HSCB and HSC Trusts.	Medical Director/ Director of Public Health	31st March 2016
	Creating the Conditions – Theme 4 Making Life Better		
14.	Develop and implement programmes which tackle poverty (including fuel, food and finance poverty) and maximise access to benefits, grants and a range of services for vulnerable groups e.g. Home Safety check schemes.	Medical Director/Director of Public Health	31st March 2016
15.	Further develop the Travelers Health and Wellbeing Forum and delivery of the regional Action Plan.	Medical Director/Director of Public Health	31st March 2016
	Empowering Communities – Theme 5 Making Life Better		
16.	Work with local government to align community planning and regeneration with support for community development and public health goals.	Director of Operations and Medical Director/Director of Public Health	31st March 2016
17.	Publish and disseminate the PHA Workplace Model with a view to increasing the number of businesses registering to complete the PHA online health employee assessment by 10%.	Medical Director/Director of Public Health	31st March 2016
	Developing Collaboration – Theme 6 Making Life Better		
18.	In conjunction with the HSCB Co-Chair Prison Service Team and monitor the implementation of commissioning plan objectives relating to prisoner health. Contribute to the delivery of the Northern Ireland Prison Service Health and Social Wellbeing strategy through a 'Whole Prison Approach': including commissioning programmes for prisoners, their families and prison staff and taking forward the annual health needs assessment.	Medical Director/Director of Public Health Director of Nursing/AHP	31st March 2016

19.	Work with RCGP to launch, disseminate and implement guidance on LGB&T patients in Northern Ireland.	Medical Director/Director of Public Health	31st March 2016
20.	Work with key stakeholders (including local partnerships) to take forward the implementation of Making Life Better.	Chief Executive	On-going throughout 2015/16

Improving the quality of HSC services

The Quality 2020 Strategy defines quality as having three core elements:

- Safety
- Effectiveness
- Patient and Client Focus

The PHA is committed to ensuring safe, effective and high quality care for the population of Northern Ireland and to continually improving services by horizon scanning and developing learning systems to maximise the potential within organisations.

The PHA will continue to lead the Quality 2020 Implementation Team, working with the HSCB, HSC Trusts and the post graduate training bodies for medicine, nursing and social work. We will also continue to support and progress the Quality agenda through a number of work streams, and have established two joint strategic groups: the Quality Safety and Experience Group/ Safety Quality Alerts Team (SQAT) to share information, gain assurance and disseminate learning.

The PHA will monitor the implementation of the DHSSPS Patient Client Experience Standards and implement the 10,000 Voices initiative to enable patients, carers and their families to affect and inform how services are delivered and commissioned. We will also work with the Leadership Centre to develop the 3 year PCE strategy and support the DHSSPS to deliver regional patient surveys. In addition, the PHA as the LSA will ensure adherence to statutory midwifery supervision.

In pursuit of this culture the PHA will continue, through membership of HSCB commissioning groups to provide regional direction and professional expertise to HSC bodies and Local Commissioning Groups in the commissioning of HSC services and associated performance monitoring to ensure that patients are treated at all times with compassion, dignity and respect.

In particular significant contribution will be made to the preparation of the annual Commissioning Plan prior to its approval by both the Board of the PHA and the Board of the HSCB. PHA staff will continue to work throughout the year with HSCB colleagues on the commissioning teams to progress agreed investments.

We will also work with the HSCB in line with the DHSSPS circular HSC(SQSD) 2/13 to introduce National Institute for Health and Clinical Excellence (NICE) Technology Appraisals and will reflect NICE Clinical Guidelines in commissioning, taking account of available resources and DHSSPS priorities.

During 2015/16 we will continue to implement service frameworks and develop patient pathways to improve quality of services for patients and clients. We will also continue to engage with the range of clinical networks and other clinical fora.

The PHA will also continue to lead on a number of strategies including, but not limited to, the Mental Health Nursing Framework, Developing Excellence Promoting Recovery, AHP Strategy, Living Matters, Dying Matters Strategy, Dementia and Maternity Strategy.

The PHA will also contribute to a number of Department reviews, including but not limited to, review of imaging services, review of District Nursing etc.

PHA consultants will continue to support the HSCB process of approving individual funding requests for treatments not routinely commissioned and for the approval of extra contractual referrals for procedures not routinely available. In many cases these relate to complex and life-long care.

The PHA will provide professional support to the HSCB Serious Adverse Incidents process and to continue to consider new methods of disseminating learning. Professional staff provide expertise as Designated Review Officers (DRO) liaising with reporting organisations regarding investigation reports, SAI process, carrying out thematic review analysis and learning.

	Action	Lead director	Timescale for completion
1.	Oversee and lead on the regional implementation of Phase 1 and pilot phase 4 of the electronic caseload analysis tool (ECATS) for district nursing and HV.	Director of Nursing/AHP	31st March 2016
2.	Continue to implement phases 2-4 of the Delivering Safe and Effective Care Project (ED, DN and HV), and agree monitoring arrangements with HSCB for implementation of Phase 1	Director of Nursing/AHP	31st March 2016
3.	Agree SBA volumes for CNS activity in acute settings and identify, develop and agree job plans with associated SBA volumes for CNS roles in acute/community and community settings.	Director of Nursing/AHP	31st March 2016
4.	Along with HSCB lead the implementation of the NI Dementia Strategy and lead the OFMDFM/AP funded Dementia Signature Project (due to complete June 2017). Including the following key areas: • Information, support and advice including media campaign • Training including dedicated work with HSC Safety Forum, using a QI approach, to develop and implement a localized care bundle to prevent or treat patients with delirium • Innovative respite and short breaks • Regional review of memory OP services	Director of Nursing/AHP	On-going throughout 2015/16
5.	Ensure adherence to statutory midwifery supervision	Director of Nursing/AHP	31st March 2016
6.	Q2020 – Lead the development of the Annual Quality Report in conjunction with the HSCB.	Director of Nursing/AHP	30th September 2015
7.	Take forward recommendations on the DHSSPS Regional Learning System (RLS).	Director of Nursing/AHP	31st March 2016
8.	Working with HSCB continue to lead a programme of work to drive the reform of AHP services including • Improving data quality • Development of minimum staff activity levels • Capacity and demand analysis	Director of Nursing/AHP	31st March 2016
9.	Continue the Regional Medicines management Dietitian Initiative	Director of Nursing/AHP	31st March 2016
10.	Continue to take forward the implementation of the AHP Strategy, providing strategic direction, collaborating with HSC Trusts and other relevant partners regarding implementation of actions and the production of bi-annual progress reports.	Director of Nursing/AHP	31st March 2016

	Action	Lead director	Timescale for completion
11.	Continue the Review of AHP Support for Children/Young people with Statements of Special Educational Needs. Working with relevant partners, provide an interim report on findings and common themes identified from Phase 2 and work towards the agreement of a proposed regional model and implementation plan.	Director of Nursing/AHP	31st March 2016
12.	On behalf of PHA work alongside DoJ, DHSSPSNI & HSCB to consider / explore the potential issues surrounding the transfer of health care from Juvenile Justice System and PSNI	Director of Nursing/AHP	On-going throughout 2015/16
13.	Lead, co-ordinate and monitor on behalf of the Department the implementation of the mental health nursing strategy 'Developing Excellence, Supporting Recovery'.	Director of Nursing/AHP	31st March 2016
14.	Lead on the sustainability phase of developing recovery services across the region working with key stakeholders both locally, nationally and internationally. Undertake an evaluation of recovery services using quality indicators.	Director of Nursing/AHP	31st March 2016
15.	The HSC Safety Forum will work with Trusts to support the further spread of the Sepsis 6 bundle beyond the pilot areas identified in the 2014/15 period.	Director of Nursing/AHP	31st March 2016
16.	The HSC Safety Forum will work with Mental Health teams to • Improve the physical health and well-being of mental health patients and • Improve approaches to crisis prevention and response.	Director of Nursing/AHP	31st March 2016
17.	Work with the HSCB to take forward the review of the Cancer Services Framework.	Medical Director/ Director of Public Health	On-going throughout 2015/16
18.	Work with the HSCB to take forward the Cardiovascular Services Framework Implementation Plan.	Medical Director/ Director of Public Health	On-going throughout 2015/16
19.	Develop an Implementation Plan for the Respiratory Service Framework, following consultation.	Medical Director/ Director of Public Health	On-going throughout 2015/16
20.	Commission patient and self-management programmes as outlined in PFG, subject to funding.	Medical Director/Director of Public Health	31st March 2016
21.	Lead on the Implementation of PPI Policy in HSC, including roll out of PPI Standards, Monitoring and Training in order to help improve quality, safety and effectiveness of services.	Director of Nursing/AHP	On-going throughout 2015/16

Improving the early detection of illness

Early detection and treatment can result in better outcomes for some conditions. Screening involves inviting people who have no symptoms of a particular disease, to be tested to see if they have the disease, or are at risk of getting it. As a result they can then be offered appropriate further investigation and treatment. It is recognised that screening programmes can do harm as well as good, so it is important that all those invited for further screening make a fully informed decision as to whether they wish to participate. The PHA is working to promote informed choice for those invited for cancer screening.

During 2015/16 the PHA will continue to commission and quality assure screening programmes for breast, bowel and cervical cancers as well as non-cancer screening programmes including: antenatal infections screening; newborn bloodspot and hearing screening; diabetic retinopathy screening; and screening for abdominal aortic aneurysm (AAA.)

Investment has been made in the Belfast HSC Trust to ensure the compliance of the laboratories to deliver agreed standards for newborn blood spot testing.

The Diabetic Retinopathy Screening Programme has been under significant pressure to deliver screening at the required intervals and to the agreed standards. A Modernisation Board from Diabetic Retinopathy Screening was established in the latter half of 2014 to oversee a number of elements of service modernisation. During 2014, RQIA undertook a review of the service and the Programme Board will be overseeing the implementations of the recommendations during 2015/16.

Other important areas of work during 2015/16 will include:

- Implementing agreed actions from the Community Resuscitation Strategy for Northern Ireland;
- Take forward the review of the Cancer Services Framework.
- Take forward the Cardiovascular Services Framework Implementation Plan.
- Develop an Implementation Plan for the Respiratory Service Framework, following consultation.
- Commission patient and self-management programmes as outlined in PFG, subject to funding.
- Take forward relevant recommendations in the Hyponatraemia Inquiry Report once published.

Improving the early detection of illness
Key actions for 2015/16

	Action	Lead director	Timescale for completion
1.	Complete the promotion of informed choice in cancer screening (particularly amongst hard to reach groups).	Medical Director/ Director of Public Health	31st March 2016
2.	Ensure robust processes are in place for booking of DRSP patients, maintaining the screening interval and promoting high uptake.	Medical Director/ Director of Public Health	On-going throughout 2015/16

Using evidence, fostering innovation and reform

The PHA is committed to using and promoting, whenever possible, the latest guidance and good practice when developing or delivering programmes to improve and protect health and wellbeing. The promotion of and investment in research and development is fundamental to this.

During 2015/16 the PHA will work with the DHSSPS on the dissemination of the new HSC R&D Strategy and on developing and operationalising the implementation plan for this Strategy.

The PHA continues to support health and social care research in its widest sense throughout the HSC and the wider HSC R&D community, as a means of securing lasting improvements in the health and wellbeing of the population of Northern Ireland. The PHA will continually explore mechanisms to enhance research activity in Northern Ireland via the Northern Ireland Public Health Network (NIPHRN), the Northern Ireland Clinical Research Network (NICRN) and Northern Ireland Cancer Trials Network (NICTN).

During 2015/16, we will continue to build on these and other previous successes in securing external funding for HSC R&D and work with the HSC R&D community to facilitate access to UK and international funding, including the NETS programmes, Horizon 2020 and other EU initiatives.

During 2015/16 the PHA will work to deliver on the aim and objectives of the new HSC R&D strategy, using evidence and fostering innovation & reform by:

- Commissioning research calls in areas of health & social care priority through the vehicles of NIPHRN, NICRN, NICTN
- Maximize opportunities to enrich the HSC R&D fund by supporting researchers to access funding from external sources
- Facilitating the development of evidence-based health & social care, through effective knowledge exchange.

We will also continue to develop and improve our health intelligence function during 2015/16, providing support across all PHA directorates through supplying and assisting in the use of health intelligence particularly in the form of research, evidence reviews, data analysis and evaluations.

	Actions	Lead director	Timescale for completion
1.	Carry out a regional Review of school nursing service	Director of Nursing/AHP	31st March 2016
2.	Ensure the delivery of commissioned research to evaluate Telemonitoring NI	Programme Director CCHSC	31st December 2015
3.	Create the implementation plan for the new HSC R&D Strategy including metrics to assess success.	Medical Director/Director of Public Health	On-going throughout 2015/16
4.	Support researchers to secure research funding from external sources including NIHR evaluation, trials and studies co-ordinating centre (NETSCC), Horizon 2020 & other EU sources.	Medical Director/Director of Public Health	On-going throughout 2015/16
5.	Work with Northern Ireland Public Health Research Network (NIPHRN) to create opportunities for commissioned research in PHA priority areas (such as EITP, Breastfeeding etc).	Medical Director/Director of Public Health	On-going throughout 2015/16
6.	Commission Research and Produce a Best Practice Report on PPI.	Director of Nursing/AHP	31st October 2015

Developing our staff and ensuring effective processes

The PHA recognises that its staff are the organisation's greatest resource and the promotion of a safe, productive and fair work environment where all staff are respected and also understand their personal responsibilities and accountability is paramount. During 2015/16 the Organisational Workforce Development Group will continue to take forward this work, including the further roll out of learning and development opportunities, to enhance and expand the knowledge base and skillset of individual staff and the organisation as a whole, as well as supporting the work of the Health and Wellbeing and Communication subgroups

The development of our new Corporate Strategy will be a priority during 2015/16; we will take the opportunity during 2015/16 to review our purpose, vision and values along with our core goals and objectives, reflecting the experience of the early years of the PHA and looking to the future, learning from and building on both the initial internal and external engagement events held during 2014/15.

During 2015/16 the PHA will build on its existing good governance arrangements, continuing to ensure that these are embedded within the organisation and further developed in line with best practice, and Departmental guidance. This will include meeting key Departmental requirements including preparing a Governance Statement and Mid-Year Assurance Statement, compliance with the NAO Audit Committee Checklist, completing ALB board self-assessment tool, mid and end year accountability meetings, meeting Controls Assurance Standards and associated self-assessments, preparing our Annual Business Plan within the specified timescales and requirements and complying with procurement and financial regulations.

The PHA will continue to provide the Department with information pertaining to its performance management and reporting requirements in an accurate and timely manner.

Developing our staff and ensuring effective processes

Key actions for 2015/16

	Actions	Lead director	Timescale for Completion
1.	Provide Professional Leadership, Advice and Guidance on PPI.	Director of Nursing/AHP	On-going throughout 2015/16
2.	Develop a new PHA 3 Year Action Plan for PPI	Director of Nursing/AHP	31st December 2015
3.	Ensure that by 30th June 2015 90% of staff will have had an annual appraisal of their performance during 2014/15.	All Directors	30th June 2015
4.	Ensure that by 31 March 2016 100% of doctors working in PHA have been subject to an annual appraisal.	Medical Director/Director of Public Health	31st March 2016
5.	Continue to take forward implementation of the PHA Procurement Plan.	Director of Operations, with all Directors	On-going throughout 2015/16
6.	Achieve substantive compliance for all 15 controls assurance standards applicable to the Public Health Agency	Director of Operations	31st March 2016
7.	Test and review the PHA business continuity management plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	Director of Operations	31st March 2016
8.	Explore the introduction and feasibility of EDRMS in PHA and depending on the outcome of this develop a business case.	Director of Operations	31st March 2016
9.	Finalise the new PHA Corporate Strategy- building on the engagement carried out in 2014/15	Director of Operations	31st March 2016
10.	Meet DHSSPS financial, budget and reporting requirements	Director of Finance	31st March 2016
11.	Develop and agree a new Internal communications strategy and action plan to ensure PHA business is supported by efficient and effective internal communication systems.	Director of Operations	On-going throughout 2015/16
12.	Review and Revise PHA digital assets including PHA Corporate and Intranet sites	Director of Operations	30th June 2015
13.	Work with HSC partners and NI Direct to disseminate HSC public health information through NI Direct website	All Directors	31st March 2016
14.	Continue and enhance social media activity to extend the reach and expand the types of content used	Director of Operations	On-going throughout 2015/16

Appendix 1

PHA board Framework for Monitoring Performance

	Proposed Timelines for Monitoring			
Area of focus	**Monthly**	**Quarterly**	**Biannual**	**Annual**
General				
Corporate Strategy / Outcomes Framework				
Commissioning Development Plan targets				
Corporate Business Plan Targets				
PHA Annual Report				
DPH Annual Report				
Financial Performance Report				
Health Improvement / Inequalities*				
Obesity (inc Physical Activity / Food and Nutrition / Breastfeeding				
Smoking Cessation				
Suicide/Mental Health Promotion incl Self harm /OneStopShops/Lifeline				
Marginalised Groups (inc Travellers / Prisoners / ethnic				
Poverty (inc MARA / Fuel Poverty)				
Building Sustainable Communities				
Teenage Pregnancy / Sexual Health				
Drugs and Alcohol				
Early Years Interventions - Roots of Empathy				
Screening and Service Development				
Bowel Cancer Screening				
Abdominal Aortic Aneurysm Screening				
Breast Screening				
Cervical Screening				
New Born Screening				
Diabetic Retinopathy Screening				
Health Protection				
Immunisation and vaccination Programmes				
HCAI				
HIV				
Seasonal Flu				
Nursing and AHP				
Family Nurse Partnerships				
Connected Health				
Ward Sister Initiative				
Quality and Safety (in line with assurance framework schedule)				
PPI				
Research and Development				
Campaign evaluations				

*Performance review also considered monthly by Health Improvement and Inequalities Monitoring Group (HIIMG)

Appendix 2

Table of directors

	Director title	Name
1.	Chief Executive	Dr Eddie Rooney, Public Health Agency
2.	Acting Director of Nursing and Allied Health Professions (AHP)	Pat Cullen, Public Health Agency
3.	Director of Operations	Ed McClean, Public Health Agency
4.	Medical Director/ Director of Public Health	Dr Carolyn Harper, Public Health Agency
5.	Director of Finance	Paul Cummings, Health and Social Care Board
6.	Director of Human Resources	Hugh McPoland, Business Services Organisation
7.	Director of Social Care and Children's Services	Fionnuala McAndrew, Health and Social Care Board

Abbreviations

AAA	Abdominal Aortic Aneurysm
ADOG	All Departments Officials Group
AHP	Allied Health Professions
ALB	Arms-Length Body
AMR	Anti-microbial resistance
BSO	Business Services Organisation
CCHSC	Centre for Connected Health and Social Care
CNS	Clinical Nurse Specialist
DHSSPS	Department of Health, Social Services and Public Safety
DN	District Nurse
DoJ	Department of Justice
DRO	Designated Review Officers (for SAIs)
DRSP	Diabetic Retinopathy Screening Programme
DSD	Department of Social Development
EDRMS	Electronic document and records management system
EITP	Early Intervention Training Programme
EU	European Union
EVD	Ebola Virus Disease
HCAI	Health Care Associated Infections
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSC R&D	Health and Social Care Research and Development Division
HSCT	Health and Social Care Trust
HSWI	Health and Social Wellbeing Improvement
HV	Health Visitor
KPI	Key Performance Indicator
LGB&T	Lesbian, Gay, Bi-Sexual & Transgender
LSA	Local Supervising Authority
MARA	Maximising Access in Rural Areas
MPD	Monitored Patient Days
MRSA	Methicillin resistant staphylococcus aureus; a bacterium with antibiotic resistance
NAO	National Audit Office
NETS	NIHR, Evaluation, Trials and Studies
NIBTS	Northern Ireland Blood Transfusion Service
NICE	National Institute for Health and Clinical Excellence
NICRN	Northern Ireland Clinical Research Network
NICTN	Northern Ireland Cancer Trial Network
NIPHRN	Northern Ireland Public Health Research Network
NSDAD	New Strategic Direction on Alcohol and Drugs
OFMDFM	Office of the First Minister and deputy First Minister
PCE	Patient and Client Experience
PfG	Programme for Government
PH	Public Health
PHA	Public Health Agency
PPI	Personal and Public Involvement
RCGP	Royal College of General Practitioners
RLS	Regional Learning System
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
SQAT	Safety Quality Alerts Team

Alternative formats

The PHA is committed to making information as accessible as possible and to promoting meaningful engagement with those who use our services.

This document can be made available on request and where reasonably practicable in an alternative format.

Should you wish to request a copy of this document in an alternative format please contact:

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HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 March 2015
Title of Paper	e-Health and Care Strategy for Northern Ireland
Agenda Item	15
Reference	PHA/08/03/15

Introduction

The eHealth and Care strategy was jointly developed by the HSCB and PHA, working across a large number of stakeholders, including the Trusts, BSO ITS, public, community and voluntary sectors, academia and commercial suppliers. Originally a technical strategy, due to the impact of eHealth and Care technology on the public the contents were developed to become a public consultation document. Again due to the impact of eHealth and Care on the public a draft EQIA was developed through research and focussed meetings with those who might be affected. This was approved for public consultation at the August meeting of the HSCB and PHA Boards. The eHealth and Care strategy was launched for public consultation on the 7th October 2014 and the consultation closed on the 23rd January 2015.

Summary

There were 96 formal responses to the strategy, through the on-line questionnaire and other written responses. There were a further 25 engagements, covering a wide range of stakeholders, from focus groups with people with a disability and their carers, focus groups with ethnic minority groups, pop-up stands at conferences and health facilities, presentations at conferences and specialist meetings as well as standard public meetings. The strategy was also publicised through the HSCB twitter account.

The data collected during these engagements fed the development of the strategy and the completion of the EQIA process. The analysis of the responses revealed the high quality of the responses and the thought and consideration which had gone into them. This complemented the open and honest consultation meetings which generated an opportunity to explore both the eHealth and Care strategy and the EQIA. We would like to thank everyone who contributed to the consultation process.

The public consultation on the eHealth and Care strategy and its Equality Impact Assessment (EQIA) has resulted in a change of emphasis in the strategy to focus more on the needs of the public. The consultation has also reinforced the need to use technology to support change across Health and Social Care (HSC) and further its use into those other organisations who provide services which support and complement those provided by the HSC.

This can be seen in the changes to the principles and the changes to the public facing outcomes in the Supporting People objective. The Supporting Change objective has also been amended to ensure that the views of the public and other stakeholders are heard within the delivery of the strategy.

There had already been consultation with the DHSSPS(NI) at a senior level on the implications of the eHealth and Care strategy prior to the recent change in the framework for strategy development. These discussions on the eHealth and Care strategy covered:

- sustaining the current funding levels,
- effective delivery processes,
- scalability and flexibility to accommodate change,
- benefits demonstration,
- progress on the development of an implementation plan;

It is anticipated that these plus the completion of the implementation plan should meet the requirements of the DHSSPS(NI) within the new framework for strategy development. This will allow the DHSSPS(NI) to approve the eHealth and Care strategy and have confidence in the continuing delivery of effective eHealth and Care services.

The eHealth and Care strategy presented is a pre-print version after initial graphic design including the changes developed as part of the public consultation. These textual changes have been reviewed and meet the requirements for retaining plain English accreditation subject to final graphic design processes.

Equality, Good Relations and Human Rights

The consultation on the eHealth and Care strategy and the draft EQIA raised a number of issues around equality of access to services on the grounds of age, ethnicity and disability.

During the consultation process these were explored with people who represented one of more of these categories to understand the impact of eHealth and Care on the services they use. This dialogue plus formal responses to the draft EQIA showed that there was broad agreement with the eHealth and Care strategy. The challenge from these consultees led to changes in the final eHealth and Care strategy, which is reflected in the final EQIA presented for approval.

Financial implications

The costs for the completion of the development of the eHealth and Care strategy are covered within the 2014/15 eHealth and Care programme budget.

The eHealth and Care strategy contains a number of recommendations on the implementation of eHealth and Care technology to support service transformation which will require funding. This will be progressed through the existing eHealth and Care programme funding process and linked to the programme implementation plan. The desire of the public to have a choice of electronic and traditional services will require investment in electronic services, integrated with current service models.

Equality Screening / Equality Impact Assessment	EQIA developed and finalised
Audit Trail	The e-Health and Care Strategy was noted by AMT on 3 March.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of eHealth and External Collaboration (HSCB)
Date	12 March 2015

Health and Social Care Board

Equality Impact Assessment

On

eHealth and Care Strategy for Northern Ireland

DATE: 5th March 2015

CONSULTATION REPORT

This document reports the outcome of the public consultation on the draft Equality Impact Assessment (EQIA) by the Health and Social Care Board on the e-Health and Care Strategy for Northern Ireland.

A copy of the full report is also available on the organisation's website at: www.hscboard.hscni.net. Consultation on the EQIA ended on the 23rd January 2014 and this EQIA contains the outcomes from the public consultation. Further information can be provided by contacting us on 0300 5550115 3323 or emailing us at eHealthstrategy@hscni.net.

Accessibility statement

Any request for the document in another format or language will be considered.

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Contents

1. Executive Summary

The Organisation

The Health and Social Care Board (HSCB), together with its Local Commissioning Groups (LCGs) is accountable to the Minister for Health, Social Services and Public Safety and translates the Minister's vision for health and social care into a range of services that deliver high quality and safe outcomes for users, good value for the taxpayer and compliance with statutory obligations.

A key role of the HSCB with the Public Health Agency (PHA) is effective engagement with providers, Patient Client Council (PCC), local government, service users, local communities, other public sector bodies and the voluntary and community sectors.

The Strategy

The eHealth and Care Strategy sets objectives to use technology to support person centred health and social care in Northern Ireland. The use of this technology in health and social care is known collectively as eHealth. The aim is to make best use of patient, client, management and administrative information that HSC already collects to ensure people and care professionals can make better, safer and more efficient decisions.

Health and social care has seen many changes in recent years, but more needs to be done to make sure we continue to meet the needs of the people of Northern Ireland. Northern Ireland has strategies setting out what these changes should be, including Transforming Your Care; Quality 2020; and the new strategic framework for public health Making Life Better. The changes we know we will face with a growing and ageing population and an increasing burden of disease mean we need to find smarter ways of doing things.

eHealth technology is a key enabler to support the vital changes in how health and social care is delivered to meet the challenges of the future. It can help to provide services remotely and also improve communications between care professionals and with patients, clients and their carers. eHealth technologies including eAssistive Technologies (eAT) are increasingly available to support or improve daily living for those with physical sensory or cognitive impairment.

Using eHealth to link existing ICT systems which don't currently work together means that information travels with the patient and connects their care team across geographical, professional and organisational boundaries, delivering a better, more joined up service with better outcomes for patients and service users.

Using information the HSC collects helps to deliver both better preventative services for individual people and also large scale service planning across Northern Ireland.

eHealth offers an opportunity for the HSC and the eHealth commercial sector in Northern Ireland to innovate – improving health and well-being and contributing to economic development.

The eHealth infrastructure needs to be maintained and modernised, keeping existing eHealth systems and services operating and supporting staff in their care for patients.

Data Collection and consultation

From October 2014 to January 2015, the HSCB published for consultation an Equality Impact Assessment (EQIA) of its proposals for a new eHealth and Care Strategy.

In preparing the draft EQIA data was gathered for two populations, namely; the general population, with a targeted focus on people with a disability, people from an ethnic minority background and older people.

The findings from a range of data and research sources were taken into account. Statistical information was available from Northern Ireland Statistical Research Agency (including Census information from 2011) and the NI Health and Social Care Inequalities Monitoring system reports and bulletins.

Targeted engagement was also undertaken with one to one meetings and round tables conducted with organisations representing section 75 groups, including older people, people with a disability and people from a minority ethnic background.

These three groups were identified in the screening as facing potential impacts to using and accessing some of the provisions of the e-Health

and Care Strategy. The decision to carry out a full EQIA to explore those issues was taken.

The needs of the wider general population, outside of the aforementioned groups were also taken into account.

A public consultation was carried out, running from 7th October 2015 to the 23rd January 2015 including a 2week requested extension. During this consultation period, as well as encouraging written responses, engagement was undertaken with a number of target groups, including Age Sector Platform, An Munia Tober, Disability Action, Barnados, HAPANI and a number of other groups.

Key Findings

Age

Older people will have a diverse response to eHealth, depending on age and experience of using technology.

The uptake of eHealth technologies by older people could be restricted by concerns of confidentiality, security, confidence, skills and experience of using technology. These technologies will supplement existing services, to allow older people to continue to access services through existing methods.

The Commissioner for Older People agreed with the key findings of the draft EQIA; pointing to areas that would need to be assessed. One such issue is that of consent stating that it is important that older people are always actively able to give their consent to eHealth usage. It is also correct that the proposed technology be used appropriately to avoid negative impacts like increasing isolation.

It is noted that the potential negative impact on older people living in remote rural isolation with no access to relevant technology to take part in the changes envisaged by these new eHealth changes cannot and must not be underestimated.

Issues with the elderly, who are often unfamiliar with technology and could be mistrustful of the doctor using it were identified but is was also pointed out that these problems with older people should dissipate once they are exposed more regularly to the technology/become more experienced using it.

It was suggested that the use of intergenerational trends/ideas for example working on a buddy system, younger and older people learn how to use the technology together could support and encourage usage.

The development of eAssistive Technology will provide a range of positive impacts for older people, providing increased independence and the ability to remain in their own home. There were concerns that whilst the impact of assistive technology may increase independence it may raise issues of consent and understanding which should be assessed as

part of any implementation. eHealth technology should be used appropriately to avoid negative impacts which could be a reduction in social contact and increasing isolation. eHealth technologies may be able to help reduce isolation through the development of on-line communities, supporting isolated older people through the use of technology.

Younger people saw a positive impact on the use of eHealth, they are used to using technology in their daily lives and will quickly adapt to eHealth technologies. Young people generally are waiting for the HSC to adopt the technologies that they use every day. The young people consulted were aware of technology in health care, such as touch screens in GPs Surgeries, text messages, on line booking and felt more could be done. The concept of patient portals where they could find reliable health care information and electronic care records to enable the flow of information around the health and social care system was seen as positive. The caveat of who could "see" the information was of concern to some young people who felt they should be able to consent to who saw their information. With regards to accessing their own records and potentially being able to add to them in the future was welcomed.

Young people with both learning and physical disabilities agreed that eAT was an area that could be developed further to improve their independence. The use of Global Positioning System (GPS) was particularly welcomed by young people with learning disabilities.

Some young people stated that although they like the idea of technology and some thought that texting, videoconferencing and emailing care staff was a good idea that they also liked face to face appointments.

Disability

The use of eHealth technology was seen as having a positive impact for those with disabilities, with the potential to provide better information, allow better care and improve independence.

The feedback from the development and the consultation process showed that the development and implementation of eHealth solutions

must respond to the needs of all users and incorporate the needs of users with disabilities in the development of eHealth care systems.

The use of assistive technologies has considerable potential to support independence for those with disabilities, balanced with the need to ensure that these technologies are correctly supported and maintained for those using them. During consultation it was felt that technology could help to engage people with physical or mental health issues who may feel isolated. In particular it was felt that mental health is a huge area where eHealth service provision would be needed.

The sharing of information was thought to provide considerable benefits, allowing care professionals to understand communications problems and complex medical histories more easily, particularly in urgent care or when they interact with a new care professional.

Participants in the consultation viewed the current system as being complex and unresponsive and the replication of requests for information in different parts of the service created great difficulties for them, their carers and those they care for. The Northern Ireland Electronic Care Record (NIECR) will allow sharing of information between care professionals throughout the patient journey. This was seen as helping with the requests for information and provides an advantage for patients. There were concerns over who had access to patient information and how a patient would consent to access to the records was raised, particularly for sensitive information. There was a strong voice for patients to contribute to their own records, including adding health information and context for clinical information. .

For people with disabilities it was highlighted that 50,000 disabled people for economic reasons cannot use the technology so there would be concern that using two systems in parallel could cause a two tiered system and increase inequalities in accessing health and social care.

In discussing eHealth with people with a learning disability the need for a range of communication methods was referenced as there is generally lower levels of literacy and limited computer skills amongst this demographic, as compared to the general population.

Ethnicity

The use of eHealth technology was seen as having a positive impact, with examples seen during the consultation process which provided positive impacts for those from an ethnic minority. These included the use of automatic translation functions and the ability to access health information in their own languages. The widespread use of smartphones by those from an ethnic minority provides a major opportunity for the use of eHealth technology.

For those consulted even if IT literacy is low, mobile phones are used by almost everyone, they have become an essential tool for many people. Travellers said that even though they may not have access or be able to use a computer, they are confident and comfortable with the use of smartphones. The younger travellers use mobile technology extensively and effectively, but use is less prevalent in older age groups.

Given the high usage of smart phone technology (over 85%) it was suggested that eHealth could possibly look more closely at the possibilities associated with the use of mobile phones rather than use of PC where access would be less (60%).

Literacy may be an issue for some people within ethnic minorities who may not be able to read messages or websites in English. For people recently arrived in Northern Ireland, the disruption to their education through conflict may mean that they are illiterate in their native languages, making it even more difficult to communicate.

Some of the travellers believed that the ECR was a good idea and would be useful if they were to attend different doctors surgeries around the country, meaning their information could be obtained no matter where they were. For other groups it was felt that the ECR and having access to records would help to partly break down barriers such as language and cultural issues.

The Roma travelling community struggle with access to technology due to lack of education and also lack of English when trying to access computers and PC's. It will be very difficult for them to adapt to new technology as there are so many barriers for them. As a result eHealth

technologies should supplement existing services, allowing the person the choice of whether to engage with the technology.

2. Background

Organisational Background

In 2005, the NI Review of Public Administration concluded that major reform was required in the administrative structures of health and social services. In addition an Independent Review of Health and Social care Services in NI conducted by Professor John Appleby the same year highlighted the need for reform and modernisation of the management of these services.

As a first phase of the RPA reforms in health and social care, five integrated Health and Social Care (HSC) Trusts were established in April 2007 to operate alongside the existing Northern Ireland Ambulance Services HSC Trust.

Following public consultation, the Minister of Health, Social Services and Public Safety announced details of the second phase of health and social care reform in Northern Ireland. Central to this was the establishment from 1st April 2009 of a new Health and Social Care Board (HSCB), including 5 Local Commissioning Groups coterminous with the Trusts, the Public Health Agency (PHA), a Business Services Organisation (BSO) and a Patient and Client Council (PCC).

The Health and Social Care Board (HSCB), together with its Local Commissioning Groups (LCGs) is accountable to the Minister for Health, Social Services and Public Safety and translates the Minister's vision for health and social care into a range of services that deliver high quality and safe outcomes for users, good value for the taxpayer and compliance with statutory obligations.

A key role of the HSCB with the Public Health Agency (PHA) is effective engagement with providers, Patient Client Council (PCC), local government, service users, local communities, other public sector bodies and the voluntary and community sectors.

In short, the HSCBs key functions include:

• In line with Ministerial objectives, ensuring effective commissioning to secure the provision of health and social services and other related

interventions that address the needs of people from pre-conception to death;

• The efficient, effective and appropriate use of delegated funding of some £4bn per annum to meet agreed objectives in line with Ministerial objectives and Department policy in order to maximise access to quality and safe services and reduce unnecessary bureaucracy;

• Implementing a comprehensive framework for performance management and service improvement that will monitor HSC performance against relevant objectives, targets and standards and provide appropriate assurance to the Department and the Minister about their achievement;

• Establishing arrangements at a regional and local level that ensures close strategic and operational partnership with key stakeholders both within the HSC and wider public sector in meeting the objectives of the Board and proactively engages and informs local communities and the voluntary and community sectors on the work of the Board;

• Establishing a close working relationship at a regional and local level with the PHA minimising unnecessary duplication and ensuring a seamless approach to the improvement of the health and social wellbeing of all the people of NI reflected in the development of an integrated annual commissioning plan for approval by the Minister;

• Facilitating and supporting Local Commissioning Groups in their role of achieving effective locality based commissioning, managing their performance, and holding them to account so that they can exercise their devolved authority within an effective framework of regional priorities and standards;

• Within the parameters of the Department's overarching Framework Document, working with other key stakeholders such as the Department, PHA, Trusts and Regulation & Quality Improvement Authority (RQIA) to ensure clarity of responsibility and appropriate provision for the safety of services, the management of critical incidents and service failings and the protection of the public;

• Ensuring that regional priorities – for example programmes for improving cancer services – are integrated into local plans while promoting real delegation to a local level within that framework; and

• Overseeing the agreed publication of performance information.

Equality Impact Assessments

Schedule 9 of the Northern Ireland Act 1998 provides for a comprehensive consideration by public authorities of the need to promote equality of opportunity, giving effect to Section 75 of the Act, between:

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

These are called ‘Section 75 groups’ because the relevant law is section 75 of the Northern Ireland Act 1998. In addition, without affecting the above duty, public authorities must have regard to the desirability of promoting good relations between people of different religious beliefs, political opinions and racial groups.

Equality Schemes must be prepared, which among other things must set out arrangements for assessing the likely impact on the promotion of equality of opportunity of the policies adopted or proposed.

Where equality impacts are likely to be major, a public authority needs to undertake an Equality Impact Assessment (EQIA). This is “a thorough and systematic analysis of a policy, whether the policy is written or unwritten, formal or informal, and irrespective of the scope of the policy or the size of the public authority.”

As part of the assessment consideration must be given of anything that could reduce any adverse impact on equality of opportunity of the policies proposed. Thinking through what opportunities exist to better promote equality must also be a part of the assessment. Consideration to alternative policies that might better promote equality of opportunity must also be given.

The strategy subjected to an Equality Impact Assessment

The eHealth and Care strategy sets objectives to use technology to support person centred health and social care in Northern Ireland. The use of this technology in health and social care is known collectively as eHealth.

This strategy covers the full range of eHealth needed for Northern Ireland,

- Delivering eHealth services for the public including information, communications and assistive technologies,
- Sharing and analysing eHealth information,
- Supporting changes to HSC services through eHealth technologies Contributing to a vibrant eHealth commercial sector,
- Maintaining the eHealth systems we already have.

Successfully implementing the strategy will mean that the right care will be given to the right person at the right time with the right resources.

eHealth services for the public in Northern Ireland are currently limited. At the moment, we do not make it easy for people to seek out information for themselves or make decisions about their own health and wellbeing. Using technology well to provide quality information to the public through online networks and websites as well as to their mobile phones will enable people to make better decisions about their health and well-being.

Communicating with health and social care services tends to rely on three methods of communication with patients, clients and carers: paper, phone and in person. Contacting health and social care services about appointments or test results for example, is still mainly done by telephone or letter. In future many of these communications could be carried out electronically, supplementing existing methods of communication with text, email, video conferencing, mobile apps and other electronic communications.

Using eHealth to link existing ICT systems which don't currently work together means that information travels with the patient and connects their care team across geographical, professional and organisational boundaries, delivering a better, more joined up service with better outcomes for patients and service users.

eHealth will make best use of the patient, client, management and administrative information that is already collected across current and

future systems to ensure people and care professionals can make better, safer and more efficient decisions.

Developing innovative eHealth solutions to improve health and well-being benefits the local eHealth industries as they seek to compete globally.

The objectives are set out over the years 2015 – 2020 and are linked to those set out in other key health and social care strategies for Northern Ireland.

These have been revised in the light of the public consultation process and a revised version can be seen in Appendix 3.

There are a number of constraints to the implementation of the strategy; in the first year of the strategy existing revenue and capital resources are identified however delivery of major elements of the strategy in the remaining 5 years will require considerable further revenue and capital investment. Secondly, as set out in other Health and Social Care Strategies, service change is critical in order to deliver the objectives of the eHealth and Care Strategy and realise the potential benefits

As a result there is a wide range of stakeholders including:

- The population of Northern Ireland - with a focus on patients, clients and their carers / advocates;
- Community and voluntary groups (including those groups representing the interests of Section 75 interest groups);
- Health and Social Care Trusts and staff;
- Local Commissioning Groups (LCGs) and Integrated Care Partnerships (PCPs);
- Independent sector (GPs, pharmacists, opticians, residential & nursing home provision);
- HSC Board (HSCB) and Public Health Agency (PHA) directors and staff;
- Patient and Client Council;
- Department of Health, Social Services and Public Safety;
- Assembly Health Committee;
- MLAs, MPs and local councillors;

- Designated political party spokespersons on health and social care;
- Professional representative bodies;
- Trades Unions;
- City, Borough and District Councils;
- Public organisations with an indirect impact on health e.g. housing, education; and
- The Press and Media

There are a number of policies, strategies as well as health and social care legislation that impact of the eHealth and Care Strategy, setting the framework within which it is developed. These include:

- Health and Social Care (Reform) Act (Northern Ireland) 2009; Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland;
- Transforming Your Care: A Review of Health and Social Care in Northern Ireland, 2011;
- Acute Services Reconfiguration, DHSSPS 2012;
- Making Life Better – A Whole System Framework for Public Health 2013-2023
- Investment Strategy for Northern Ireland 2011-2021, Strategic Investment Board, November 2011;
- Northern Ireland Executive Economic Strategy, Northern Ireland Executive,10 January 2011; and
- Personal & Public Involvement Strategy, January 2011, DHSSPS

Following both the strategy and the equality impact assessment consultations a strategy implementation plan will be developed. This plan will outline what needs to happen to deliver the outcomes in the strategy, including:

- List the projects in the delivery programme
- Show what outcomes they will help deliver
- Show when they are to be delivered
- Explain how this process will be managed
- Explain how this process will be monitored

Screening and Scope of the Equality Impact Assessment

A screening was carried out while developing the draft eHealth and Care strategy. It was determined that a full equality impact assessment was necessary on the basis of the proposals within the strategy being strategically significant and having potential and unknown impact. Based on professional experience and research literature, it was determined that particular impacts are likely to arise for people with a disability, people from a minority ethnic background and older people. Those most immediately impacted by the strategy are patients, clients, carers and staff.

The eHealth developments outlined in the strategy have potential to impact all areas of an older person's or someone with a disability, be it their physical and cognitive abilities or social and emotional life. The extent of such impact varies significantly between different groups of people. The delivery of the strategy has no impact for many very old people living alone in remote rural areas who don't have access to communications technology through location who will continue to use existing services. A very significant positive impact will be seen for people living, for example in assisted living homes with substantial eHealth technology who will become less reliant on existing services. It is also likely that there will be groups of people for whom the impact of such technologies will still be minimal. Such groups are likely to be affected by 'generational exclusion', lack of skills, affordability issues or a conscious choice to not use this technology.

The extent of the impact is likely to continuously increase in the future as more people attain ICT skills, new devices and solutions influence all activities and new services, become available on mass scale.

For people from a minority ethnic background where English is not their first language and where cultural differences with regards to the use of eHealth technologies exist there is the potential for disadvantages arising in relation to usability and access. On the other hand, lack of interpreting services and interaction difficulties with care professionals is cited as barriers for this group interacting with HSC. eHealth has the potential to enable greater choice in modes of communication and thus produce clear benefits for this group. However, cognisance must be

given to language and access to technology within this population group to ensure that they are in a position to take full advantage of the potential benefits.

The scope of the Equality Impact Assessment therefore is on the equality outcomes and impacts, with a particular focus on potential barriers to accessibility and particular needs for people within those three Section 75 categories; age, disability and ethnicity.

The strategy recognises that people may have difficulty accessing eHealth through disability, age or ethnicity or through lack of access to technology and language difficulties. In particular the objective of "Supporting People" proposes to provide eHealth services by supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care.

3. Data Collection and consultation

In line with the Equality Commission (NI) Guide to the Statutory Duties and EQIA Guidelines, data was drawn from a number of sources to help us prepare this EQIA.

Data was gathered for a range of communities, namely:

- the general population,
- section 75 groups - with a targeted focus on people with a disability, people from an ethnic minority background and older people,

The needs of the wider general population, outside of the aforementioned groups, were also taken into account.

In preparing the EQIA, the findings from a range of data and research sources were taken into account. Statistical information was available from Northern Ireland Statistical Research Agency (including Census information from 2011) and the NI Health and Social Care Inequalities Monitoring system reports and bulletins.

Targeted engagement was also undertaken with one to one meetings and focus groups prior to the consultation with:

Age

Age NI

The eHealth team met with a range of representatives from Age NI, including staff from their Services, Policy and Communications teams, as well as trustees and members of the Age NI Consultative Forum.

Aging Well Together Network – North West

The eHealth team held a roundtable and engaged with professionals and users of the North West Aging Well Together Network and discussed use of technology and barriers to accessing HSC for older

people and their families and carers. The group included representatives from Old Library Trust, GABLE/SHELTER NI, Age NI, Rural North West, Easilink Community Transport, Strabane Community Project and Strabane & District Citizen's Advice Bureau. The Aging Well Together Network offered to support the further consultation process and help to engage more widely with service users.

Commissioner for Older People Northern Ireland (COPNI)

The eHealth team met with staff from COPNI to discuss the strategy and any impacts that there may be for older people in Northern Ireland.

Include Youth

The eHealth team held a round table with a small group of young people aged 16-19 years. They explored how they currently access Health and Social Care Services. What their experiences have been and their access to, and use of technology generally. There were four females and one male in the group and all had regular contact with health and social care services. The young people expressed an interest in eHealth in particular looking at new ways to communicate with social care professionals such as texting and video calls.

Disability

Disability Action

The eHealth Team held a round table and engaged with disabled people and organisations representing disabled people to discuss the strategy and any likely impacts for people with a disability. This was hosted by Disability Action, and included representatives from the North West Forum for People with Disabilities, RNIB, Habinteg Housing Association and Disability Action. It was suggested that consultation with the wider North West Forum for People with Disabilities would be beneficial during the consultation phase.

MENCAP

The eHealth team engaged with professionals in MENCAP and discussed use of technology and barriers to accessing HSC for people with a learning disability and their families and carers. We requested further engagement with MENCAP and in particular people with a learning disability during the consultation phase of the strategy.

Royal National Institute of Blind People (RNIB)

The e-Health and Social Care Strategy team explored the JAWS, Zoomtext and other accessibility solutions for blind and partially sighted people and engaged with the RNIB Products and Technology team.

Ethnicity

Horn of Africa People's Aid Northern Ireland (HAPANI)

The eHealth team held a round table with ten refugees from the Horn of Africa and explored how they currently access HSC services. Their experiences and their access to, and use of technology was also discussed.

Northern Ireland Council for Ethnic Minorities (NICEM)

The eHealth team met with staff from NICEM to discuss the strategy and any impacts that there may be for minority ethnic people in Northern Ireland.

Strabane Ethnic Minority Forum

The eHealth team met a representative from the Strabane Ethnic Minority Forum and discussed the impact of eHealth services on ethnic minorities in the Strabane area.

General Equality

Equality Coalition

The eHealth team met a representative group within the Equality Coalition including representatives from the Committee on the Administration of Justice, UNISON, Northern Ireland Council for Voluntary Action, Disability Action, The Rainbow Project and MENCAP. We discussed various aspects of accessibility to eHealth provisions by

section 75 groups. Further consultation with section 75 groups will form part of the wider public and equality consultation process.

Equality Commission

The eHealth team met with policy professionals in the Equality Commission for Northern Ireland and discussed access issues for people with a disability and the design of the strategy and associated services in the context of the UN Convention on the Rights of Persons with a Disability.

During the consultation process staff in the Health and Social Care Sector will be consulted on the equality impact of the strategy. This will have a particular emphasis on staff with a disability, staff from a minority ethnic background and older staff.

Twelve week consultation

Data was collected over the course of a 12 week consultation exercise. This included the submission of written responses and targeted engagement with a number of groups, including Age Sector Platform An Munia Tober, Disability Action, Barnados, HAPANI and a number of other groups.

Key findings

This section outlines our key findings across the nine equality groups outlined in Section 75(1) of the Northern Ireland Act. This analysis has been produced following a desktop review of available local, National and International literature and an extensive engagement programme with three of the categories, namely, Age, Disability and Ethnicity, as outlined in section 3 and a twelve week public consultation exercise.

As far as the availability of data allows, across the nine equality categories each section looks at (1) profile, (2) use of technologies and (3) any other needs identified

Gender

Population Profile

The population of Northern Ireland on Census Day 2011 was 1,810,900

Males 887,300 (49%)
Females 923,500 (51%)

Accurate figures on the number of transgender people are not currently available. McBride (2011) 'Healthcare Issues for Transgender People Living in Northern Ireland' estimates that the number of people who say they are transgender in Northern Ireland is 8 per 100,000 (120) people (aged 16 and over). There is a higher proportion of male to female transitions.

Negative attitudes are displayed towards transgender people, according to the 2011 Equality Awareness Survey by the Equality Commission. This found that 35% of respondents would mind (a little or a lot) having a transgender person as a work colleague, while 40% would mind having one as a neighbour and 53% would mind having one as an in-law.

Negative attitudes were stronger among people over 65 years old. They were more likely to mind having a transgender person as a work colleague (52%), as a neighbour (54%), or in a relationship with a close relative (69%) compared with the younger age groups aged 16–29 years old (29%, 33% and 46%, respectively) or 30 to 44 years old (28%, 34% and 48%, respectively).

In 2005, there were significantly more men using the Internet in all age groups. This difference seems to have diminished and was no longer significant in 2007 for the youngest age group (15 - 25 years). Of women aged 15 - 25 years, 83.5% used the Internet for health purposes in 2007. The corresponding proportion for men was 72.4%. At the other end of the age scale (66 - 80 years), the opposite effect was seen, where 22.6% of men and 9.9% of women used the Internet for health purposes. The same effect was visible in 2005, but it was not so clear.

The study Kummervold et al 2008 J Med Internet Res. 2008 Oct-Dec; 10(4):analysed trends (from 2005 to 2007, looking at age, gender, and employment status and their effect on the use of the Internet, Internet health information, and interactive health services. The logistic analysis showed no significant effect of gender on the use of the Internet. There is, however, a significant interaction effect between gender and age, where the proportion of men is largest in the highest age groups. Employment status is also a significant factor, since a very large proportion of students are using the Internet.

The perceived importance of the Internet as a health information source is increasing. There is relative growth in all age groups and for both men and women in Internet use for health purposes, with especially strong growth among young women. Along with this growth, we also see that the second generation of Internet health users is using the Internet for more than just reading information. They are using the Internet as a channel, for direct communication with health professionals as well as with peers.

Staff Profile

At March 2013, the HSC employed around 66000 people either full-time or part-time. This accounted for almost 10% of all employment in Northern Ireland as shown in the (Northern Ireland Health and Social Care Workforce Census, March 2013

- The majority of the HSC workforce is female (81%). Of these female staff, 49% are employed full-time.
- Males represent 19% of all HSC staff employed. Of these male staff, the majority (84%) were employed full-time.

Age

Population Profile

Compared with the England, Scotland and Wales, Northern Ireland had the fastest-growing and youngest population between 2001 and 2011, with an estimated increase of 7.5%. It is projected to have the youngest population during 2011-2021. This equates to 24% or 432,814 children and young people aged less than 18 years. (Source: NISRA 2009 Mid-year Population Estimates)

The population of Northern Ireland is getting older. Between the 2001 and 2011 censuses the median age increased from 34 years to 37 years. According to NISRA, the population aged 85 and over has increased by 9,000 people (38 per cent) in the 10 year period between June 2002 and June 2012. This is five times faster than the overall population growth of just over seven per cent over this same period. Within Northern Ireland this population is projected to grow from the 31,800 at the 2011 census to 100,000 by 2041.

In March 2013 Age UK launched a twenty page fact sheet highlighting those over 85 whom they labelled as the ‘oldest old’. Some key points to note from the Age UK briefing were:

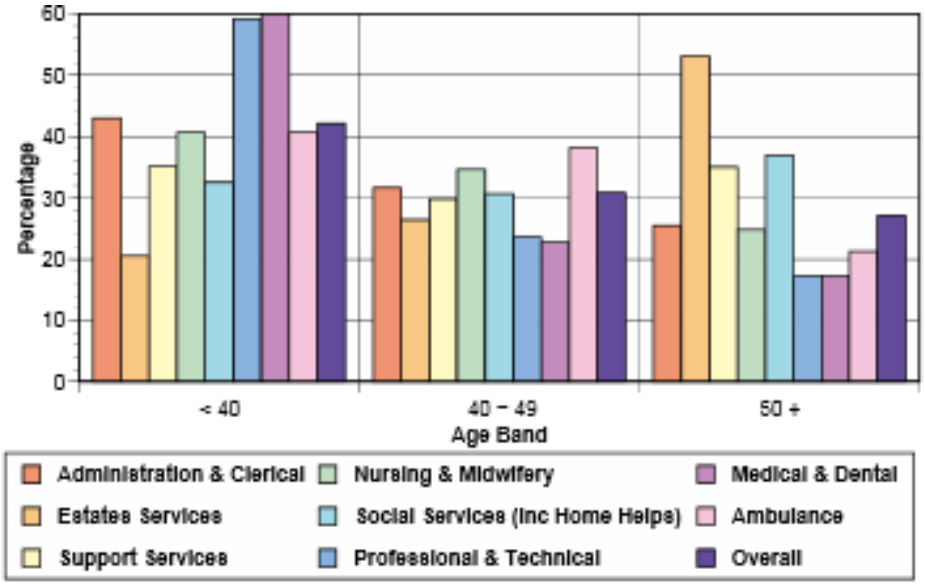
- Almost three quarters (74.8%) of the oldest old live on their own
- Malnutrition rather than obesity was an issue (33% of admissions to hospital in 80+ , 40% of 90+ were thought to be malnourished)
- Malnutrition of those entering care homes over 85 is at 52%
- Significantly more likely to have fallen.
- A ‘considerable’ number are vitamin D deficient
- Dementia affects one in six over eighty and one in three over ninety-five.
- Only 8.5% of those dying of cancer aged over eighty-five die in a hospice compared with 20% of all cancer deaths and a lower proportion of those over eighty-five access specialist palliative care.
- In the UK nearly 50,000 people aged over 85 provide unpaid care to a partner, family member or other person.

- The ‘oldest old’ are as a group at greater risk of poverty than the ‘younger’ old.
- Ninety per cent of those over eighty-five are estimated to spend an average of 80% of time in their home.
- Thirty per cent of those over 80 have limited access to services such as shops and GPs and 25% are cut off from friends and family.
- About 40% of the ‘oldest old’ have a ‘severe disability’ (but 60% do not)
- The Newcastle 85+ study found urinary incontinence in 21.3%, hearing impairment in 59.6% and visual impairment in 37.2%.

Staff Profile

Two fifths (42%) of all HSC Staff were under the age of 40, while 31% were aged between 40 and 49 and 27% were aged 50 and over. Age distribution varied between the Occupational Families with 60% of Medical & Dental staff and 59% of Professional & Technical staff aged under 40, while only 21% of Estates Services staff were aged under 40.

Table1: Age profile of HSC Staff by occupational group



Use of ICT /eHealth

The extent of ICT development impacting older people's living conditions at home and in the community can be considered from two perspectives: the extent of the adoption of ICT solutions by older people and the potential impact these solutions can have on people's lives, once adopted.

As regards impacts once adopted, three different spheres of influence can be distinguished: cognitive function, physical function and social and emotional life. Different ICT solutions vary in terms of their impact, benefits and risks to older people's activities at home and in the wider community. Technology solutions also play different roles for various phases of the ageing process: they can help to delay the effects of ageing (facilitate ageing well) or assist in dealing with the ageing affects by making lives of older people with diseases and disabilities easier.

There are potential risks associated with their unwarranted application. With an increased uptake of telehealth solutions there is the risk that older people become over-sensitive around their health causing anxiety and stress. Another potential negative effect of such transformation could be a change in long-established behaviour to 'listen to one's body' in favour of relying on quantitative data. Another risk is associated with people who have no or very limited skills and understanding of technology, who through changes in the health and social care model may find themselves surrounded by technology that they do not understand or trust leading to a feeling of confinement.

Finally, there is also an increased risk of social isolation. eHealth although very beneficial from a physical and psychological point of view, may pose risks for the emotional well-being. Replacing a face-to-face contact of an elderly patient with their care professional with a remote connection may result in deepened social isolation and feelings of exclusion and disconnect.

Thus, while there is no doubt that ICT solutions have a very positive and in many cases transformative impact on older people's living conditions,

most of the risks associated with their application appear to be related to their impact on the emotional and social sphere. More research exploring the impact of ICT on older peoples' emotional and social sphere is required to better understand this matter and ensure that risks associated with it are minimised.

According to Eurostat (Seybert, 2011) 25% people aged 16 to 74 in the EU had never used the internet.

In 2012 amongst individuals aged between 55 and 64, 40% never used internet and amongst those aged between 65 and 74 it was 63%. In terms of computer skills, 16% of individuals aged 55 to 64 could perform 1-2 computer related activities while in the group aged 65 to 74, only 12% could perform 1-2 computer related activities. The involvement in social networks amongst older people is also low – in the USA only 7% of those aged 65 and over has a profile on online social network (Senior Journal , 2009).

Given the current low level of use of computers and internet amongst older people the extent of impact ICT technologies are likely to have on their living conditions is set to be low. Yet, as the number of older people using ICT technologies is continuously growing ICT will influence their living conditions in the future to much greater extent. One in 50 people aged 75 and over use Wii Fit as a way to keep fit while in the group over 50 year olds that number doubled. Also, in the same group one in ten people use electronic brain-training games to maintain mental fitness (SAGA, 2011). The uptake of other ICT technologies, such as telemedicine and smart home solutions, amongst older people is even smaller, although it is set to rise more rapidly.

The factors underlying the level of adoption of ICT technologies amongst older people are related to older adults' computer skills, access to hardware and broadband, which in turn may be influenced by financial constraints or service availability. For some solutions more personal factors may be at play, e.g. having a need for technological solutions, willingness to learn necessary skills or acceptability of ICT solutions.

Personal values and attitudes are often linked to the lack of confidence in one's ability to learn, negative experiences, privacy concerns or lack of clear understanding of the benefits as well as the disadvantages.
In the Netherlands, a study was undertaken to gauge older patients' interest in the use of eHealth applications. In this instance, the application was an Online Health Community for the frail elderly, "aimed at facilitating multidisciplinary communication". The report concluded that those most likely to properly engage with this idea were those with a high computer literacy.

This Aging Well Together Network members thought that there was great potential for assistive technologies and eHealth generally for those older people willing and able to use these services. However they stated that for a long time into the future a number of older people who would be unable to use these services, needing to access services in the traditional fashion. It is important that older people are not coerced into using eHealth technology and that current services and processes are maintained.

The participants in the Age NI roundtable were broadly positive about the benefits of eHealth technologies for older people, both as direct users of the service but also as beneficiaries of staff working smarter and more efficient.

A lot of older people do not trust technology and cannot be convinced of the benefits of it. They do not want to learn how to use it or embrace it. Existing services will need to be maintained for those people that do not want to use it. Many older people want face to face meetings and there will need to be cognisance of that in the strategy and implementation.

Older people broadly see benefits in terms of service quality for older people if they don't have to repeat their story over and over and if information is flowing around the HSC system more freely, giving a fuller picture of someone's condition.

It is important to consider the vast differences on experiences and capabilities of older people and the 'older' old, that is, those over 85. eHealth should not completely remove the current services as there will be many older people that do not use, trust or want to use ICT. A balance therefore needs to be considered in the use of these

technologies and how they either reduce or compound isolation of older people. The views of the older people must always be considered.

It is also important to consider privacy issues with regard assistive technologies.

The sharing of health and social care information among professionals was highlighted as an area of interest for the group of young people we engaged as their experiences to date have meant they have often had to repeat “their story” as they moved around the HSC system.

Staff use of technology

Concerning the attitudes of nurses towards computerisation, the literature is almost equally divided between those which found nurses to have positive attitudes and those which found them to have negative attitudes. A number of published studies have focused on the attitudes of nurses toward computerisation (Marasovic et al, 1997; Simpson and Kenrick,1997). Most of these researches were carried out in the UK, USA, Australia, Taiwan and other developed countries.

Eley et al. (2009) also state that nurses generally demonstrated positive attitudes towards computer use and acknowledged the benefits of ICT to clinical care. Their assertion is supported by Hwang and Park (2011) who found that nurses had favourable attitudes toward computerisation.

Several factors have been found to shape the attitudes of nurses towards the use of computer systems. Age, educational level, years of nursing experience and experience with computers have frequently been described as factors influencing nurses’ attitudes towards computerisation. According to Lee, et al. (2008) cited by Huryk (2010), age was consistently found to influence nurses’ attitudes towards computerised nursing care plans. Younger nurses demonstrated a greater enthusiasm in the use of the technology. Simpson and Kenrick (1997) were in agreement when they asserted that younger, less experienced nurses had positive attitudes towards computerisation.

Marital Status

Population profile

Table 2: Marital Status of Northern Ireland residents aged 16+ years, Census 2011

Marital status	Count	Percentage
Married	680,831	47.6
Single	517,393	36.1
Same-sex civil partnership	1,243	0.1
Separated	56,911	4.0
Divorced	78,074	5.5
Widowed or surviving partner	97,088	6.8

(Source: NISRA (2012) Table KS103)

The table shows that almost half (48%) of people aged 16 years and over on Census Day 2011 were married, and over a third (36%) were single. Just over 1,200 people (0.1%) were in registered same-sex civil partnerships. A further 9.4% of residents were separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8% were either widowed or a surviving partner (Source: NISRA (2012) Table KS103).

The urban areas of Belfast and Derry/Londonderry had the largest proportions of single people (47% and 42% respectively), while Ards and Banbridge (both 54%) had the highest proportion of married people.

No data has been identified to suggest that the use of technology differs by marital status.

Religion

Population Profile

In Northern Ireland most people are of Christian faith, as shown in the table below. There are gaps in the information about those of non-Christian faiths and those with no faith.

On Census Day 2011, the usual population of Northern Ireland was 1,810,863. The table shows the change in the religious make-up of Northern Ireland between the 2001 and the 2011 Census.

Table 3: Changes in religious make up of Northern Ireland between 2001 and 2011 censuses

	Census 2001		Census 2011		
Religion/ religion brought up in	**Count**	**Percentage (%)**	**Count**	**Percentage (%)**	**Percentage change (%)**
Protestant /other Christian	895,377	53.1	875,717	48.4	-2.2
Roman Catholic	737,412	43.8	817,385	45.1	10.8
Other religions	6,569	0.4	16,592	0.9	152.6
None	45,909	2.7	101,169	5.6	120.4

(Source: NISRA, Table KS07b (2003); KS212 (2012))

No data has been identified to suggest that the use of technology differs by religion.

Ethnicity

Population Profile

Since the 2001 Census, there has been a marked change in Northern Ireland's ethnic diversity. On Census Day 2011, 1.8% (32,400) of the resident population belonged to minority ethnic groups, more than double the proportion in 2001 (0.8%). The main minority ethnic groups were Chinese (6,300 people), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3% of the population.

	Census 2001		Census 2011		Difference
Ethnic group	**Count**	**Percentage**	**Count**	**Percentage**	**Count**
White	1,670,988	99.2	1,778,449	98.2	107,461
Chinese	4,145	0.2	6,303	0.4	2,158
Indian	1,567	0.1	6,198	0.3	4,631
Mixed	3,319	0.2	6,014	0.3	2,695
Other Asian	194	0	4,998	0.3	4,804
Other	1,290	0.1	2,353	0.1	1,063
Black African	494	0	2,345	0.1	1,851
Irish Traveller	1,710	0.1	1,301	0.1	- 409
Pakistani	666	0	1,091	0.1	425
Black other	387	0	899	0.1	512
Bangladeshi	252	0	540	0	288
Black Caribbean	255	0	372	0	117

Table 4: Changes in ethnic makeup of Northern Ireland between 2001 and 2011 censuses

(Source: NISRA, Table KS06 (2003); KS201 (2012)

Irish Travellers comprised 0.1% of the population. Since 2001, the minority ethnic count rose from 14,300 to 32,400. Increases were recorded for all groups with the exception of Irish Travellers, whose number fell from 1,700 in 2001 to 1,300 in 2011.Belfast (3.6%), Castlereagh (2.9%), Dungannon (2.5%) and Craigavon (2.1%) had the highest proportions of residents from minority ethnic groups.

Residents born outside Northern Ireland in March 2011 accounted for 11% (202,000) of the population, compared with 9% (151,000) in April 2001. This change resulted largely from inward migration by people born in the 12 countries that have joined the European Union since 2004 (EU 12). These accounted for 2% (35,700) of Northern Ireland residents on Census Day 2011, compared with 0.1% in 2001.

The rest of the population born outside Northern Ireland consisted of 4.6% born in Great Britain, 2.1% born in the Republic of Ireland, 0.5% born in countries that were EU members before 2004, and 2% born elsewhere. The detail is shown in Table 5 overleaf.

The number of requests received by the Northern Ireland Health and Social Care Interpreting Service has risen from 10,257 in 2005/6 to 63,868 in 2011/12, showing the increasing demand on services responding greater diversity in the population. Responses to the TYC Vision to Action consultation noted how important it was to have foreign-language interpreters available.

According to the “All-Ireland Traveller Health Study” (AITHS), the Traveller population in Northern Ireland is estimated at 3,905, with 1,562 families. The age profile of this community is markedly different from that of the general population. Some 70% of Travellers are aged 30 or under, and only 1% are aged 65 and over. This partly reflects a higher birth rate, a higher death rate and inward migration

Table 5: Breakdown of country of birth for the population of Northern Ireland

Country of birth	Count	Percentage
Northern Ireland	1,608,853	88.8
Outside Northern Ireland	202,000	11.2
England	64,717	3.6
Scotland	15,455	0.9
Wales	2,552	0.1
Republic of Ireland	37,833	2.1
EU before 2004	9,703	0.5
EU 12	35,704	2.0
Other	36,046	2.0

(Source: NISRA (2012) Table KS204)

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National research suggests there are differences within black and minority ethnic (BME) groups generally when compared with the white population. Ill health often starts at an earlier age in BME groups than among white people. There are variations from one health condition to another; for example, BME groups have higher rates of cardiovascular disease than white people but lower rates of many cancers. Diabetes is more common in BME groups and high blood pressure is more common in Asian groups.

Evidence suggests a lack of knowledge among BME groups about social care services. There is a particular lack of knowledge about services for those with dementia and their carers.

People from BME groups face particular difficulties in accessing services, making complaints and getting mistakes corrected. The Health Professions Council's 'Scoping Report on Existing Research on Complaints Mechanisms' says this can partly be explained by a relative lack of knowledge about how services work. People from BME groups may also be more likely to fear the consequences of complaining or asserting themselves.

Medical Sociology Online produced a report based on research undertaken in Western Scotland. The report details the opinions of patients from ethnic minorities on the use of eHealth. There were varying concerns from different community groups. The report highlighted "issues of trust, language barriers as well as a perceived lack of relevance" as reasons why Chinese patients might be reluctant to engage with eHealth.

Confidentiality issues persisted with patients from the African community; those going through the asylum process were particularly reticent to hand out their information. Even in the case of an interpreter, these patients feared that confidentiality would be breached and members of their own "small close-knit" community might become aware of otherwise private information.

Language barriers remained the single biggest issue for the Horn of Africa (HAPANI) refugees to accessing Health and Social Care in Northern Ireland. Communications from HSC was almost always in English, which means that people have to rely on friends or family members that can read and/or speak English for translation. This raises potential and real human rights issues, namely around privacy and also potential issues around gender equality.

There was some examples of good practice raised by the HAPANI round table, such as GP's surgeries that have a touch screen in reception that have a Somali flag that when touched allows the user to type in their name and it will confirm in the patients native language that they have the correct appointment. The roundtable discussed this further and acknowledged that while this is good practice, it is also important that when they see the GP, in this instance, that they can still communicate with the GP and receive the appropriate care.

An issue of not being kept informed was flagged up by the HAPANI roundtable, with people highlighting instances of waiting considerable times for information and then having to have this translated which delayed the process even further.

The issue of older people from an ethnic minority background was raised during the engagement with the Strabane ethnic minority forum, where they may find particular difficulty in accessing healthcare and using eHealth.

NICEM raised issues around the strategy in the context of settled migrants in Northern Ireland tending to be better off than new migrants in terms of socioeconomic status. New migrants (particularly those from eastern bloc countries) tend to be younger. New migrants however embrace technology more than the older settled migrant community, however they tend to access it in their own language, so language will still be an issue.

Culturally Travellers don't embrace traditional computers and don't have them in their homes. However they have smart phones, it will be important to ensure that whatever is developed from the strategy is compatible across multiple devices.

Staff Profile

Table 6 Equality and diversity data for the register as of July 2011 , responses have been received from 286,190 out of 665,545 registrants or 43% of nurses and midwives employed

	White British	Other White	Asian	Black African	Black Caribbean	Other/Mixed
Overall	73%	11%	7%	5%	2%	2%
England	72%	9%	8%	7%	2%	2%
Northern Ireland	55%	39%	5%	0.4%	few	0.6%
Scotland	89%	6%	2%	1%	few	0.4%
Wales	84%	9%	5%	1%	0.3%	0.9%
Non-UK	36%	46%	9%	4%	2%	1%
Midwives	79%	11%	2%	4%	2%	1%
Nurses	72%	11%	8%	6%	2%	2%
SCPHNs	83%	9%	2%	3%	2%	0.7%

NB- Some combinations with fewer than 30 correspondents are marked "few" for anonymity

Political Opinion

Population Profile

There is limited data available; however the Electoral Commission's data on the first-preference votes per party in the Northern Ireland Assembly Elections 2011 gives a good guide to political preferences in the province as a whole.

Table 7: First preference votes per party in Northern Ireland Assembly Elections 2011

Political party	Votes
Democratic Unionist Party	**198,436**
Sinn Fein	**178,222**
Social Democratic and Labour Party	**94,286**
Ulster Unionist Party	**87,531**
Alliance	**52,384**
Other	**52,284**

(Source: Electoral Office NI, 2011)

A DHSSPS literature review of equality and human rights on fair access to health and social care said it is difficult to know how statutory health and social services perform as regards political opinion. This is partly because of a lack of research (See http://www.dhsspsni.gov.uk/eq-literature-review).

Staff

This strategy applies to most HSC staff. It is important to protect the identity of individuals by excluding specific information. However the data has been considered. Many members of staff chose not to disclose their political opinion. There is no evidence of difference in eHealth technology use by political opinion available.

Disability

Population Profile

Census figures show that in 2011 just over one in five of the resident population (21%) had a long-term health problem or disability that limited their day-to-day activities, similar to the proportion in 2001 (20%). Strabane and Belfast (both 24%) had the highest proportions of residents with a long-term health problem or disability.

Table 8: Long-term health problem or disability of Northern Ireland Population

Disability	Count	Percent %
Long-term health problem or disability: day-to-day activities limited a lot	215,232	11.9
Long-term health problem or disability: day-to-day activities limited a little	159,414	8.8
Long-term health problem or disability: day-to-day activities not limited	1,436,217	79.3

(Source: NISRA (2012) Table KS301 – Health and unpaid care)

According to a NISRA survey carried out in 2006; some 37% of households include at least one person with a disability and 20% of these include more than one disabled person.

For both men and women, the rate of disability increases with age. Women on average live longer than men therefore disability tends to be more common among women. The rate is particularly high for women aged 75 and above (at 62%). It is only among the youngest adults aged 16 to 25 that the rate for men (at 6%) is higher than for women (4%) (Northern Ireland Survey of Activity Limitation and Disability (2006/07).

Some 32% of the 1,860 people receiving direct payments from their local Health and Social Care Trust have a physical or sensory disability (January 2011).

In Northern Ireland there are about 16,500 people with a learning disability. McConkey et al (2006) predict this will increase by 20.5% by 2021. Any change to older people's services must take account of the needs of older people with learning disabilities as well as other forms of disability. (McConkey et al, 'Accessibility of healthcare information for people with a learning disability. A Review and Discussion Paper' (2006)

Table 9: Percentage of People in Northern Ireland population by type of long term condition or disability

Type of long – term condition	Percentage of population with condition %
Deafness or partial hearing loss	5.14
Blindness or partial sight loss	1.7
Communication Difficulty	1.65
Mobility of Dexterity Difficulty	11.44
Learning, intellectual, social or behavioural difficulty.	2.22
Emotional, psychological or mental health condition	5.83
Long – term pain or discomfort	10.10
Shortness of breath or difficulty breathing	8.72
Frequent confusion or memory loss	1.97
A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy.	6.55
Other condition	5.22
No Condition	68.57

(Census 2011)

In a June 2011 report entitled 'Digital Inclusion for People with a Disability', Disability Action NI concluded that 'government should ensure that products and services are usable and accessible for older

and disabled people'. While this was a general recommendation as Northern Ireland progresses to a more ICT-literate future, the need for digital inclusion of specific members and groups of our society extends to their inclusion in eHealth initiatives in Northern Ireland.

In Australia, the Disability Information and Resource Centre has been encouraging patients to make the most of eHealth opportunities offered by the government. Registering for an eHealth record allows patients private access to their record "anywhere, anytime in Australia via a secure website". This also affords those with disabilities to track immunization, organ and tissue donation status. This would be helpful to allow those with a disability to maintain all of their healthcare information in a secure singular location. It might afford them peace of mind, and prove invaluable for clinicians they come into contact with.

In Queensland, Australia, there have been steps taken by local disability groups to build a social eHealth record. The record allows people with disabilities, and their families and carers to save relevant personal and health information in a secure location. This allows clinicians to keep a record of patient-specific information that might otherwise be lost in paper records or simply forgotten. The ethos behind this socially-created record is that "…people living with a disability have much more information that needs to be retained centrally". Engaging with the affected group at the beginning of an eHealth process is of great importance, for the most user-friendly result. This record is also notable in that it allows the patient and their family to modify it, rather than exclusively clinicians.

Web accessibility refers to the inclusive practice of removing barriers that prevent access to websites by people with disabilities. When sites are correctly designed, developed and edited, all users have equal access to information and functionality. For example, when a site is coded with semantically meaningful HTML, with textual equivalents provided for images and with links named meaningfully, this helps blind users using text-to-speech software and/or text-to-Braille hardware. When text and images are large and/or enlargeable, it is easier for users with poor sight to read and understand the content. When links are underlined (or otherwise differentiated) as well as coloured, this ensures

that colour blind users will be able to notice them. When clickable links and areas are large, this helps users who cannot control a mouse with precision. When pages are coded so that users can navigate by means of the keyboard alone, or a single switch access device alone, this helps users who cannot use a mouse or even a standard keyboard. When videos are closed captioned or a sign language version is available, deaf and hard-of-hearing users can understand the video. When flashing effects are avoided or made optional, users prone to seizures caused by these effects are not put at risk. And when content is written in plain language and illustrated with instructional diagrams and animations, users with dyslexia and learning difficulties are better able to understand the content. When sites are correctly built and maintained, all of these users can be accommodated without decreasing the usability of the site for non-disabled users.

The needs that Web accessibility aims to address include:

- Visual: Visual impairments including blindness, various common types of low vision and poor eyesight, various types of colour blindness;
- Motor/Mobility: e.g. difficulty or inability to use the hands, including tremors, muscle slowness, loss of fine muscle control, etc., due to conditions such as Parkinson's Disease, muscular dystrophy, cerebral palsy, stroke;
- Auditory: Deafness or hearing impairments, including individuals who are hard of hearing;
- Seizures: Photoepileptic seizures caused by visual strobe or flashing effects.
- Cognitive/Intellectual: Developmental disabilities, learning disabilities (dyslexia, dyscalculia, etc.), and cognitive disabilities of various origins, affecting memory, attention, developmental "maturity," problem-solving and logic skills, etc.

There are a number of issues in particular which have a potential impact on the use of eHealth by people with learning disabilities, their families and carers.

Accessing reliable health and social care information for parents or carers of young people with a learning disability is cited. This information needs to be aimed at the right people – should this be the carer, parent or person with a learning disability – at the right time, to enable people to make the right choices for themselves or those they care for.

There is an issue, particularly for parents of young people with a learning disability, in navigating the social care system. Parents are usually calling and making contact with the service in times of crisis and sometimes it can take considerable time to get through to the correct service area and considerable time to receive a response from the correct professional.

When access to a service requires choosing options on an automated phone switchboard, complicated pathways can create unnecessary barriers for a person with a learning disability. If similar pathways are transferred through the eHealth Strategy from phones to computers, the same difficulties will exist.

Rarely are the communication needs of people with a learning disability considered as part of their care in other parts of the HSC, requiring family members or carers to engage with the care professional to explain the communication needs. A system that allowed care professionals across the HSC service to be made aware of the communication needs of the person with a learning disability no matter where they are accessing services and being cared for would be beneficial

For people with a learning disability, there are issues around ownership of information and how information is shared, both amongst care professionals and between the professionals and the person with the learning disability and/ or their family and carers.

At the round table hosted by Disability Action, the participants emphasised the need for continued engagement with disabled people throughout the design and implementation phases of many of the initiatives being proposed as this will ensure it works best.

It is important to consider different health needs, not just the main impairment that a disabled person has and it is also important to

understand that many disabilities are not static, they are recurrent and fluid.

Electronic processes shouldn't replace one to one contact; health information is sometimes very personal information and people may be reluctant to give this information over to a machine or computer and prefer a person to speak to. There is a 'fear' around technology for many disabled people, particularly older disabled people.

It is important that the ambulance service are linked into the eHealth framework and that relevant information, particularly for disabled people, who may not be able to communicate effectively, or be on medication that is constantly changing for example, is available to them as this would improve the care for disabled people significantly.

Staff Profile

Table 10 shows the statistics for nurses and midwives employed who answered yes to having a disability

	Yes	No
Overall	6%	94%
England	6%	94%
Northern Ireland	4%	96%
Scotland	5%	95%
Wales	6%	94%
Non-UK	12%	88%
Midwives	6%	94%
Nurses	6%	94%
SCPHNs	5%	95%

Dependants

Population Profile

In the 2011 Census respondents were asked whether they provided any unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health/disabilities, or problems related to old age. Twelve per cent of the population (213,980) provided such unpaid care, around a quarter (26%) of whom did so for 50 or more hours a week, a total of 56,000 people.

Between the 2001 and the 2011 Censuses there was an increase in the number of people providing unpaid care.

Table 11: Changes in the provision of unpaid care in Northern Ireland between 2001 and 2011 censuses

	2001 Census		2011 Census	
Care provided	**Count**	**Percentage %**	**Count**	**Percentage %**
Provides no unpaid care	1,500,201	89.0	1,596,883	88.2
Provides 1-19 hours unpaid care per week	110,407	6.6	122,301	6.8
Provides 20-49 hours unpaid care per week	28,000	1.7	35,369	2.0
Provides 50+ hours unpaid care per week	46,659	2.8	56,310	3.1
Total	1,685,267	100	1,810,863	100

(Sources: NISRA Univariate table UV021(2001 numbers) and NISRA (2012) Table KS301 – Health and unpaid care (2011 numbers))

Based on the most recent information from Carers Northern Ireland (June 2011), the following facts relate to carers:

- 1 in every 8 adults is a carer;
- There are about 207,000 carers in Northern Ireland;
- One quarter of all carers provide over 50 hours of care per week;
- People providing high levels of care are twice as likely to be permanently sick or disabled as the average person;
- About 30,000 people in Northern Ireland care for more than one person; and
- 64% of carers are women; 36% are men.

In 2006 the DHSSPS published a *Survey of Carers of Older People in Northern Ireland*. Of which providing this care over three-quarters (77%) were female and almost a quarter were male. Fifteen per cent were aged 75 or over, 48% were aged 55-74, 35% were aged 35-54 and only 2% were aged under 35. Just over three-quarters of the male carers (76%) were aged 55 or more, compared with three-fifths (60%) of female carers. Almost a quarter (24%) of the male carers and 12% of the female carers were aged 75 or more.

The majority of informal care is provided by family members, usually spouses or adult children.

There has been a policy drive in recent years towards supporting carers in their caring role and ensuring that health and social services assist carers in maintaining their own health and well-being. Yet, despite this many carers continue to feel marginalised and often believe that their own particular health and social care needs are overlooked (Arksey et al, 2003:1).

Barriers relating to service issues include, GP surgeries not identifying or carers' health records; a lack of training in carers' issues amongst staff; "gate-keeping", inflexible appointments systems; waiting times; and, lack and/or cost of transport and parking at health care facilities (2003:45).
Barriers relating to information and knowledge issues include, carers not being provided with sufficient information regarding available services and how to access them; professional concerns about confidentiality and disclosing information to carers (2003:58). The provision of reliable online information and access to expert knowledge via eHealth technologies could improve this situation.

eHealth has the potential to provide health and social care services in settings which are accessible and acceptable to carers, such as the use of video conferencing and email from home therefore recognising and addressing the transport needs of carers (especially those in rural areas).

Sexual Orientation

Population Profile

Accurate figures are not available on the sexual orientation of the general population, and estimates vary considerably. The Northern Ireland Statistics and Research Agency (NISRA), along with other UK census offices, concluded that the census was not suitable for obtaining such information. The 2011 Census does provide some information, based on same-sex civil partnerships.

Research by HM Treasury shows that from 5%–7% of the UK population say they are gay, lesbian, bisexual or ´trans´ (transsexual, transgendered and transvestites).

The 2010 Northern Ireland Life and Times survey (1,205 adults) reported the figure as only 1%. The Office for National Statistics 2010 report (450,000 respondents) found that in Northern Ireland 92.5% said they were heterosexual and 0.9% of respondents said they were LGB, although 0.4% reported as 'other' and 6.2% said they didn't know or refused to respond. The 2012/13 Health Survey from the DHSSPS(NI) Information Analysis Directorate provided the following population split 93% Heterosexual/Straight; 1% Gay/Lesbian; 2% Bisexual; 1% Other; and, 3% Not specified.

Between 2006 and 2012, there were 715 recorded Civil Partnerships regionally. However, this is not indicative of the LGB population.

There is no data available on the use and attitudes to technology varying with sexual orientation.

Staff Profile

Some Trusts and Health and Social Care Organisations collect data on sexual orientation, however there are gaps in the data and a significant non-disclosure rate. It can however be reasonably assumed that the sexual orientation demographic of staff reflects that of the general population, around 5%-10%.

Table 12 shows figures for nurses and midwives employed by sexual orientation

	Bisexual	Gay / lesbian	Heterosexual
Overall	1.5%	1.5%	97%
England	1.5%	1.5%	97%
Northern Ireland	1.9%	0.5%	98%
Scotland	1.1%	1.4%	98%
Wales	1.5%	1.2%	97%
Non-UK	1.7%	1.9%	96%
Midwives	0.8%	0.6%	99%
Nurses	1.6%	1.6%	97%
SCPHNs	0.5%	0.8%	99%

- NB- Some combinations with fewer than 30 correspondents are marked "few" for anonymity

There is no data available on the use and attitudes to technology varying with sexual orientation.

4. Good Relations

We have identified no issues impacting on good relations.

There is no evidence of differing eHealth technology use across the religious groups noted within the 2011 Census. The variable difference in technology use among those from different minority ethnic backgrounds has no impact on good relations and there is no evidence of differing eHealth technology use among those with different political opinions, that would impact on good relations.

5. Disability Duties

Through the development of the eHealth and Care Strategy we have consistently considered our obligations under both the Disability Discrimination Act 1995 and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). We have engaged with organisations representing disabled people and disabled people directly through the drafting of the Equality Impact Assessment.

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

We acknowledge General Comment No. 2 (2014) of the Eleventh Session of the Committee on the Rights of Persons with Disabilities, namely; *"While different people and organizations understand differently what information and communications technology (ICT) means, it is generally acknowledged that ICT is an umbrella term that includes any information and communication device or application and its content. Such a definition encompasses a wide range of access technologies, such as radio, television, satellite, mobile phones, fixed lines, computers, network hardware and software. The importance of ICT lies in its ability to open up a wide range of services, transform existing services and create greater demand for access to information and knowledge,*

particularly in underserved and excluded populations, such as persons with disabilities".

The development and implementation of this Strategy contributes to meeting contributes to meeting the UK Government's obligation under the UNCRPD, namely:

Article 9 Accessibility

1 To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban an in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

(*b*) Information, communications and other services, including electronic services and emergency services.

Article 21 Freedom of expression and opinion, and access to information

States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by:

(a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost

Article 25 Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to

health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(*c*) Provide these health services as close as possible to people's own communities, including in rural areas

(*d*) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care

Article 26 Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(*b*) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Disability Discrimination Act 1995

The implementation and out workings of the eHealth and Care Strategy can significantly contribute to the two duties of the HSCB of the Disability Discrimination Act 1995.

1. Encouraging disabled people to participate in public life

Involving people in their own care and giving people greater autonomy and choice is central to the eHealth and Care Strategy. Key to making this work is the design, testing and implementation of new technologies and the development of existing technologies. Service user involvement, including disabled people, is important, if we are to get this right. Encouraging disabled people, from outside of the statutory sector, to contribute to any implementation boards or working groups that are established as a result of this strategy is fundamental to how we will proceed. Additionally, through the use of technologies such as video conferencing as part of these processes, will enable the HSC to potentially reach and engage disabled people with significant mobility issues or other complex needs.

2. Promoting positive attitudes towards disabled people

One of the six core objectives of the strategy is to use information and analytics (infomatics) to map trends and support care. This information can also be used to identify people with disabilities entering the system, which parts of the system they are entering, what they are entering the system for; allowing HSC to identify service gaps, including potentially any training needs of staff, which will assist with the promotion of positive attitudes towards disabled people across the HSC service.

6. Human Rights

The impact of the eHealth and Care strategy human rights was identified as affecting Article 8 – Right to respect for private & family life, home and correspondence.

There may be potential interference with the right to privacy by increased sharing of care information, through the expansion of the use of the Northern Ireland Electronic Care Record (ECR). The privacy and confidentiality requirements of the ECR have been extensively investigated during its development including guidance from the Information Commissioner and the Privacy Advice Committee of the DHSSPS(NI). This has included the development of the “The Data Protection considerations associated with the electronic processing of personal data for direct care purposes” DHSSPS(NI) 2012 policy document.

The ECR contains information which was already collected and held electronically, in hospitals, clinics and GP practices. The ECR replaces manual transfers with an electronic system, but does not change the information gathered or the use of the information to care for the person. This indicated that the impact on privacy by the ECR would be limited and managed through consent and effective communication arrangements.

The ECR issued a leaflet to all Northern Ireland households explaining how their data would be used and how you could opt out of the ECR. A small number of people decided to opt-out of the ECR. The ECR also implemented a strong consent model prior to clinical staff accessing the record.

A separate consultation has been undertaken by the DHSSPS(NI) on the secondary use of patient identifiable data. This will set out the future framework for using health data for purposes other than the care of person the data is about.

The development of e Assistive Technologies (eAT) through the strategy has the potential to promote the rights under article 8 of those with a physical or cognitive disability. The use of this technology could allow more independent living and thus more privacy for those with specific disabilities.

7. Conclusions

Summary and Assessment of Key Findings

Age

Older people will have a diverse response to eHealth, depending on age and experience of using technology.

The uptake of eHealth technologies by older people could be restricted by concerns of confidentiality, security, confidence, skills and experience of using technology. These concerns should be considered in the introduction of large scale eHealth technologies. These technologies will supplement existing services, to allow older people to continue to access services through existing methods.

The Commissioner for Older People agreed with the key findings of the draft EQIA; pointing to areas that would need to be assessed. One such issue is that of consent stating that it is important that older people are always actively able to give their consent to eHealth usage. It is also correct that the proposed technology be used appropriately to avoid negative impacts like increasing isolation.

It is noted that the potential negative impact on older people living in remote rural isolation with no access to relevant technology to take part in the changes envisaged by these new eHealth changes cannot and must not be underestimated.

Issues with the elderly, who are often unfamiliar with technology and could be mistrustful of the doctor using it were identified but is was also pointed out that these problems with older people should dissipate once they are exposed more regularly to the technology/become more experienced using it.

It was suggested that the use of intergenerational trends/ideas for example working on a buddy system, younger and older people learn how to use the technology together could support and encourage usage.

The development of eAssistive Technology (eAT) will provide a range of positive impacts for older people, providing increased independence and the ability to remain in their own home. There were concerns that whilst the impact of assistive technology may increase independence it may raise issues of consent and understanding which should be assessed as part of any implementation. eHealth technology should be used appropriately to avoid negative impacts which could be a reduction in social contact and increasing isolation. eHealth technologies may be able to help reduce isolation through the development of on-line communities, supporting isolated older people through the use of technology.

Younger people saw a positive impact on the use of eHealth, they are used to using technology in their daily lives and will quickly adapt to eHealth technologies. Young people generally are waiting for the HSC to adopt the technologies that they use every day. The young people consulted were aware of technology in health care, such as touch screens in GPs Surgeries, text messages, on line booking and felt more could be done. The concept of patient portals where they could find reliable health care information and electronic care records to enable the flow of information around the health and social care system was seen as positive. The caveat of who could “see” the information was of concern to some young people who felt they should be able to consent to who saw their information. With regards to accessing their own records and potentially being able to add to them in the future was welcomed.

Young people with both learning and physical disabilities agreed that eAT was an area that could be developed further to improve their independence. The use of Global Positioning System (GPS) was particularly welcomed by young people with learning disabilities.

Some young people stated that although they like the idea of technology and some thought that texting, videoconferencing and emailing care staff was a good idea that they also liked face to face appointments.

Disability

The use of eHealth technology was seen as having a positive impact for those with disabilities, with the potential to provide better information, allow better care and improve independence.

The feedback from the development and the consultation process showed that the development and implementation of eHealth solutions must respond to the needs of all users and incorporate the needs of users with disabilities in the development of eHealth care systems.

The use of assistive technologies has considerable potential to support independence for those with disabilities, balanced with the need to ensure that these technologies are correctly supported and maintained for those using them. During consultation it was felt that technology could help to engage people with physical or mental health issues who may feel isolated. In particular it was felt that mental health is a huge area where eHealth service provision would be needed.

The sharing of information was thought to provide considerable benefits, allowing care professionals to understand communications problems and complex medical histories more easily, particularly in urgent care or when they interact with a new care professional.

Participants in the consultation viewed the current system as being complex and unresponsive and the replication of requests for information in different parts of the service created great difficulties for them, their carers and those they care for. Northern Ireland Electronic Care Record (NIECR) will allow sharing of information between care professionals throughout the patient journey. This was seen as helping with the requests for information and provides an advantage for patients. There were concerns over who had access to patient information and how a patient would consent to access to the records was raised, particularly for sensitive information. There was a strong voice for patients to contribute to their own records, including adding health information and context for clinical information. .

For people with disabilities it was highlighted that 50,000 disabled people for economic reasons cannot use the technology so there would

be concern that using two systems in parallel could cause a two tiered system and increase inequalities in accessing health and social care.

In discussing eHealth with people with a learning disability the need for a range of communication methods was referenced as there is generally lower levels of literacy and limited computer skills amongst this demographic, as compared to the general population.

Ethnicity

The use of eHealth technology was seen as having a positive impact, with examples seen during the consultation process which provided positive impacts for those from an ethnic minority. These included the use of automatic translation functions and the ability to access health information in their own languages. The widespread use of smartphones by those from an ethnic minority provides a major opportunity for the use of eHealth technology.

For those consulted even if IT literacy is low, mobile phones are used by almost everyone, they have become an essential tool for many people. . Travellers said that even though they may not have access or be able to use a computer, they are confident and comfortable with the use of smartphones. The younger travellers use mobile technology extensively and effectively, but use is less prevalent in older age groups.

Given the high usage of smart phone technology (over 85%) it was suggested that eHealth could possibly look more closely at the possibilities associated with the use of mobile phones rather than use of PC where access would be less (60%).

Literacy may be an issue for some people within ethnic minorities who may not be able to read messages or websites in English. For people recently arrived in Northern Ireland, the disruption to their education through conflict may mean that they are illiterate in their native languages, making it even more difficult to communicate.

Some of the travellers believed that the ECR was a good idea and would be useful if they were to attend different doctors surgeries around the country, meaning their information could be obtained no matter where they were. For other groups it was felt that the ECR and having access

to records would help to partly break down barriers such as language and cultural issues.

The Roma travelling community struggle with access to technology due to lack of education and also lack of English when trying to access computers and PC's. It will be very difficult for them to adapt to new technology as there are so many barriers for them. As a result eHealth technologies should supplement existing services, allowing the person the choice of whether to engage with the technology.

Other section 75 areas

The remaining 8 areas, gender, marital status, religion, political opinion dependants and sexual orientation do not show significant variation in the use of eHealth.

Action

The complexity of eHealth, the funding challenges and the rapid advance of technology mean that in many areas of the strategy it is not possible to predict precisely the equality impacts of the implementation of the strategy now.

Sub-strategies

Issue – The major sub-strategies of the eHealth and Care strategy may have some equality issues which will need to be investigated.
Action - The sub-strategies, for example the Information and analytics delivery plan and the Social Media and alternative communications strategy will be equality screened.
When – They will be equality screened during their development process.

Individual Projects

As well as the screening of the sub-strategies large scale individual projects in the strategy must undertake individual equality screening. This is particularly important for those projects which will interact with the public directly and for those which change the way staff and patients

interact. An example of this would be the development of a web portal or the replacement of the patient administration system in hospitals.

Issue - The accessibility needs of specific groups need to be taken into consideration when developing new systems and services to ensure that they are accessible for those with a disability.

Action - Best practice for technology project delivery is to ensure that end users are involved in the development of the project. Projects delivering in the eHealth programme will include user representation as appropriate, from older users, users with a disability or who are not fluent in English.
When - A user forum will be set up as part of the eHealth implementation.

Proposed Monitoring

The eHealth and Care programme has defined the governance arrangements for the delivery of the programme, with a range of stakeholders engaged in managing the delivery process.

The eHealth and Care strategic board will ensure that the principles set out in this draft EQIA are reflected in the projects that deliver the strategy. This will be part of the annual review of the eHealth and Care programme which reviews progress and sets direction for the year ahead.

The EQIA will also be reviewed at the bi-annual review of the strategy to ensure that this is still accurate.

Appendix 1 – The Steps of an EQIA

What is an Equality Impact Assessment? (EQIA)

An EQIA is "a thorough and systematic analysis of a policy, whether the policy is written or unwritten, formal or informal, and irrespective of the scope of the policy or the size of the public authority."

The Steps of an EQIA

What is it we are actually looking at? ('Aims of Policy')

The first part of an EQIA involves thoroughly understanding the policy to be assessed; what context it is set in; who is responsible for what; what links there are with other organisations or individuals in implementing the policy etc.

How can we tell what is happening on the ground? ('Consideration of Data')

This involves reviewing what data is available in-house or elsewhere and identifying what data needs to be newly collected. 'Data' means statistics and the views, experiences and suggestions of those affected by the policy. 'Collecting new data' means going out and doing a survey and also talking to people who are affected by a policy or those who are involved in implementing the policy, for example in delivering a service.

So are there any problems for any of the groups? ('Assessment of Impacts')

All relevant data that has been identified (whether collected from available sources or newly gathered) is brought together and analysed. Conclusions are drawn as to the impact of the policy on the nine groups.

What can be done to make things fairer? ('Consideration of Measures')

Now the findings are related back to action: proposals are what can be done to address any inequalities/ unfairness that the analysis of the data has revealed.

Are we getting the right picture and are we thinking of doing the right thing? ('Formal Consultation')

The findings and the proposed actions are brought back to the public at this stage, usually on the basis of a draft report. Now it's time to find out what people think about the analysis and proposals!

With what people have told us – what are we going to do? ('Decision by Public Authority')

After the wider public has had a chance to comment on the analysis and proposals it's time for the organisation to take final decisions and commit themselves to action points.

This is what we have found out and this is what we will do ('Publication of Results of EQIA')

These decisions and commitments are published in a final report alongside the findings from the analysis of collected data and the comments raised by the wider public during formal consultation.

Keeping a close eye on what is happening ('Monitoring of Adverse Impacts')

An EQIA is not a one off. It's important to keep a close eye on what difference the changes to the policy actually make.

Appendix 2 – Changes in response to EQIA comments

Consultation Comment	HSCB Response
There are significant challenges in ensuring this equality of access for those who cannot or choose not to use eHealth and Care technology. Older people, people with a disability and those from an ethnic minority may be less likely to use eHealth technology	HSCB will be realistic about the capacity of the strategy to deliver within an environment in Northern Ireland where people may not have access to technology. eHealth services will supplement "traditional" services to ensure choice of access as is stated in the strategy. Issues of consent and understanding will be assessed as part of any implementation and considered in the Information and Analytics delivery plan
eHealth may create greater social isolation	eHealth will not replace face to face contact if that is the users choice as stated in the strategy. For some people, the use of technology such as video conferencing, remote consultation and online discussion forums may reduce social isolation
Electronic documents are a good idea, and this could include the patient passport	HSC will build on existing pilot schemes to reduce paper and develop ways of allowing citizens to interact with the HSC electronically. This has been highlighted within the strategy and the outcome **"Develop ways of allowing people to enter information into the right place in their health record, including through the use of telemonitoring and other capture tools"**
Having information all in one place (portal) is a good idea	HSC will develop a web portal providing trusted advice, self-care information, information on HSC services and secure access to online services.
The ECR is a good idea, and citizens should have access to their own ECR	The responses across the groups indicated that there was wide support for the ECR system, which provides access to key health and social care information drawn from a patient's records. With the patient's consent, this information can be quickly shared between care providers involved in the patient's care. The consultation process asked that this be extended to reflect wider treatment patterns "**Work with England, Scotland, Wales and Ireland to develop data sharing arrangements to allow information to**

	be shared to support peoples care"".
We must continue to think carefully about the security of the information and how to protect peoples data. There should be restricted access around information sharing. Not everyone needs to see your information; it should only be those that need to see it to help you	eHealth and ECR data is stored in a secure data centre, in line with a Security Policy Framework. eHealth records are also protected by legislation. Patient records will be protected by audit trails, technology and data management controls, record including controls around access by care professionals and controls on sensitive information. as well as security measures to protect against unauthorised access to your information. Access to and use of information will be covered by the Information and Analytics delivery plan
Assistive technologies that help people be independent are a good thing	The outcome in this area has been strengthened and now reads **"HSC will support the use of eAT, Telemonitoring and Telecare to enable people to live independently, working effectively with a range of partners to deliver better care** "Along with other appropriate agencies such as housing and councils, HSC will develop new ideas and funding opportunities to enhance the quality of life and wellbeing of older people and those who care for them. This will include more integrated community-oriented services, more sustainable home and neighbourhood design, and more age-friendly smart Living technologies.
Mental health is a huge area where eHealth service provision would be needed	HSCB will work with mental health commissioners and users to ensure eHealth technologies that are implemented meet need and enhance user experience. This will be included in the implementation plan.
Some people may not be able to access eHealth services due to lack of access to PC's and smartphones, or not being IT literate or	eHealth services will complement existing services and provide more options on how to access services, allowing people who cannot or choose not to use eHealth services to keep accessing services. This has been addressed in the changes to the principles within the strategy to reflect the need to maintain choice.

computer literate.

Appendix 3 – Strategy Objectives

Strategic Objective	Outcomes
Supporting people **Provide eHealth services, supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care**	• HSC will develop a web portal providing trusted advice, self-care information, information on HSC services and secure access to online services. • HSC will provide online access to your own health records. • HSC will build on existing pilot schemes to reduce paper and develop ways of allowing citizens to interact with the HSC electronically for example booking clinic appointments on-line. • HSC will optimise the use of current GP systems to facilitate access to GP records and other ways of communicating and interacting with GPs, e.g. prescription ordering and online booking. • HSC will encourage the development and use of mobile health apps to support, facilitate and extend the relationship between care professionals and users for self-care and management. • **HSC will support the use of eAT, telemonitoring and telecare to enable people to live independently, working effectively with a range of partners to deliver better care**. • Along with other appropriate agencies such as housing and councils, HSC will develop new ideas and funding opportunities to enhance the quality of life and well-being of older people and those who care for them. This will include more integrated community-oriented services, more sustainable home and neighbourhood design, and more age-friendly smart Living technologies. • The HSC will develop a Social Media and Alternative Communications Plan by 2015, evaluating the use of social media, smart phone technology and self-service technologies for communication with

	citizens. • **Develop ways of allowing people to enter information into the right place in their health record, including through the use of telemonitoring and other capture tools.**
Sharing information **Give care professionals appropriate access to information to improve the speed and quality of the care decisions they make, and the outcomes for the individual**	• Continue enriching NIECR to link in more HSC clinical and care information systems and develop NIECR functionality, including providing care professionals with appropriate role-based access to clinical and care information systems including NIECR. • Provide staff with mobile access to the HSC network and systems in 2015/16, as part of a three-year investment plan. • Provide secure and appropriate access to NIECR information for community pharmacists, dentists, opticians and independent health and social care providers, such as nursing homes. • Build links with independent health and social care providers to allow them to contribute to the NIECR to help make sure all relevant patient information is captured and able to be shared. • Digitalise manual processes and paper records to allow information to be shared and re-used appropriately. • **Work with England, Scotland, Wales and Ireland to develop data sharing arrangements to allow information to be shared to support peoples care.**
Using information and analytics **Develop ways to transform data and information into knowledge (informatics) that supports care, from being able to suggest personalised preventative care through to supporting population-level health and care planning**	• **Develop links between HSC information systems that improve how we can analyse information. An Information and Analytics Delivery Plan will examine the legal and ethical frameworks needed, the standardisation and coding of HSC information needed, and the training and education needs of staff. This strategy will take account of the outcome of the DHSSPS consultation on secondary use of information - "Caring for Your Information". The information and Analytics delivery plan will be complete by**

	December 2015. • Use risk-stratification techniques to provide early-intervention support to help citizens keep healthy.
Supporting change **Make thinking about eHealth central to planning any changes to health and care services to make sure we are making the most of technical opportunities and the potential for improved information flows to support improvements**	• Demonstrate that eHealth can improve patient-centred care, for example collecting patient experiences of the HSC to help improve services. • Develop eHealth Clinical Lead roles to drive and direct the use of eHealth to support care delivery. • Put in place a new leadership and governance structure, with care professionals at the heart, and design it to ensure consistency and equity in service delivery. • Support the development of staff to allow them to best use eHealth technologies, through training and support, working with professional bodies and existing training providers. This will integrate with current DHSSPS and professional workforce planning and education strategies. • Develop new ways for patients, clients and their carers to receive services from the HSC for example through videoconferencing, email and text messaging. • **Develop ways of engaging the public with the eHealth and Care implementation, bringing their views into the development of the eHealth programme.** • **Ensure that the range of stakeholders involved in the development of the eHealth and Care strategy are included in the eHealth and care Strategy implementation.** • **Develop appropriate eHealth technologies to improve processes and support patient safety, both within new systems and specialist systems as needed.**

Fostering innovation **HSC will work with businesses colleges and universities, community and voluntary organisations, other government departments and international partners to develop uses of eHealth to help improve health and wellbeing, recognising there may be opportunities where such work contributes to developing sustainable economic growth in Northern Ireland**	• **By 2020 be more widely recognised as a leader in Europe in the use of technology to support better care of the people of Northern Ireland.** • We will continue to develop both the Northern Ireland Connected Health Ecosystem and our partnerships outside Northern Ireland. We will develop our own capacity to innovate, using local and international partnerships to access the expertise needed to develop solutions to problems affecting our patients. • We will work with other partners to take forward the recommendations in the Economy and Jobs Initiative Task and Finish Group's report. This can be found at www.dhsspsni.gov.uk/t_f_final_report.pdf. • We will work with local eHealth industry to develop and use innovative products and systems we can sell worldwide, supporting the local economy and increasing local employment. • We will build on our success in developing and delivering EU programmes, drawing funding, ideas and expertise into Northern Ireland. • We will support an annual eHealth Innovation Award and Conference to celebrate and promote best practice in the use of eHealth.
Maintaining and improving what we have **Maintain a modern, reliable eHealth infrastructure, including investment in supporting, modernising and replacing key systems and HSC networks and hardware as needed**	• Develop and extend HSC ICT access to all parts of the health economy that need it, either through mobile, wireless or fixed networks including improvements in access and bandwidth. • Develop an Infrastructure Strategy. This strategy will set out the future direction for HSC infrastructure including networks, datacentres and storage, including the appropriate adoption of cloud computing and cloud storage. • Develop an Application Strategy. This strategy will set out the future development and replacement pathway for HSC applications, including the adoption when appropriate of open-

source applications.

- Deliver the eHealth technologies needed to support service change; areas identified include medicines management and pathology services.

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eHealth and Care Strategy

FOR NORTHERN IRELAND

Improving health and wealth through the use of information and communication technology.

HSC Health and Social Care

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eHealth and Care Strategy Project Team

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HSC Health and Social Care

Foreword

Northern Ireland's health and social care system is facing major challenges that affect how it operates now and in the future. These challenges include caring for more people who are living longer, and coping with limited increases in funding. To ensure our services work effectively we must keep working to change them.

At the same time, the public are asking for electronic, accessible services similar to those they use in other parts of their lives. We are living in an age of digital technology, where data can be captured and sent from person to person at the touch of a button. The internet and mobile phones are everyday ways of communicating and the public expect to use them to access our services. This gives us an opportunity to make our health and care system more responsive and better focused on the people it serves.

To tackle these issues we have started a transformation programme. This will redesign our health and care services so that they better meet the needs of the individual. We have set out this new model of person-centred care in three strategic documents: 'Transforming Your Care' (2011); 'Quality 2020' (2011); and the new strategic framework for public health, 'Making Life Better' (2014). The recent review by Sir Liam Donaldson "The Right Time, The Right Place", challenges Northern Ireland to become recognised as the most advanced health and social care system in Europe by using technology and innovation to drive improvement.

Our new way of working will mean we put more emphasis on preventing ill-health, as well as supporting people to make healthier choices and live independently for as long as possible. It will also mean we move more services out of hospitals and closer to people's homes, for example into GPs' surgeries and local clinics when this is safe and suitable. Our priority is to ensure we give people the right care at the right time in the most suitable setting.

Many public services use technology creatively, and health and social care should be no exception. Technology can support care in many ways, including patient education; promoting healthy living; preventing disease; improving clinical information and management systems; and monitoring patients. It could help us provide a wide range of new services to improve access to health and social care, such as online appointment bookings and remote consultations with GPs or hospital specialists.

In Northern Ireland we have already taken bold steps to use technology in our health and care system. For instance, we have introduced the Northern Ireland Electronic Care Record. This has improved care professionals' access to patient information, which helps them work more safely and effectively. A regional remote telemonitoring programme – which enables people with long-term conditions to monitor their health from home, with access to clinical and professional advice as necessary – is also widely used across Northern Ireland.

These are examples of eHealth, the use of technology-based systems to share information among the professionals who need it to prevent ill-health and look after patients and social-work clients.

This strategy document describes other examples of what we have already achieved with eHealth. There is much more we can do to use eHealth to provide more modern health and social care services. I want to ensure we build on our successes and embrace the potential for new technology to improve the quality of care for patients, social-work clients and other service users. Our reform agenda will also enable our local universities and companies to play a role in improving services, with potential benefits for the Northern Ireland economy.

Technology is a powerful tool to help us develop and modernise our services. We need to take full advantage of its potential, and of our scale and skill base in Northern Ireland, to achieve our ambition of being the best in Europe.

Mr. Jim Wells MLA

Minister of Health, Social Services and Public Safety

About this document

Who should read this document

This document is for anyone who wants to contribute to the development of the strategy or wants to learn more about the potential for technology to:

- help people make decisions about their own health and wellbeing
- support new ways of arranging services around the patient, such as care pathways
- help change the way care professionals work to give them more time and the information they need to make better, faster care decisions for their patients or clients.

The document is divided into a number of sections which will provide an introduction to eHealth and the need for an eHealth and Care strategy for Northern Ireland. We outline our vision and principles before discussing each of the strategy's objectives in turn. Within the objective sections we ask:

- where are we now?
- where do we want to go?
- how are we going to get there?

How we developed the strategy

We asked the following people to tell us what we needed to do for the future of health services:

- Citizens (including patients, carers and clients).
- Community and voluntary sector organisations.
- HSC staff and organisations including primary care.
- Internal, local and national ICT suppliers.
- DHSSPS(NI).

We also used the 'National eHealth Strategy Toolkit' published by the World Health Organisation. A regional steering group and an external panel of experts oversaw the strategy. For more details and our methods, please see Appendix 1.

We then carried out a public consultation process on the strategy and the Equality Impact Assessment (EQIA). This enabled the public to tell us what they thought about the issues raised in the strategy and the EQIA.

After listening to the public and exploring the issues with them we wrote the response to the consultation document, the revised strategy and EQIA.

This final strategy includes what we learned during the consultation.

This document should be read alongside the EQIA and the response to the consultation document available on the HSCB website or in other versions (such as translation) by request.

Executive Summary

'eHealth and Social Care' is the use of information that is needed by people and care professionals to make better decisions about prevention, treatment and care. This includes:

- information provided by you and your caregivers.
- information held within our systems.
- information generated by self-monitoring devices and sensors.
- information needed for management and administration.

Northern Ireland has the unique advantage of having an integrated health and social care system. To make this document easier to read, we use the word eHealth to mean both health and social services' use of technology and information.

This eHealth and Care Strategy for Northern Ireland 2015-2020 describes how the Department of Health, Social Services and Public Safety (DHSSPS) and the wider Health and Social Care organisations in Northern Ireland (HSC), want to make the best use of information and communications technology (ICT) in order to:

- improve the safety and quality of patient and client care.
- improve public health.
- promote opportunities that support the Northern Ireland economy.

The strategy outlines how eHealth will support people, current services and help information to flow around the system to improve decision making for better care. It describes how eHealth will support the changes that must be made to improve health and wellbeing in Northern Ireland, set out in health and social care legislation, 'Transforming Your Care', 'Quality2020' and 'Making Life Better'.

We want to build on the good foundations that Northern Ireland already has. There are skilled and committed staff providing health and social care across Northern Ireland, who have a strong desire to use technology to support better care. Northern Ireland has strong universities and colleges that provide first-class research and education and a growing local technology sector that can support eHealth innovation. Citizens, patients, clients and carers have told us they want to use eHealth information and systems to support their health, wellbeing and independence. In our public consultation, people across Northern Ireland confirmed they wanted to use eHealth

Over the last ten years, the HSC has invested in improved eHealth, leading to a dramatic improvement in eHealth support for better care. Across Northern Ireland this includes:

- a Health and Care number for everyone, which is used by the HSC to maintain data quality.
- a world-class electronic care record, providing care staff with an up-to-date record covering a range of patient and client information.
- the regional X-ray system, NIPACS, allowing all X-rays to be viewed and reported electronically.
- computerisation, networking and the introduction of two-way electronic communication for all GP practices.
- major improvements to networks, data centres and other major eHealth infrastructure.

In this document's "Maintaining and improving what we have" section, we provide more information on some of the other improvements we have made.

We are proud of what has been achieved, but we know there is much more that can be done to support health and wellbeing. We need to overcome several difficulties to make eHealth work in the HSC:

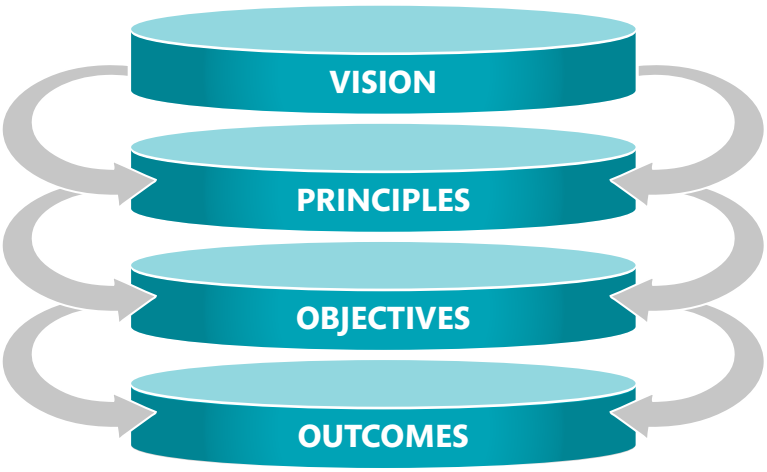
- Paper records are still widely used. Information on paper is difficult to share, and the use of paper is embedded in many HSC staff members' working practices.
- The public and HSC staff are concerned about maintaining patient and client confidentiality. We must ensure we share and use information appropriately and responsibly with the understanding of the public and patients.

- eHealth can change relationships and working practices for the public, patients, clients, their carers and HSC staff. If we are asking staff and the public to do things differently, we need to make sure we are bringing real benefits to the people affected and demonstrate those benefits to justify the investment in eHealth.
- Some people may have difficulty accessing eHealth through disability, age or ethnicity or through lack of technology.

This strategy covers the full range of eHealth needed for Northern Ireland, from public communications, through large-scale information technology systems and personalised assistive technology, to the contribution health and social care technologies could make to developing a vibrant eHealth commercial sector. Successfully implementing the strategy will mean that the right care will be given to the right person at the right time with the right resources. eHealth success will also allow local industry to grow, innovate and compete globally, contributing to Northern Ireland's prosperity.

Strategy vision

Through eHealth, we will empower people to be more active in their own care and support health and social care staff to achieve real change that delivers the best possible health and wellbeing for everyone.

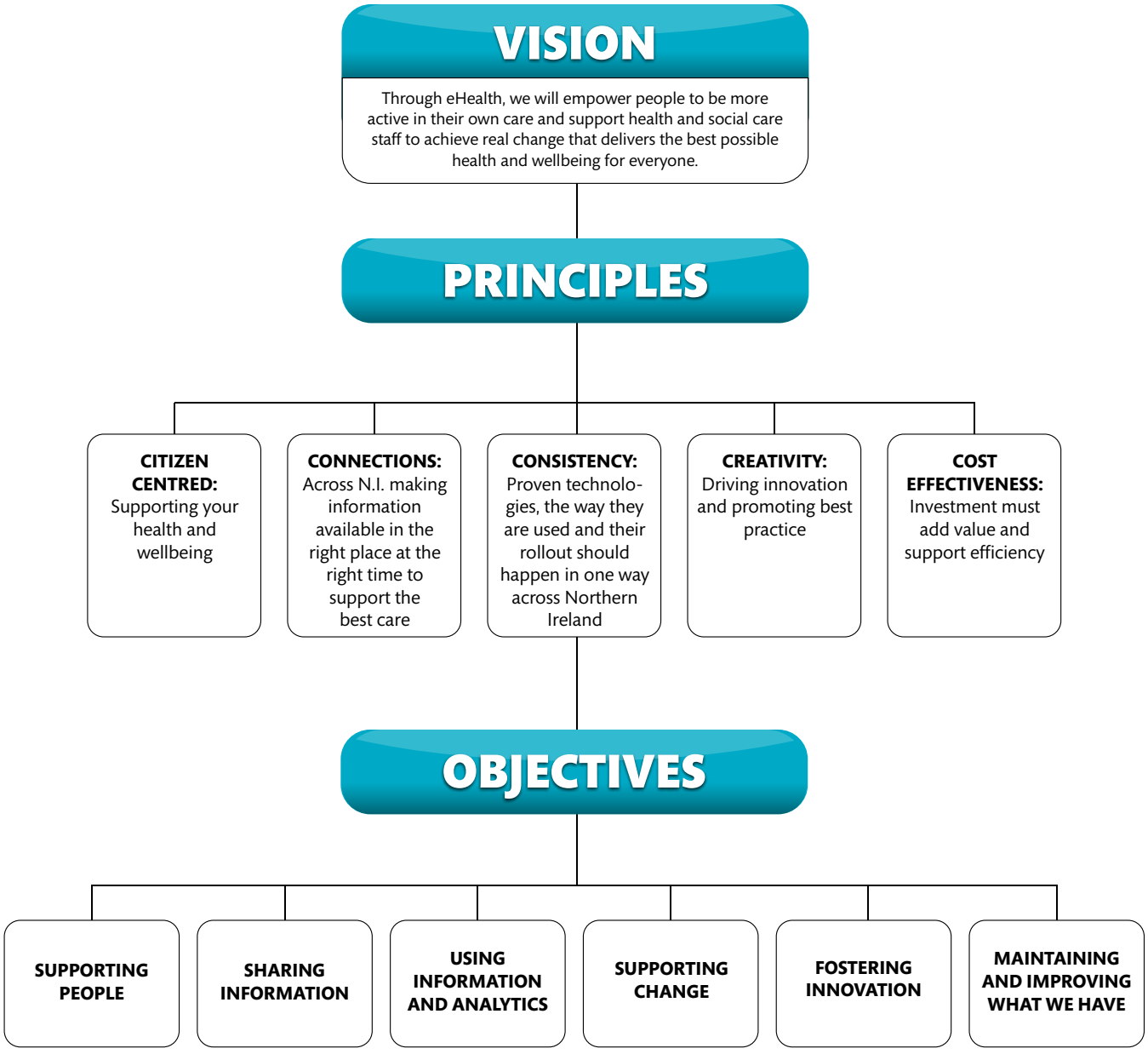


Principles

Five key principles underpin the strategy:

- Citizen centred: supporting your health and wellbeing.
- Connections: across Northern Ireland, making information available in the right place, at the right time to support the best care, with the right safeguards in place.
- Consistency: proven technologies, the way they are used and their rollout should happen in one way across Northern Ireland.
- Creativity: driving innovation and promoting best practice.
- Cost effectiveness: investment must add value and support efficiency.

These principles have guided the development of objectives for the strategy and will underpin plans to implement the strategy.



Objectives

1. **Supporting people**
   Provide eHealth services, supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care.

2. **Sharing information**
   Give care professionals appropriate access to information to improve the speed and quality of the care decisions they make, and the outcomes for the individual.

3. **Using information and analytics**
   Develop ways to transform data and information into knowledge (informatics) that supports care, from being able to suggest personalised preventative care through to supporting population-level health and care planning.

4. **Supporting change**
   Make thinking about eHealth central to planning any changes to health and care services to make sure we are making the most of technical opportunities and the potential for improved information flows to support improvements.

5. **Fostering innovation**
   HSC will work with businesses, colleges and universities, community and voluntary organisations, other government departments and international partners to develop uses of eHealth to help improve health and wellbeing, recognising there may be opportunities where such work contributes to developing sustainable economic growth in Northern Ireland.

6. **Maintaining and improving what we have**
   Maintain a modern, reliable eHealth infrastructure, including investment in supporting, modernising and replacing key systems and HSC networks and hardware as needed.

You will find detail on each of these objectives, including how we propose to achieve them, in the next sections of the strategy. Under each of the objectives we state a number of important outcomes that we plan to deliver in the strategy period. The level of available resources will determine the pace of implementation and transformation of services. A summary table sets out the objectives and outcomes on page 26.

What is eHealth?

eHealth is the use of information needed by people and by care professionals so they can make better decisions about prevention, treatment and care. This includes information provided by you and your caregivers, information held in our systems, information generated by self-monitoring devices and sensors, and information needed for management and administration.

This use of information is made easier by information technology-based systems that allow the information to flow and be shared between people and organisations. Northern Ireland has the unique advantage of an integrated health and social care system; therefore we have called our plan for change an eHealth and Care Strategy. Throughout this document, we use the word eHealth to cover both health and social services.

eHealth is important for a number of reasons:

We live increasingly in an 'information society' with nearly every aspect of our daily lives touched by technology – whether this is in our homes, in our wider communities or in our working lives. How we book holidays, how we read the news, and how we keep in touch with our families and friends have all been revolutionised. eHealth is about bringing the benefits of that revolution to bear on our health and wellbeing.

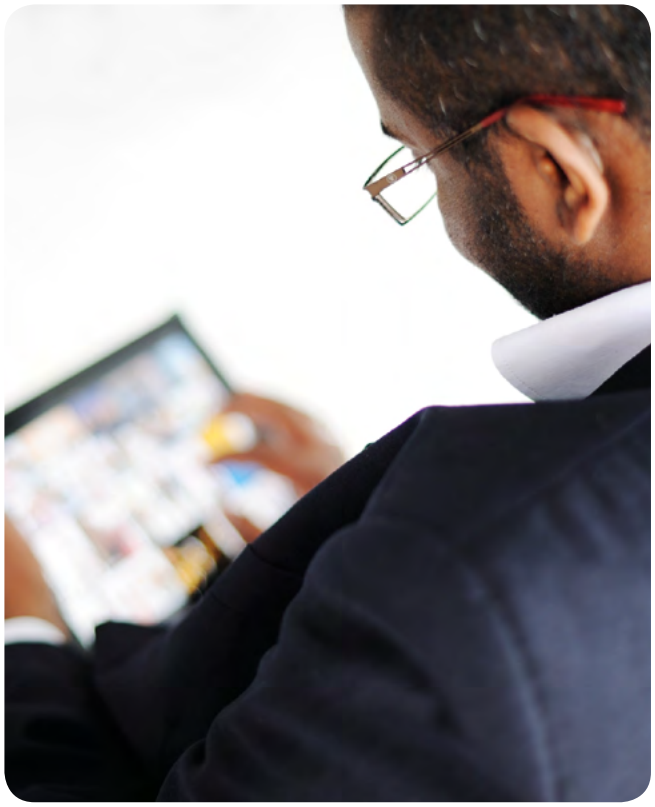
Of course, not everybody has access to the internet or technology or is happy using them. The use of eHealth will supplement face-to-face services with a more diverse mix of e-enabled services.

Why do we need an eHealth and Care strategy?

Health and social care has seen many changes in recent years, but more needs to be done to make sure we continue to meet the needs of the people of Northern Ireland. Northern Ireland has strategies setting out what these changes should be, including 'Transforming Your Care'; 'Quality 2020'; and the new strategic framework for public health 'Making Life Better'. The changes we know we will face with a growing and ageing population, and an increasing burden of disease mean we need to find smarter ways of doing things.

eHealth technology will support the vital changes in how health and social care is delivered to meet the challenges of the future. It can help to provide services remotely and also improve communications between care professionals and with patients, clients and their carers. By improving access to information both citizens and care professionals will be able to make better health and wellbeing decisions.

A clear eHealth implementation plan to support care transformation will make it easier to develop partnerships with universities, colleges and industry that support better care. The Connected Health and Prosperity Board Task and Finish Group Report has outlined how this will develop opportunities for employment, business and export-led growth.



What are the challenges?

We need to overcome several difficulties to make eHealth work in the HSC:

- It often takes too long for the good ideas that support new models of health and care delivery to become mainstream practice. We need to encourage and support the adoption of successful innovations.
- eHealth can change relationships and working practices for the public, patients, clients, their carers and HSC staff. Most people are naturally resistant to change. We need to make sure we are bringing real benefits to the people affected.
- Paper records are still widely used. Information on paper is difficult to share, and the use of paper is embedded in many HSC staff members' working practices.
- We need more standardisation and structured data if we are to make best use of the information being collected.
- Some of our older ICT systems in use in the HSC are not able to link to other systems.
- The public and HSC staff are concerned with maintaining patient and client confidentiality. Some people feel that sharing information digitally may be less secure and put them at greater risk of having their confidentiality breached.
- The current system of planning and paying for heath and care services does not take account of the changes that eHealth will support.
- Not everybody has access to the internet or technology.
- There may be access difficulties for people with a disability, older people and people from a minority ethnic background, particularly those for whom English is not a first language or who have other communication needs.
- It is not always easy to prove the benefits of eHealth to the public and to HSC decision makers. We need to be able to justify using scarce HSC resources in this way if we are to allow eHealth systems to support innovative new ways of providing services.

In the objectives and outcomes, we set out how we will overcome these difficulties across Northern Ireland, providing benefits for the public and improvements for HSC.

Current eHealth developments

Northern Ireland has strong foundations for eHealth to develop in ways that will support health and well-being improvement. Since the HSC ICT Strategy was published in 2005, the use and availability of ICT systems have greatly improved, forming the foundation for this eHealth and Care strategy.

Across Northern Ireland, care delivery is already supported by eHealth in the following ways:

- A world-class electronic care record (NIECR), providing care staff with an up-to-date medical record covering a range of clinical information.
- The regional X-ray system, NIPACS, allowing X-rays to be taken, reviewed and reported electronically.

- A system to support operating theatres in hospitals.
- Patient tracking and bed-management systems across all Trusts.
- New and redeveloped community information systems across all Trusts.
- Computerisation, networking and introduction of two-way electronic communication for all GP practices in Northern Ireland.
- Electronic Prescribing and Eligibility System (EPES) using systems and bar codes to simplify prescriptions and payments.
- A Health and Care number for everyone, and then making sure that HSC uses it to maintain data quality.
- Specialised ambulance systems designed to improve patient care.
- A data warehouse for data in Northern Ireland, allowing analysis for research, audit, service development and performance management.
- Major improvements to networks, data centres and other major eHealth infrastructure.
- A number of pilots, trialling eHealth technologies across Northern Ireland, some of which we will be rolling out as part of this strategy.

You can read more about our current eHealth technologies in the section "Maintaining and improving what we have".

What do we want to achieve?

Strategy vision

Through eHealth, we will empower people to be more active in their own care and support health and social care staff to achieve real change that delivers the best possible health and wellbeing for everyone.

Principles

Five key principles underpin the strategy:

- Citizen centred: supporting your health and wellbeing.
- Connections: across Northern Ireland, making information available in the right place; at the right time to support the best care; and with the right safeguards in place.

- Consistency: proven technologies, the way they are used and their rollout should happen in one way across Northern Ireland.
- Creativity: driving innovation and promoting best practice.
- Cost effective: investment must add value and support efficiency.

These principles have guided the development of objectives for the strategy and will underpin plans to implement the strategy.

To successfully achieve these objectives, a number of key factors will need to be addressed:

- There must be ongoing, meaningful engagement with the public to make sure we continue to do the right things in the right way. This was highlighted during the consultation. We have reflected this response in an additional outcome that will form part of the implementation of the strategy.
- Plans for implementing the strategy at regional and at Trust level must uphold the five key principles and engage health and care professionals in order to promote a culture of 'doing things differently'.

The pace of implementation and the level of transformation of services will be determined by the timing and level of available resources.

The objectives and related outcomes are shown in a summary table on page 26.

Supporting people

Provide eHealth services, supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care.

Where are we now?

eHealth services for the public in Northern Ireland are currently limited. At the moment, we do not make it easy for people to seek out information for themselves or make decisions about their own health and wellbeing. We tend to rely on three methods of communication with patients: paper, phone and in person. Contacting health and social care services about appointments or test results for example, is still mainly done by telephone or letter.

Where do we want to go?

Supporting healthy citizens

eHealth has a role in health promotion, protection and improvement. Using ICT well to provide quality information services is very important to this.

People said they would like to use eHealth technologies to add to traditional ways of contacting and using health and care services. Trusted online health portals can provide access to a variety of health information and signposting services. Setting up well-moderated support communities that give accurate information, can provide a valuable help in enabling people to stay independent.

Online booking can be used to make appointments. Mobile apps can be developed to help monitor health conditions and to supplement patient-held records.

Alice is a new mum who is well supported by her health visitor but wants to get some more information about healthy eating and exercise after pregnancy. Alice logs on to the HSC web portal and follows the signposts to information and links for recipes and fitness guides. She also finds a list of groups in her area where she could go to meet other new mums.

A personal health portal could let people store information such as healthy-eating advice and self-recorded data that they might have gathered through

the use of health and lifestyle apps on their mobile phones. The portal would use the wide range of fitness trackers and applications on phones, along with online tracking, to encourage people to take ownership of their own health. This is particularly important for people with complex health problems who find it very hard to maintain their physical health. When needed they may share some of this data with their care team to help take more informed decisions together. This can help reduce illness and help people become empowered and supported in their care.

Bronagh is a fit and healthy 30-year-old who enjoys looking after her health. She has recently bought a fitness tracker and now keeps an online record of all her fitness activity and her diet. At a recent visit to a physiotherapist for a minor sports injury, Bronagh was able to share her recorded data through a patient portal and jointly make a decision about a new fitness plan.

e-Learning programmes and podcasts can offer a new way for people to receive education regarding health and lifestyle issues and condition-specific information. For example someone diagnosed with diabetes will be able to supplement face-to-face patient education with online sessions.

Supporting communication

Many people are increasingly comfortable with self-service models as we use them every day to shop and book holidays, for example. Traditional ways of contacting the HSC will still be available for people who prefer these but there will be a range of digital services, for example:

- online appointment booking
- online self-referral
- text message reminders
- emails
- social media
- video calls

Brian was discharged from hospital four weeks ago following surgery. He has just received an email with a link for booking an outpatient's appointment for two weeks' time. Brian logs on to the new HSC portal via the emailed link and is able to 'click and book' a convenient appointment that suits him.

A Social Media and Alternative Communications Plan will be developed to look at how we can best use these technologies for the greatest benefit to all patients and service users.

Virtual health communities are developing in Northern Ireland. These social media groups or applications help people support each other in dealing with a shared health condition.

Hassan is a 40-year-old who was recently diagnosed with a respiratory condition called COPD. He is well supported by his GP, specialist respiratory nurse and hospital consultant, but Hassan gets a lot out of 'meeting' other people with his condition on a local online discussion forum. He enjoys the peer support and advice that others give him, especially if he is having a bad day.

During the development of the strategy, people we talked to said having some access to their own electronic care records would help people to keep track of their own hospital letters, appointments and test results. There is also the opportunity to let people add information to their records and to help make sure the information we hold is accurate.

Supporting independence

Helping people stay independent is important to older people, those with long-term conditions, mental health problems or a learning disability, to carers and for everyone wanting to look after their own health and wellbeing.

- **Telemonitoring technologies** can be effective support tools for people with long-term conditions, helping them live independently at home with an improved quality of life. As telemonitoring becomes more widely used and embedded into health care, patients who have monitoring needs such as high blood pressure, heart rate and blood sugar can benefit from being monitored remotely. Those with potential maternity complications such as gestational diabetes and people wanting to monitor their weight can also benefit from telemonitoring.
- **Telecare** is a tool that supports people – particularly the elderly or those with physical or mental health conditions or a learning disability – to live at home for as long as they want. Sensors in the home or worn by the individual inform the care team about certain key information, such as if a person may have had a fall, or another safety issue so that the person can be visited when needed.

Susan is a family carer who looks after her elderly parents. From time to time Susan can feel overwhelmed with the numerous physical, emotional, and financial challenges she faces. The social worker suggests that Susan considers telecare for her parents which would allow her to have a break during the day knowing that her parents are still safe even if she is away from them. Telecare devices for falls and exit alerts are installed in Susan's parents' home following a discussion with them to explain the benefit of the equipment for their safety. Susan can now leave them for periods during the day knowing that if alerts are raised, someone will call her immediately.

Telecare can also be used to send messages to the individual, such as prompts to take medications. Virtual coaching through video technology could also help keep older people fit and active both physically and mentally.

• **Electronic assistive technologies** (eAT) are increasingly available to help support or improve daily living for people with physical, sensory or cognitive impairment. eAT includes a broad range of technologies, from 'low-tech' to 'high tech'. For older people and others with limited mobility who may be housebound and living away from their family and friends, it is easy to lose touch and become isolated and lonely. Using eHealth could enhance the quality of life and social wellbeing of these people in their own homes through the use of smart technology such as TVs, phones and computers including hand-held devices. Communication can be improved by creating online 'clubs' or social networks as well as allowing these people to stay in touch with family and friends. For care professionals, these technologies can also allow them to contact isolated patients and clients.

eAT includes devices that help control the physical environment, such as opening doors and curtains, controlling heating, lighting and entertainment at the click of a button. Intelligent use of home technology can take care of the little tasks and make a big difference to day-to-day life.

The development of eAT provides a wealth of opportunity to support independence and help people to maintain their health and wellbeing. For these opportunities to be fully exploited, new arrangements for funding will need to be set up across a range of agencies and account taken of self-funding opportunities.

How are we going to get there?

- HSC will develop a web portal providing trusted advice, self-care information, information on HSC services and secure access to online services.
- HSC will provide online access to your own health records.
- HSC will build on existing pilot schemes to reduce paper and develop ways of allowing citizens to interact with the HSC electronically.
- HSC will optimise the use of current GP systems to facilitate access to GP records and other ways of communicating and interacting with GPs, e.g. prescription ordering and online booking.
- HSC will encourage the development and use of mobile health apps to support, facilitate and extend the relationship between care professionals and users for self-care and management.
- HSC will support the use of eAT, telemonitoring and telecare to enable people to live independently, working effectively with a range of partners to deliver better care.
- Along with other appropriate agencies such as housing and councils, HSC will develop new ideas to enhance the quality of life and wellbeing of older people and those who care for them. This will include more integrated community-oriented services, more sustainable home and neighbourhood design, and more age-friendly smart Living technologies.
- HSC will develop a Social Media and Alternative Communications Plan, evaluating the use of social media, smart phone technology and self-service technologies for communication with citizens.
- Develop ways of allowing people to enter information into the right place in their health record, including through the use of telemonitoring and other capture tools.

Sharing information

Give care professionals appropriate access to information to improve the speed and quality of the care decisions they make, and the outcomes for the individual.

Where are we now?

Information about you is needed to make sure you get the best care possible. Sharing your information between members of the care team or between different care professionals is often essential in the delivery of health and social care. Your information is already recorded on paper and increasingly on secure computer systems in HSC organisations such as GP surgeries and hospitals.

The HSC still generates large amounts of paper records, which often duplicates the information we have in our computer systems. Paper records are difficult to share quickly and securely. Whenever a person attends a new hospital or clinic, it is likely that a new paper record is created and these different records are difficult to join up.

When information is held electronically, it is often only available to staff using that computer system within that organisation or department. Lots of our computer systems do not talk to each other, even for sharing basic details such as your name and address, date of birth, and GP practice.

Paper records and the fact that many computer systems do not talk to each other make it hard for us to make sure your information follows you throughout the HSC. It can lead to members of your care team not having all the information they need to best treat or care for you. It can mean you having to needlessly repeat your details and care professionals having to needlessly spend time collecting your information.

We put in place the Northern Ireland Electronic Care Record (NIECR) in 2013 and this been successfully adopted across HSC. NIECR links core information systems from hospitals and clinics throughout Northern Ireland and includes lab tests, x-rays, appointments, discharge and clinic letters and details of any drugs prescribed and allergies recorded from your GP's system.

With NIECR in place, Northern Ireland is in a strong position to further develop digital records. NIECR is bringing in additional information to benefit the shared record as it becomes electronically available, building links with old and new HSC systems and technologies. This is improving care coordination, reducing delays to treatment and decision making caused by information not being available and improving patient safety. NIECR is reducing unnecessary duplication across the HSC, meaning less patient and staff time wasted and less inconvenience.

The NIECR will be further developed by actions arising from "The Right Time, The Right Place" (DHSSPS(NI) 2015).

The Electronic Northern Ireland Single Assessment Tool (eNISAT) is another example of information being collected electronically and consistently across the HSC. eNISAT allows care professionals to contribute to the one assessment for a patient or client in the community sector. This helps to avoid duplication and improve the co-ordination of a person's care across different HSC services.

The benefits of NIECR and eNISAT are considerable, but are still limited by difficulties that some HSC staff have getting basic access to a secure HSC PC, laptop or mobile device and a reliable network connection that allows them to connect to these systems.

Jean is a 79-year-old woman who lives alone in her own house. She suffers from osteoarthritis, diabetes, bronchitis and heart disease. Jean has been assessed on several occasions by various professionals, including a social worker, physiotherapist, occupational therapist, and a specialist diabetes nurse and is seeing consultants in two different hospitals. Jean found it frustrating that she had to provide the same information each time she was assessed. Using the Northern Ireland Electronic Care Record (NIECR), all the care professionals involved in looking after Jean can now share information and coordinate her care. Jean doesn't have to repeat 'her story' to everyone. She's having to have fewer blood tests as recent results are available to all the care team

and, if there's a crisis, the Out of Hours or Emergency Department team have enough information to let them make the best possible decisions about Jean's care.

Where do we want to go?

eHealth will enable electronic communication between care professionals. Expanding the use of mobile technologies and moving towards fully electronic records, building on the NIECR and other core HSC computer systems, will help make this happen across HSC.

In developing electronic records we will ensure that:

- information that is useful to the citizen and those caring for them will be recorded digitally.
- information 'blockages', such as when a patient moves from one care setting to another, will be identified and addressed. Information will flow electronically with the patient.
- electronic records will be easy to use, and will help HSC staff spend more time doing their jobs.
- appropriate security measures, the ability to check how the system is being used and confidentiality safeguards will all be put in place to make sure electronic records are used and viewed correctly.
- the public and patients will be kept informed about how their digital information is used and shared. Sharing a person's identifiable information for any reason other than for their direct care will require explicit, informed consent except in rare situations such as the cancer registry where information is used to improve the quality of care.
- there will be secure, reliable and well-maintained HSC data centres and networks to keep this information safe, make sure our systems run well and minimise the risk of technical failure.
- there will be investments in mobile technology pilot schemes to improve how staff access shared information and to increase the potential benefits from these systems.
- we will develop new ways for patients, clients and their carers to receive services from the HSC and access services, for example through video-conferencing, email and text messaging.

Throughout the discussions on sharing information people told us they needed a balance between (a) sharing their information and (b) security and control. We will explore this balance in the information and analytics delivery plan.

Annette is a member of the nursing team on a busy medical ward. Annette is concerned about the amount of time she and other members of the team are spending away from the patients' bedsides to complete paperwork and worries that this could be harming the quality of patient care. The nursing team agrees to use handheld devices to record information at the bedside. The digital form is already filled in with key information pulled in from NIECR for Annette to check with the patient. She is able to add and update new or changed information using predictive lists, often only needing to type the first few letters. Annette captures valuable information on weight, mobility, cognitive function and risk scores. Instead of this information existing on paper forms, when patients are discharged home or to another ward it will travel electronically with them, allowing the wider care team to understand how the patients' health has been recently.

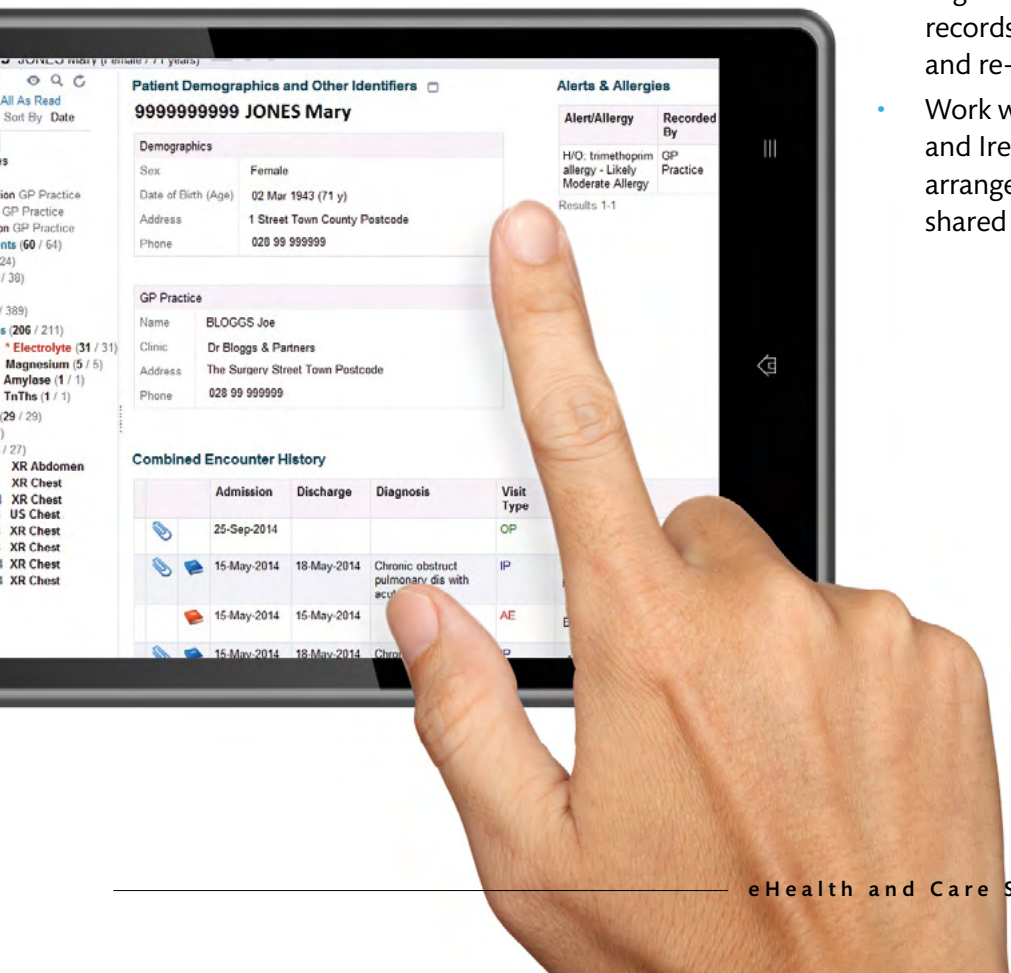
Sean is a social worker working in West Belfast. He is currently involved with a family and needs to make an assessment of their needs for additional support with their children. Sean has always been frustrated that he has had to complete the paperwork when he is in his clients' home and then type out the information again when he gets back to the office and his computer. Since the introduction of mobile working, Sean can now use his laptop computer when sitting with the family and complete the documents immediately. As he also has internet connections he is able to help the family find online information and services that they can look at when he leaves them.

Electronic communication, such as video-conferencing, e-Learning and electronic requests for advice between primary and secondary care will support better patient care and reduce travel time for patients and staff. An example of the way this technology can be used is Project ECHO. This uses video-conferencing technology to link GPs with hospital care teams to help manage the care of patients who have complex needs, bringing specialist expertise into primary care.

Dr Jones, a GP in Fermanagh, wants to learn more about how to look after his patients with complex conditions so he joins Project ECHO. The project brings together a number of specialist doctors and nurses as well as the GPs and community teams via video meetings. Over a series of meetings the GP and community teams learn from the specialists. The specialist teams also learn from them about what is needed to allow patients' care to improve outside hospital. Together the specialist and primary care teams work together to ensure that patients with complex conditions get the care they need, closer to home, and with less travelling to hospital for planned or emergency care.

How are we going to get there?

- Continue enriching NIECR to link in more HSC clinical and care information systems and develop NIECR functionality, including providing care professionals with appropriate role-based access to clinical and care information systems including NIECR.
- Provide staff with mobile access to the HSC network and systems in 2015/16, as part of a three-year investment plan.
- Provide secure and appropriate access to NIECR information for community pharmacists, dentists, opticians and independent health and social care providers, such as nursing homes.
- Build links with independent health and social care providers to allow them to contribute to the NIECR to help make sure all relevant patient information is captured and able to be shared.
- Digitalise manual processes and paper records to allow information to be shared and re-used appropriately.
- Work with England, Scotland, Wales and Ireland to develop data sharing arrangements to allow information to be shared to support peoples care.



Use of information and analytics

Develop ways to transform data and information into knowledge (informatics) that supports care, from being able to suggest personalised preventative care through to supporting population-level health and care planning.

Where are we now?

Information about you and your care is gathered electronically in many parts of the HSC but some is still collected on paper. Some electronic information such as attendances at hospital, drugs prescribed by your GP and visits from community nurses is collected to help the HSC to support research, audit, service development and performance management. This information goes to a central database (the HSC Data Warehouse), where it is held securely and is pseudonymised or anonymised before use.

Work is going on using limited, summary-level information from GP systems to let GPs find out who in their practice is at risk of starting to have problems with their health. This lets the GP offer additional support to these patients to help them stay healthy for longer.

The use of information and analytics in the HSC will require engagement with the public. In the DHSSPS(NI) consultation-

'Caring for Your Information' a change to the law was discussed to allow data sharing. The results of this and the outcome of "The Right Time, The Right Place" review will shape the Information and Analytics delivery plan.

Where do we want to go?

In future we will collect more information electronically. Health analytics is about making best use of this information to benefit the wider population by:

- supporting better decisions about the services we provide to get the most benefits for patients and clients.
- informing technical and medical evaluations of new therapies and treatment plans.
- making sure the services we provide are equitable and high quality.
- identifying those at risk of health problems and taking early steps with the patient to keep them in good health (risk stratification).
- letting us model the future, forecasting needs and planning care delivery to meet the identified need.

Pavel has managed his diabetes successfully over the last few years and he feels fine keeping busy at work and at home. As he feels so well, Pavel does not attend the diabetic clinic as often as he should. Information on the care of people with diabetes in his GP practice area is analysed. It picks up a group of people at risk of diabetic complications, including Pavel. The data links information about his blood-sugar levels and his non-attendance at clinics. Next time Pavel asks for his repeat prescription he's asked to make an appointment with his GP who notices a small red mark on the sole of his foot, which could be the start of an ulcer. The GP refers Pavel electronically to the podiatrist for foot care and Pavel books electronically at a time he can attend. Seeing the podiatrist means the ulcer does not develop.

For this to work, HSC needs information standards so that the right information is collected in the right way and is correctly entered into information systems. This means information can be linked across HSC. We need information systems that work well with each other so there are no blockages in the flow of information. All of the work we do and will do involving the use of information about you will comply with data protection policy, obligations and relevant codes of practice.

How are we going to get there?

- Develop links between HSC information systems that improve how we can analyse information. An Information and Analytics delivery plan will examine the legal and ethical frameworks needed, the standardisation and coding of HSC information needed, and the training and education needs of staff. The information and Analytics delivery plan will be available by December 2015.
- Use risk-stratification techniques to provide early-intervention support to help citizens keep healthy.

Supporting change

We want to make eHealth central to planning any changes to health and care services, to make sure we are making the most of technical opportunities and the potential for improved information flows to support improvements.

Where are we now?

HSC Trusts and staff are already using technology to help them transform their services for patients and clients. However, some areas are not aware of or have limited access to eHealth systems that could better support their daily work, even though they may use technology extensively outside work.

Too often, the technology needed to support changes has not been included in the plan for improvement. In the past, ICT has been seen as something for technical specialists. This view is changing: our staff who deliver and manage frontline patient and client care are increasingly taking an active role in using technology to help them.

An HSC ICT Programme Board has been governing the last 10 years' progress. However, this was largely technically focused and had limited contact with care professionals.

Where do we want to go?

We need effective leadership and a shared governance structure across the HSC organisations. This needs to:

- place care professionals at the heart of decision making, focusing on the impact of eHealth on health and wellbeing.
- involve the public in setting the direction of the eHealth and Care programme.
- use the excellent technical knowledge and experience within the HSC.
- involve business, academic, and community and voluntary sectors.
- deliver projects supporting transformational change, service improvements and benefits to patients and clients.
- ensure consistency and equity in access to eHealth services across HSC.
- minimise waste, duplication and divergence from best practice.

- create space for innovation and support the roll-out of successes across HSC.
- identify policy changes that may be needed to help bring in the strategy.

An eHealth and Care Strategic Board, led by the HSCB, will replace the HSC ICT Programme Board and direct the grouped programmes and projects. The eHealth and Care Strategic Board will make sure stakeholders, particularly citizens, can influence the direction of the programme and the implementation plan.

A Design Integrity Group will oversee proposals for projects and investments to ensure we stay on the strategic and technical track across HSC and make the best use of the resources we are given.

Using eHealth may mean changes in traditional roles and the ways of working of some HSC staff. Some may need training and support to make best use of the technology and information. Adaptations may be needed to support staff whose lack of computer skills may hinder their use of eHealth technology. As well as working within their recognised professional codes of conduct and competency frameworks, all care staff should be supported by adequate clinical supervision, training and ongoing support. To help identify and meet the training and skills needs of staff, this strategy recommends the setting up of and coordination of activities with relevant professional bodies and education providers.

We regard the use of technology to support patient safety as vital in supporting change. This was also raised in "The Right Time, The Right Place" as part of the process of improving patient care across the HSC

How are we going to get there?

- Demonstrate that eHealth can improve patient-centred care.
- Develop eHealth Clinical Lead roles to drive and direct the use of eHealth to support care delivery.
- Put in place a new leadership and governance structure, with care professionals at the heart, and design it to ensure consistency and equity in service delivery.
- Support the development of staff to allow them to best use eHealth technologies, through training and support, working with professional bodies and existing training providers. This will integrate with current DHSSPS and professional workforce planning and education strategies.
- Develop new ways for patients, clients and their carers to receive services from the HSC and access services for example through videoconferencing, email and text messaging.
- Develop ways of engaging the public with the eHealth and Care implementation, bringing their views into the development of the eHealth programme.
- Ensure that the range of stakeholders involved in the development of the eHealth and Care strategy are included in the eHealth and care Strategy implementation.
- Develop appropriate eHealth technologies to support patient safety, both within new systems and specialist systems as needed

Fostering innovation

HSC will work with businesses, colleges and universities, community and voluntary organisations, other government departments and international partners to develop uses of eHealth and help improve health, wellbeing, prosperity and job creation.

Where are we now?

In Northern Ireland we have dynamic businesses, internationally recognised universities and strong community and voluntary organisations. HSC has worked with these partners for many years, bringing innovation into health and social care which benefits patients, clients and public health.

In 2011 a Memorandum of Understanding (MOU) on Connected Health and Prosperity was agreed between Northern Ireland's Health and Enterprise Ministers. The agreement sets out how the DHSSPS and DETI will continue to work together in developing connected health solutions that will improve the wellbeing of patients and help support the Northern Ireland economy. As a result of the agreement, the Northern Ireland Connected Health Ecosystem (NICH ECO) was established in 2012 to bring together the health, academic and industry sectors, along with patients and the voluntary and community sector. Its aim is to identify the challenges in bringing about transformative change to our health and social care services and to consider potential solutions.

The Economy and Jobs Initiative was agreed by the NI Executive in 2013. This included a focus on the contribution health could make to the economy. A Task and Finish Group was established to provide an assessment of the potential opportunities for employment and business development from Health and Social Care through greater innovation and export-led growth. In May 2013 the T&F Group published it's Report along with a number of proposals that Health and Social Care could make to being a major driver for innovation and economic growth. The report's recommendations include developing an International Health Analytics Centre (IHAC) to make the most of the data generated by the health and social care sector to support global advances in health and social care research. The report also recommends setting up a Connected Health Integration Platform (CHIP) which could link digital care records to applications running on smart devices such as phones, tablets and computers.

We are also working with the health community in other European regions and the US:

- Northern Ireland has been given 3* Reference Site status through the European Commission's European Innovation Partnership on Active and Healthy Ageing (EIP-AHA) initiative. We are working on a number of EIP-AHA projects to develop new technologies and innovative approaches to improve patient care.
- DHSSPS has established an EIP-AHA Reference Site Collaborative Network, bringing together all European Reference Sites to exchange and share best practice in the development of health and care strategies, policies and service delivery models.

- DHSSPS has eHealth Memorandum of Understanding agreements with a number of European Regions and the New York State Health Department, with others in development.
- These partnerships mean we can benefit from sharing ideas and best practice. They also mean Northern Ireland is best placed to maximise support from Europe that will help us take forward further research and projects.

Where do we want to go?

We want Northern Ireland to be a global centre of excellence in the field of eHealth, with:

- improved access to information for the public and HSC staff.
- models of health and care designed and delivered around patients.
- patients and clinicians better able to monitor and manage health conditions.
- improved outcomes for the public.

- more support for innovative businesses and social entrepreneurs wanting to work with us in developing innovative eHealth solutions.
- better opportunities for businesses, universities and community and voluntary organisations bringing new jobs to Northern Ireland.

How are we going to get there?

- By 2020 be more widely recognised as a leader in Europe in the use of technology to support better care of the people of Northern Ireland.

- We will continue to develop both the Northern Ireland Connected Health Ecosystem and our partnerships outside Northern Ireland. We will develop our own capacity to innovate, using local and international partnerships to access the expertise needed to develop solutions to problems affecting our patients.

- We will work with other partners to take forward the recommendations in the Economy and Jobs Initiative Task and Finish Group's report. This can be found at www.dhsspsni.gov.uk/t_f_final_report.pdf

- We will work with local eHealth industry to develop and use innovative products and systems we can sell worldwide, supporting the local economy and increasing local employment.

- We will build on our success in developing and delivering EU programmes, drawing funding, ideas and expertise into Northern Ireland.

- We will support the annual eHealth and Care Awards and Conference to celebrate and promote best practice in the use of eHealth.

Maintaining and improving what we have

Maintain a modern, reliable eHealth infrastructure, including investment in supporting, modernising and replacing key systems and HSC networks and hardware as needed.

Where are we now?

We have developed a strong ICT foundation for eHealth over the last 10 years as a result of the 2005 HSC ICT Strategy and investment in many regional and Trust-level projects:

- The Northern Ireland Electronic Care Record (NIECR) and the expansion of systems across the community sector, including the delivery of Community Information Systems and the development of the electronic Northern Ireland Single Assessment Tool (eNISAT) are bringing real benefits to patient and client care. They are a strong starting point for developing more tools to support high-quality integrated care.
- Health and Care Number (HCN), the unique identifier for everyone in Northern Ireland. This unique identifier is important as it allows your health and social care information to be safely linked together and helps the HSC work together to keep your basic demographic details (name, address, date of birth) accurate and up to date.
- Northern Ireland Picture Archiving and Communications System (NIPACS), our regional system for x-rays.
- Theatre Management System (TMS), managing operating theatres in hospitals.
- Cancer Patient Pathways System (CaPPS), improving cancer diagnosis and treatment.
- Electronic Prescribing and Eligibility System (EPES), supporting primary-care medicines management.
- ICT infrastructure improvements including secure HSC and GP networks, desktop and mobile devices and consolidated regional HSC data centres.

- Several Trusts have developed electronic clinical noting systems, aimed at replacing paper-based inpatient care records. Other excellent local innovations continue to be developed across Northern Ireland including:
  - electronic discharge correspondence, where information needed by GPs, nurses and other care professionals in the community can be sent electronically rather than in a letter that has to be hand delivered by the patient when they go home.
  - bed-management systems – an interactive whiteboard on hospital wards that allows staff to deal with admissions, transfers to others wards and discharges.
  - electronic patient check-in in outpatient departments, where patients can use a touch-screen to let staff know they have arrived.
  - for care professionals in some hospitals, bedside computing, which allows them to collect and connect to information needed when they are with patients, while the use of mobile technology allows staff who move about hospitals or work in the community to do the same.
  - patient websites, providing information on hospital services, which are now available for all Trusts.
  - the Northern Ireland Ambulance Service (NIAS), which has invested resources in implementing systems required by a modern ambulance service, including Call Line Identification (CLI) integrated with hospitals and a pilot of an Electronic Patient Report Form system (EPRF) using digital-pen technology.
  - electronic patient monitoring, also used by NIAS to send clinical information to the Emergency Department before the ambulance and patient arrives.

- All general practices in Northern Ireland are computerised and connected to the secure HSC network. The results of tests that the GP has asked for are sent electronically. GPs are able to send electronic referrals to consultant services in Trusts. Information on patients' drugs and allergies is sent from GP systems to NIECR.
- The current Telemonitoring NI service supports patients with long-term conditions. This regional service lets patients self-monitor and better manage their condition with care-professional support when needed. The regional Telecare service supports people to live independently at home for longer, for example by using sensors to alert care workers to possible problems, like a fall.
- Pharmacists, dentists and opticians have also invested in ICT to support their services.
- The community and voluntary sector are making good use of the internet for providing information. They lead the way in developing apps to help support people to stay healthy and happy.

Where do we want to go?

It will need significant investment of time and money to operate the eHealth and Care's underlying infrastructure and systems in a way that fully supports an advanced eHealth economy. We will need to renew or upgrade parts of this eHealth foundation during 2015-2020.

Our principles will guide investment in the maintenance and renewals process, delivering consistently efficient services across Northern Ireland. This will include, where appropriate, the use of single systems, data structures and technologies to reduce complexity and cost. We plan to complete two technical strategies to inform the implementation - an Application Strategy and an Infrastructure Strategy. These will examine the existing infrastructure and systems, creating a clear picture of the current position and linking it to the implementation plan.

How are we going to get there?

- Develop and extend HSC ICT access to all parts of the health economy that need it, either through mobile, wireless or fixed networks including improvements in access and bandwidth.
- Develop an Infrastructure Strategy. This strategy will set out the future direction for HSC infrastructure including networks, datacentres and storage, including the appropriate adoption of cloud computing and cloud storage.
- Develop an Application Strategy. This strategy will set out the future development and replacement pathway for HSC applications, including the adoption when appropriate of open-source applications.
- Deliver the eHealth technologies needed to support service change; areas identified include medicines management and pathology services.

SUMMARY OF OBJECTIVES & OUTCOMES

STRATEGIC OBJECTIVE	OUTCOMES
Supporting people Provide eHealth services, supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care.	• HSC will develop a web portal providing trusted advice, self-care information, information on HSC services and secure access to online services. • HSC will provide online access to your own health records. • HSC will build on existing pilot schemes to reduce paper and develop ways of allowing citizens to interact with the HSC electronically for example booking clinic appointments on-line. • HSC will optimise the use of current GP systems to facilitate access to GP records and other ways of communicating and interacting with GPs, e.g. prescription ordering and online booking. • HSC will encourage the development and use of mobile health apps to support, facilitate and extend the relationship between care professionals and users for self-care and management. • HSC will support the use of eAT, telemonitoring and telecare to enable people to live independently, working effectively with a range of partners to deliver better care. • Along with other appropriate agencies such as housing and councils, HSC will develop new ideas and funding opportunities to enhance the quality of life and wellbeing of older people and those who care for them. This will include more integrated community-oriented services, more sustainable home and neighbourhood design, and more age-friendly smart Living technologies. • HSC will develop a Social Media and Alternative Communications Plan by evaluating the use of social media, smart phone technology and self-service technologies for communication with citizens. • Develop ways of allowing people to enter information into the right place in their health record, including through the use of telemonitoring and other capture tools
Sharing information Give care professionals appropriate access to information to improve the speed and quality of the care decisions they make, and the outcomes for the individual.	• Continue enriching NIECR to link in more HSC clinical and care information systems and develop NIECR functionality, including providing care professionals with appropriate role-based access to clinical and care information systems including NIECR. • Provide staff with mobile access to the HSC network and systems in 2015/16, as part of a three-year investment plan. • Provide secure and appropriate access to NIECR information for community pharmacists, dentists, opticians and independent health and social care providers, such as nursing homes. • Build links with independent health and social care providers to allow them to contribute to the NIECR to help make sure all relevant patient information is captured and able to be shared. • Digitalise manual processes and paper records to allow information to be shared and re-used appropriately. • Work with England, Scotland, Wales and Ireland to develop data sharing arrangements to allow information to be shared to support peoples care.

STRATEGIC OBJECTIVE	OUTCOMES
Using information and analytics Develop ways to transform data and information into knowledge (informatics) that supports care, from being able to suggest personalised preventative care through to supporting population-level health and care planning.	• Develop links between HSC information systems that improve how we can analyse information. An Information and Analytics delivery plan will examine the legal and ethical frameworks needed, the standardisation and coding of HSC information needed, and the training and education needs of staff. The Information and Analytics delivery plan will be complete by December 2015. • Use risk-stratification techniques to provide early-intervention support to help citizens keep healthy.
Supporting change Make thinking about eHealth central to planning any changes to health and care services to make sure we are making the most of technical opportunities and the potential for improved information flows to support improvements.	• Demonstrate that eHealth can improve patient-centred care for example collecting patient experiences of the HSC to help improve services. • Develop eHealth Clinical Lead roles to drive and direct the use of eHealth to support care delivery. • Put in place a new leadership and governance structure, with care professionals at the heart, and design it to ensure consistency and equity in service delivery. • Support the development of staff to allow them to best use eHealth technologies, through training and support, working with professional bodies and existing training providers. This will integrate with current DHSSPS and professional workforce planning and education strategies . • Develop new ways for patients, clients and their carers to receive services from the HSC and access services for example through videoconferencing, email and text messaging. • Develop ways of engaging the public with the eHealth and Care implementation, bringing their views into the development of the eHealth programme. • Ensure that the range of stakeholders involved in the development of the eHealth and Care strategy are included in the eHealth and care Strategy implementation. • Develop appropriate eHealth technologies to improve processes and support patient safety, both within new systems and specialist systems as needed

STRATEGIC OBJECTIVE	OUTCOMES
Fostering innovation HSC will work with businesses colleges and universities, community and voluntary organisations, other government departments and international partners to develop uses of eHealth to help improve health and wellbeing, prosperity and job creation.	• By 2020 be more widely recognised as a leader in Europe in the use of technology to support better care of the people of Northern Ireland. • We will continue to develop both the Northern Ireland Connected Health Ecosystem and our partnerships outside Northern Ireland. We will develop our own capacity to innovate, using local and international partnerships to access the expertise needed to develop solutions to problems affecting our patients. • We will work with other partners to take forward the recommendations in the Economy and Jobs Initiative Task and Finish Group's report. This can be found at *www.dhsspsni.gov.uk/t_f_final_report.pdf* • We will work with local eHealth industry to develop and use innovative products and systems we can sell worldwide, supporting the local economy and increasing local employment. • We will build on our success in developing and delivering EU programmes, drawing funding, ideas and expertise into Northern Ireland. • We will support the annual eHealth and Care Awards and Conference to celebrate and promote best practice in the use of eHealth.
Maintaining and improving what we have Maintain a modern, reliable eHealth infrastructure, including investment in supporting, modernising and replacing key systems and HSC networks and hardware as needed.	• Develop and extend HSC ICT access to all parts of the health economy that need it, either through mobile, wireless or fixed networks including improvements in access and bandwidth. • Develop an Infrastructure Strategy. This strategy will set out the future direction for HSC infrastructure including networks, datacentres and storage, including the appropriate adoption of cloud computing and cloud storage. • Develop an Application Strategy. This strategy will set out the future development and replacement pathway for HSC applications, including the adoption when appropriate of open-source applications. • Deliver the eHealth technologies needed to support service change; areas identified include medicines management and pathology services.

Glossary

AHA	Active and Healthy Aging. A stream of work funded by the European Union to allow countries to work together to transform services.
CaPPS	Cancer Access and Patient Protocol System
CHIP	Connected Health Integration Platform which can link digital records to other applications.
CLI	Call Line Identification for emergency calls.
DETI	Department of Enterprise Trade and Investment
DHSSPS	Department of Health, Social Services and Public Safety
eAT	Electronic Assistive Technology
eNISAT	(Electronic) Northern Ireland Single Assessment Tool
EPES	Electronic Prescribing and Eligibility System
EPRF	Electronic Patient Report Form used for the handover from ambulance staff to other care staff.
EIP	European Innovation Partnership. EIPs are a new approach to EU research and innovation to help bring together countries working in particular areas to transform services.
HCN	Health & Care Number
HSCB	Health and Social Care Board
HSC	Health and Social Care in Northern Ireland
ICT	Information and Communication Technology
IHAC	International Health Analytics Centre
MoU	Memorandum of Understanding is an agreement between countries to work together and benefit from the collaboration.
NIAS	Northern Ireland Ambulance Service
NICH	Northern Ireland Connected Health
NIECR	Northern Ireland Electronic Care Record
NIPACS	Northern Ireland Picture Archiving and Communications System
PHA	Public Health Agency
TMS	Theatre Management System
TYC	Transforming Your Care is the strategy that outlines the plans for making changes in health and social services from 2012-2017.
care pathway	Also known as clinical pathways, critical pathways, integrated care pathways, or care maps, are one of the main tools used to manage the quality in health and social care because their use reduces the variability in clinical practice and improves outcomes. Pathways promote organised and efficient patient care based on evidence based practice in the hospital or community care setting.
care professional	An individual health and/or social care provider within any professional group e.g. medicine, nursing, allied health professional, social work, dentistry, pharmacy, etc. The practice of care professionals is regulated by appropriate regulatory bodies.
citizen	An individual living in Northern Ireland.

design authority	This is a care professional led group within the governance structure of the strategy which will provide momentum and guidance to the various projects involved in implementing the strategy.
equality impact assessment	An assessment of the impact of a strategy or policy across specific groups that may be affected.
informatics	The use of information science, computer science, and health care. It deals with the resources, devices, and ways to improve the gathering, storage, retrieval, and use of information in health and biomedicine. Health informatics tools include computers, clinical guidelines, formal medical terminologies, and information and communication systems.
IT infrastructure	Information technology infrastructure is the framework needed to support the flow and processing of information.
mobile working	Mobile working with the use of smart devices such as phones, iPads and tablets.
network coverage	Is the term used to describe how good or bad the mobile 'signal' is in a particular geographical area.
paper-light	An organisation that will have less reliance on paper would be called paper light.
web portal	A specially designed website that brings together information from different sources so that it can be easily accessed e.g. a website giving information about health and social care services in Northern Ireland.
telecare/ telemonitoring/ telehealth	Telehealth is the delivery of health-related services and information via technology. Telemonitoring allows patients to monitor their own condition by using health devices at home and then results are sent electronically to their care professional. Telecare ensures people can be safe at home by using environmental sensors to meet a risk; for example, a falls monitor.

Appendix 1

Strategy Development details

The development of the eHealth and Care Strategy for Northern Ireland includes the following:

1. Stakeholder engagement.
2. Review of strategic context and future of health and care in Northern Ireland.
3. Best practice and the future of technology.
4. Current situation.
5. Lessons learned from previous strategies, both IT and within health care.
6. Leadership and governance.
7. Consultation process on strategy content.
8. Review and editing
9. Publication

This method is based on previous strategic development in the HSC and the use of the National eHealth Strategy Toolkit published by the World Health Organisation.

1. Stakeholder engagement

The main aspect of the development process was a large-scale engagement with stakeholders across Northern Ireland. The groups consulted included:

- citizens (including patients, carers and clients – all ages and sections of the community)
- community and voluntary sector organisations
- HSC staff and organisations
- internal local and national ICT suppliers
- DHSSPS(NI).

Each of these groups provided a different context for eHealth and Care services in Northern Ireland and enabled us to incorporate local and regional innovations into the consultation document.

2. Review of strategic context

Northern Ireland has a well-developed strategic framework for the future of HSC services. Transforming Your Care (DHSSPS, 2011), Quality 2020 (DHSSPS, 2011) and the new strategic framework for public health, Making Life Better (DHSSPS, 2014). Each of these, along with other professional strategies, was reviewed to ensure the content of the consultation document was relevant and in line with regional health and social care directions.

3. Best practice and the future of technology

We gathered best practice from four sources:

- The local innovations accessed through the stakeholder workshops.
- The national and international best practice through review of existing information.
- Previous visits nationally and internationally.
- Engagement with major IT suppliers.

4. Current situation

From the stakeholder engagement and direct engagement with Trust ICT staff, the current eHealth situation was outlined. This included both strengths and weaknesses and what staff felt was the way forward to improve service delivery.

5. Lessons learned from previous strategies

We reviewed the lessons learnt from the previous ICT strategy period. We also reviewed other countries' eHealth strategies, including Scotland, England, Ireland, Australia and South Africa. We used the external reference group to provide their personal experience of managing and delivering eHealth in their countries to improve what we had learned.

6. Leadership and governance

The steering group acted as a project board and provided leadership and governance for the development process. An external reference group of experts in the area of eHealth and service change gave additional quality assurance. The project delivery team was made up of clinical, technical and management staff.

Steering group

The steering group provided the overall direction for the strategy development and demonstrated the HSC's commitment to the eHealth and Care strategy.

Mr John Compton	Chief Executive HSCB (retired 31/03/14) (Chair)
Mr Eddie Rooney	Chief Executive PHA
Mrs Julie Thompson	Deputy Secretary DHSSPS(NI)
Mrs Catherine Daly	Deputy Secretary DHSSPS(NI)
Mr Hugh McCaughey	Chief Executive South East HSCT
Mrs Mairead McAlinden	Chief Executive Southern HSCT
Mr Liam McIvor	Chief Executive Northern Ireland Ambulance Service
Mr Sean Donaghy	Director of eHealth and External Collaboration – HSCB
Mr Eddie Ritson	Programme Director – CCHSC PHA
Mr David Bingham	Chief Executive Business Services Organisation

Expert advisory group

The external reference group provided advice and challenge to the project team and the steering group.

Mr Paul Wickens	Chief Executive NICS Enterprise Shared Services Centre
Mr Gwyn Thomas	Ex CIO Wales and UKCHIP Chair
Dr Charles Gutteridge	CCIO Barts Health NHS Trust
Mr Bill McCluggage	Ex CIO Ireland

7. Consultation process

The public consultation for the strategy and the EQIA has been successfully completed, with over 90 responses received and over 20 focus groups,. Presentations, pop-up stands and public meetings providing more detailed information. This provided significant information to inform the development of the strategy and allow us to complete the final version.

8. Review and editing

Based on the responses and the feedback from the other consultation methods a response to consultation document was developed and will be published on the HSCB website. The EQIA has had additional information added, based on the feedback from the consultation and a final version will be published on the HSCB website.

The strategy was edited, reflecting the changes needed from both the response to consultation and the EQIA. This will be the final strategy for the next 5 years.

9. Publication

This will be published through the Board website and form part of the ongoing communications process as the strategy moves towards implementation.

References

- DHSSPS (2009) Health and Social Care (Reform) Act (Northern Ireland) available at http://www.legislation.gov.uk/nia/2009/1/notes/contents
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- DHSSPS (2011) Transforming Your Care – A review of health and Social Care in Northern Ireland available at http://www.dhsspsni.gov.uk/tyc.htm
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- World Health Organisation (2012) National eHealth Strategy Toolkit available at www.who.int/ehealth/publications/overview.pdf

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Health and Social Care

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 March 2015
Title of Paper	Quality Improvement Biannual Report
Agenda Item	16
Reference	PHA/09/03/15

Summary

Introduction

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) each have a duty under Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals; and the environment in which it provides them.
The HSC framework (DHSSPS, 2011) requires HSCB/PHA to gain assurance on progress with regional safety and quality priorities via Quality Improvement Plans (QIPS). The Commissioning Plan (PHA and HSCB, 2014/15) is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Services and Public Safety, 2014/2015 and identifies the key strategic priorities. These consider the safety and quality indicators which must be included in Quality Improvement Plans developed by Trusts.

Process

HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB/PHA Commissioning Plan and locally identified quality improvement initiatives. Data of agreed measures relating to the commissioning plan indicators are required to be submitted via an electronic SharePoint within six weeks of each quarter end. An escalation protocol has been agreed in the event timely submissions are not received. This data is reviewed and analysed by the Quality, Safety and Experience Team, PHA and used to inform this report. The data relating to each indicator is accompanied by commentary to allow explanation of variation in compliance or outcome and any actions taken in response. Findings are used to prioritise the PHA Safety and Quality Work plan to support on-going quality improvement initiatives.

The key areas covered in this report are:

1 Prevention of Pressure Ulcers
2 Reduction of Harm from Falls
3 Reduction of harm to patients from Venothromboembolism
4 Sepsis6 Bundle

Audit Trail	This report was approved by AMT on 3 March 2015.
Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Nursing and AHPs
Date	9 March 2015

HSC Public Health Agency

Quality Improvement

Bi-Annual Report

Quarter One & Two April 2014 to October 2014

December 2014

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1.0 INTRODUCTION

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) each have a duty under Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals; and the environment in which it provides them.

The HSC framework (DHSSPS, 2011) requires HSCB/PHA to gain assurance on progress with regional safety and quality priorities via Quality Improvement Plans (QIPS). The Commissioning Plan (PHA and HSCB, 2014/15) is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Services and Public Safety, 2014/2015 and identifies the key strategic priorities. These consider the safety and quality indicators which must be included in Quality Improvement Plans developed by Trusts.

The purpose of this report is to provide a bi-annual report which demonstrates the progress in relation to quality improvement in key areas identified in The HSCB / PHA Commissioning Plan and Trusts QIPS. The information will provide assurance to commissioners that patient and client healthcare services are being provided to the required standard in these priority areas. The report is intended to compliment key information available from other sources, for example Patient Client Experience monitoring, Complaints and Serious Adverse Incident (SAI) reporting.

HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB PHA Commissioning Plan and locally identified quality improvement initiatives. The framework for reporting and review including definitions of each quality indicator and measures of improvement have been developed by the PHA in collaboration with HSC Trusts, this can be found in Appendix 1.

Data of agreed measures relating to the commissioning plan indicators are required to be submitted via an electronic SharePoint within six weeks of each quarter end. An escalation protocol has been agreed in the event timely submissions are not received. This data is reviewed and analysed by the Quality, Safety and Experience Team, PHA and used to inform this report.

The key areas covered in this report are:

1 Prevention of Pressure Ulcers

2 Reduction of Harm from Falls

3 Reduction of harm to patients from Venothromboembolism (VTE)

4 Sepsis6 Bundle

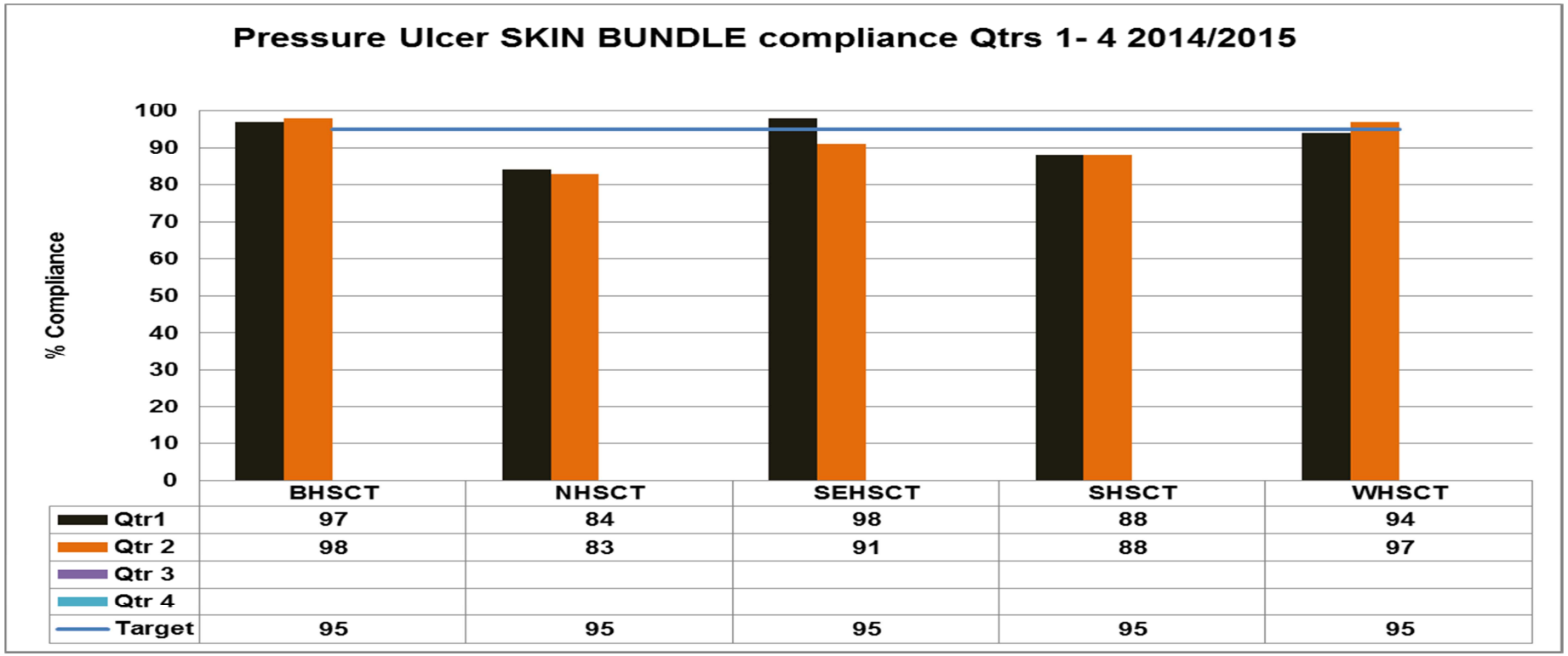
The data relating to each indicator is accompanied by commentary to allow explanation of variation in compliance or outcome and any actions taken in response. Findings are used to prioritise the PHA Safety and Quality Work plan to support on-going quality improvement initiatives.

Q1 &2 2014--15 Update on QIP Indicators

Prevention of Pressure Ulcers

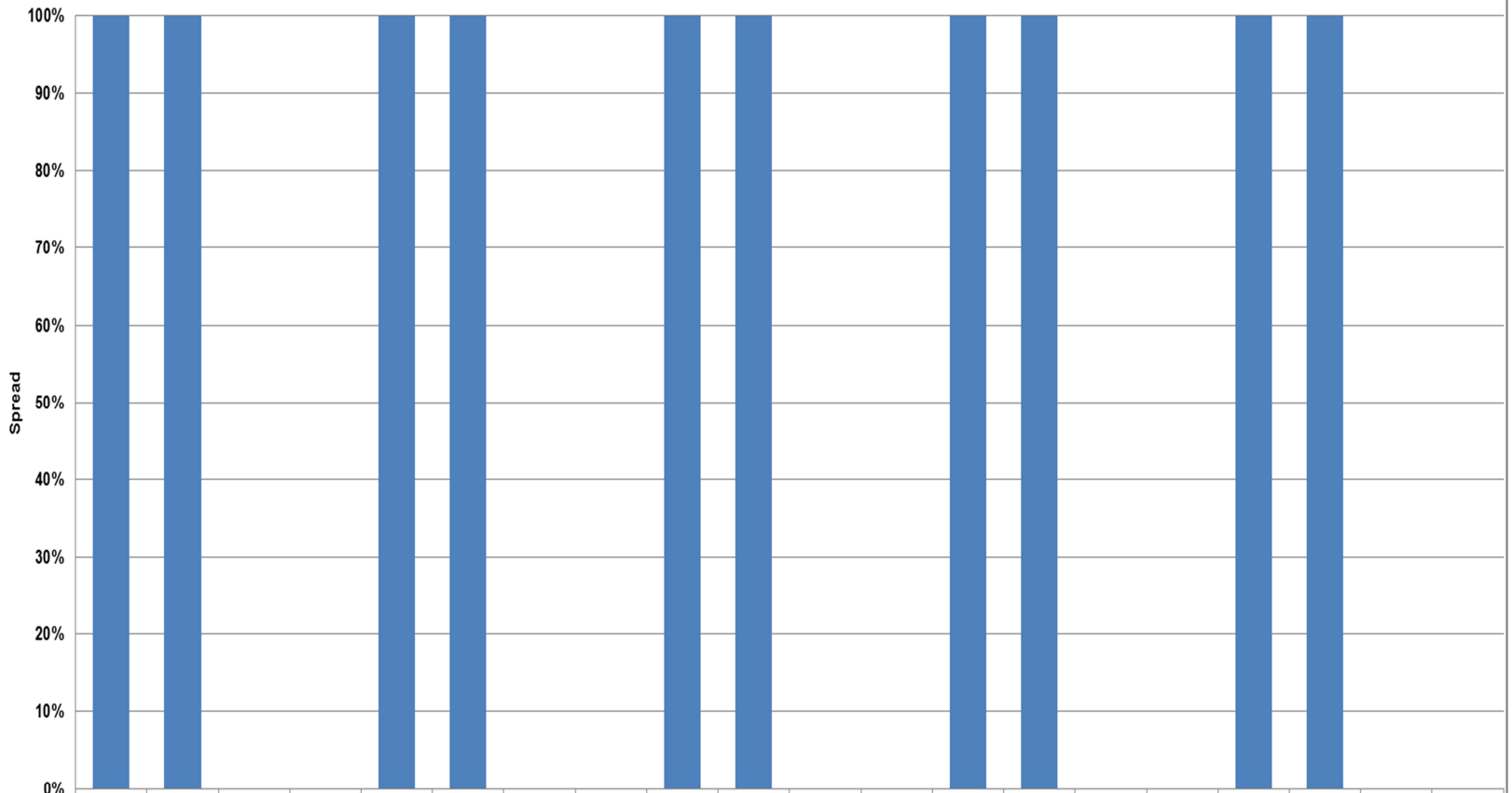
Pressure ulcers are now a target in 2014 Commissioning Plan Direction - 2014-2015 Trusts will achieve 10% reduction in reported pressure ulcers, in adult in patient wards.

2014-2015 Commissioning Plan requirements - Trust will spread the SKIN Bundle to all adult inpatient areas / Wards ensuring 95% compliance by March 2015. Trusts will monitor and provide reports on bundle compliance.



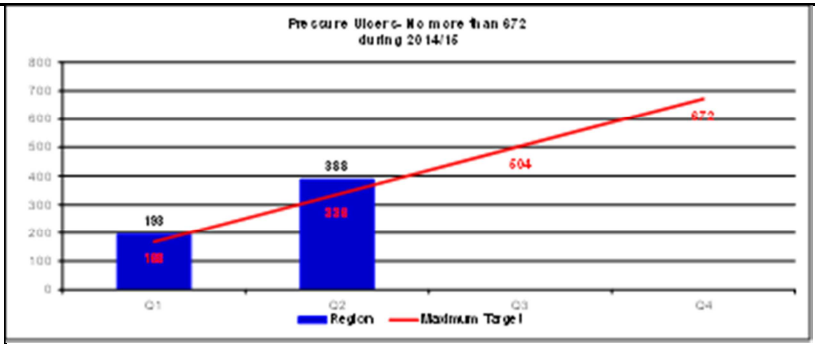
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr1	97	84	98	88	94
Qtr 2	98	83	91	88	97
Qtr 3					
Qtr 4					
Target	95	95	95	95	95

Prevention of Pressure Ulcers: Spread of SKIN Bundle Per Quarter
QTR 1- 4 2014-2015



	BHSCT Q1	BHSCT Q2	BHSCT Q3	BHSCT Q4	NHSCT Q1	NHSCT Q2	NHSCT Q3	NHSCT Q4	SEHSCT Q1	SEHSCT Q2	SEHSCT Q3	SEHSCT Q4	SHSCT Q1	SHSCT Q2	SHSCT Q3	SHSCT Q4	WHSCT Q1	WHSCT Q2	WHSCT Q3	WHSCT Q4
Remaining Areas to Spread to	0	0			0	0			0	0			0	0			0	0		
Number of Clinical areas spread	78	78			27	27			31	31			26	26			32	32		

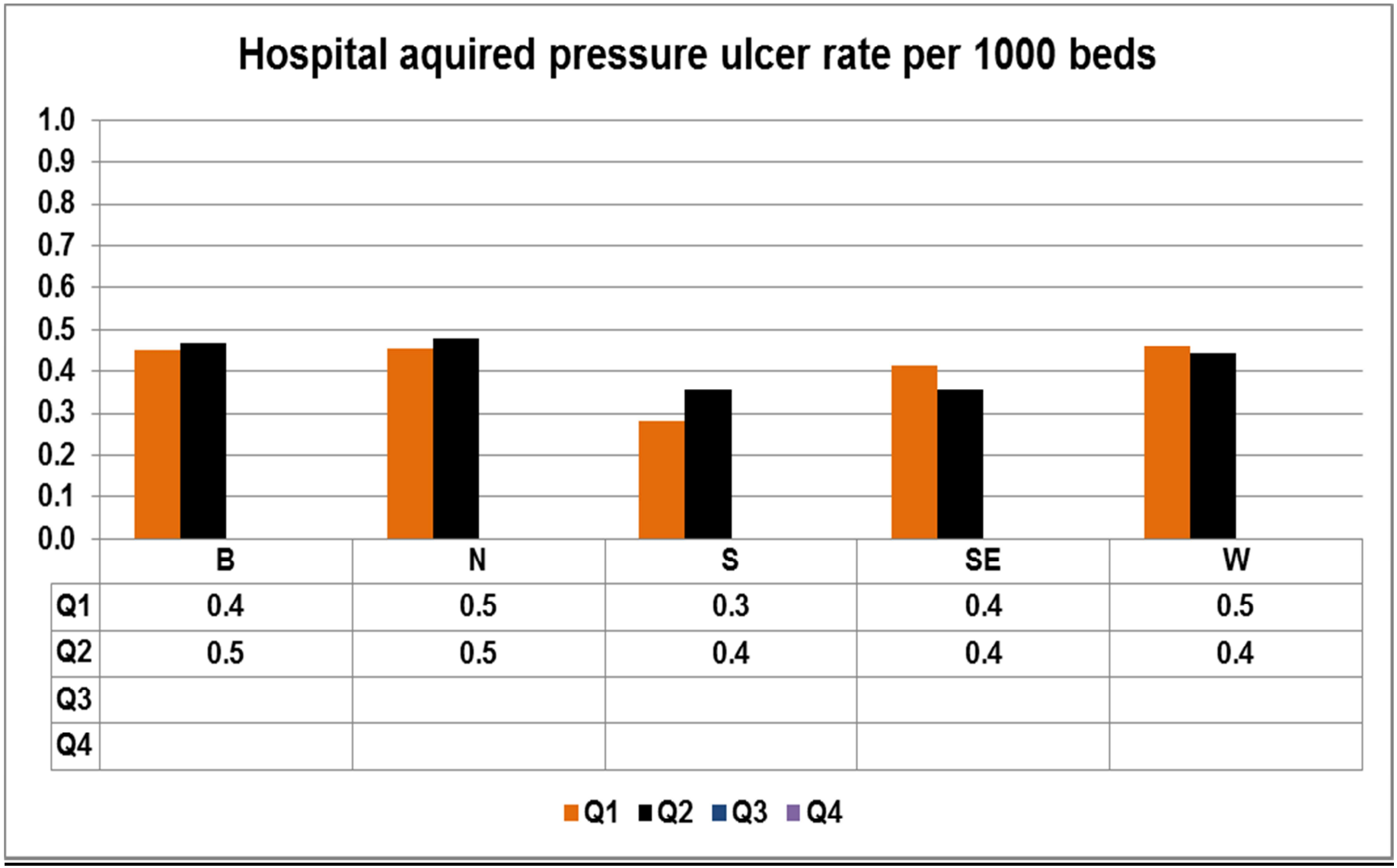
Pressure ulcers (Target) – by March 2015, secure a 10% reduction in pressure ulcers in all adult inpatient wards.



Trust	Pressure Ulcers - 10% reduction by March 2015			
	Profile Reduction (Q2)	Actual (Q2)	Variance (Actual vs profile)	% Variance (Actual vs profile)
Belfast	121	154	33	27%
Northern	52	71	20	38%
South Eastern	53	58	5	9%
Southern	29	42	14	47%
Western	82	63	-19	-23%
Region	336	**388**	**52**	**15%**

The Trusts have reached 100% compliance with rolling out the implementation of the Skin Bundle across all hospital inpatient wards (at the end of March 2014) which is aimed at reducing pressure ulcers and increasing staff awareness of the factors that lead to pressure ulcers. Trusts are committed to keep pressure ulcer prevention as a priority as part of their Quality Improvement Plans. The initial increase in the incidence of pressure ulcers is an expected outcome of the spread and increase in awareness.

At the end of quarter two, there have been 388 instances of pressure ulcers in adult inpatient wards against a reduction profile of 331 cases. This may result in achieving a target challenging, especially for those trusts who have achieved spread of the SKIN bundle in recent months. Data reported to DHSSPS has been caveated with this information



	B	N	S	SE	W
Q1	0.4	0.5	0.3	0.4	0.5
Q2	0.5	0.5	0.4	0.4	0.4
Q3					
Q4					

Analysis of Results from Prevention of Pressure Ulcer Feedback

Whilst some pressures ulcers are unavoidable, many are preventable. The SKIN Bundle is an evidence based collection of interventions proven to prevent pressure ulcers. PHA supports HSC Trusts through The Regional Prevention of Pressure Ulcer Quality Improvement Collaborative to Implement SKIN in all Hospitals in Northern Ireland

The indicator required the Trusts to have spread the SKIN Bundle to all adult inpatient areas by March 2015, to date all 5 Trusts have achieved this.

The SKIN Care Bundle is a powerful tool as it defines and ties best practices together. The bundle also makes the actual process of preventing pressure ulcers visible to all. This minimises variation in care practices. A process is a series of actions which are required in order to achieve a desired outcome (such as a reduction in the number of pressure ulcers). Reliably delivering all elements of the care bundle at every care opportunity, will improve the pressure area care that a person receives. This will have impact on improving care outcomes. The four elements of the SKIN bundle are:

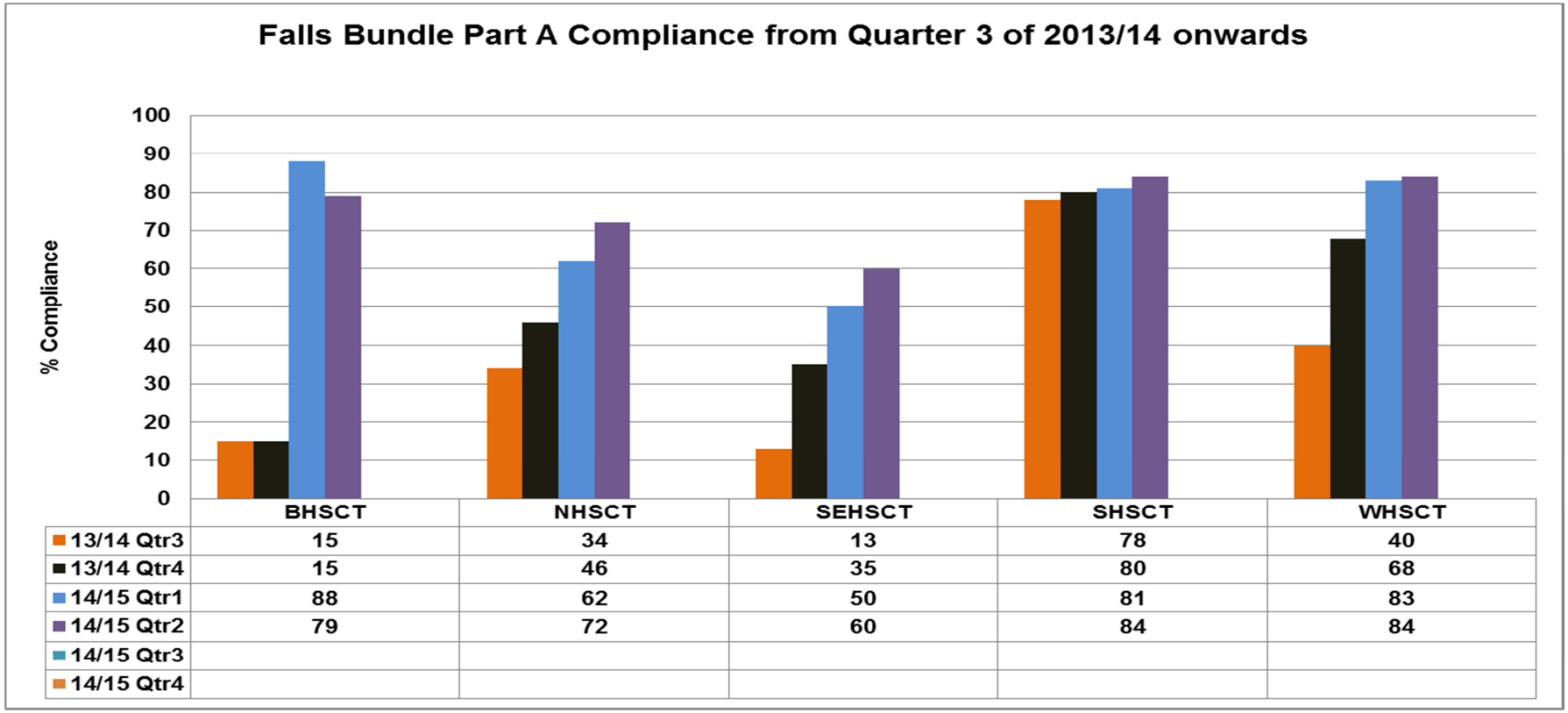
- Surface.
- Keep Moving
- Incontinence
- Nutrition

This has provided a challenge for achieving the pressure ulcer compliance due to the rapid spread of the initiative over the past year, and requires some time to ensure the practice is embedded in the new inpatients area where the bundle has been spread. All Trusts are achieving between 84% to 98% compliance with the bundle.

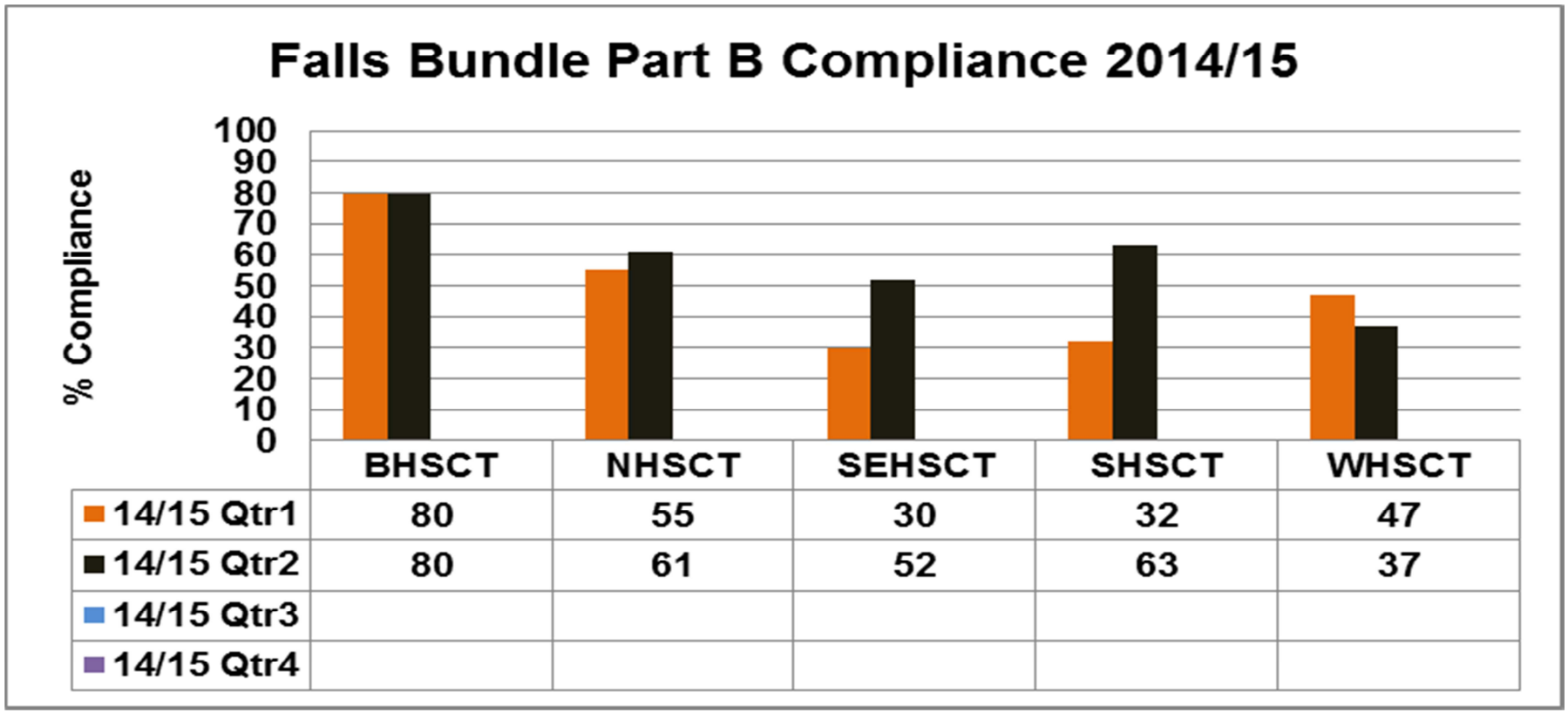
For 2014/15 the following target was set ‘by March 2015 trust will secure a 10% reduction in pressure ulcers’. There has been challenge in relation to achieving this looking at the projected target. At the end of quarter two, there have been 388 instances of pressure ulcers in adult inpatient wards against a reduction profile of 331 cases. Trusts are committed to keep pressure ulcer prevention as a priority as part of their Quality Improvement Plans. The initial increase in the incidence of pressure ulcers is an expected outcome of the spread and increase in awareness. It is unlikely at this stage that Trust will achieve the 10% reduction.

Prevention of Harm from Falls in Hospitals

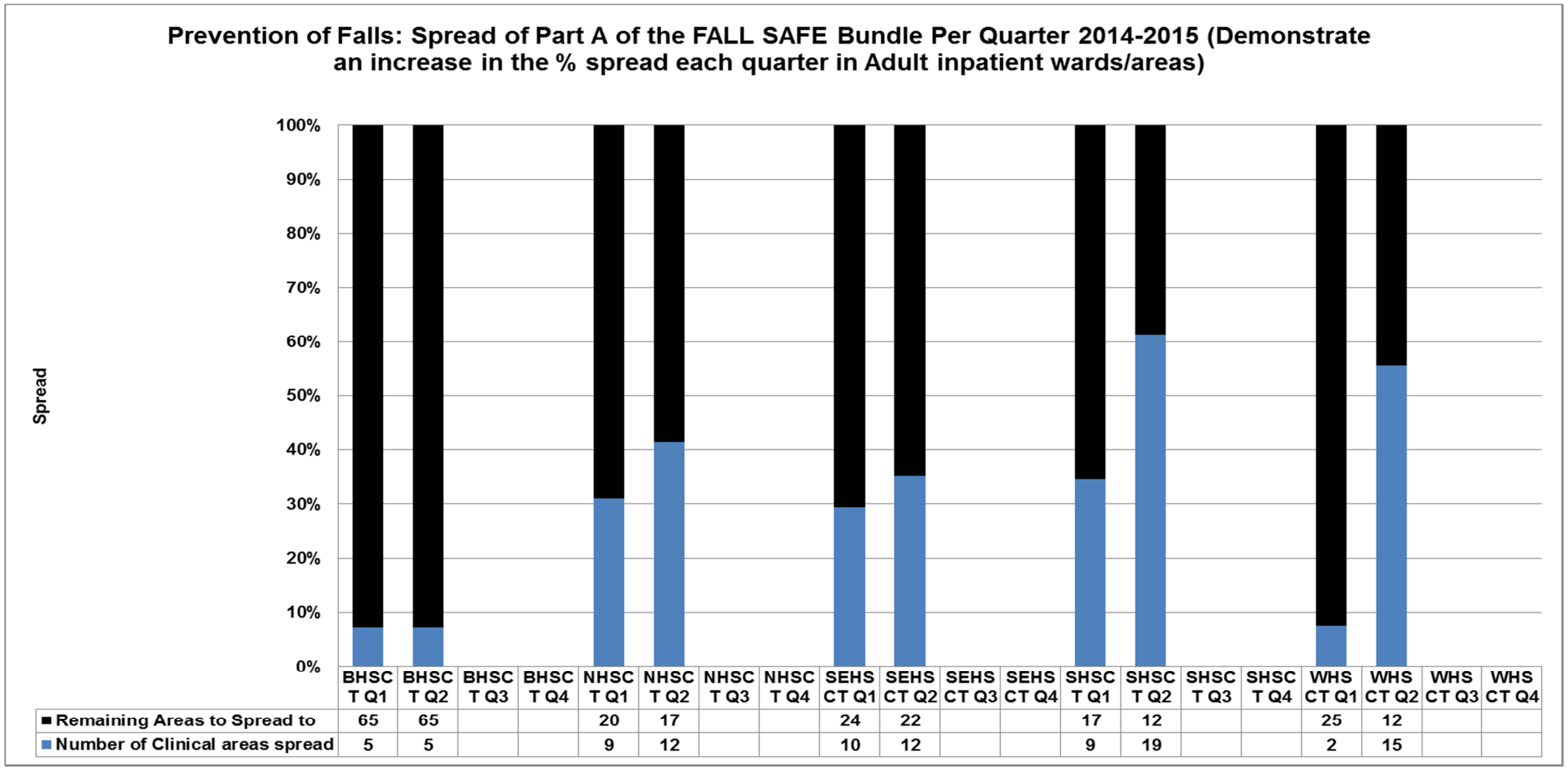
Commissioning Plan Indicator of Performance description: The total number of patient falls (i.e. forms) in hospital, and those resulting in harm with severity of moderate and above, across all programmes of care.
2014-2015 Commissioning Plan requirement - Trusts will continue in pilot areas to improve compliance with Part B of the 'Fallsafe' Bundle. Trusts will spread Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented.

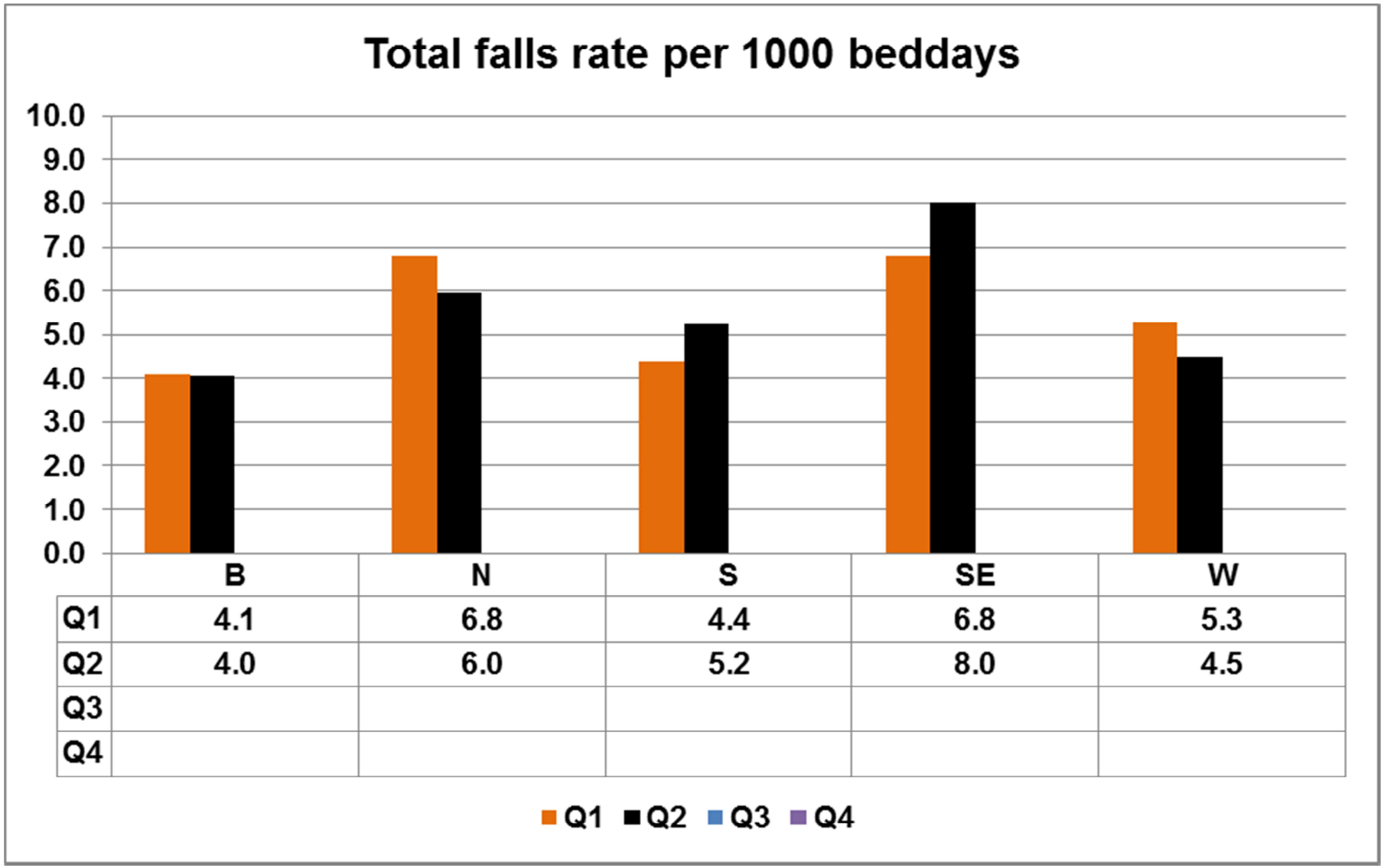


	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
13/14 Qtr3	15	34	13	78	40
13/14 Qtr4	15	46	35	80	68
14/15 Qtr1	88	62	50	81	83
14/15 Qtr2	79	72	60	84	84
14/15 Qtr3					
14/15 Qtr4					

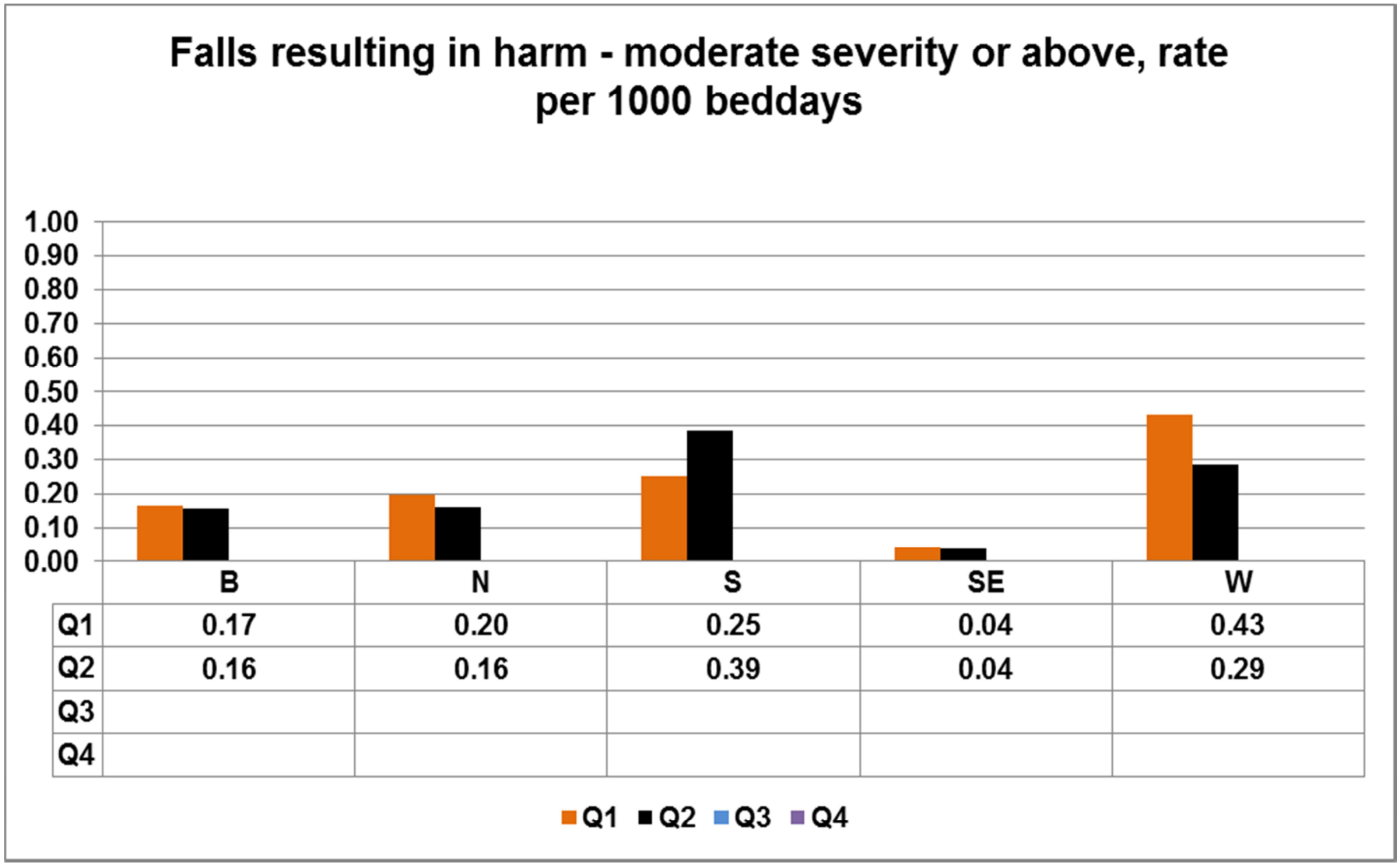


	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
14/15 Qtr1	80	55	30	32	47
14/15 Qtr2	80	61	52	63	37
14/15 Qtr3					
14/15 Qtr4					


Prevention of Falls: Spread of Part A of the FALL SAFE Bundle Per Quarter 2014-2015 (Demonstrate an increase in the % spread each quarter in Adult inpatient wards/areas)
Spread
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
BHSCT Q1 BHSCT Q2 BHSCT Q3 BHSCT Q4 NHSCT Q1 NHSCT Q2 NHSCT Q3 NHSCT Q4 SEHSCT Q1 SEHSCT Q2 SEHSCT Q3 SEHSCT Q4 SHSCT Q1 SHSCT Q2 SHSCT Q3 SHSCT Q4 WHSCT Q1 WHSCT Q2 WHSCT Q3 WHSCT Q4
Remaining Areas to Spread to 65 65 20 17 24 22 17 12 25 12
Number of Clinical areas spread 5 5 9 12 10 12 9 19 2 15



	B	N	S	SE	W
Q1	4.1	6.8	4.4	6.8	5.3
Q2	4.0	6.0	5.2	8.0	4.5
Q3					
Q4					



	B	N	S	SE	W
Q1	0.17	0.20	0.25	0.04	0.43
Q2	0.16	0.16	0.39	0.04	0.29
Q3					
Q4					

Analysis of Results from Prevention of Falls

There is evidence that falls are a significant cause of harm to patients in receipt of health and social care in Northern Ireland. Falls are among the top five (5) most frequent adverse incidents reported within Health and Social Care (HSC) Trusts All falls cannot be prevented without unacceptable restrictions to patients' independence, dignity and privacy. Research has shown that falls can be reduced by 20-30% through multifactorial assessments and interventions.

The PHA leads a project to implement The Royal College of Physicians 'Fallsafe' bundle in hospitals in Northern Ireland. This is an evidence based bundle of interventions for falls reduction.

For 2014-2015 the Commissioning Plan requirement is 'Trusts will continue in pilot areas to improve compliance with Part B of the 'Fallsafe' Bundle. Trusts will spread Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented'. The PHA is required to monitor this supported by the HSCB.

The compliance with Part A of the bundle from April to October 2014 has improved, with Trusts now achieving between 60-84% compliance with the agreed 7 elements of part A of the bundle.

- Asked about a history of falling in the past 12 months
- Asked about a fear of falling
- Urinalysis performed
- Call bell in sight and reach
- Safe footwear on feet
- Personal items within reach
- No slips or trips hazards

Four elements of Part B of the Bundle have been introduced in 2014/15 to pilot areas, in addition to Part A of the bundle.

- Cognitive Screening
- Lying and Standing Blood Pressure
- Full Medication Review
- Bedrails Risk Assessment

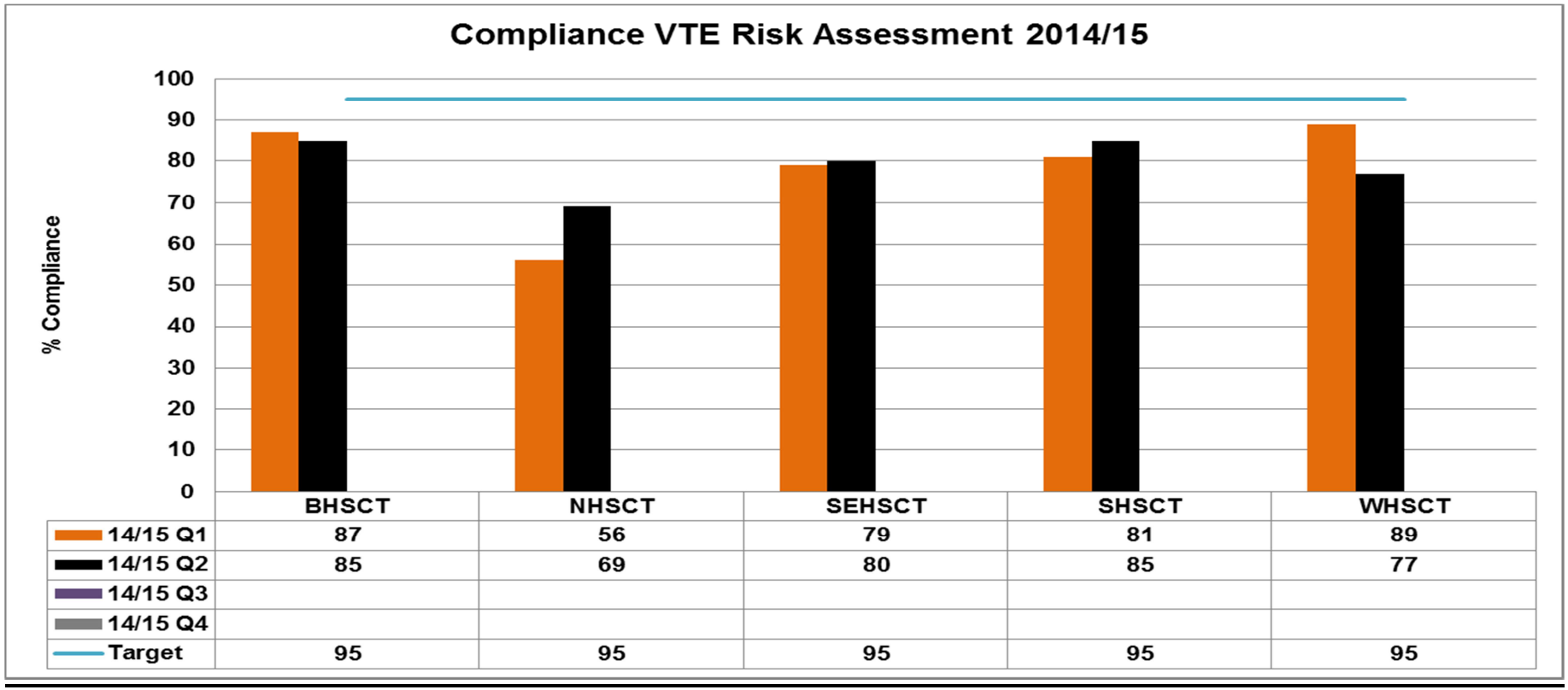
The compliance with these four elements is between 37% and 80%.

The spread of Part A of the Fall Safe bundle demonstrates an increase in the % spread each quarter in all Trusts with the exception of the BHSCT; however they have a spread plan in place and have made the relevant preparations to increase spread further for quarter 3 and 4.

The total number of patient falls (i.e. forms) in hospital, and those resulting in harm with severity of moderate and above, across all programmes of care, are calculated based on the rates per 1000 bed-days and are reported to the DHSSPS as an indicator of performance.

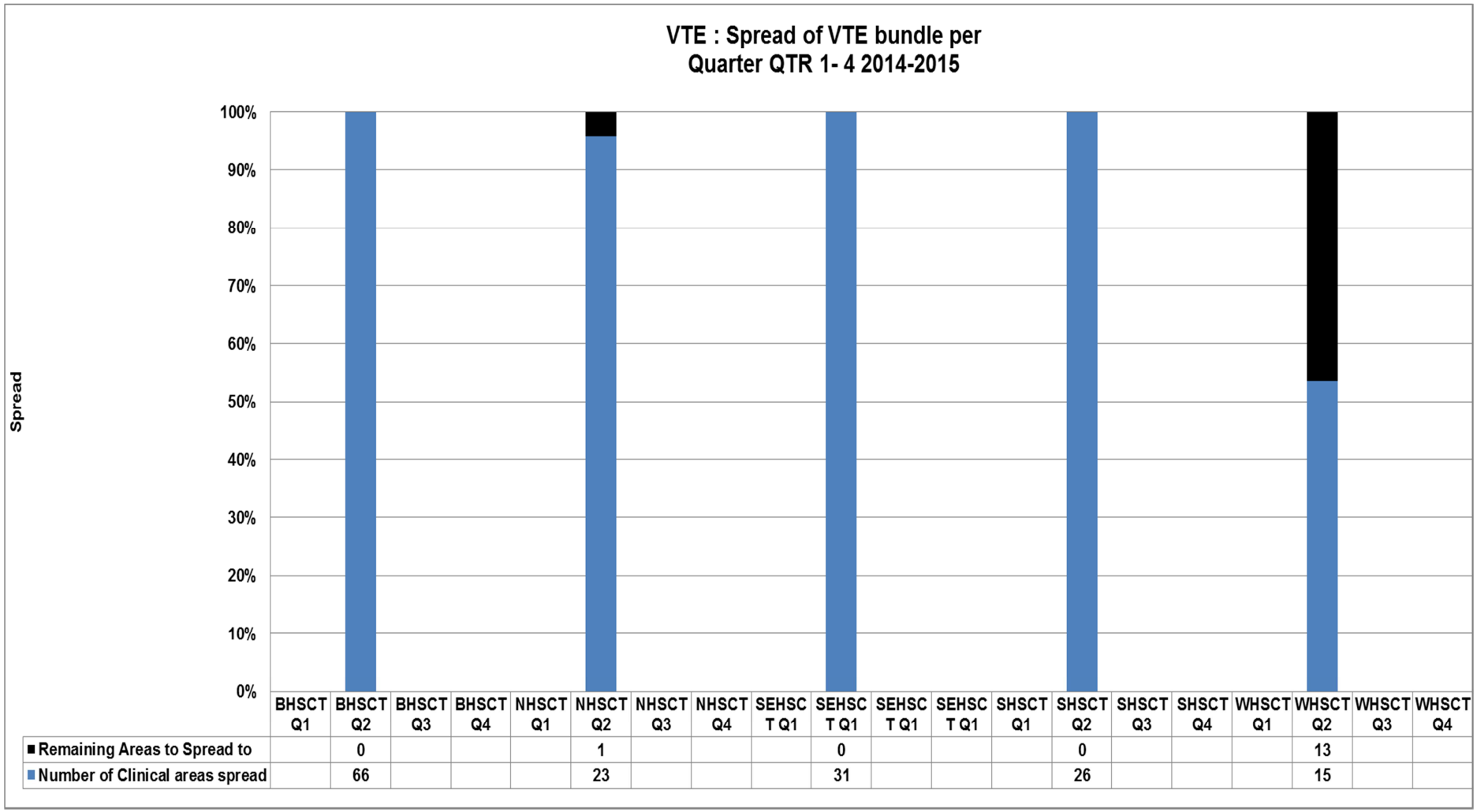
Preventing Harm from VTE

2014-2015 Commissioning Plan requirement - Trusts will achieve 95% compliance with VTE risk assessment across all inpatient hospital wards by March 2015.



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
14/15 Q1	87	56	79	81	89
14/15 Q2	85	69	80	85	77
14/15 Q3					
14/15 Q4					
Target	95	95	95	95	95

The following chart below shows the spread of VTE bundle:



Analysis of Preventing Harm from VTE

VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance has been endorsed by DHSSPS and implemented in Northern Ireland. Assessing the risks of VTE and bleeding is a key priority for implementation of the guidelines.

The 2014-2015 Commissioning Plan requirement is that 'Trusts will achieve 95% compliance with VTE risk assessment across all inpatient hospital wards by March 2015'.

The number of risk assessments completed between April 2014 - October 2014 has increased regionally. All Trusts, across the region demonstrate a closing of the gap between minimum and maximum results. Trusts reported they found it a significant challenge in achieving compliance with the risk assessment for VTE but all are committed towards achieving improvement.

Four out of five Trusts have spread the VTE bundle to 100% of their inpatients wards, with the WHSCT reported that this has been a significant challenge; however the Medical Director is working with colleagues towards the achievement of this indicator. The WHSCT is currently reporting 54% spread to inpatient areas.

Sepsis6

It is estimated that around 37,000 people die of Sepsis in the UK each year. The majority of such deaths are avoidable. The Sepsis6 is a set of interventions which, when delivered promptly by a clinical team are known to significantly improve outcomes for patients with severe sepsis

The Sepsis6 intervention, which should be completed within 1 hour is as follows:

1. Administer high flow oxygen.

2. Take blood cultures

3. Give appropriate antibiotics

4. Give intravenous fluid challenges

5. Measure serum lactate

6. Measure accurate hourly urine output

The commissioning plan requirement for 2014/15 stated that 'the Safety Forum will work with Trusts to implement and spread Quality Improvement in the Early Management of Sepsis (e.g. use of Sepsis6) in medical assessment units (or in other pilot wards by agreement) by March 2015'.

In order to assist Trusts in implementation of the Sepsis6 Care Bundle, the HSC Safety Forum hosted a half day workshop on Severe Sepsis in October 2014. A core team, nominated by their Trust to lead this quality improvement work attended the event. This programme included presentations on severe sepsis, the theory behind the use of the sepsis6 and potential strategies to enhance successful introduction into the designated pilot.

Each Trust has identified at least two clinical areas to pilot the use of the Sepsis6 Care Bundle (outside of the Emergency Department or any other clinical areas where the bundle had already been piloted). Following the workshop, Trusts have also agreed a set of actions to take forward their quality improvement work (available on request).

In order to monitor progress and to show that change is leading to an improvement, it has been agreed with the Trust teams that each pilot area will supply data on Sepsis6 Bundle compliance. Data will be reported to the HSC Safety Forum on a monthly basis, from December 2014 - April 2015.

Communication tools have been developed and shared with Trust teams to assist with the implementation of the Bundle.

The HSC Safety Forum will bring teams together for a follow-up event in Spring, 2015. This will provide a platform for Trusts to share their experiences in the implementation of the Sepsis6 Care Bundle and the opportunity to review bundle compliance over the initial 6 month implementation period.

Appendix one

Commissioning Plan Indicator	Process Measure	Outcome Measure
Pressure Ulcers Whilst some pressures ulcers are unavoidable, many are preventable. The SKIN Bundle is an evidence based collection of interventions proven to prevent pressure ulcers. PHA supports HSC Trusts through The Regional Prevention of Pressure Ulcer Quality Improvement Collaborative to Implement SKIN in all Hospitals in Northern Ireland **2014/2015** • **Trusts will secure a 10% reduction in pressure ulcers and sustain spread to all adult inpatient areas/wards.** • **Trusts will monitor and provide reports on bundle compliance and the rate of pressure ulcers per 1,000 bed days.**	% Compliance with the SKIN Bundle. .	Number of reported pressure ulcers. Rate of pressure ulcers per 1,000 occupied bed days.

Falls There is evidence that falls are a significant cause of harm to patients in receipt of health and social care in Northern Ireland. Falls are among the top five (5) most frequent adverse incidents reported within Health and Social Care (HSC) Trusts. All falls cannot be prevented without unacceptable restrictions to patients' independence, dignity and privacy. Research has shown that falls can be reduced by 20-30% through multifactorial assessments and interventions. Implementation of The Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls has been agreed. **2014/15** • **Trusts will continue to improve compliance with 'Fallsafe' Bundle Part B in identified pilot clinical areas.** • **Trusts will spread Part A of the 'Fallsafe' bundle and demonstrate an increase each**	Compliance with a Falls Bundle. Part A and Part B in pilot and spread areas.	Number of falls and those coded as moderate severity or above. Rate of falls per 1,000 bed days.

quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented. • **Trusts will monitor and provide reports on bundle compliance, the number of incidents of falls, those which cause moderate or more severe harm and the rate per 1,000 bed days.**		
Preventing Harm from VTE VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance has been endorsed by DHSSPS and implemented in Northern Ireland. Assessing the risks of VTE and bleeding is a key priority for implementation of the guidelines. • **Trusts will achieve 95% compliance with VTE risk assessment across all adult inpatient hospital wards by March 2015**	95% compliance with VTE risk assessment in all clinical areas by March 2015.	As there is no agreed outcome measure, assurance is currently sought on the process measure

Sepsis 6 - Early Management of Sepsis • **HSC Safety Forum will work with Trusts to implement and spread Quality Improvement in the Early Management of Sepsis (e.g. use of the Sepsis6) in medical assessment units (or in other pilot wards by agreement) by March 2015"**		