DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

FRAMEWORK DOCUMENT

Index

1. INTRODUCTION

1.1. The Department has produced this Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

Background

1.2. The reform of the health and social care system in Northern Ireland has its origins in the Review of Public Administration (RPA) which was initiated by the Northern Ireland Executive in June 2002. The purpose of RPA was to review Northern Ireland's system of public administration with a view to putting in place a modern, citizen-centred, accountable and high quality system of public administration.

1.3. The need to reform the health and social care system at the earliest possible opportunity was widely supported. The new design is more streamlined and accountable and aimed at maximising resources for front-line services and ensuring that people have access to high quality health and social care. Another key feature is that public health and wellbeing is put firmly at the centre of the new system, with a greater emphasis on prevention and support for vulnerable people to live independently in the community for as long as possible.

1.4. The Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the Reform Act") provides the legislative framework within which the new health and social care structures operates. It sets out the high level functions of the various health and social care bodies. It also provides the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the

effective delivery of health and social care in Northern Ireland.

Framework Document

1.5. The Health and Social Care (Reform) Act (NI) 2009, Section 5(1), requires the Department of Health, Social Services & Public Safety ('the Department') to produce a 'Framework Document' setting out, in relation to each health and social care body:

i 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;

ii the matters for which the body is responsible;

iii 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

iv the arrangements for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC bodies.

1.6. Section 1 (5) of the Reform Act defines "health and social care bodies" as:

i Regional Health and Social Care Board (known as Health and Social Care Board);

ii Regional Agency for Public Health and Social Well-being (known as Public Health Agency);

iii Regional Business Services Organisation (known as Business Services Organisation);

iv HSC Trusts;

v Special Agencies (i.e. Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency);

vi Patient and Client Council; and

vii Regulation and Quality Improvement Authority

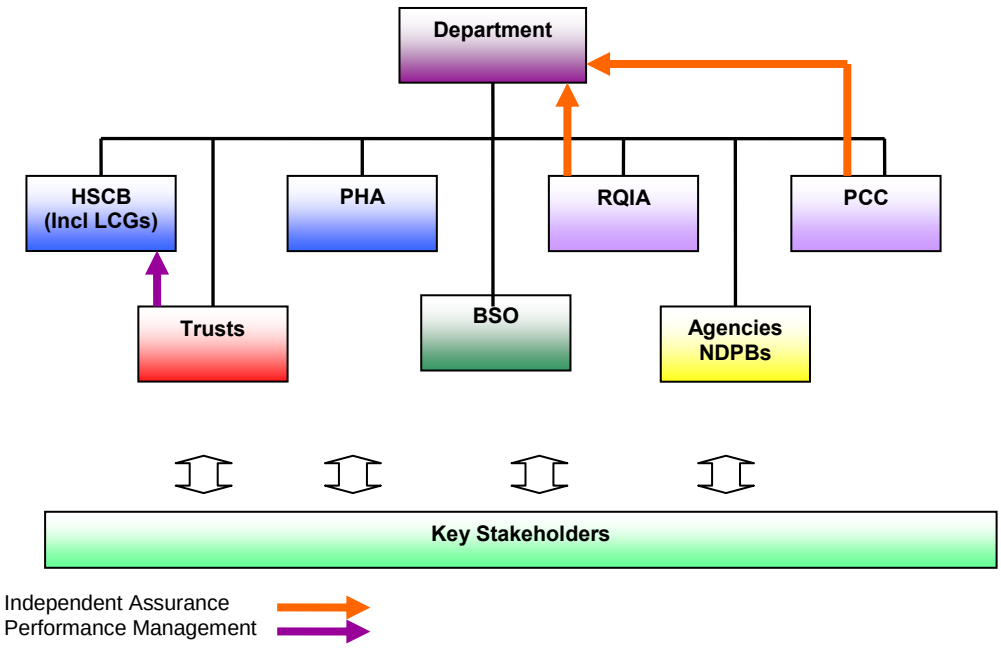
1.7. The focus of the Framework Document is the health and social care system in Northern Ireland and, although not covered by the Reform Act, the Northern Ireland Practice and Education Council and the Northern Ireland Social Care Council are included in the document for completeness. The Northern Ireland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

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

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

2. STRUCTURES, ROLES AND STATUTORY RESPONSIBILITIES

2.1. This section outlines the roles, responsibilities and relationships between the Department and health and social care (HSC) bodies. The diagram below shows the structure of the health and social care system.



Key: HSCB = Health and Social Care Board
LCGs = Local Commissioning Groups
PHA= Public Health Agency
BSO = Business Services Organisation
RQIA = Regulation and Quality Improvement Authority
PCC = Patient and Client Council
Agencies = Special Agencies (Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency)

Department of Health, Social Services & Public Safety

2.2. Section 2 of the Reform Act places on the Department a general duty to promote an integrated system of:

i health care designed to secure improvement:
- in the physical and mental health of people in Northern Ireland, and
- in the prevention, diagnosis and treatment of illness; and

ii social care designed to secure improvement in the social well-being of people in Northern Ireland.

2.3. In terms of service commissioning and provision, the Department discharges this duty primarily by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and to a number of other HSC bodies created to exercise specific functions on its behalf. All these HSC bodies are accountable to the Department which in turn is accountable, through the Minister, to the Assembly for the manner in which this duty is performed.

2.4. In addition, the Department retains the normal authority and responsibilities of a parent Department as regards direction and control of an arm's length body. The main principles, procedures etc are set out in the DFP guidance *Managing Public Money Northern Ireland* and are reflected in each body's management statement/financial memorandum (MSFM), in the letter appointing its chief executive as accounting officer for the body, and in the letters appointing its chair and other non-executive board members. The functioning of the bodies covered by this Framework Document is to be viewed in the context of, and without prejudice to, the Department's overriding authority and overall accountability.

Health & Social Care Board

2.5. The HSCB, which is established as the Regional Health & Social Care Board, under Section 7(1) of the Health & Social Care (Reform) Act

(Northern Ireland) 2009, has a range of functions that can be summarised under three broad headings.

2.6. **Commissioning** – this is the process of securing the provision of health and social care and other related interventions that is organised around a "commissioning cycle" from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need by agreeing with providers the delivery of appropriate services, monitoring delivery to ensure that it meets established safety and quality standards, and evaluating the impact and feeding back into a new baseline position in terms of how needs have changed. The discharge of this function and the HSCB's relationship with the PHA are set out in sections three and four.

2.7. **Performance management and service improvement** – this is a process of developing a culture of continuous improvement in the interests of patients, clients and carers by monitoring health and social care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance through appropriate interventions, service development and, where necessary, the application of sanctions and identifying and promulgating best practice. Working with the PHA, the HSCB has an important role to play in providing professional leadership to the HSC.

2.8. **Resource management** – this is a process of ensuring the best possible use of the resources of the health and social care system, both in terms of quality accessible services for users and value for money for the taxpayer.

2.9. The HSCB is required by the Reform Act to establish five committees, known as Local Commissioning Groups (LCGs), each focusing on the planning and resourcing of health and social care services to meet the needs of its local population. LCGs are co-terminus with the five HSC Trusts.

Public Health Agency

2.10. The PHA, which is established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009 incorporates and builds on the work previously carried out by the Health Promotion Agency, the former Health and Social Services Boards and the Research and Development Office of the former Central Services Agency. Its primary functions can be summarised under three broad headings.

2.11. **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;

2.12. **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;

2.13. **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.

2.14. 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.

Health and Social Care Trusts

2.15. HSC Trusts, which are established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991, are the main providers of health and social care services to the public, as commissioned by the HSCB. There are now six HSC Trusts operating in Northern Ireland:

- Belfast Health and Social Care Trust (covering local council areas of Belfast and Castlereagh);
- South Eastern Health and Social Care Trust (covering local council areas of Newtownards, Down, North Down and Lisburn);
- Northern Health and Social Care Trust (covering local council areas of Coleraine, Moyle, Larne, Antrim, Carrickfergus, Newtownabbey, Ballymoney, Ballymena, Magherafelt and Cookstown);
- Southern Health and Social Care Trust (covering local council areas of Dungannon, Armagh, Craigavon, Banbridge and Newry and Mourne);
- Western Health and Social Care Trust (covering local council areas of Derry, Limavady, Strabane, Omagh, and Fermanagh)
- Northern Ireland Ambulance Service Trust (covering all of Northern Ireland)

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

2.17. Section 21 of the Reform Act places a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

Business Services Organisation

2.18. The BSO, which is established as the Regional Business Services Organisation under Section 14 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, contributes to health and social care in Northern Ireland by taking responsibility for the provision of a range of business support and specialist professional services to other health and social care bodies, as directed by the Department in accordance with Section 15 of the Reform Act.

2.19. The BSO incorporates the majority of services previously provided by Central Services Agency. The BSO, however, provides a broader range of support functions for the health and social care service, bringing together services which are common to bodies or persons engaged in providing health or social care. These include: administrative support, advice and assistance; financial services; human resource, personnel and corporate services; training; estates; information technology and

information management; procurement of goods and services; legal services; internal audit and fraud prevention. Such support services may be provided directly by the BSO or through a third party.

Patient and Client Council

2.20. The PCC, which is established under Section 16 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, is a regional body supported by five local offices operating within the same geographical areas covered by the five HSC Trusts and LCGs. The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers, and communities on health and social care issues through the exercise of the following functions:

- to represent the interests of the public by engaging with the public to obtain their views on services and engaging with Health and Social Care (HSC) organisations to ensure that the needs and expectations of the public are addressed in the planning, commissioning and delivery of health and social care services;
- to promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
- to provide assistance to individuals making or intending to make a complaint relating to health and social care; and
- to promote the provision of advice and information to the public by the HSC about the design, commissioning and delivery of health and social care services.

Regulation and Quality Improvement Authority (RQIA)

2.21. The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Although accountable to the Department, it is an independent health and social care regulatory body, whose functions

include:

i Keeping the Department informed about the provision, availability and quality of health and social care services;

ii Promoting improvement in the quality of health and social car services by, for example, disseminating advice on good practice and standards;

iii Reviewing and reporting on clinical and social care governance in the HSC - the RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, reporting to the Department and the Health and Social Care and making recommendations to take account of good practice and service improvements. Such reviews may be instigated by RQIA or commissioned by the Department;

iv Regulating (registering and inspecting) a wide range of health and social care services. Inspections are based on a new set of minimum care standards which ensures that both the public and service providers know what quality of services is expected. Establishments and agencies regulated by the RQIA include nursing and residential care homes; children's homes; independent hospitals; clinics; nursing agencies; day care settings for adults; residential family centres; adult placement agencies and voluntary adoption agencies. The Reform Act also transferred the functions of the former Mental Health Commission to the RQIA with effect from 1 April 2009. The RQIA now has a specific responsibility for keeping under review the care and treatment of patients and clients with a mental disorder or learning disability.

2.22. The RQIA is also the enforcement authority under the Ionising Radiation and Medical Exposure (Amendment) Regulations (N.I.) 2010 [IRMER] and is one of the four designated National Preventive Mechanisms under the United Nations Optional Protocol for the Convention against Torture [OPCAT] with a responsibility to visit individuals in places of detention and to prevent inhumane or degrading treatment. RQIA also conducts a rolling programme of hygiene inspections in HSC hospitals.

2.23. The Department can ask the RQIA to provide advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. The RQIA may also advise the Department about any changes which it considers should be made in the standards set by the Department.

Special Agencies

2.24. Special Agencies are established under the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 to provide specific functions on behalf of the Department.

2.26. **Northern Ireland Blood Transfusion Service (NIBTS)** - The NIBTS is responsible for the collection, testing and distribution of blood donations each year. The main aim of the NIBTS is to fully supply the needs of all hospitals and clinical units in Northern Ireland with safe and effective blood, blood products and other related services. The discharge of this function includes a commitment to the care and welfare of blood donors.

2.27. **Northern Ireland Medical and Dental Training Agency (NIMDTA)** – The NIMDTA was established to ensure that doctors and dentists are effectively trained to provide the highest standards of patient care. The NIMDTA is responsible for funding, managing and supporting postgraduate medical and dental education. It provides a wide range of functions in the organisation, development and quality assurance of postgraduate medical and dental education and in the delivery and quality assurance of continuing professional development for general, medical and dental practitioners.

2.28. **Northern Ireland Guardian ad Litem Agency (NIGALA)** – The NIGALA is responsible for maintaining a register of Guardians ad Litem who are independent officers of the court experienced in working with

children and families. Under the Children (NI) Order 1995, a Guardian ad Litem is appointed to safeguard the interests of children who are subject to family and adoption court proceedings and to ensure that their feelings and wishes are made clear to the court. The NIGALA also has a pivotal role in ensuring that the Children (Northern Ireland) Order is implemented as intended. The provision of an effective and efficient Guardian ad Litem Service is vital if the Children Order is to operate satisfactorily. It occupies a similar role under the Adoption (Northern Ireland) Order 1987 in that it brings an independence and objectivity to the task of safeguarding the interests of the child.

Non Departmental Public Bodies (NDPBs)

2.29. **The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) -** The NIPEC was established under the Health and Personal Social Services Act (Northern Ireland) 2002 as a non-departmental public body to support the development of nurses and midwives by promoting high standards of practice, education and professional development. The NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.

2.30. **The Northern Ireland Social Care Council (NISCC)** - The NISCC was established under the Health and Personal Social Services Act (Northern Ireland) 2001 as a non-departmental public body to protect the public, specifically those who use social care services, and to promote confidence and competence in the social care workforce. It achieves this aim by registering and regulating the social care workforce, setting and monitoring the standards for professional social work training and promoting training within the broader social care workforce.

Summary of working relationships

2.31. In common with all Arms Length Bodies (ALBs), on issues of

governance and assurance, all the HSC bodies are directly accountable to the Department. Detailed accountability arrangements are set out in section 6 of this Framework Document.

2.32. Article 67 of the Health and Personal Social Services (Northern Ireland) Order 1972 as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009 provides that "In exercising their respective functions, health and social care bodies, district councils, Education and Library Boards and the Northern Ireland Housing Executive shall co-operate with one another in order to secure and advance the health and social welfare of Northern Ireland."

2.33. Under the Reform Act, the Department has an overall duty to promote an integrated system of health and social care designed to improve the health and social well-being of the people in Northern Ireland. All health and social care bodies must work closely and co-operatively with the Department, with each other and with organisations outside the Department, in the manner best calculated to further that overall duty. Whilst this general duty of co-operation is paramount, there are a number of specific areas where co-operative working needs to be highlighted and these are dealt with in the following paragraphs.

2.34. The Department sets the strategic context for the commissioning of health and social care services through a Commissioning Direction to the HSCB. It may also direct the HSCB as to the performance indicators it should employ in improving the performance of HSC Trusts.

The Health and Social Care Board and the Public Health Agency

2.35. Under Section 8 of the Reform Act, the HSCB is required to produce an annual commissioning plan in response to the Commissioning Direction, in full consultation and agreement with the PHA. The form and content of the commissioning plan is directed by the Department in accordance with Section 8 of the Reform Act. This requirement is at the core of the

key working relationship that translates the strategic objectives, priorities and standards set by the Department into a range of high quality, accessible health and social care services and general improvement in public health and wellbeing. In practice, the employees of the HSCB and PHA work in fully integrated teams to support the commissioning process at local and regional levels.

2.36. Developing, securing approval for and implementing the annual commissioning plan and associated Service and Budget Agreements with providers is the responsibility of the HSCB. The HSCB is, however, statutorily required to have regard to advice and information provided by the PHA and cannot publish the plan unless it has been approved by the PHA. In the unlikely event that the HSCB and the PHA cannot agree on the commissioning plan, the matter is referred to the Department for resolution. The HSCB and the PHA must also work together in a fully integrated way to support providers to improve performance and deliver desired outcomes.

2.37. Given the Department's retained responsibilities in areas such as human resources and estate management, strategic planning for health and social services must take place in a spirit of co-operation between the Department, the HSCB, the PHA and other HSC stakeholders, notwithstanding the formal accountability arrangements described elsewhere in this Framework Document.

Health and Social Care Board and HSC Trusts

2.38. Trusts must provide services in response to the commissioning plan, and must meet the standards and targets set by the Minister. Service and Budget Agreements (SBAs) are the administrative vehicle for demonstrating that these obligations will be met. SBAs are established between the HSCB and Trusts setting out the services to be provided and linking volumes and outcomes to cost.

2.39. Working with the PHA as appropriate, the HSCB is responsible for managing and monitoring the achievement by Trusts of agreed objectives and targets, including financial breakeven. At the same time, the HSCB and PHA also work together closely in supporting Trusts to improve performance and achieve the desired outcomes.

2.40. Section 10 of the Reform Act gives the HSCB power, subject to the approval of the Department, to give guidance or direction to a Trust on carrying out a Trust function. Before giving direction, the HSCB is required to consult with the Trust concerned except when the urgency of the matter may preclude consultation. The HSCB must not however give any direction or guidance to a Trust that is inconsistent with this Framework Document or inconsistent with any other direction or guidance already given to the Trust by the Department.

Health and Social Care Board and Family Practitioner Services

2.41. Primary care in general and family practitioner services (FPS) in particular are central to the health and social care system. Family practitioners and those who work with them in extended primary care teams act as the first point of contact and as a gateway to a wider variety of services across the HSC. The HSCB has a key role to play in managing contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy. The HSCB is accountable to the Department for the proper management of FPS budgets.

Business Services Organisation and the Wider HSC

2.42. The role of BSO is to provide support services on behalf of HSC bodies as directed by the Department. The relationships between the BSO and HSC bodies are governed by the development of SLAs between the BSO and the relevant organisation setting out the range, quantity, quality

and costs of the services to be provided. These SLAs will develop in accordance with the phased expansion of the range of services provided by the BSO.

Patient and Client Council and Wider HSC

2.43. In addition to the overall requirement on HSC bodies to co-operate with each other to secure and advance the health and social welfare of Northern Ireland, Section 18 of the Reform Act places a specific duty on certain HSC bodies, as defined in the Act, to co-operate with the PCC in the exercise of its functions. This means that HSC bodies must consult the PCC on matters relevant to the latter's functions and must furnish the PCC with the information necessary for the discharge of its functions. Furthermore, HSC bodies must have regard to advice provided by the PCC about best methods and practices for consulting and involving the public in health and social care matters.

2.44. The PCC's relationship with the other HSC bodies is therefore characterised by, on the one hand, its independence from these bodies in representing the interests and promoting the involvement of the public in health and social care and, on the other, the need to engage with the wider HSC in a positive and constructive manner to ensure that it is able to efficiently and effectively discharge its statutory functions on behalf of patients, clients and carers. It also has considerable influence over the manner in which consultations are conducted by the HSC.

2.45. The PCC's functions do not include a duty to consult on behalf of the HSC. Each HSC body is required to put in place its own arrangements for engagement and consultation.

Regulation and Quality Improvement Authority, the Department and Wider HSC

2.46. The RQIA's relationship with the Department and other HSC bodies is

driven by its independent role in keeping the Department informed about the availability and quality of services, drawing on its regulatory functions, and its wider statutory responsibility to encourage improvement in the quality of services. HSC bodies look to the RQIA for independent validation of their internal arrangements for clinical and social care governance. Examples of RQIA's work in this respect can be seen within its rolling programme of special and thematic reviews within the HSC. The RQIA must also work closely with HSC Trusts in the discharge of its functions relating to regulation of independent sector providers, particularly in terms of safeguarding the interests of vulnerable people.

Special Agencies and the Department

2.47. Special Agencies carry out a range of discrete functions as set out above. Their primary relationship is with the Department, on behalf of which they discharge their functions. The services they deliver are largely in support of the wider health and social care system and they must therefore develop appropriate working relationships with other health and social care bodies.

The Northern Ireland Practice and Education Council, the Department and the HSC

2.48. The NIPEC's primary relationship is with the Department on behalf of which it discharges its functions. NIPEC also works closely with key stakeholders in the HSC system to support registered nurses, midwives and specialist community public health nurses to provide a safe and effective nursing and midwifery service to the population of Northern Ireland.

The Northern Ireland Social Care Council (NISCC), the Department and the Wider HSC

2.49. The NISCC's primary relationship is with the Department, on behalf of which it discharges its functions. The NISCC provides a framework for commissioners and providers to promote consistency in standards of conduct and practice throughout the social care system. The NISCC also works closely with its registrants and other key stakeholders to achieve its aims of raising the quality of social care practice.

3. SETTING THE AGENDA

Establishing the Priorities

3.1. In terms of setting the strategic agenda for the Health and Social Care system, Section 2 of the Reform Act requires the Department to:

i develop policies to secure the improvement of the health and social wellbeing of, and to reduce health inequalities between, people in Northern Ireland;

ii determine priorities and objectives for the provision of health and social care;

iii allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

iv set standards for the provision of health and social care;

v formulate the general policy and principles by reference to which particular functions are to be exercised.

3.2. The Department sets the strategic vision and priorities for Health and Social Care. The strategic vision provides an overarching direction of travel for the HSC that reflects already well-established policies and strategies. The strategic vision underpins the Department's contribution to budget process and Programme for Government (PfG) and, flowing from this, provides the context for the development of an annual Commissioning Direction, Priorities for Action (PfA), Commissioning Plan and Trust Delivery Plans (TDPs).

3.3. The Programme for Government (PfG) and a framework of Public Service Agreements (PSAs) express the Executive's strategic aims and

policies in measurable objectives and targets.

3.4. The Department publishes annually Priorities for Action (PfA), which translates the PfG and other ministerial priorities into an achievable and challenging agenda for Health and Social Care.

3.5. The Department sets out the Minister's instructions to the commissioners in the annual Commissioning Direction under Section 8 (3) of the Reform Act. This reflects the priorities in the PfA as revised annually, and the relevant standards and obligations that apply every year. Hence this makes clear the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

3.6. Every year the HSCB is responsible for producing a commissioning plan in full consultation and with the approval of the PHA. The plan must outline how they plan to deliver on the key priorities standards or targets set in PfA. This plan provides the framework for each HSC Trust to develop its annual Trust Delivery Plan (TDP) detailing the Trust's response to the annual commissioning priorities and targets set out in the commissioning plan.

Allocating the resources

3.7. Section 2 of the Reform Act requires the Department to allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way.

3.8. Resources available to the Northern Ireland Block are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. This sets the overall Departmental Expenditure Limit (DEL) for Northern Ireland. The funding levels are normally set for three or more financial years and may be reviewed every two years or so. Within the constraints of the NI DEL, gross spending power available to the Executive can be increased, currently

through revenue generated from the Regional Rate and borrowing power within the Reinvestment and Reform Initiative. Within the overall Block limits set by Treasury (i.e the NI DEL), the NI Executive establishes, in the light of local priorities, the three or four year resource allocations for all NI Departments, which cover both current expenditure and capital investment. The PfG specifies the Executive's plans and priorities for the years covered by the relevant budget period, while a separate Investment Strategy establishes capital priorities over a 10-year period.

3.9. It is the Department's responsibility to secure, as part of the Budget process, resources that enable the health and social care system to satisfy the population's need for high quality, accessible services.

3.10. In allocating current expenditure to HSC bodies, the Department must strike a balance between facilitating full and timely deployment of resources to the frontline and the need to ensure that appropriate control of funds is retained centrally by the Department. The aim is to channel the maximum resources to the point of service delivery at the earliest possible stage, with appropriate controls in place to ensure that they are deployed in accordance with Government priorities.

3.11. A Capitation Formula informs the Department (and, in turn, the HSCB) as to the most fair and equitable allocation of revenue funding for LCG areas. It does this by taking into account the number of people living within an area, with suitable adjustments relating to the age, sex and additional needs (largely due to deprivation) of the populations in question. The HSCB is required annually to provide the Department with an assessment of equity gaps, including the potential for re-distribution of resources across LCG populations and to demonstrate that resources have in fact benefited the populations for which they were intended. Allocation of capital expenditure to HSC Trusts is managed by the Department, with input from commissioners on the associated current expenditure funding required. The capital allocation and reporting process in described in more detail later in this section.

Funding the Health and Social Care Board and the Public Health Agency

3.12. The HSCB is responsible and accountable for commissioning of services, resource allocation and performance management, whilst the primary objective of PHA is to protect and improve the health and social well-being of the Northern Ireland population.

3.13. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. Each organisation holds the administrative and programme resources appropriate to their respective roles and responsibilities. Where such resources are deployed outside the context of the commissioning plan, the HSCB and the PHA submit, for Departmental approval, separate business plans in respect of those resources.

3.14. The following principles apply in relation to the funding arrangements for the HSCB and the PHA:

i Each of the bodies receives the bulk of its funding directly from the Department and each organisation remains separately accountable for all of the funds allocated to it;

ii In accordance with the detailed commissioning arrangements set out in section four, the funds allocated to the HSCB are:

- Committed to secure the provision of health and social care services for local populations from the six HSC Trusts, Family Health Services and other providers, consistent with the approved Commissioning Plan; and
- used for staffing, goods and services associated with the discharge of its functions;

iii The PHA directly funds initiatives related to its core roles of health improvement, screening or health protection activity, partnership working with local government, staffing and goods and services. Plans for use of the PHA's funding are incorporated within the Commissioning Plan, developed by the HSCB in consultation with and the agreement of the PHA. Similarly, services commissioned by the PHA from HSC Trusts and independent practitioners are reflected the Commissioning Plan as appropriate. Whilst the payment of funds for these services is administered by the HSCB on behalf of the PHA through the Service and Budget Agreements with HSC Trusts, the PHA remains accountable to the Department for the deployment of the resources. In the case of services commissioned from Family Health Service contractors, such as GPs, the HSCB takes primary responsibility for contract management, taking input from the PHA as appropriate.

Funding the Patient and Client Council

3.15. The Department directly meets the operating costs of the Patient and Client Council (PCC) to ensure that it operates independently from the service. The PCC produces, for Departmental approval, an annual business plan demonstrating how these resources will be used.

Funding the Business Services Organisation

3.16. Funding for the Business Services Organisation's (BSO) operating costs will flow through Service and Budget Agreements (SBAs) with its customers, the other HSC bodies. The SBAs determine the range, quality and costs of services to be provided. Movement towards the position of the BSO as an organisation fully financed from its service agreements with customers is being staged over a transitional period from April 2009.

3.17. The Health and Social Care (Reform) Act requires BSO to ensure that the arrangements which it puts in place for securing support services for its customers are the most economic, efficient and effective way of providing such services. It is required to have these arrangements approved by the Department before they are put in place. The Department approves the BSO's annual corporate business plan.

Funding Health and Social Care Trusts

3.18. HSC Trusts access funds by means of Service and Budget Agreements (SBAs) with their commissioners. Trusts are required to submit annual delivery plans (TDPs) to the HSCB for approval. TDPs must address both the content of the agreed SBAs with commissioners and the wider range of other corporate responsibilities. The HSCB provides assurance to the Department about the service and financial viability of TDPs.

Funding the Regulation and Quality Improvement Authority

3.19. The RQIA is funded directly by the Department on the basis of the priorities and objectives set out in its annual business plan and 3- year corporate strategy, which are approved by the Department. RQIA generates the balance of income through statutory fee charges for regulation of establishments and agencies.

Funding the Northern Ireland Guardian ad Litem Agency

3.20. NIGALA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Medical and Dental Training Agency

3.21. NIMDTA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is

approved by the Department.

Funding the Northern Ireland Blood Transfusion Service

3.22. Resources are allocated initially to the HSCB and are then channelled to Trusts through their Service and Budget Agreements (SBAs). NIBTS accesses the funds through the SBAs it has with Trusts for its services.

Funding the Northern Ireland Practice and Education Council

3.23. The NIPEC is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Social Care Council

3.24. The NISCC is funded substantially by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department. It also receives income from registration fees, Skills for Care and Development and in respect of student placements in the criminal justice sector (funded by the Department of Justice).

The Capital Allocation and Reporting Process

3.25. The strategic capital planning function, together with responsibility for overseeing procurement and performance management of capital programme delivery, rests with the Department. The Investment Strategy for Northern Ireland (ISNI), managed by the Strategic Investment Board (SIB) in conjunction with OFMDFM provides an indicative 10-year funding envelope for the Department. The Department contributes to the development of the ISNI, which is approved by the NI Executive.

3.26. Resources available to the Northern Ireland are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. The NI Executive establishes, on the basis of its own priorities, the spending plans for all NI departments. In parallel, the Executive's infrastructure plans are set out in a separate 10-year Investment Strategy for Northern Ireland. The current Strategy covers the period 2008-2018.

3.27. To inform ministerial decisions on capital allocation, the Department conducts a biennial Capital Priorities Review, with input from a Policy Infrastructure Forum comprising representatives from the Department, the HSCB and the PHA. A 10-year rolling capital plan is produced as the output of these regular reviews.

3.28. The HSCB and the PHA are responsible for identifying and quantifying the services required to meet assessed needs and for commissioner endorsement of the associated current expenditure costs subject to considerations of affordability.

3.29. The Trusts and the HSCB (for ICT), are responsible for preparing and obtaining approval for business cases for the capital requirements needed to deliver the service. These business cases must have commissioner support before approval.

3.30. The Department has overall responsibility for the capital investment programme and also acts as a Centre of Specialist Expertise (COSE) and a Centre of Procurement Expertise (COPE) for capital infrastructure and undertakes a performance management role in relation to the estate.

3.31. The HSCB, taking account of professional advice from the PHA, is responsible for confirming the appropriate models of care to deliver health and social care across Northern Ireland and the associated indicative infrastructure requirements.

3.32. BSO is the responsible Centre of Procurement Expertise for the procurement of services, supplies and IT equipment.

4. COMMISSIONING

Introduction

4.1. The purpose of HSC commissioning is to improve and protect the health and social well-being of the people of Northern Ireland and reduce differences in access to good health and quality of life. Commissioning aims to achieve a progressive improvement in services through investment based on evidence of effectiveness, compliance with quality and efficiency standards and a focus on addressing the determinants of poor health and wellbeing. The involvement of patients, clients, carers and communities and engagement with other partners has a central role in the commissioning process.

4.2. The Department sets the policy and legislative context for health and social care in Northern Ireland. It also determines the standards and targets by which quality, access and outcomes should be measured and provides the strategic direction for the health and social care professions. The commissioning process, which includes resource and performance management and is led by the HSCB, translates the agenda set by the Department into a comprehensive, integrated commissioning plan for health and social care services. Commissioning must maintain a strong focus on identifying and prioritising the needs of patients, clients, carers and communities. In doing so, it is the driver for continuous service improvement and provides assurance that resources are delivering the maximum benefits for users and taxpayers alike. In management terms, the separation of commissioners and providers is designed to promote a patient and client-centred system.

The Commissioning Cycle

4.3. Commissioning includes the following activities:

i Assessing the health and social well-being needs of groups,

populations and communities of interest;

ii Prioritising needs within available resources;

iii Building the capacity of the population to improve their own health and social well-being by partnership working on the determinants of health and social well-being in local areas;

iv Engaging with patients/clients/carers/families and other key stakeholders and service providers at local level in planning health and social care services to meet current and emerging needs;

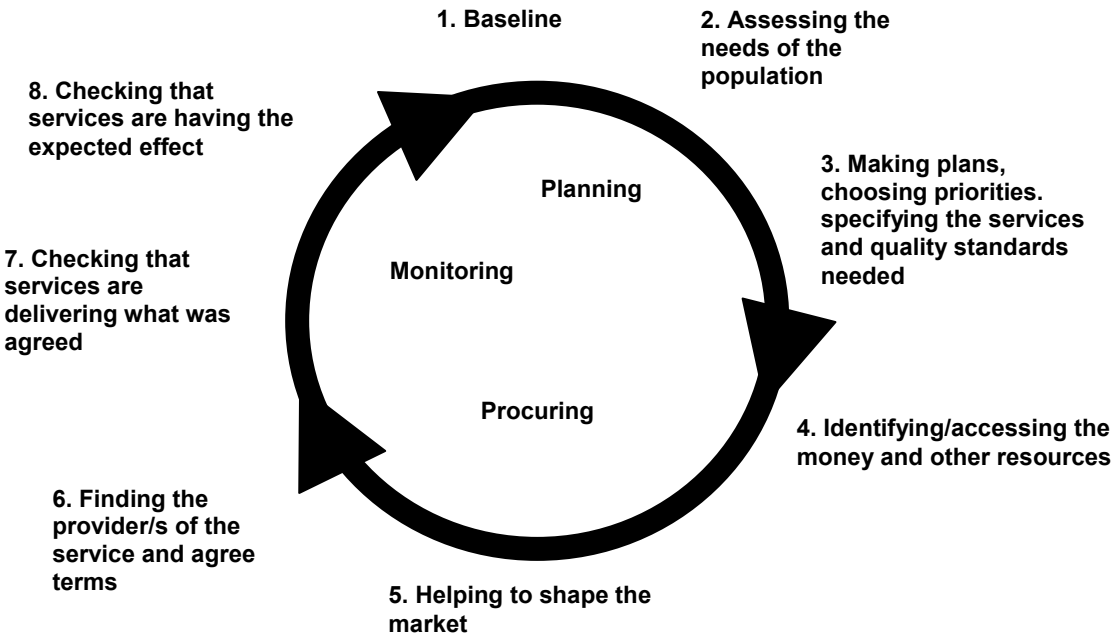
v Securing, through Service and Budget Agreements, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;

vi Safeguarding the vulnerable; and

vii Using investment, performance management and other initiatives to develop and reform services.

4.4. In the context of the integrated health and social care system in Northern Ireland, commissioning should be seen as an 'end to end' process. It organises activities around a commissioning cycle that moves through from assessing needs, strategic planning, priority setting, securing resources to address needs, agreeing with providers the delivery of appropriate services, monitoring that delivery, evaluating impact and feeding back that assessment into the new baseline position in terms of how needs have changed. Throughout the cycle, the HSCB and its LCGs engage with stakeholders, including service providers, at regional and local level.

4.5. Commissioners will facilitate a more integrated provider system by managing the interfaces between providers (statutory, independent and voluntary), developing provider networks and acting as 'guardians' of the care pathway.



The Commissioning Plan Direction

4.6. In exercising the powers conferred on it by Section 8 (3) of the Reform Act, the Department sets out the Minister's instructions to commissioners in an annual commissioning plan direction. The commissioning plan direction sets the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

The Commissioning Plan

4.7. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. The commissioning direction specifies the form and content of the commissioning plan in terms of the services to be commissioned and the resources to be deployed. The plan may not be published unless approved by the PHA. In the unlikely event of failure to agree the commissioning plan, the matter is referred to the Department for resolution.

Local Commissioning

4.8. The reformed system of commissioning introduced from 1 April 2009 established five geographically based Local Commissioning Groups (LCGs) that are co-terminus with the boundaries of the five Health and Social Care Trusts. The status of LCGs as committees of the HSCB is established in primary legislation.

4.9. LCGs have a lead role in the strategic commissioning process, in particular, having helped to shape strategic thinking, to apply it locally on behalf of their populations. They have responsibility for assessing health and social care needs in their areas, planning to meet current and emerging needs and securing the delivery of a comprehensive range of services to meet the needs of their populations. They have full delegated authority to discharge these responsibilities, including a significant ability to direct resources. The capitation formula identifies funds for the populations of each LCG area, and the HSCB is accountable for ensuring that they are used for that purpose. LCGs identify local priorities taking account of the views of patients, clients, carers, wider communities and service providers. They forge partnerships and involve a range of stakeholders in designing and reshaping services to better meet the needs of their local communities. The resources for each LCG population may be used to secure services for that population from any appropriate provider.

4.10. For the most part, the HSCB's Commissioning Plan reflects the decisions and recommendations of the LCGs in relation to the use of the capitation-based shares of the budget for their populations at local level. However, it is recognised that some services, by virtue of their specialist nature, restricted volume or statutory accountability, must be commissioned collaboratively on a regional basis, and hence the LCGs' decisions and recommendation will include contributions to the commissioning of regional services. The HSCB is responsible for establishing appropriate mechanisms for this process, which will ensure

that fair shares from the capitation-based budgets are committed to regionally commissioned services.

4.11. As committees of the HSCB, LCGs work within strategic priorities set by the Department, the HSCB, regional policy frameworks, available resources and performance targets. Section 9 (4) of the Reform Act requires LCGs to work in collaboration with the PHA and have due regard to any advice or information provided by it. To ensure a joint approach to commissioning, LCGs are supported by fully integrated, locally based, multi-disciplinary commissioning support teams made up of staff from the PHA and HSCB. Professional staff from both the HSCB and PHA are included in the membership of LCGs.

4.12. Each year the HSCB determines, in consultation with LCGs, the range of services to be commissioned locally and regionally and identifies the budgets from which such services are to be commissioned. LCGs prepare local commissioning plans, in keeping with the priorities and objectives of the HSCB. LCG commissioning plans are incorporated within the overall commissioning plan, which must be approved by the HSCB and the PHA.

Link between Commissioning and Performance Management

4.13. Monitoring performance of providers against the agreements they make in relation to service delivery is a key part of the commissioning cycle, and commissioners continue to ensure that this role remains core to how they work with providers. The HSCB and PHA must maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes.

4.14. The HSCB incorporating its LCGs must have appropriate monitoring arrangements to confirm that commissioned services are delivered, to benchmark comparative performance, and to ensure that quality outcomes, including positive user experience, are delivered.

4.15. Providers must have appropriate monitoring arrangements to ensure that they are meeting the requirements of commissioners and performing efficiently, effectively and economically.

4.16. The Department maintains appropriate monitoring arrangements in relation to the HSCB and the PHA to ensure that resources are used to best effect in the achievement of agreed strategic objectives and targets.

4.17. The HSCB and PHA also work together closely in supporting providers, through professional leadership and management collaboration, to improve performance and achieve desired outcomes. The HSCB is the lead organisation for supporting providers in relation to the delivery of a wide range of health and social care services and outcomes, with support provided by PHA professional staff. PHA is the lead organisation for supporting providers in the areas of health improvement, screening and health protection, with support provided by the performance, commissioning, finance, primary and social care staff of the HSCB.

Procurement by HSC Trusts

4.18. At the present time, it is not practical or desirable for the HSCB to contract directly with the full range of providers involved in the HSC system. The services involved are numerous, diverse, need to be provided flexibly and often need to be arranged at short notice, to meet the needs of individuals. Therefore a wide range of services commissioned by the HSCB are sub-contracted by Trusts to independent sector providers.

5 PERSONAL AND PUBLIC INVOLVEMENT

5.1 Patients, clients, carers and communities must be put at the centre of decision making in health and social care. This means that they must be properly involved in the planning, delivery and evaluation of their services. HSC bodies are accountable to people and communities for the quality, accessibility and responsiveness of the services they plan and provide.

5.2 Section 19 of the Reform Act places a statutory requirement on each organisation involved in the commissioning and delivery of health and social care to provide information about the services for which it is responsible; to gather information about care needs and the efficacy of care; and to support people in accessing that care and maintaining their own health and wellbeing.

5.3 This statutory requirement extends to the development of a consultation scheme, which must set out how the organisation involves and consults with patients, clients, carers and the Patient Client Council (PCC) about the health and social care for which it is responsible. Consultation schemes must be submitted to the Department for approval. The Department may approve a consultation scheme, with or without amendments, after consulting with the PCC.

5.4 Section 20 of the Reform Act specifies the form that consultation schemes should take, but this is supplemented by detailed policy guidelines for the HSC on personal and public involvement and the development and approval of consultation schemes.

Roles in Personal and Public Involvement (PPI)

5.5 In respect of Personal and Public Involvement (PPI), the Reform Act places a specific responsibility on the PCC to promote best practice in

involvement and in the provision of information about health and social care services. HSC bodies are required by the Reform Act to co-operate fully with the PCC in the discharge of these statutory responsibilities. The Department may consult the PCC in respect of specific consultation schemes before approving them.

5.6 The Department sets the policy and standards for Personal and Public Involvement (PPI). Working through the HSCB, the PHA has responsibility for ensuring that Trusts meet their PPI statutory and policy responsibilities and leading the implementation of policy on PPI across the HSC. A PPI Forum, chaired by the PHA and involving representatives from all HSC organisations, has been established for that purpose. This in no way detracts from the individual statutory responsibilities of organisations with regard to PPI.

5.7 The HSCB is responsible for ensuring that its LCGs establish arrangements for effective PPI which will allow the views of stakeholders to inform the development of commissioning plans. The HSCB should also ensure that Family Practitioner Services are meeting the requirements laid down in Departmental guidance on PPI.

5.8 HSC Trusts are responsible for establishing individual organisational governance arrangements, and for implementing their PPI consultation schemes, to meet their statutory duty of involvement, as well as any requirements laid down in Departmental guidance on PPI.

5.9 Special agencies also have responsibilities in respect of PPI. The NI Blood Transfusion Service (NIBTS), the NI Guardian Ad Litem Agency (NIGALA) and the NI Medical and Dental Training Agency (NIMDTA) should establish arrangements to ensure they meet their statutory duty of involvement and any requirements laid down in Departmental guidance. Each of these three special agencies will be accountable directly to the Department for the discharge of these functions.

5.10 The PCC will undertake research and conduct investigations into the most effective methods and practices for involving the public and provide advice on these to HSC organisations. The PCC also has an important challenge role for those HSC bodies prescribed in the Reform Act in respect of PPI, and will accordingly be expected to comment upon and scrutinise the actions and decisions of these bodies as they relate to PPI.

5.11 RQIA will continue to provide independent assurance to the Minister, via the Department, of the effectiveness of PPI structures in HSC organisations by continuing to monitor these as part of its programme of review of clinical and social care governance arrangements against the Quality Standards.

6 HOLDING THE SYSTEM TO ACCOUNT

Introduction

6.1. Ultimate accountability for the exercise of proper control of financial, corporate and clinical and social care governance in the HSC system rests with the Department and the Minister. Within a system of such magnitude and complexity, assurance about the rigour of control mechanisms can only be derived from the development and operation of robust systems and processes at all levels of decision making.

Performance and Assurance Dimensions

6.2. This section of the Framework Document describes the various lines of accountability and how they are exercised at different levels within the HSC system. The key performance and assurance roles and responsibilities are encompassed in the four dimensions of:

i Corporate Control – the arrangements by which the individual HSC bodies direct and control their functions and relate to stakeholders;

ii Safety and Quality – the arrangements for ensuring that health and social care services are safe and effective and meet patients' and clients' needs, including appropriate involvement;

iii Finance – the arrangements for ensuring the financial stability of the HSC system, for ensuring value for money and for ensuring that allocated resources are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework;

iv Operational Performance and Service Improvement – the arrangements for ensuring the delivery of Departmental targets and required service improvements.

Key Principles

6.3. The requirements in relation to performance and assurance roles may differ from body to body but some key principles underpin the overall approach to holding the HSC system to account:

i the Department has ultimate accountability for the effective functioning of the HSC across the four dimensions;

ii the Department will provide clear guidance across each of the four dimensions, specifying outputs and outcomes that are appropriate, affordable and achievable. This guidance will be developed with the involvement of the HSC bodies, consistent with their roles and responsibilities;

iii each HSC body is locally accountable for its organisational performance across the four dimensions and for ensuring that appropriate assurance arrangements are in place. This obligation rests wholly with the body's board of directors. It is the responsibility of boards to manage local performance and to manage emerging issues in the first instance;

iv the standard assurance arrangements and associated information streams within individual HSC organisations will, as far as possible, be used to meet the assurance requirements of the HSCB and PHA, and those of the Department, subject to such additional independent verification as may be deemed necessary;

v the Department, and in turn the HSCB and PHA (where they have a performance and assurance role in relation to one or more of the other bodies), will maintain a relationship with other HSC bodies based on openness and the sharing of information, adopting an informal, supportive approach to clarify and resolve issues as they

arise, and thereby minimising the need for formal intervention.

Corporate Control Dimension

6.4. Corporate control encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the HSC body is fulfilling its essential obligations as a public body. Most of the requirements reflect those in place across the public sector, but a few have been instituted for reasons peculiar to the field of health and social care – notably the statutory duty of quality created by Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003. In addition to that obligation, the controls relate to: the existence of appropriate board roles, structures and capacity; corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance of those processes.

6.5. All HSC bodies shall:

i adhere to the terms of the Accounting Officer appointment letter issued by the Department. This letter specifies the governance responsibilities and duties which the body owes to the Departmental Accounting Officer;

ii comply, in full, with the control framework requirements set out in the Management Statement/Financial Memorandum issued by the Department, in a form agreed by the Department of Finance and Personnel;

iii submit to the Department an annual Statement on Internal Control, signed by the Accounting Officer of the body, covering the range of issues in the standard form prescribed by the Department of Finance and Personnel, augmented by the additional health and social care-specific requirements set by the Department;

iv submit to the Department a mid-year assurance statement on control issues covering the same areas as the annual Statement on Internal Control;

v report as required on compliance with controls assurance and quality standards set by the Department including compliance with the Department's requirements for implementation of a risk management strategy and evidence that guidance on an assurance framework is being followed;

vi ensure that the appointment processes carried out by the body are demonstrably independent and free from external conflicts of interest;

vii adopt an Assurance Framework to strengthen board-level control and assurance in general, the Statement on Internal Control, and the mid-year assurance statement;

viii operate a board-approved scheme of delegated decision-making within the body based on systems of good practice updated by the Department;

ix ensure compliance with accepted or prescribed standards of public administration set by the Department – for example, in relation to equality of opportunity, equality legislation, complaints, etc;

x ensure compliance with the checklist of actions required of sponsor branches in the Department in obtaining assurance from their respective body's covering: roles and responsibilities; business planning and risk management; governance; and internal audit;

xi ensure compliance with procurement policy securing value for money, economically advantageous outcomes, equality of opportunity, sustainable development, etc., in accordance with the

policy framework set by the Executive and the Department of Finance and Personnel, key performance indicators set by the Department, the procurement strategy led by Regional Procurement Group (supported by BSO) and procurement under the Department's Infrastructure Strategy;

xii ensure that an Internal Audit function within each body operates to HM Treasury standards, including the requirement for external assessments, adhering to the professional qualifications, conduct and remit set out by the Department, and giving a comprehensive professional opinion from the chief internal auditor on the adequacy and effectiveness of the body's system of internal control;

xiii ensure implementation of agreed Northern Ireland Audit Office and Public Accounts Committee recommendations; and

xiv comply with the NI Executive's pay policy for the HSC e.g. arrangements for senior executive pay.

6.6. Compliance with the requirements at (i) – (x) are the subject of ongoing monitoring by the Department, and issues for resolution are resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

6.7. In relation to the requirement at (xi) the Regional Procurement Group, supported by BSO, as a centre of procurement expertise, promotes and oversees implementation of the overall procurement strategy and monitors compliance with procurement policy, while the Department secures assurance on adherence to policy rules and achievement of key performance indicators. All capital infrastructure is procured in conjunction with the centre of procurement expertise within the Department.

6.8. Adherence to the requirement at with (xii) is subject to ad hoc scrutiny by

the Department's Head of Internal Audit, with issues resolved at bi-annual accountability reviews or through ad hoc action if deemed appropriate by the Department.

6.9. Compliance with (xiii) is the subject of ongoing monitoring by the Department (or HSCB or PHA as determined by the Department), with issues for resolution will be resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department. Progress in relation to the recommendations is reported by the Department to the Northern Ireland Audit Office, Public Accounts Committee and the Department of Finance and Personnel.

6.10. Compliance at (xiv) is monitored by the Department, with issues for resolution addressed at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

Safety and Quality Dimension

6.11. Safety and quality covers a broad agenda, overlapping with many areas of operational performance and, to some extent, with financial performance and corporate control. It also applies to all programmes of care, including health improvement and health protection, and to infrastructure. This section describes assurance arrangements for specified elements of safety and quality, in particular, the arrangements for ensuring that HSC services are:

i safe - doing no harm to patients or clients and provided in an environment that is safe and clean;

ii effective - achieving agreed clinical and social care outcomes, which reflect high quality care and treatment and have a proven impact on health and wellbeing, especially prevention of poor health and wellbeing;

iii personalised - centred on the needs of individual patients clients and carers through their involvement in planning, delivery and evaluation.

6.12. Assurance to the Department and the Minister about the safety and quality of services is provided from a number of different sources. Each health and social body has clearly defined roles and responsibilities in this regard, which are summarised below.

6.13. The HSCB, working with the PHA on (i) to (viii) and (xii) below, is responsible for monitoring and reporting to the Department on:

i Compliance with Priorities for Action safety and quality requirements at least quarterly e.g. quality improvement plans;

ii Implementation of the RQIA and other independent safety and quality review recommendations in accordance with agreed plans;

iii Implementation of National Institute for Health and Clinical Excellence (NICE) technology appraisals endorsed by the Department;

iv Application by Trusts of lessons from adverse incidents and near misses (including those to be recorded on the PHA-managed RAIL system) and communicating, acting upon and reporting action taken in relation to safety information issued through the Northern Ireland Adverse Incident Centre Safety Alert Broadcast System (SABS);

v Evidence of provider-initiated action to improve safety and quality;

vi Family Practitioner Services' compliance with accepted standards e.g. clinical and social care governance arrangements, evidence of quality improvement, professional regulation and training and

development etc;

vii Trusts' compliance with accepted standards e.g. professional regulation and training and development (excluding those covered in para 6.14 (i) below);

viii Independent sector contracts related to waiting lists initiatives regarding for example conformity with clinical and social care governance arrangements and their performance on specified quality measures;

ix Independent sector contracts related to the provision of social care, regarding compliance with clinical and social care governance arrangements and specific quality standards;

x Implementation of statutory functions under agreed Schemes of Delegation;

xi Trust compliance with accepted standards for social care professionals e.g. professional regulation and training and development; and

xii Safety and quality aspects of HSCB contracts with independent sector providers.

6.14. The PHA is responsible for monitoring and reporting to the Department on:

i Trust compliance with accepted standards for medical, nursing and allied health professionals e.g. professional regulation and training and development; and

ii Compliance with statutory midwifery supervision requirements;

iii The identification and effective promulgation of learning from investigation of adverse incidents through the Regional Adverse Incident and Learning (RAIL) system and support for the development of quality improvement plans; and

iv Safety and quality aspects of PHA contracts with independent sector providers.

6.15. Joint Commissioning Teams led by the HSCB or PHA, as appropriate, are responsible for monitoring:

i Implementation of Service Frameworks;

ii Implementation of mandatory policy or guidance issued by the Department, which are not subject to formal performance arrangements, e.g. pandemic 'flu plans, quality of screening programmes, etc

iii Compliance with safety and quality and clinical and social care governance requirements specified by the commissioners of HSC services.

6.16. Trusts are responsible for monitoring independent sector contracts for health and social care to ensure compliance with relevant Departmental, HSCB or Trust guidance, including clinical and social care governance, relevant quality standards and arrangements to duly safeguard children and vulnerable adults.

6.17. The HSCB, working with the PHA, is responsible for monitoring Trust compliance with policies, standards and specific targets for the patient and client environment and support services including laundry and linen, catering, cleaning, portering and car parking.

6.18. The Department is responsible for monitoring:

i Compliance with policy, legislation and standards in respect of reusable medical devices;

ii Compliance with policy, legislation, standards and guidance in respect of the safe operation of life-critical healthcare-specific systems and processes.

6.19. In addition to assurance processes outlined above, the RQIA has an overall responsibility to encourage continuous improvement in the quality of health and social care across the public and independent health and social care sectors, against standards set by the Department, and to provide independent assurance on the quality of that care. When asked to do so by the Department it provides advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. It may also, at any time, advise the Department on any changes which it thinks should be made in the minimum standards set by the Department. RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, examining services provided, and highlighting areas of good practice, and making recommendations for improvement and reporting lessons learned to the Department and the wider HSC. Such reviews may be conducted as part of RQIA's ongoing independent assessment of quality, safety and availability of HSC services or may be commissioned by the Department.

Finance Dimension

6.20. Appropriate financial accountability mechanisms are necessary to:

i Ensure that the optimum resources are secured from the Executive for health and social care;

ii Ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money;

iii Deliver and maintain financial stability, through effective operation of the financial accountability of Trusts via the HSCB to the Department;

iv Ensure that the commissioners can be assured that financing of services is managed on the agreed and approved basis set by the HSCB, its LCGs and the PHA;

v Facilitate the delivery of economic, effective and efficient services by rewarding planned activity that maximises effectiveness and quality and minimises cost; and

vi Facilitate the development of innovative and effective models of care.

6.21. All financial resources delegated by the Department to HSC bodies remain subject to the same standards of probity and accountability irrespective of where day-to-day management and control is vested.

6.22. All organisations are ultimately accountable to the Department for the achievement of overall financial balance. The Department monitors on a monthly basis the break-even performance of each organisation and, exceptionally, bids for unanticipated and inescapable in-year pressures. The HSCB monitors the performance and financial breakeven of Trusts, measuring against Service and Budget Agreements and delivery of service targets, reporting on its monitoring to the Department;

6.23. To guard against over-spending and minimise under-spending, the Department undertakes monthly monitoring of the overall HSC (and Departmental) financial position, reporting the evolving position to the Department of Finance and Personnel. The Department is also responsible for the strategic capital planning process and oversight of procurement and programme management, taking action where slippage or potential overspends become apparent. HSC Trusts are required to report on capital expenditure on a monthly basis and detailed liaison on projects is undertaken through quarterly Strategic Investment Group meetings.

6.24. The Department undertakes monitoring of the efficiency savings obligations contained in the Executive's Budget settlement. Each HSC body is required to provide such information in order to satisfy itself, and the Executive, that the conditions attached to the efficiencies are being met.

6.25. Trust Financial Returns and Strategic Resource Framework-related data, which provide essential information on expenditure on HSC services and contain cost comparisons across providers, continue to be produced under Departmental guidance. Responsibility for collation, analysis etc lies with HSCB.

6.26. The Department is responsible for keeping the counter-fraud strategy under review, and for the development and issuing of related guidance. It also approves publication of the annual fraud report and addresses performance issues relating to the counter-fraud assurance arrangements in each HSC body. It is for the BSO to maintain and provide to the Department all monitoring information that it, DFP or the NIAO may require. Each HSC body is required to comply with prescribed fraud prevention, fraud reporting, fraud investigation and other operational counter-fraud processes, availing itself of BSO support as appropriate.

6.27. The Department, informed by Department of Finance and Personnel, is the focal point for developing and cascading financial guidance, circulars and memoranda. This includes the specification of statutory and other reporting requirements.

Operational Performance and Service Improvement

6.28. Performance management and service improvement arrangements are those that are necessary to ensure the achievement of Government and ministerial objectives, standards and targets.

6.29. Section 8 of the Reform Act requires that the HSCB exercise its functions with the aim of improving the performance of HSC Trusts, by reference to such indicators as the Department may direct. In determining responsibilities for performance management and service improvement, the overriding principle is that, unless there is good reason to the contrary, as in the case of capital expenditure, estate management and Human Resources, all such functions should be undertaken by the HSCB because: this is a core function of the HSCB; it minimises the lines of accountability for providers; it maximises the 'breadth of sight' for the HSCB, allowing it to adopt a holistic view of performance taking account of all relevant factors.

6.30. Possible exceptions to this principle are areas for which the HSCB does not have lead responsibility, or where there is likely to be significant formal interaction with other Government departments, e.g. joint responsibility for the delivery of Public Service Agreement (PSA) targets (in which case the Department would take the lead on behalf of the HSC sector).

6.31. The HSCB is in the lead for monitoring and supporting providers in relation to the delivery of a wide range of HSC services and outcomes, with support from PHA professional staff. The PHA is in the lead for monitoring and supporting providers in the areas of health improvement, screening and health protection, with relevant support provided by the HSCB. The organisations are, therefore to establish and maintain a number of joint programme teams, consisting of relevant staff from each organisation.

6.32. In relation to the monitoring of provider performance, the resolution of any performance issues is a matter for the HSCB, in close co-operation with the PHA, escalating to the Department only if required.

6.33. With the approval of the Department, the HSCB and the PHA (where

appropriate) produce detailed practical definitions for the application of targets. They also put in place arrangements to: monitor progress against targets, assess risks to achievement; hold regular performance meetings with providers; and escalate risks as appropriate. The HSCB reports on this process to the Department to enable it to maintain an overview of performance in these areas. The HSCB also resolves performance issues, escalating to the Department only where such resolution cannot be achieved. Capital, estate management and human resource targets are performance managed by Department.

6.34. The HSCB is responsible for the collection of all routine information from HSC Trusts for performance monitoring or statistical publication purposes at agreed intervals and to agreed standards, and for providing this to the Department. This will minimise the potential for duplication and establish a clear, single channel for submission and validation of information

6.35. In pursuit of service improvements in their respective areas of responsibility, the HSCB and the PHA must:

i identify evidenced-based good practice and develop an annual programme of action;

ii take account of patient, client and carer experience, including lessons learnt from complaints;

iii lead regional reform programmes, issuing guidance and specifying required actions;

iv provide training and support;

v review Trust action plans;

vi provide support to individual providers to address specific issues

and manage provider-provider interfaces;

vii review implementation of reforms and make available any reports on progress;

viii make regular reports to the Department, as required, on their activities in this field.

6.36. Regarding Public Service Agreement targets, the Department is responsible for their development and agreement, and for reporting progress against them to the Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel.

6.37. The Department sets HSC productivity and other HR-related targets and reports to Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel on progress towards their achievement. The HSCB is responsible for the regular ongoing monitoring of progress by providers, addressing issues of under-performance where they arise, escalating to the Department only where necessary;

6.38. The European Working Time Directive has put in place compliance arrangements, for which the Department sets targets for the medical workforce. The HSCB monitors progress, addresses issues of under-performance and reports to Department on compliance and progress. It is for the HSCB to resolve any compliance etc issues, escalating matters to the Department's attention only where necessary.

6.39. The Department is responsible for setting targets and monitoring HSC Trust performance in relation to the level of compliance with policy, legislation, standards and guidance in respect of the management of the HSC estate. HSC Trusts are accountable for the practical application of such guidance etc, for the effective management of the associated operational risks, and for providing appropriate assurance as to the

discharge of these responsibilities. The Department has in place an appropriate review process to allow Trusts to report to the Department on a regular basis as to their overall management of the HSC estate.

Independent Challenge

6.40. In considering how the HSC system is held to account, special mention should be made of the Regulation and Quality Improvement Authority and the Patient and Client Council, both of which have a particular role to play. They each provide an independent perspective on the performance of the HSC system, one which validates and challenges the system's own performance management arrangements.

6.41. The RQIA focuses on the quality and safety of services, using statutory and other standards agreed by the Department to benchmark not only the services but also the governance frameworks within which they are provided. PCC focuses on the interests of patients, clients and carers in HSC services. This goes beyond a straightforward information or advocacy role; it includes working with HSC bodies to promote the active involvement of patients, clients, carers and communities in the design, delivery and evaluation of services. The RQIA and the PCC also have the power to look into specific aspects of health and social care and report their findings publicly to the Department.

6.42. Both of these organisations provide important independent assurance to the wider public about the quality, efficacy and accessibility of health and social care services and the extent to which they are focused on user needs.

7 Conclusion

7.1 This Framework Document is a summary of the structures, functions and processes that underpin the planning, delivery and evaluation of health and social care services in Northern Ireland. It will be kept under continuous review in the light of emerging policy and legislation.

7.2 If you have any enquiries about the content of the Framework Document, please contact:

Office of Permanent Secretary
DHSSPS
Permanent.Secretary [redacted]