HSC Business Services Organisation

Directorate of Legal Services
— Practitioners in Law to the Health & Social Care Sector —

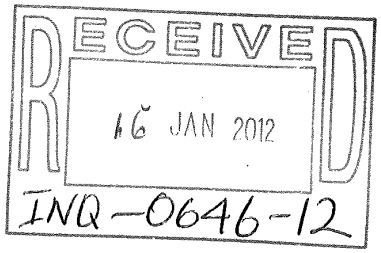
2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref: BC-0063-11

Our Ref: HYP B4/01

Date: 16.1.12

Ms Bernie Conlon
Secretary to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB



Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letter (BPC-0063-11).

I am instructed, as regards 1 (b) (part 1) that the Trust's Clinical Governance Framework (April 1999) supplied as enclosure No. 6 to Mr. William McKee's letter to the Inquiry dated 26th July 2005 led to the First Clinical Governance Report 1999/2000 (supplied as enclosure No.7). The Royal Group of Hospitals draft 2004/2005 – 2009/2010 Clinical Governance Strategy is enclosed (a final version copy is not available). This was followed the Belfast Health & Social Care Trust's Board Assurance Framework 2007/2008, then 2010/2011 and this has since been superseded by the 2011/12 Belfast Health and Social Care Trust Board's Assurance Framework (copies enclosed).

Yours faithfully,

Joanna Bolton
Solicitor Consultant
Email: [redacted]
Tel: [redacted]

Deleted: Draft/ Board of Directors/ 01.07.04

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HSS TRUST

EXCELLENCE AND GOVERNANCE STRATEGY 2004/2005 – 2009/2010

Summary

This strategy sets out the arrangements by which the Board of Directors will assure a comprehensive system for **continuous quality improvement, controls assurance, risk management and** clinical and social care governance. **The foundations for this system are found in** 'A Vision of Success':

Deleted: This system is set within The Royal Hospitals' excellence and governance framework, and is closely aligned to the organisations' strategic aims as set out in

Deleted: .

'We will....continue to improve arrangements for excellence and governance ensuring that high standards, learning and good practice are shared'

'We will.... provide the highest quality healthcare in the best possible environment for all our patients;'

'We will....strive for excellence in everything we do;'

'We will....further develop the culture of continuous improvement using the framework of the EFQM model which focuses on results that are important to patients, staff and the community we serve;'

('A Vision of Success, The Royal Hospitals, 2003)

The strategic context of this document is to develop integrated governance arrangements encompassing all domains of governance in health and personal social services i.e. clinical and social care governance, corporate governance, research governance, information governance and financial governance. This strategy document is an incremental step in that strategic direction.

Crucial to the success of this strategy is the fostering of an 'open and fair culture' and this is defined later in the document. Objectives and success criteria are also set out.

The responsibilities of directors, managers and all staff are defined alongside the management techniques and practical measures necessary to successfully implement this strategy. Each section **of this strategy document** informs the others, but can be used separately. **The document ends with a governance delivery plan and a quality plan for 2004/05.**

Deleted: It is laid out in three sections.

Deleted: Section two sets out the objectives and action plan for 2004/2005.

Contents

Deleted: Table 1 Excellence and governance reporting arrangements¶
¶

Deleted: Appendix

Deleted: -

Deleted: g

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Formatted: Bullets and Numbering

Section 1

1.1 Introduction

This document describes the steps taken and those **proposed**, by The Royal Hospitals, in developing an integrated approach to governance. **The Royal Hospitals has decided to use the European Foundation for Quality Management (EFQM) 'Excellence Model' to achieve this. The EFQM 'Excellence Model' provides the overarching model within which governance is a key process.**

For the first time, The Royal Hospitals has agreed a single strategy document that incorporates a:

- risk management strategy
- clinical and social care governance development plan
- quality plan

The document builds on the significant progress that has been achieved since the first risk management strategy was published in 2001. This revised strategy incorporates the common principles described in 'Standards Australia Risk Management AS/NZS 4360:1999' and responds to the developing clinical and social care governance agenda. **The document also builds on a history of continuous quality improvement at The Royal Hospitals stretching back to the establishment of the first Quality Steering Committee in 1990.**

The strategy is closely linked to and will support The Royal Hospitals' strategic aims. It will inform the management planning process and assist us in achieving corporate and divisional objectives. By endorsing this strategy, the Board of Directors recognises the importance of **continuous quality improvement, controls assurance, risk management and clinical and social care** governance **as essential elements** in assuring organisational governance **for The Royal Hospitals.**

1.2 Key definitions

The EFQM 'Excellence Model' is a framework based on nine criteria that can be used to assess an organisation's progress towards excellence. Its flexibility means that it is applicable to organisations of different sizes, from the public, private and voluntary sectors. It is based on the premise that:

'Excellent results with respect to performance, customers, people and society are achieved through leadership driving policy and strategy, that is delivered through people, partnerships and resources and processes.' (EFQM, 2004)

Deleted: It incorporates

Deleted: a

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Formatted: Bullets and Numbering

Deleted: and

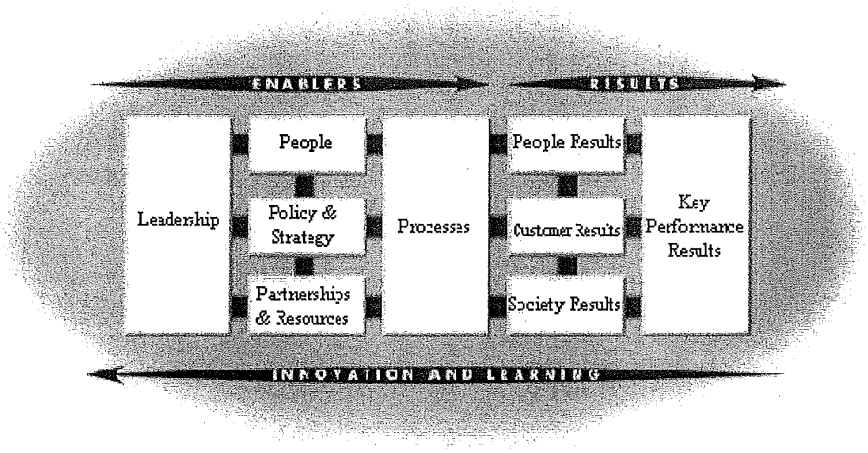
Deleted: .

Deleted: .

Deleted: (hereafter referred to as healthcare governance)

Deleted: within the developing integrated governance arrangements

Deleted: t



Governance or corporate governance is 'the system by which an organisation directs and controls its functions and relates to its stakeholders.' (HM Treasury)

In other words, the way in which organisations:

- manage their business
- determine strategy and objectives
- go about achieving these objectives
- maintain quality standards
- engage with stakeholders

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

There are different aspects of governance in health and personal social services i.e. clinical and social care governance, corporate governance, research governance, information governance and financial governance.

The Royal Hospitals is developing an integrated approach to corporate governance that recognises the substantial overlap between clinical and social care governance, patient/user involvement, organisational and clinical risk management, and financial control. This approach incorporates the arrangements for internal control, including controls assurance. **Integrated governance** can be defined as 'systems and processes by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services, and in which they relate to the wider community and partner organisations.' (NHS Confederation)

Why do we need 'integrated governance'?

A recent NHS Confederation paper entitled 'The development of integrated governance' (May 2004) points to a number of reasons that are applicable at The Royal Hospitals:

- Governance responsibility has been fulfilled through a number of strands, developed separately and not necessarily aligned e.g. financial allocations may not be fully informed by the pressures of clinical governance or the corporate risk register
- The need to avoid duplication of activity or wasted effort that can stem from managing the different aspects of governance in silos
- Danger that the data and assurances needed by the Board of Directors for proper governance are either not available or presented in a way which is unintelligible

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Risk can be defined as anything that poses a threat to the achievement of The Royal Hospitals' role and objectives as an acute general hospital, a provider of specialist third level services and a teaching/ research centre. This may include damage to the reputation of The Royal Hospitals that could undermine public confidence.

Health and personal social services organisations are required to sign an annual statement of **internal control** or SIC (1). The Department of Health Controls Assurance Team uses the following definition:

Deleted: (See also an explanation of The Royal Hospitals' approach to acceptable risk, contained in the policy statement and the description of risk management in the appendices.)¶
¶

Deleted: ¶
¶

Deleted: z

'Internal control is a process designed to provide reasonable assurance that the organisation's objectives will be achieved. It includes all measures and practices that are used to control and manage risks to the attainment of those objectives. It is a continuous process, operating at all levels within the organisation, which, in turn, should be continuously monitored for effectiveness of the system by the board.' (2)

The SIC should therefore be the end result of a process of management that is embedded in the planning, operational, monitoring and review activities of the body, these activities being the critical elements of the statement. Production of the SIC should not be conducted as an 'add-on', end of year activity.

The most widely used definition of **clinical governance** is the following:

'A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.' (3)

Clinical and social care governance is an extension of the same concept, which reflects the wider remit of health and personal social services in Northern Ireland.

Open and fair culture - The Royal Hospitals will aim for a culture and establish processes that encourage staff to report near misses and adverse incidents. This will be undertaken in a supportive, open, honest and participative way to ensure lessons are learned and practices and policies are changed accordingly. Following voluntary disclosure of near misses, or adverse events a supportive rather than disciplinary

approach will be taken, where it is reasonable to do so. Clear arrangements, that meet best practice standards, will be maintained for investigating adverse incidents or near misses.

No individual providing information, opinion, counsel or services to an incident investigation or Trust committee shall be liable in a suit for damages. This is provided that such an individual acted in good faith and with a reasonable belief that said actions were warranted in connection with, or in furtherance of, The Royal Hospitals' governance strategy.

1.3 Risk management policy statement (incorporating a definition of acceptable risk)

The policy statement outlined below represents the corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of The Royal Hospitals' responsibilities and their individual responsibilities for risk evaluation and control.

Policy statement

The Royal Hospitals is committed to providing and safeguarding the highest standards of care for patients. The Royal Hospitals will do its reasonable best to protect patients, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Royal Hospitals will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Royal Hospitals recognises that implementation of a risk management strategy will support this commitment. The strategy will help ensure that the services provided by The Royal Hospitals are safe and secure. The Royal Hospitals will provide a safe workplace that encourages learning and development through an 'open and fair culture'.

In turn, staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Royal Hospitals acknowledges that it is impossible and not always desirable to eliminate all risks and that systems of controls should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably The Royal Hospitals may have to set priorities for the management of risk. It will identify **acceptable risks** through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Royal Hospitals may be willing to accept a level of risk in order to take advantage of a new and innovative method of service delivery.

Formatted: Font: Bold

Section 2

Delivering this strategy

2.1 Communicating this strategy

The Royal Hospitals will communicate this strategy to its stakeholders through existing communication mechanisms, including staff training/ induction, our newsletter 'Stitches', publication on our intranet/ internet site and regular reports in our quarterly governance update.

Deleted: '
Deleted: a wide audience of
Deleted: s
Deleted: ranet

2.2 The objectives of the strategy are to:

- **encourage further use of the EFQM 'Excellence Model' across the organisation**
- establish an 'open and fair culture' encouraging a collaborative approach to the development and maintenance of best practice in which lessons are learned
- integrate clinical governance and risk management into the performance framework of The Royal Hospitals to help assure the best outcomes for patients and users of our services
- ensure a system of internal control is maintained
- ensure compliance with the statutory duty of quality and the delivery of safe, high quality patient care
- protect the health and safety of patients, staff, visitors and others who may be affected by The Royal Hospitals' activities
- establish priorities for the control of risks, based on a suitable assessment process
- minimise financial liability through effective controls assurance
- minimise potential loss or damage to the assets and reputation of The Royal Hospitals
- raise staff awareness of the principles and practice of risk management and clinical and social care governance
- **initiate the development of integrated governance arrangements**

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm
Formatted: Bullets and Numbering

2.3 Performance framework

It is important to monitor our success in implementing this strategy. This will be done by incorporating measures of performance into The Royal Hospitals' accountability review process. This will help to ensure ownership at all levels of the organisation.

Deleted: will be

Divisions will have an ongoing commitment to comply with statutory obligations and ensure that significant risks are identified and managed. A report will be submitted with other accountability review papers, detailing changes to the divisional/directorate risk register and action taken since the previous accountability review.

Arrangements will be maintained to ensure that staff participate in annual appraisal. The effective management of health and safety and risk will be part of the performance review of all managers and directors. Clinical staff members have an individual responsibility to ensure that they meet the ethical and clinical standards set by their regulatory bodies and colleges.

The Royal Hospitals set a series of performance indicators, which overlap with current risk issues. Progress against them is addressed through the existing performance management arrangements, including the accountability review process

and bi-monthly performance monitoring. The Board of Directors receives regular reports.

2.4 Success criteria

Establishment of an open and fair culture where staff are encouraged to report adverse incidents* and people are able to learn from their own and others mistakes.

In the medium term this may be measured by:

- participation in adverse incident reporting by different grades of staff
- rolling out of root cause analysis
- more effective use of information derived from complaints and litigation

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

The development of functioning corporate and divisional risk registers which inform management and accountability processes. In the medium term progress in this area will be measured by:

- evidence of an organisation wide system of risk assessment
- substantive compliance with health and personal social services controls assurance standards
- effective management of organisational and clinical risk at divisional and corporate levels
- successful completion of internal and external audit

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Deleted: HPSS

Development of an effective framework for clinical and social care governance with improved outcomes for patients will be demonstrated by:

- compliance with the statutory duty of quality and the delivery of safe, high quality patient care within an open and fair culture
- evidence of the value of clinical audit in changing practice and improving care
- implementation, monitoring and action of National Institute for Clinical Excellence guidance, national and regional quality alerts, standards and guidance
- clinical participation in national confidential enquiries, regional, national and local clinical audits, benchmarking and outcome projects
- systems in place that are safe, transparent and clinically effective
- implementation of a plan for user, staff and community involvement in excellence and governance

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Deleted: NICE

Improved health and safety management will be measured by:

- the successful implementation of the agreed action plan
- external review of progress against this action plan
- benchmarking with available standards and other organisations in the NHS/HPSS

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

*An adverse incident is any unexpected or unplanned incident that has a detrimental effect on patients, staff or others, or which causes material loss or damage, loss of opportunity or damage to reputation. Near misses are included in this definition.

Maintenance of effective research governance will be evidenced by functioning divisional research governance committees.

2.5 Reporting and accountability arrangements

This strategy informs The Royal Hospitals' corporate management plan. Progress in implementation will be measured through the accountability review process. In addition, Executive Team will make a series of reports to the Excellence and Governance Committee:

Table 1 - Excellence and governance reporting arrangements

Report	Reporting arrangements	Timing	Nominated lead
Excellence and Governance Strategy	Annual review	February	Dr M McBride
Clinical and social care governance -progress on development of clinical and social care governance -Adverse clinical incident management -Clinical audit -Complaints management	Annual report	June	Dr M McBride
CPD/research and regulation -Continuing professional and personal development -Professional regulation -Research and education	Annual	June	Dr M McBride/ Mrs D O'Brien
Controls assurance and internal control **Corporate Risk Register and action plans**	Bi-annual report (corporate risk register and action plans)	February and October	Mr W McKee
Health and safety	Annual report	October	Dr M McBride
Oversight of the implementation of the European Foundation for Quality Management 'Excellence Model'	Annual report	October	Mrs D O'Brien

Deleted: L
Deleted: Director
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: HealthCare Governance strategy
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Internal Control
Deleted: Controls assurance and internal control¶
¶
Corporate Risk Register and action plans
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: Quality¶
¶
Deleted: ¶

Report	Reporting arrangements	Timing	Nominated lead
Litigation	Quarterly report	All meetings	Dr M McBride

Deleted: L
Deleted: Director
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Page Break
¶

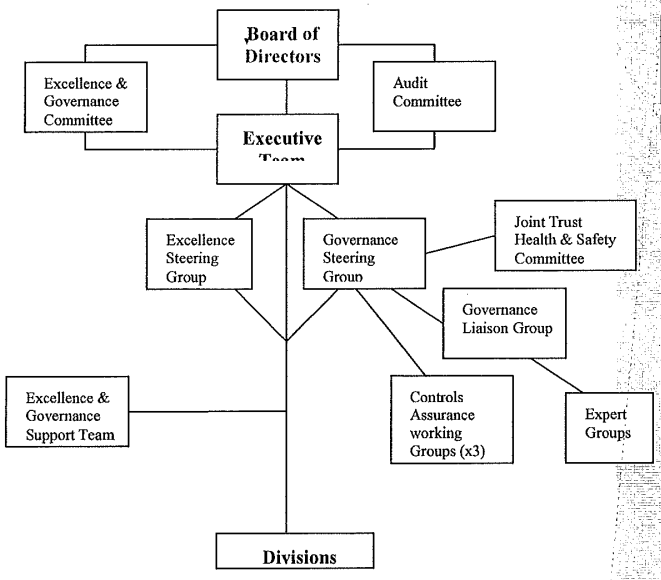
Section 3

Organisational arrangements

3.1 Structures for excellence and governance

The organisational arrangements **excellence and governance at** The Royal Hospitals' **are as follows:**

Deleted: for risk management should be considered within the context of T
Deleted: wider arrangements for excellence and governance:
Deleted: Figure 1 – The Royal Hospitals' organisational structure for governance¶
¶
¶
Deleted: Trust



<Need to add the quality coordinators' group to the above diagram>

The **Board of Directors ' is responsible for the success of the hospitals by providing a framework of good governance within which the organisation can thrive and grow' ('A Vision of Success', 2003). To** assist in this two committees have been established – **the Audit Committee and the Excellence and Governance Committee.** The Board of Directors **takes** regular reports from these committees, together with the annual report from The Royal Hospitals' external auditors. The Board of Directors will review this strategy annually.

Deleted: will provide scrutiny of The Royal Hospitals' risk management process. To
Deleted: will take

In March 2003, the Board of Directors approved the establishment of a new standing committee whose purpose is to have oversight of The Royal Hospitals' work on

excellence and governance – the **Excellence and Governance Committee**. Membership consists of The Royal Hospitals' non-executive directors with the Chief Executive and other senior staff in attendance. The committee meets at least three times a year. The committee seeks to ensure:

- that risks are identified and managed
- local community, user group and staff input
- that timely reports are made to the Board of Directors, including recommendations and remedial action taken or proposed where there is an internal failing in systems or services

(See terms of reference for further details of remit and membership.)

The **Audit Committee** comprises of non-executive directors. Its role is to assist the Board of Directors in ensuring an effective internal control system is in operation. The remit of the Committee includes:

- ensuring the effectiveness of the internal financial controls
- review of both the internal and external audit functions to ensure their independence and effectiveness including approval of their annual programmes of work in advance and consideration of their key findings and reports
- ensuring proper accounting books and records are maintained
- assessment of the Trust's control environment including measures in place to detect and prevent fraud and corruption
- ensuring the reliability of financial information by exercising a challenge function with key personnel and information
- safeguarding the assets of the Trust
- addressing the financial aspects of governance within the Trust
- approving the annual accounts including the statement of internal control and recommending their adoption to the **Board of Directors**

(See terms of reference for further details of remit and membership.)

Financial management systems, such as those at The Royal Hospitals have been in existence for some time and demonstrate the key features of a good governance system i.e. local level responsibility, overarching control and board level accountability.

Section 1.2 referred to the NHS Confederation paper on integrated governance. This refers to separate audit, risk and clinical governance committees and the danger of preserving the silo nature of the separate committees. In the future, The Royal Hospitals may wish to consider building on the work of the Excellence and Governance Committee and the Audit Committee by replacing them with a single standing committee with overall responsibility for integrated governance.

Executive Team is responsible for ensuring that an independently assured risk management system is in place that conforms to the principles contained in Standards Australia AS/NZS 4360:1999. Executive Team will ensure that this system is embedded at all levels within the organisation and that risk management is an integral part of the accountability process.

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Formatted: Bulleted + Level: 1 + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Deleted: E

Deleted: A

Deleted: E

Deleted: S

Deleted: A

Deleted: A

Deleted: Trust Board

Executive Team will prepare and regularly update a corporate risk register. It will maintain a risk action plan based on this register, which will inform the management planning, service development and accountability review processes.

Executive Team will report regularly to the Board of Directors on progress in implementing this strategy, **the governance plan and the quality plan.**

The **Governance Steering Group** will be made up of members of Executive Team, who will oversee the implementation of this strategy. It will ensure integration of **continuous quality improvement,** internal control, clinical **and social care** governance and financial control into the performance framework. The group will prepare summary reports for Executive Team and Board of Directors on performance against the objectives of this strategy, reporting early on any variation. The group will be responsible for updating the corporate risk register and maintaining the associated action plan, monitoring arrangements for internal control and for drafting the SIC. The group will be led initially by the Medical Director and will include the Director of Finance, Deputy Chief Executive/ Director of Operations and Performance Management and **the Director of Nursing and Patient Services.**

<Action: prepare terms of reference and convene first meeting to approve amendments to this strategy document>

The **Excellence and Governance Support Team** draws together specialist practitioners from within **The Royal Hospitals,** who by virtue of their skills and /or position have an important role to play in supporting the development of healthcare governance. The team will function as a resource to all parts of the organisation. It will report to the Governance Steering Group. The team will provide technical and specialist support to divisions and will monitor progress against the objectives of this strategy. It will also have as a key task, the integration of governance activities across the organisation. The team will be **chaired** by the Deputy Medical Director and will include **key senior staff from across the organisation. (See terms of reference for further details of remit and membership.)**

Controls Assurance Working Groups will coordinate the continuing controls assurance process. They will report to the Governance Steering Group. Each is responsible for a basket of controls assurance standards. Each working group will oversee the **self-assessment** process and prepare a verifiable audit trail against the standards. **The working groups are as follows:**

Deleted: and the risk action plan.

Deleted: organisational governance,

Deleted: e

Deleted: t

Deleted: b

Deleted: d

Deleted: Facilities Director

Deleted: the Trust

Deleted: coordinated

Deleted: the Risk Manager, Quality Manager, Clinical Governance Manager, Associate Medical Director (litigation), Directors/ manager of education and research.

Deleted: self assessment

Deleted: ¶

Deleted: Table 2 - Working groups¶

Group 1 Chaired by Finance Director	Group 2 Chaired by Deputy Director Facilities	Group 3 Chaired by Deputy Medical Director
Standards covered: Finance Governance Purchasing and supply Human Resources Records management Professional/product liability,	Standards covered: Buildings, land etc Catering and food hygiene Environmental management Fire safety Fleet and transport Security management Waste management, **Information management/technology**	Standards covered: Risk Management Emergency planning Medical devices **management**, Infection Control Medicines management Decontamination etc Health and safety management,

The **Governance Liaison Group** will coordinate the activities of specialist groups or committees within the organisation, ensuring they are part of the accountability framework. The Medical Director will chair the liaison group. The membership will include the chairs of **each specialist group or committee**,

3.2 Responsibilities

The **Chief Executive** is accountable to the Board of Directors for having in place, an effective system of risk management and internal control and a framework for clinical and social care governance. He is required to sign an annual statement of internal control in the annual report.

The **Medical Director** is the executive director with lead responsibility for the implementation of this strategy. He is the nominated lead director for implementing clinical and social care governance within The Royal Hospitals. He **is** assisted in this by a deputy, who **is** responsible for coordinating excellence and governance activities across the organisation. An associate medical director **is** responsible for litigation management.

The **Director of Finance** is responsible for ensuring that an effective system of financial controls in keeping with statutory requirements is in place. This will be tested by the production annually of audited accounts.

The Deputy Chief Executive/ Director of Operations, Performance and Planning is responsible for the performance framework and the accountability review arrangements for the organisation, which is the means by which we will direct and assess the success of the implementation of this strategy.

The **Director of Nursing and Patient Services** has the lead role for developing patient and user involvement, as part of our clinical and social care governance framework. **She is also responsible for implementation of the quality plan through the Assistant Director of Nursing and a network of quality coordinators across the organisation.**

Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: mgt
Deleted: Information management/technology¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
¶
Deleted: /
Deleted: The chair of each group will be a member.
those committees listed in paragraph 3.1.7 below and such other committees as are identified.
Deleted: will be
Deleted: will be
Deleted: will be
Deleted: &
Deleted: organisation which
Deleted: cces
Deleted: s
Deleted: of the
Deleted: is responsible for the further development of our culture of continuous improvement using EFQM 'Excellence Model'. This provides the overarching model within which governance is a key process. She

All directors are accountable to the Chief Executive for ensuring that the organisational arrangements described in this strategy are fully implemented within their directorates/ divisions. In particular it is essential that directors ensure a governance committee is established, that risk audits and assessments are carried out and that a risk register and action plan for risk control are prepared and acted on. Where this is not possible the director must ensure that Executive Team is made aware of residual risks. The performance of directorates/ divisions with respect to risk management will be subject to audit by the Excellence and Governance Support Group and the accountability review process.

The **Facilities Director** will be responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of The Royal Hospitals' estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that The Royal Hospitals meets its statutory obligations with regard to the management of fire safety and will report annually to the Board of Directors on progress.

The **clinical governance general manager, complaints manager, risk manager, health and safety manager, quality manager, waste manager, senior nurse infection control, decontamination manager** must ensure that the systems necessary for effective clinical governance and risk management are implemented and maintained at all levels of The Royal Hospitals. They are responsible for collecting data on performance and providing reports on collated data for use by Executive Team, management and staff. These managers must investigate adverse events and complaints, according to agreed procedures and provide reports and recommendations for action. They will also act as a resource for expert advice.

All **managers** must ensure that activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible, the manager must ensure that the director is advised. They are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse event reporting are adhered to. **Managers must ensure that the objectives set out in the governance plan and the quality plan are reflected in their directorate/ divisional management plans, implemented and reported on at each accountability review meeting.**

Staff are required to co-operate with the introduction of this strategy, to comply with safe systems of working and to report any adverse events, including accidents and near misses. **Everyone has a responsibility to continuously improve the quality of service that they provide to patients and their colleagues across the organisation.**

References

1. Statement of Internal Control. DHSSPSNI circulars
   -HSS (F) 24/2001, issued on 21/5/01
   -HSS (FAU) 19/2003, issued on 2/5/03
2. Canadian Institute of Chartered Accountants, Criteria of Control Board (Nov 1995)

Deleted: D

Deleted: will be

Deleted: safety manager

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 0.63 cm + Indent at: 0.63 cm

3. Scally G and Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. Br Med J (4 July); 61-65:1998

Associated policies and procedures

Health and Safety Policy & Procedures
These include a health and safety risk assessment procedure)
Systematic Tool for Assessment and Audit of Risk (STAAR).
(A trust wide system for general risk assessment)
Management of Adverse Incident Policy & Procedures
Decontamination of Medical Devices Procedures
Management of Medical Devices/Equipment Policy & Procedures
Whistle blowing Policy
Complaints – Management of Formal & Informal
Occupational health policies and procedures
Statement of internal control
Human resources policies and procedures including:
Recruitment and selection
Equal opportunities
Disciplinary
Grievance
Harassment
Financial policies and procedures are outlined in:
Standing financial instructions
Standing orders
Audit committee's terms of reference
Annual budget pack
Monthly financial report

This is not a definitive list, but reflects the key processes for risk management and governance.

Approved at Board of Directors meeting on 1 July 2004

APPENDIX 1

Excellence and Governance Delivery Plan for 2004/05

Objective/target	Implementation	Timescale/measure	Responsibility
Obtain external verification of the extent to which The Royal Hospitals has successfully implemented the EFQM 'Excellence Model'	**Apply for the NI Quality Award**	**Submission – September 2004 Assessment – November 2004 Obtain feedback – December 2004/ January 2005**	**Director of Nursing and Patient Services General Manager (Corporate Centre)**
Maintain functioning corporate and divisional risk registers and action plans	Agree and implement action plans over three years based on risks identified in the Corporate Risk Register Monitor progress against divisional action plans Review corporate risk register	Sept 2004 – first action plan Report at 6 monthly accountability review February 2005 Report to E&G committee	Medical Director Executive team Divisions Medical Director Executive team
Achieve compliance against NI/GB controls assurance standards	Establish 3 CA working groups and a steering group. Agree and implement an action plan to: further consolidate 'substantive' levels of compliance with the core controls assurance standards; Ensure the required level of compliance for other NI controls assurance standards;	September 2004 March 2005 March 2005	Medical Director Chairs and members of working groups Chairs and members of working teams

Objective/target	Implementation	Timescale/measure	Responsibility
	ensure at least moderate compliance with remaining GB standards Re-audit against GB/NI standards	January 2005	Medical Director
Improve our ability to prevent adverse incidents and learn lessons	**Implement a comprehensive procedure for the reporting and investigation of adverse incidents** **Extend program of root cause analysis training** **Review adverse incident reports quarterly** **Annual report of collated data on adverse incidents** **Agree common codes for complaints, incidents and med-neg claims** **Implement a protocol for the management of all external reports with the aim of maximizing learning (to include reports from HM Coroner, Ombudsman,**	**March 2005** **March 2005** **2004/05 Demonstrate appropriate intervention (e.g. investigation/RCA /risk assessment)** **Report to Exec Team and E&G committee October 2004** **December 2004** **March 2005**	**Medical Director Divisions** **Medical Director Divisions** **Divisions** **Medical Director** **Medical Director** **Medical Director**

Deleted: T
Deleted: M
Deleted: ¶
¶

Objective/target	Implementation	Timescale/measure	Responsibility
	develop and implement clinical performance monitoring systems against local, regional and national targets. (CHKS and Outcome Monitoring)	December 2004	Director(s) of Corporate Services, Nursing and Human Resources
	Prepare and implement a plan for user, staff and community involvement in excellence and governance	October 2004	Medical Director Divisions
	Agree and implement forward programmes of clinical audit and care pathway activity within Divisions/Sub-Divisions (PFA 2004/2005)	October 2004	Medical Director Director Nursing Divisions
	Develop educational governance arrangements		
Ensure the health, safety and welfare of staff and others	Implement the health and safety action plan	March 2005	Medical Director Divisions
	Introduce a strategy for effective management of stress	March 2005	Medical Director Divisions
	Implement revised trust health and safety policy/procedures	March 2005	Divisions Medical

Deleted: T

Deleted: M

Objective/target	Implementation	Timescale/measure	Responsibility
	Royal Colleges)		
Emergency/service Continuity planning	Review existing contingency plans in Facilities Organise workshop on SCP Revise SCP/s for Trust Complete redraft of MIP Complete and test SARS contingency plan	October 2004 October 2004 March 2005 September 2004 October 2004	Medical Director and Director Facilities Medical Director Divisions Medical Director Medical Director Divisions
Further develop arrangements for clinical and social care governance	Ensure that each division has functioning research and governance committees Review and update Clinical Governance Baseline Assessment Work with HPSS Clinical Governance Support Team in relation to Action Planning from Baseline Assessment (PFA 2004/2005) Implement action plans arising from baseline assessment Continue to	Report at accountability review October 2004 March 2005 March 2005 March 2005	Divisions Medical Director Medical Director Medical Director Divisions Medical Director Divisions

Deleted: T

Deleted: M

Objective/target	Implementation	Timescale/measure	Responsibility
Improve participation in mandatory training	Continue and develop decontamination audits Trust wide training needs analysis for risk management Set divisional targets for mandatory training, based on risk	Sept 2004 March 2005 Monitor progress through accountability reviews	Director Divisions Medical Director Executive team Divisions

Deleted: T

Deleted: M

Deleted: ——Page Break——

Deleted: ¶

Deleted: ¶

Deleted: ¶

APPENDIX 2

Quality Plan for 2004/05

Objective/target	Implementation	Timescale/measure	Responsibility
Seek stakeholders views to inform delivery of high quality healthcare	Carry out arrival corporate patient satisfaction surveys	3,000 each year	Quality Manager
	Survey GPs	100 – June 2004	GP Liaison Manager
	360° stakeholder feedback	December 2004	General Manager (Corporate Centre)
	Divisional surveys of patient views	Each ward - 20 patients per month	Quality facilitators
	Internal user surveys	1 per service per year	Quality facilitators
	Focus groups	Minimum 1 per year per service	Quality facilitators
Each member of staff is made aware of the role of quality within the organisation and their personal responsibility	Induction (corporate and local)	100%	Quality Manager and divisional team
	Role of quality coordinators/ facilitators	100%	Line manager
	Team meetings agenda	100% annually	Line manager/divisional manager
	Performance review	100% biannually	Divisional team
Reviewing performance of service delivery including commissioners' quality schedule as requested	Agree divisional performance indicators	Annually	Divisional team
	Audit performance indicators	3-6 monthly	
	Develop action plans	3-6 monthly	

Objective/target	Implementation	Timescale/measure	Responsibility
	Re auditing of indicators	6 monthly	Service Development Manager
	Service Development Manager to inform divisions of quality schedule items	Quarterly	
Patient Partnership Group (PPG)	Develop terms of reference for group	April 2004	Quality Manager
	Carry out end of year review	March 2004	Quality Manager
	Articles in 'Stitches'	3 monthly	Quality Manager
	Involve PPG in focus groups, working groups, committees and surveys	Ongoing	Divisional staff
	Inform PPG of outcomes of work/projects they are involved in	Within 2 months of completion	Project leader
Encourage staff participation in quality initiatives and recognise their efforts	Make staff aware of quality awards	As each is launched	Quality Manager and quality coordinators
	Divisions should encourage staff to undertake quality initiatives	Divisional meetings and one to ones	Divisional staff
	Provide support to staff for both initiatives and awards	As above	As above
	Corporate and divisional recognition must be provided	Arrange celebration at least annually	Quality Manager and Divisional Team

Objective/target	Implementation	Timescale/measure	Responsibility
	Incorporate into appraisal process	6 monthly/annually	Line managers
Fulfill our environmental responsibilities	Raise awareness of environmental issues in relation to the organisation at team meetings, 'Stitches' etc	Each team/management meeting	Divisional team
	PEAT inspection 1 per year for each division	Each division to include this in their management plan	Divisional team
	ISO 14000 up and running in one division	Estates Manager to pursue with a division	Estates Manager
	Each division to develop a plan to reduce waste	Annually in management plan	Quality coordinator with Divisional Team
Provide recognition for staff who show initiative, dedication inventiveness in their day to day work and also to those who have given long service to the organisation	Review the current policy	November 2004	Director of Human Resources Quality Manager
Corporate quality initiatives e.g.			
Adolescent Group	New policy Transition work Activity coordinator training	April 2004 March 2005 March 2005 Annually	Adolescent Group
Patient information	New policy Annual audits	April 2004 Annual	Patient Information Group

Objective/target	Implementation	Timescalc/measure	Responsibility
	Intranet site	May 2005	
Reduce number of complaints	Identify areas for improvements, develop action plans and produce annual report	Annually	Divisional teams
Develop, review and ensure compliance with policies	Ensure circulation and awareness of Trust policies to all staff	Monthly	Divisional/directorate teams

Belfast Health and
Social Care Trust

BOARD ASSURANCE FRAMEWORK

2007/08

Index

1. Introduction

The Board of Directors of the Belfast HSC Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled.

The Assurance framework is an integral part of the governance arrangements for the Belfast HSC Trust and should be read in conjunction with the Corporate Plan.

The Assurance Framework and Corporate Risk Register describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives [1]
- Identified principal risks that may threaten the achievement of those objectives;
- Controls in place to manage these risks, underpinned by core controls assurance standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast Health and Social Care Trust – Corporate Plan 2007/08

On an ongoing basis the Board will:

- Assess the assurances given;
- Identify where there are gaps in controls and/or assurances;
- Take corrective action where gaps have been identified; and
- Maintain dynamic risk management arrangements including, crucially, a regularly reviewed risk register.

2. Strategic Context

In order to produce the outcomes for which the Department of Health, Social Services and Public Safety (the Department) is ultimately responsible, a strong partnership is required between the Department and those HPSS organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

The Minister's annual ***Priorities for Action*** (PfA)[2] reflect the *Priorities and Budget* focus on reform and modernisation of services within the context of the resources available to the Department, as well as the attainment of efficiency targets, and together they form an action plan for the HPSS.

The Trust Delivery Plan (TDP) describes how the Belfast Trust plans to use its resources to deliver health and social care services to patients, clients, children and young people, carers and families, and presents the Trust's proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets.

3. Objective Setting

The Trust's Corporate Plan sets out the vision and purpose, core values and long term corporate objectives that will shape the strategic direction and priorities for the Trust over the next 3 – 5 years.

The Trust has five long term corporate objectives. These are:

- To provide safe, high quality and effective care
- To modernize and reform our services
- To improve health and wellbeing through engagement with our users, communities and partners
- To show leadership and excellence through organisational and workforce development
- To make the best use of our resources to improve performance and productivity.

The Corporate Plan and the Trust Delivery Plan set out annual targets to progressively deliver these corporate objectives.

[2] http://www.dhsspsni.gov.uk/prior_action/index.asp

The Trust Delivery Plan is developed annually as a response to the Department's Priority for Action targets and the commissioning plans of Health and Social Services Boards as expressed in their annual Health and Wellbeing Improvement Plans.

While the Corporate Plan incorporates these Departmental/ commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets under each corporate objective.

The Corporate Objectives and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Service Group Annual Performance Plans
- Service/Team annual plans
- Individual objectives

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

4. What assurance means

The Board can properly fulfil their responsibilities when they have a full grasp of the principal risks facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HPSS-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

The Board is committed to debating and making the connections between the corporate objectives, risks and the range and effectiveness of existing assurance reporting. This will require some consideration of the principle of **reasonable** rather than **absolute** assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

This framework defines the approach of the Board of the Belfast HSC Trust to **reasonable** assurance. It is clear that assurance, from whatever source, will never provide **absolute** certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

5. Accountability

5.1 Accountability to Minister and the DHSSPS

Health and Well Being Investment Plans and Trust Delivery Plans are the main vehicles for conveying where and by what means PfA targets, efficiency savings and service improvements will be delivered. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements and throughout the year 2007 – 08 some of these arrangements are likely to change as the Health and Social Care Authority takes on its performance monitoring responsibilities. The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social services to the people of Northern Ireland and for good governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

5.2 Accountability between HSS Boards and Trusts

Health and Social Services Boards and Health and Social Care Trusts are accountable to the public for the services that they commission and provide.

The basis for HPSS accountability is the Health and Personal Social Services (Northern Ireland) Order 1972[3] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department the duty to:

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

Under Article 16 of the 1972 HPSS Order, the HSS Boards were established for the purpose of administering and providing health and personal social services within their respective areas. This broad remit changed in the early 1990s when

[3] S.I.1972/1265 (N.I.14)

the HPSS (NI) Order 1991[4] (augmented by the HPSS (NI) Order 1994[5]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards' planning and commissioning of services for their resident populations, and the Trusts' provision of those services, remains to this day, and their accountability relationship rests on it.

Regarded from the accountability perspective, there are two broad categories of HPSS activity:

- Category one: those services identified as being needed and commissioned by HSS Boards from Trusts and also issues which are statutory obligations of Trusts. These comprise the full range of HPSS's business and relate to the provision of health and social services, the volume and quality of which are detailed in Service and Budget Agreements between the commissioners and the providers. They include delegated statutory functions.

- Category two: certain duties to be performed by HPSS organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

In accountability terms, there are differences between the two categories. In category one, Trusts are, initially answerable to the commissioning HSS Board(s), via their Service and Budget Agreements, for the quantity, quality and efficiency of services. This relationship has been strengthened by the introduction of the statutory duty for the quality of services commissioned for, and provided to, the population which applies to both HSS Boards and Trusts[6]. In this category, therefore, Trusts are responsible to HSS Boards for the delivery of services to the quantity, cost and quality specified in Service and Budget Agreements. (There may also be a shared responsibility between HSS Board and Trust to the Department, as in the achievement of Priorities for Action targets.)

Within this category, however, there exists a sub-set of services where a heightened degree of accountability between a Trust and HSS Board obtains. This originates in the 1994 Order, where certain functions – specified as "relevant functions" are the immediate responsibility of HSS Boards; the Trusts duly submit for approval by the relevant HSS Board and by the Department, 'schemes' setting out how they intended to discharge the functions or services in question. With the exception of those discharged under the Mental Health (NI) Order

[4] S.I. 1991/194 (N.I. 1)
[5] S.I. 1994/429 (N.I. 2)
[6] Paragraph 5 of HSS(PPM) 10/2002

1986[7], the functions in question are drawn from what are generally regarded as personal social services (including children and adoption services).

In accountability terms this means that, where a Trust scheme for a relevant function is in operation, the delegating HSS Board should monitor its operation. The Board must check that the Trust is complying with the terms of the scheme and hold the Trust to account for how it discharges that function. As a separate legal entity, accountable for the discharge of relevant statutory functions, the Trust will create sound organisational arrangements to discharge such functions effectively. The discharge by the Trust of its powers and duties under the legislation will involve: interventions in matters of personal liberty; the protection of vulnerable people; the provision of vital services; and the exercise of regulatory functions. The Trust will develop systems that are robust and capable of balancing appropriately the complex issues of protection and care.

In category two (financial control, governance, and for overall organisational performance etc) each HPSS organisation is accountable directly to the Department. HSS Boards may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc on governance or financial control.

6. The Assurance Framework

This assurance framework provides a comprehensive and systematic approach to effectively managing the risks to meeting our objectives. The framework illustrates the wide range of assurances from internal and external sources.

The most objective assurances are those derived from independent reviewers – which will include the Regulation and Quality Improvement Authority, Departmental special enquiries or reviews and Internal and External audit. These are supplemented from non-independent sources such as performance management, multi-disciplinary audit, self assessment reports and professional monitoring and review processes within legislative and professional regulatory guidance.

It is important that as information is collated and evaluated across the Trust that this is done in a consistent and efficient way, is proportionate and minimizes duplication of work by different reviewers.

This framework provides a structure for acquiring and examining the evidence to support the Statement of Internal Control.

[7] S.I. 1986/595 (N.I .4)

Risk Management

The Belfast Trust will develop a risk management strategy that will be underpinned by its policy on risk (see Appendix A) and explain its approach to acceptable risk.

The Belfast Trust will adopt an open and learning culture that encourages continual quality improvement, but with openness when things go wrong. Processes for managing and learning from adverse incidents, complaints and litigation will be introduced as an immediate priority.
Controls assurance will remain a key process for the Belfast Trust.

The Belfast Trust will identify key Directors to be accountable for action planning against each standard. The results will be used to inform the Trust's corporate risk register and will be mainstreamed with other aspects of the Trust's Delivery Plan through the Assurance Framework.

Organisational Arrangements

Proposed organizational arrangements for governance and assurance are set out in Appendix B. An important element of the Trust's arrangements is the need for robust governance within service groups. This will be tested through the accountability review process. There are a number of internal and external mechanisms that will support this.

The **Board of Directors** is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team
- Ensuring accountability to the public for the organisation's performance
- Assuring that the organisation is managed with probity and integrity.

The membership of the Board of the Trust is defined in the Establishment Order to include the Directors of Social Work, Medicine, Nursing and Finance.

The Audit Committee

The Audit Committee (a standing committee of the Board of Directors) is comprised of non-executive directors. Its role is to assist the Board in ensuring an effective control system is in operation. This includes the effectiveness of internal financial controls, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance in the Belfast Trust.

The Assurance Committee

The Assurance Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors only. Its role is to assist the Board of Directors in ensuring an effective assurance framework is in operation for all aspects of the Trusts undertakings, other that finance. The Assurance Committee is also responsible for the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Executive Team

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by the Board of Directors as part of the performance management and assurance processes, is available.

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update a corporate risk register, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to co-ordinate the work of the assurance/scrutiny committees and service groups assurance quality and safety committees. The Assurance Group will be responsible on behalf of the Executive Team for developing and maintaining the assurance framework, including the corporate risk register. It will be responsible for maintaining a programme of self-assessment and independent audit/verification against required standards other than finance.

The Scrutiny, Professional & Advisory Committees

These committees report through the Assurance Group to Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice within Service Groups.

7. Accountabilities and Responsibilities for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be clear about the functions of governance and their roles and responsibilities. Good governance means promoting values for the whole organisation and demonstrating the value of good governance through behaviour; taking informed and transparent decisions, and managing risk; developing the capacity and capability of the Board of Directors to be effective and engage in stakeholders and making accountability real.

The role of the Board

The role of the Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trusts strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance. By setting the Trusts values and standards the Board ensures that the Trust's obligations to patients, the community and staff are understood and met.

The role of the Chairman

The role of the Chairman and the Chief Executive is to lead the Board and the Assurance Committee in ensuring it's effectiveness on all aspects of its role and agenda setting. He will ensure the provision of accurate and timely information to Board members and effective communication with staff, patients and the public.

The role of the Non-Executive Directors

Non-executive directors will assure themselves and the Trust Board that the Assurance Committee and its related committees are addressing key governance issues within the organisation. Their responsibilities include strategy, by constructively challenging and contributing to the development of strategy; performance, through scrutiny of the performance of management in meeting agreed goals and objectives; risk, by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible. Non Executive Directors are responsible for ensuring the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

The role of the Chief Executive

The Chief Executive through his leadership creates the vision for the Board and the Trust to modernise and improve services. He is responsible for the Statutory Duty of Quality. He is responsible for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. His responsibilities include leadership, delivery, performance management, governance and accountability to the Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

The role of the Executive Team

The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team are responsible for ensuring that the Board, as a whole, are kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

Role of the Chief Operating Officer/Deputy Chief Executive

The Chief Operating officer is accountable to the Chief Executive for ensuring that the Trust operates sound systems of operational performance, working in conjunction with the Director of Finance.

The Chief Operating Officer has a lead role in ensuring organisational progress against the Trust objectives and Management Plan.

As part of the Trust's performance framework the Corporate and Service Group Directors, together with the Chief Operating Officer, are accountable for the Trust Management Plan and individual Service Group Directorate's plans based on the, Quality, Patient and Client Safety objectives and standards, financial objectives and targets agreed by the Board. The Chief Operating Officer maintains the review/monitoring process. The outcome of the review/monitoring process will contribute to the Board's Performance and Assurance Framework.

The Medical Director – Lead Director responsible for Integrated Governance and Risk Management and Involving Clinical Governance

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management excluding finance. This responsibility is shared with the Director of Nursing, Director of Social Work and Director of Finance.

He ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet it's statutory and legal responsibilities relating to his area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Boards information schedule. He will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on the Boards ability to fulfil it's governance responsibilities. As part of the Trust's performance and assurance process, the Chief Operating Officer and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Director of Nursing and Lead Director for Governance in Nursing

The Director of Nursing is responsible for all issues relating to nursing and midwifery policy, statutory and regulatory requirements and functions, professional practice and workforce requirements. She is responsible for providing strong professional leadership and for ensuring high standards of nursing and patient/client experience in all health and social care services.

The Director of Social Services – Lead Director for Governance in Social Services

The Director of Social Services ensures on behalf of the Chief Executive and the Board of Directors that the systems and structures are in place for the Trust to meet it's delegated Statutory Functions in child care services, services to people with a mental illness, learning disability, physical disability and older people.

The Director of Social Services ensures that the Board of Directors receives the relevant information, including the annual Statutory Functions Report and the Corporate Parenting reports. He/she is responsible for social work standards within the Trust including professional workforce issues as stipulated within the legislative regulations and guidance.

Director of Finance – Lead Director responsible for Financial Governance

The Director of Finance is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. He/she is, with the Chief Executive, responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with Department of Health and Treasury requirements.

The Director of Finance ensures that, on behalf of the Chief executive, the Trust has in place systems and structure to meet its statutory and legal responsibilities relating to finance, financial management and financial controls. He/she ensures the Trust has in place Standing Orders and Standing Financial Instructions, including a Reservation of powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

Director of Human Resources

The Director of Human Resources is accountable to the Chief Executive for ensuring the Trust has in place systems of staff management which meet legal and statutory requirements and are based on best practice and guidance from the Department of health and other external advisory bodies. Working closely with other Directors he/she maintains a system of monitoring the application of the Trust's Human Resources Strategy, Policies and procedures and, on behalf of the Board, ensures it receives the relevant information/annual reports according to the Board's information schedule.

The Trust's Learning and Development function falls within the remit of the Director of Human Resources. As such he/she works with relevant Directors to ensure the system in place meets the educational needs of staff and highlights management and clinical governance processes.

Director of Planning and Redevelopment

The Director of Planning and Redevelopment is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to the Board of Directors.

Service Group Directors

The Service Group Directors are:-

- Director of Older People, General Medicine and Surgery
- Director of Mental Health and Learning Disability Services
- Director of Head and Skeletal Services
- Director of Specialist Services
- Director of Clinical Services
- Director of Family and Children's Services

The Service Group Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance. Each Service Group will establish a Service Group Assurance Committee and develop systems and structures to support the various governance strategies, policies and procedures and ensure these are audited and monitored. Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management and the assurance framework, the Service Group Directors agree with the Chief Executive and the Chief Operating officer, the objectives and targets for their Service Group based upon the management plan agreed by the Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Service Group Directorate performance reviews.

The Service Group Directorates are supported and facilitated to meet their governance requirements by their dedicated governance leads and the risk and governance staff of the Medical Director's office.

8. Board Reporting

It is important that key information is reported to the Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow the Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Chief Operating Officer/Deputy Chief Executive, Medical Director and Finance Director will be responsible for providing the monitoring and support for the Assurance Framework and providing an updated position on performance and governance, the effectiveness of the Trust's system of internal control; providing details of positive assurances on principal risks where controls are

effective and objectives are being met; where the organisation's achievement of its objectives is at risk through significant gaps in control; and where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It will be important for the quality and robustness of this assurance framework to be evaluated by the Board annually.

Appendix A

RISK MANAGEMENT POLICY STATEMENT (INCORPORATING A DEFINITION OF ACCEPTABLE RISK)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

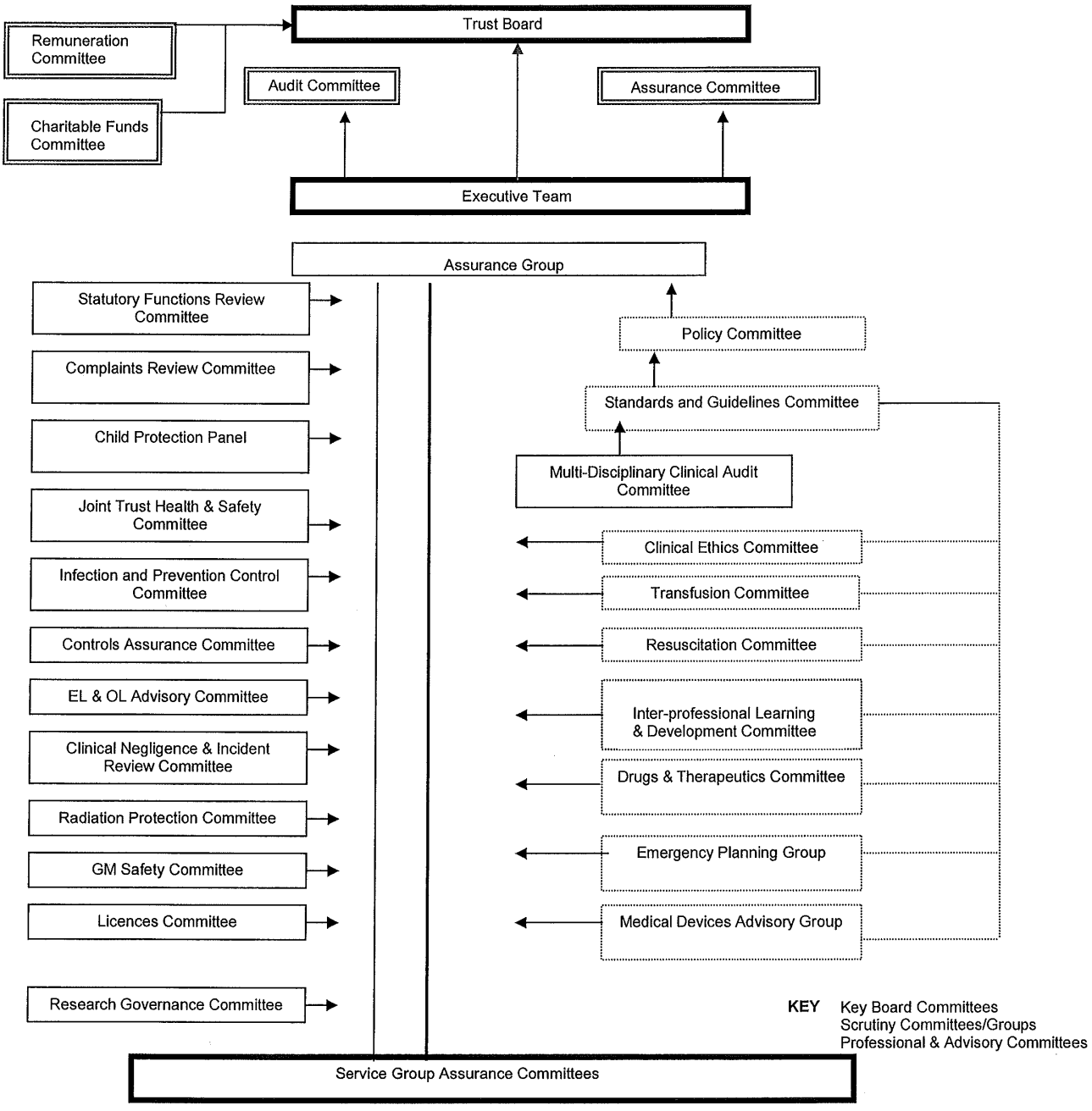
The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

Appendix B

ASSURANCE COMMITTEE
SUB COMMITTEE STRUCTURE



Belfast Health and Social Care Trust

BOARD ASSURANCE FRAMEWORK
(AND CORPORATE RISK REGISTER)

2010/11

Revised 21 May 2010

1. Introduction

The Board of Directors of the Belfast HSC Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled.

The Assurance Framework is an integral part of the governance arrangements for the Belfast HSC Trust and should be read in conjunction with the Corporate Plan.

The Assurance Framework (and Corporate Risk Register) describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the Trust's systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives [1]
- Identified principal risks that may threaten the achievement of those objectives;
- Controls in place to manage these risks, underpinned by core controls assurance standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast Health and Social Care Trust – Corporate Management & Delivery Plans

On an ongoing basis the Board will:

- Assess the assurances given;
- Identify where there are gaps in controls and/or assurances;
- Take corrective action where gaps have been identified; and
- Maintain dynamic risk management arrangements including, crucially, a regularly reviewed risk register.

2. Strategic Context

In order to produce the outcomes for which the Department of Health, Social Services and Public Safety (the Department) is ultimately responsible, a strong partnership is required between the Department and those HSC organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

The Minister's annual ***Priorities for Action*** (PfA)[2] reflect the *Priorities and Budget* focus on reform and modernisation of services within the context of the resources available to the Department, as well as the attainment of efficiency targets, and together they form an action plan for HSC.

The Trust Delivery Plan (TDP) describes how the Belfast Trust plans to use its resources to deliver health and social care services to patients, clients, children and young people, carers and families, and presents the Trust's proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets.

3. Objective Setting

The Trust's Corporate Plan sets out the vision and purpose, core values and long term corporate objectives that will shape the strategic direction and priorities for the Trust over the next 3 – 5 years.

The Trust has five long term corporate objectives. These are:

- To provide safe, high quality and effective care
- To modernize and reform our services
- To improve health and wellbeing through engagement with our users, communities and partners
- To show leadership and excellence through organisational and workforce development
- To make the best use of our resources to improve performance and productivity.

The Corporate Plan and the Trust Delivery Plan set out annual targets to progressively deliver these corporate objectives.

[2] http://www.dhsspsni.gov.uk/prior_action/index.asp

The Trust Delivery Plan is developed annually as a response to the Department's Priority for Action targets and the commissioning plans of the Health and Social Care Board as expressed in its annual Health and Wellbeing Improvement Plan.

While the Corporate Plan incorporates these Departmental/ commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets under each corporate objective.

The Corporate Objectives and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Service Group Annual Performance Plans
- Service/Team annual plans
- Individual objectives

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

4. What assurance means

The Board can properly fulfil their responsibilities when they have a full grasp of the principal risks facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HPSS-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

The Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of **reasonable** rather than **absolute** assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

This framework defines the approach of the Board of the Belfast HSC Trust to **reasonable** assurance. It is clear that assurance, from whatever source, will never provide **absolute** certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

5. Accountability

5.1 Accountability to Minister and the DHSSPS

Health and Well Being Investment Plans and Trust Delivery Plans are the main vehicles for conveying where and by what means PfA targets, efficiency savings and service improvements will be delivered. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements. The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social care to the people of Northern Ireland and for good governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

5.2 Accountability with the Health & Social Care Board

The Health & Social Care Board and Health and Social Care Trusts are accountable to the public for the services that they commission and provide.

The basis for HSC accountability is the Health and Personal Social Services (Northern Ireland) Order 1972[3] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department the duty to:

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

Under Article 16 of the 1972 HPSS Order, the HSS Boards were established for the purpose of administering and providing health and personal social services within their respective areas. This broad remit changed in the early 1990s when the HPSS (NI) Order 1991[4] (augmented by the HPSS (NI) Order 1994[5]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards' planning and commissioning of services for their resident populations, and the Trusts' provision of those services, remains but the HSS Boards functions have now been subsumed into those of the single regional Health & Social Care Board (HSCB). The Board was established in April 2009 by the Health and Social Care

[3] S.I.1972/1265 (N.I.14)
[4] S.I. 1991/194 (N.I. 1)
[5] S.I. 1994/429 (N.I. 2)

(Reform) Act (Northern Ireland) 2009 and includes five Local Commissioning Groups (LCGs) coterminous with the Trusts, Public Health Agency (PHA), a Business Services Organisation (BSO) and a Patient and Client Council (PCC).

Regarded from the accountability perspective, there are two broad categories of HPSS activity:

- Category one: those services identified as being needed and commissioned by the Health & Social Care Board from Trusts. The volume and quality of which are detailed in Service and Budget Agreements between the commissioner and the providers. This category also includes statutory obligations of Trusts including delegated statutory functions.

- Category two: certain duties to be performed by HSC organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

In accountability terms, there are differences between the two categories. In category one, Trusts are, initially answerable to the HSCB, via their Service and Budget Agreements, for the quantity, quality and efficiency of services. This relationship has been strengthened by the introduction of the statutory duty for the quality of services commissioned for, and provided to, the population which applies to both the HSCB and Trusts [6]. In this category, therefore, Trusts are responsible to the HSCB for the delivery of services to the quantity, cost and quality specified in Service and Budget Agreements.

Trusts, as corporate entities, are responsible in law for the discharge of statutory functions. The Trust is accountable to the HSCB for the discharge of those statutory functions delegated by the HSCB (relevant functions) and those conferred directly on Trusts by primary legislation. It is obliged to establish sound organisational arrangements to discharge such functions effectively. The majority of these functions relate to services provided by the Trust's professional Social Work and Social Care workforce.

The Scheme for the Delegation of Statutory Functions (the Scheme) sets out for each Service Sector the statutory duties delegated by the HSCB to the Trust and the accountability arrangements pertaining to these functions.

The Scheme specifies the organisational control and assurances processes informing the Trust's discharge of its statutory functions.

The nature and scope of the statutory functions and related services discharged by the Trust give rise to enhanced levels of public scrutiny. These include interventions in matters of personal liberty, the protection of vulnerable children

[6] Paragraph 5 of HSS(PPM) 10/2002

and adults, the Trust's corporate parenting responsibilities, the provision of vital services and the exercise by the Trust of regulatory functions. Their effective discharge is central to organisational integrity. As a consequence, they have a heightened organisational and corporate significance and related assurance profile. The Trust is required to have in place systems that are robust and capable of balancing appropriately the complex issues of protection and care.

The Trust is accountable to the HSCB for the effective discharge of its statutory functions as well as the quantity, quality and efficiency of the related services it provides. The HSCB has the authority to monitor and evaluate such services and requires the Trust to produce an annual report on how it has discharged its relevant functions

In category two (financial control, governance, and for overall organisational performance etc) the HSCB is accountable directly to the Department. The HSCB may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc on governance or financial control.

6. The Assurance Framework

This assurance framework provides a comprehensive and systematic approach to effectively managing the risks to meeting our objectives. The framework illustrates the wide range of assurances from internal and external sources.

The most objective assurances are those derived from independent reviewers – which will include the Regulation and Quality Improvement Authority, Departmental special enquiries or reviews and Internal and External audit. These are supplemented from non-independent sources such as performance management, multi-disciplinary audit, self assessment reports and professional monitoring and review processes within legislative and professional regulatory guidance.

The role of the Courts in the "regulation" and the holding of the Trust to account with regard to its discharge of its statutory functions is of key importance.

It is important that as information is collated and evaluated across the Trust that this is done in a consistent and efficient way, is proportionate and minimizes duplication of work by different reviewers.

This framework provides a structure for acquiring and examining the evidence to support the Statement of Internal Control.

Risk Management

The Belfast Trust will maintain and regularly update a risk management strategy that will be underpinned by its policy on risk (see Appendix A) and explain its approach to acceptable risk.

The Belfast Trust will adopt an open and learning culture that encourages continual quality improvement, but with openness when things go wrong. Processes for managing and learning from adverse incidents, complaints and litigation will be introduced as an immediate priority.

Controls assurance will remain a key process for the Belfast Trust. The Belfast Trust will identify key Directors to be accountable for action planning against each standard. The results will be used to inform the Trust's corporate risk register and will be mainstreamed with other aspects of the Trust's Delivery Plan through the Assurance Framework.

Organisational Arrangements

Proposed organizational arrangements for governance and assurance are set out in Appendix B. An important element of the Trust's arrangements is the need for robust governance within service groups. This will be tested through the accountability review process. There are a number of internal and external mechanisms that will support this.

The **Board of Directors** is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team
- Ensuring accountability to the public for the organisation's performance
- Assuring that the organisation is managed with probity and integrity.

The membership of the Board of the Trust is defined in the Establishment Order to include the Chief Executive, the Directors of Social Work, Medicine, Nursing and Finance.

The Audit Committee

The Audit Committee (a standing committee of the Board of Directors) is comprised of non-executive directors. Its role is to assist the Board in ensuring an effective control system is in operation. This includes the effectiveness of internal financial controls, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance in the Belfast Trust.

The Assurance Committee

The Assurance Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors only. Its role is to assist the Board of Directors in ensuring an effective assurance framework is in operation for all aspects of the Trusts undertakings, other than finance. The Assurance Committee is also responsible for the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Executive Team

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by the Board of Directors as part of the performance management and assurance processes, is available.

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update a corporate risk register, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to co-ordinate the work of expert and advisory committees as set out in Appendix B and service groups assurance, quality and safety committees. The Assurance Group will be responsible on behalf of the Executive Team for developing and maintaining the assurance framework, including the corporate risk register. It will be responsible for maintaining a programme of self-assessment and independent audit/verification against required standards other than finance.

The Expert Advisory Committees (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice within Service Groups.

7. Accountabilities and Responsibilities for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be clear about the functions of governance and their roles and responsibilities. Good governance means promoting organisational values at all levels, taking informed and transparent decisions, managing risk, developing the capacity and capability of the Board of Directors to be effective and engaging with stakeholders and making accountability real.

The role of the Board

The role of the Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trusts strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance. By setting the Trusts values and standards the Board ensures that the Trust's obligations to patients, the community and staff are understood and met.

The role of the Chairman

The role of the Chairman and the Chief Executive is to lead the Board and the Assurance Committee in ensuring its effectiveness on all aspects of its role and agenda setting. He will ensure the provision of accurate and timely information to Board members and effective communication with staff, patients and the public.

The role of the Non-Executive Directors

Non-executive directors will assure themselves and the Trust Board that the Assurance Committee and its related committees are addressing key governance issues within the organisation. Their responsibilities include strategy, by constructively challenging and contributing to the development of strategy; performance, through scrutiny of the performance of management in meeting agreed goals and objectives; risk, by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible. Non Executive Directors are responsible for ensuring the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

The role of the Chief Executive

The Chief Executive through his leadership creates the vision for the Board and the Trust to modernise and improve services. He is responsible for the Statutory Duty of Quality. He is responsible for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. His responsibilities include leadership, delivery, performance management, governance and accountability to the Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance.
This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, health and safety and risk management.

The role of the Executive Team

The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team are responsible for ensuring that the Board, as a whole, are kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

The role of the Deputy Chief Executive/Director of Finance

The Deputy Chief Executive/Director of Finance is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. She is, with the Chief Executive, responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with Department of Health and Treasury requirements.

The Deputy Chief Executive/Director of Finance ensures that, on behalf of the Chief Executive, the Trust has in place systems and structure to meet its statutory and legal responsibilities relating to finance, financial management and financial controls. She ensures the Trust has in place Standing Orders and Standing Financial Instructions, including a Reservation of powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

The Deputy Chief Executive has a key role in ensuring organisational progress against the Trust objectives and Corporate Plan.

The Medical Director – Lead Director responsible for Integrated Governance and Risk Management, including Clinical Governance

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management excluding finance. This responsibility is shared with the Director of Nursing, Director of Social Work and Director of Finance.

He ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet its statutory and legal responsibilities relating to his area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Boards information schedule. He will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on the Boards ability to fulfil its governance responsibilities. As part of the Trust's performance and assurance process, the Deputy Chief Executive and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Director of Performance & Service Delivery

The Director of Performance & Service Delivery is accountable to the Chief Executive for ensuring that a performance and accountability framework suitable for the delivery of the Trust Delivery Plan and Corporate Plan is in place, and ensuring the Trust operates sound systems of operational performance.

The Director of Nursing and User Experience

The Director of Nursing is responsible for all issues relating to nursing and midwifery policy, statutory and regulatory requirements and functions, professional practice and workforce requirements. She is responsible for providing strong professional leadership and for ensuring high standards of nursing and patient/client experience in all health and social care services.

The Director of Social Work – Lead Director for Governance in Social Services

The Director of Social Work is responsible for ensuring the effective discharge of statutory functions across all Service Sectors and the establishment of organisational arrangements and structures to facilitate same. She/he is required to report directly to Trust Board on the discharge of these functions, including the presentation of the annual Statutory Functions and six-monthly Corporate Parenting Reports.

The Director of Social Work provides professional leadership to and is responsible for the maintenance of professional standards and all regulatory issues pertaining to the Trust's social work and social care workforce.

Director of Human Resources

The Director of Human Resources is accountable to the Chief Executive for ensuring the Trust has in place systems of staff management which meet legal and statutory requirements and are based on best practice and guidance from the Department of health and other external advisory bodies. Working closely with other Directors he/she maintains a system of monitoring the application of the Trust's Human Resources Strategy, Policies and procedures and, on behalf of the Board, ensures it receives the relevant information/annual reports according to the Board's information schedule.

The Trust's Learning and Development function falls within the remit of the Director of Human Resources. As such she works with relevant Directors to ensure the system in place meets the educational needs of staff and highlights management and clinical governance processes.

Director of Planning and Redevelopment

The Director of Planning and Redevelopment is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to the Board of Directors.

Service Group Directors

The Service Group Directors are:-

- Director of Cancer and Specialist Services
- Director of Specialist Hospitals and Child Health
- Director of Social and Primary Care
- Director of Acute Services

The Service Group Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance. Each Service Group will establish a Service Group Assurance Committee and develop systems and structures to support the various governance strategies, policies and procedures and ensure these are audited and monitored. Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management and the assurance framework, the Service Group Directors agree with the Chief Executive the objectives and targets for their Service Group based upon the management plan agreed by the Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Service Group performance reviews.

The Service Group are supported and facilitated to meet their governance requirements by their dedicated governance leads and the risk and governance staff of the Medical Director's office.

8. Board Reporting

It is important that key information is reported to the Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow the Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Deputy Chief Executive / Director of Finance, Medical Director and Director of Performance & Service Development will be responsible for providing the monitoring and support for the Assurance Framework and providing an updated position on performance and governance, the effectiveness of the Trust's system of internal control; providing details of positive assurances on principal risks where controls are effective and objectives are being met; where the organisation's achievement of its objectives is at risk through significant gaps in control; and where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It will be important for the quality and robustness of this assurance framework to be evaluated by the Board annually.

APPENDIX A

RISK MANAGEMENT POLICY STATEMENT (INCORPORATING A DEFINITION OF ACCEPTABLE RISK)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

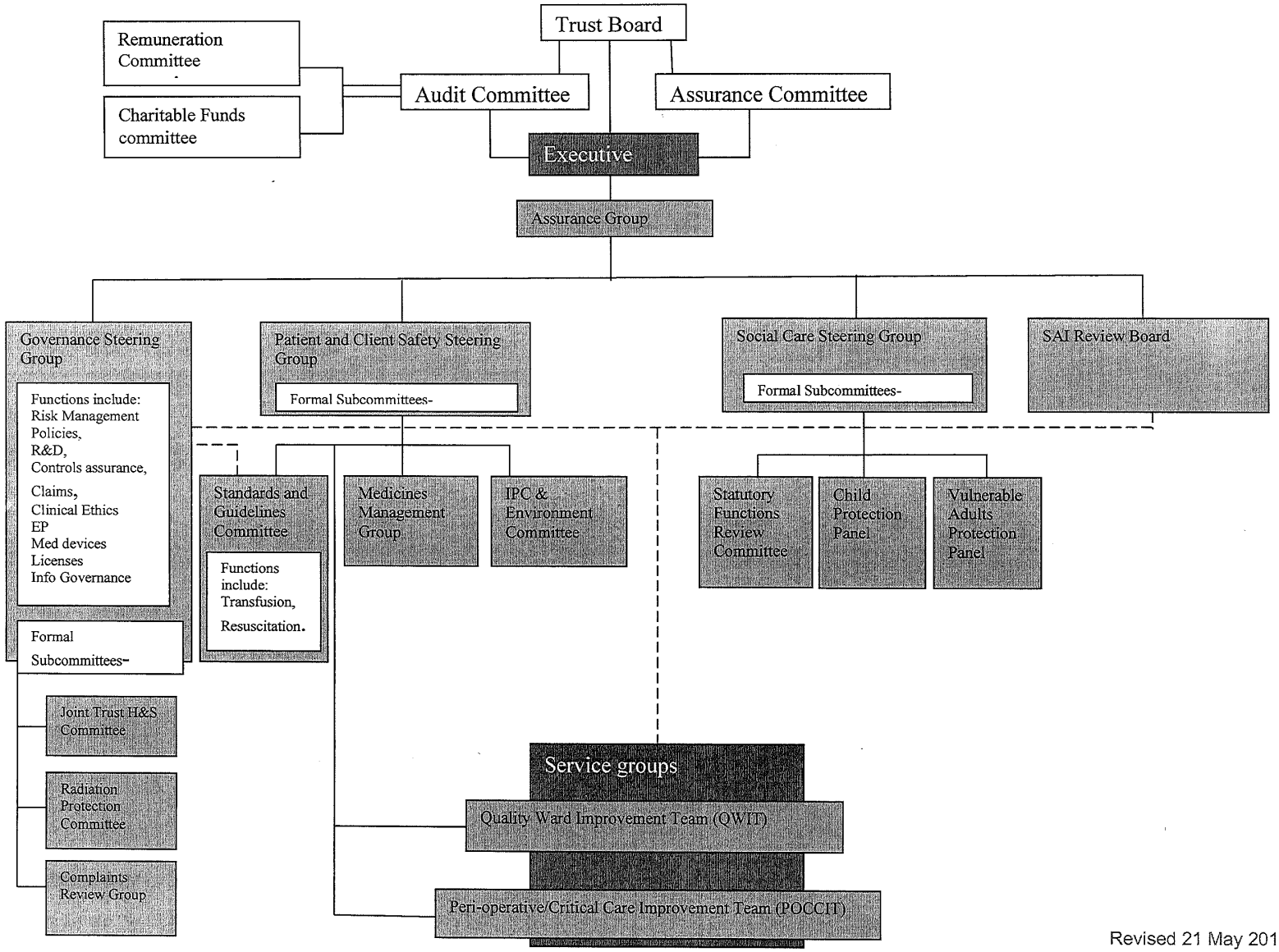
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

ASSURANCE COMMITTEE – SUBCOMMITTEE STRUCTURE



Revised 21 May 2010

Belfast Health and
Social Care Trust

BOARD ASSURANCE FRAMEWORK

2011/12

Index

1. Introduction

The Board of Directors of the Belfast HSC Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled.

The Assurance Framework is an integral part of the governance arrangements for the Belfast HSC Trust and should be read in conjunction with the Corporate Plan.

The Assurance Framework (and Principal Risk Document) describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives[1];
- Identified principal risks that may threaten the achievement of those objectives;
- Controls in place to manage these risks, underpinned by core Controls Assurance Standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast Health and Social Care Trust – Corporate Management & Delivery Plans

On an ongoing basis the Board will:

- Assess the assurances given;
- Identify where there are gaps in controls and/or assurances;
- Take corrective action where gaps have been identified; and
- Maintain dynamic risk management arrangements including, crucially, a regularly reviewed risk register.

2. Strategic Context

In order to produce the outcomes for which the Department of Health, Social Services and Public Safety (the Department) is ultimately responsible, a strong partnership is required between the Department and those HSC organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

The Minister's annual ***Priorities for Action*** (PfA)[2] reflect the *Priorities and Budget* focus on reform and modernisation of services within the context of the resources available to the Department, as well as the attainment of efficiency targets, and together they form an action plan for the HSC.

The Trust Delivery Plan (TDP) describes how the Belfast Trust plans to use its resources to deliver health and social care services to patients, clients, children and young people, carers and families, and presents the Trust's proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets.

3. Objective Setting

The Trust's Corporate Plan sets out the vision and purpose, core values and long term corporate objectives that will shape the strategic direction and priorities for the Trust over the next 3 – 5 years.

The Trust has five long term corporate objectives. These are:

- To provide safe, high quality and effective care;
- To modernise and reform our services;
- To improve health and wellbeing through engagement with our users, communities and partners;
- To show leadership and excellence through organisational and workforce development;
- To make the best use of our resources to improve performance and productivity.

The Corporate Plan and the Trust Delivery Plan set out annual targets to progressively deliver these corporate objectives.

[2] http://www.dhsspsni.gov.uk/prior_action/index.asp

The Trust Delivery Plan is developed annually as a response to the Department's Priority for Action targets and the commissioning plans of Health and Social Services Boards as expressed in their annual Health and Wellbeing Improvement Plans.

While the Corporate Plan incorporates these Departmental/ commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets under each corporate objective.

The Corporate Objectives and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Directorate Annual Performance Plans;
- Service/Team annual plans;
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

4. What assurance means

The Board can properly fulfil its responsibilities when it has a full grasp of the principal risks facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

The Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of **reasonable** rather than **absolute** assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

This framework defines the approach of the Board of the Belfast HSC Trust to **reasonable** assurance. It is clear that assurance, from whatever source, will never provide **absolute** certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

5. Accountability

5.1 Accountability to Minister and the DHSSPS

Health and Well Being Investment Plans and Trust Delivery Plans are the main vehicles for conveying where and by what means PfA targets, efficiency savings and service improvements will be delivered. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements. The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social services to the people of Northern Ireland and for good governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

5.2 Accountability with the Health & Social Care Board

The Health and Social Care Board and Health and Social Care Trusts are accountable to the public for the services that they commission and provide.

The basis for HSC accountability is the Health and Personal Social Services (Northern Ireland) Order 1972[3] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department the duty to:

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

Under Article 16 of the 1972 HPSS Order, the HSS Boards were established for the purpose of administering and providing health and personal social services within their respective areas. This broad remit changed in the early 1990s when the HPSS (NI) Order 1991[4] (augmented by the HPSS (NI) Order 1994[5]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards' planning and commissioning of services for their resident populations, and the

[3] S.I.1972/1265 (N.I.14)
[4] S.I. 1991/194 (N.I. 1)
[5] S.I. 1994/429 (N.I. 2)

Trusts' provision of those services, remains but the HSS Boards functions have now been subsumed into those of the single regional Health & Social Care Board (HSCB). The Board was established in April 2009 by the Health and Social Care (Reform) Act (Northern Ireland) 2009 and includes five Local Commissioning Groups (LCGs) coterminous with the Trusts, Public Health Agency (PHA), a Business Services Organisation (BSO) and a Patient and Client Council (PCC).

Regarded from the accountability perspective, there are two broad categories of HPSS activity:

- Category one: those services identified as being needed and commissioned by HSS Boards from Trusts. The volume and quality of which are detailed in Service and Budget Agreements between the commissioner and the providers. This category also includes statutory obligations of Trusts including delegated statutory functions.

- Category two: certain duties to be performed by HSC organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

In accountability terms, there are differences between the two categories. In category one, Trusts are, initially answerable to the HSCB, via their Service and Budget Agreements, for the quantity, quality and efficiency of services. This relationship has been strengthened by the introduction of the statutory duty for the quality of services commissioned for, and provided to, the population which applies to both the HSCB and Trusts[6]. In this category, therefore, Trusts are responsible to the HSCB for the delivery of services to the quantity, cost and quality specified in Service and Budget Agreements.

Trusts, as corporate entities, are responsible in law for the discharge of statutory functions. The Trust is accountable to the HSCB for the discharge of those statutory functions delegated by the HSCB (relevant functions) and those conferred directly on Trusts by primary legislation. It is obliged to establish sound organisational arrangements to discharge such functions effectively. The majority of these functions relate to services provided by the Trust's professional Social Work and Social Care workforce.

The Scheme for the Delegation of Statutory Functions (the Scheme) sets out for each Service Sector the statutory duties delegated by the HSCB to the Trust and the accountability arrangements pertaining to these functions.

The Scheme specifies the organisational control and assurance processes informing the Trust's discharge of its statutory functions.

[6] Paragraph 5 of HSS(PPM) 10/2002

The nature and scope of the statutory functions and related services discharged by the Trust give rise to enhanced levels of public scrutiny. These include interventions in matters of personal liberty, the protection of vulnerable children and adults, the Trust's corporate parenting responsibilities, the provision of vital services and the exercise by the Trust of regulatory functions. Their effective discharge is central to organisational integrity. As a consequence, they have a heightened organisational and corporate significance and related assurance profile. The Trust is required to have in place systems that are robust and capable of balancing appropriately the complex issues of protection and care.

The Trust is accountable to the HSCB for the effective discharge of its statutory functions as well as the quantity, quality and efficiency of the related services it provides. The HSCB has the authority to monitor and evaluate such services and requires the Trust to produce an annual report on how it has discharged its relevant functions.

In category two (financial control, governance, and for overall organisational performance etc) the HSCB is accountable directly to the Department. The HSCB may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc on governance or financial control.

6. The Assurance Framework

This Assurance Framework provides a comprehensive and systematic approach to effectively managing the risks to meeting our objectives. The framework illustrates the wide range of assurances from internal and external sources.

The most objective assurances are those derived from independent reviewers – which will include the Regulation and Quality Improvement Authority, Departmental special inquiries or reviews and Internal and External audit. These are supplemented from non-independent sources such as performance management, multi-disciplinary audit, self-assessment reports and professional monitoring and review processes within legislative and professional regulatory guidance.

The role of the Courts in the 'regulation' and the holding of the Trust to account with regard to the discharge of its statutory functions is of key importance.

It is important that as information is collated and evaluated across the Trust that this is done in a consistent and efficient way, is proportionate and minimises duplication of work by different reviewers.

This framework provides a structure for acquiring and examining the evidence to support the Statement of Internal Control.

Risk Management

The Belfast Trust will develop a risk management strategy that will be underpinned by its policy on risk (see Appendix A) and explain its approach to acceptable risk.

The Belfast Trust will adopt an open and learning culture that encourages continual quality improvement, but with openness when things go wrong. Processes for managing and learning from adverse incidents, complaints and litigation will be introduced as an immediate priority.

Controls Assurance will remain a key process for the Belfast Trust. The Belfast Trust will identify key Directors to be accountable for action planning against each standard. The results will be used to inform the Trust's corporate risk register and will be mainstreamed with other aspects of the Trust's Delivery Plan through the Assurance Framework.

Organisational Arrangements

Proposed organisational arrangements for governance and assurance are set out in Appendix B. An important element of the Trust's arrangements is the need for robust governance within Directorates. This will be tested through the accountability review process. There are a number of internal and external mechanisms that will support this.

The **Board of Directors** is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team;
- Ensuring accountability to the public for the organisation's performance;
- Assuring that the organisation is managed with probity and integrity.

The membership of the Board of the Trust is defined in the Establishment Order to include the Directors of Social Work, Medicine, Nursing and Finance.

The Audit Committee

The Audit Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors. Its role is to assist the Board in ensuring an effective control system is in operation. This includes the effectiveness of internal financial controls, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance in the Belfast Trust.

The Assurance Committee

The Assurance Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors only. Its role is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Executive Team

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by the Board of Directors as part of the performance management and assurance processes, is available.

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update a corporate risk register, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to co-ordinate the work of the assurance/scrutiny committees and Directorates' assurance quality and safety committees. The Assurance Group will be responsible on behalf of the Executive Team for developing and maintaining the Assurance Framework, including the Principal Risk Document. It will be responsible for maintaining a programme of self-assessment and independent audit/verification against required standards other than finance.

The Expert Advisory Committees (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice within Directorates.

7. Accountabilities and Responsibilities for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be

clear about the functions of governance and their roles and responsibilities. Good governance means promoting organisational at all levels, taking informed and transparent decisions, and managing risk; developing the capacity and capability of the Board of Directors to be effective and engage in stakeholders and making accountability real.

The role of the Board

The role of the Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to patients, the community and staff are understood and met.

The role of the Chairman

The role of the Chairman and the Chief Executive is to lead the Board and the Assurance Committee in ensuring its effectiveness on all aspects of its role and agenda setting. He will ensure the provision of accurate and timely information to Board members and effective communication with staff, patients and the public.

The role of the Non-Executive Directors

Non-Executive Directors will assure themselves and the Trust Board that the Assurance Committee and its related committees are addressing key governance issues within the organisation. Their responsibilities include strategy, by constructively challenging and contributing to the development of strategy; performance, through scrutiny of the performance of management in meeting agreed goals and objectives; risk, by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible. Non-Executive Directors are responsible for ensuring the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

The role of the Chief Executive

The Chief Executive through his leadership creates the vision for the Board and the Trust to modernise and improve services. He is responsible for the Statutory Duty of Quality. He is responsible for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. His responsibilities include

leadership, delivery, performance management, governance and accountability to the Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

The role of the Executive Team

The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team is responsible for ensuring that the Board, as a whole, is kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

The role of the Deputy Chief Executive / Director of Human Resources

As Deputy he/she both deputises for the Chief Executive and undertakes duties beyond the scope of Human Resources in line with service needs and organisational objective.

The Deputy Chief Executive/Director of Human Resources is accountable to the Chief Executive for ensuring the Trust has in place systems of staff management which meet legal and statutory requirements and are based on best practice and guidance from the Department of Health and other external advisory bodies. Working closely with other Directors he/she maintains a system of monitoring the application of the Trust's Human Resources Strategy, policies and procedures and, on behalf of the Board, ensures it receives the relevant information/annual reports according to the Board's information schedule.

The Trust's Learning and Development function falls within the remit of the Director of Human Resources. As such he/she works with relevant Directors to ensure the system in place meets the educational needs of staff and highlights management and clinical governance processes.

The role of the Director of Finance

The Director of Finance is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. He is, with the Chief Executive, responsible for ensuring that the

statutory accounts of the Trust are prepared in accordance with the Department of Health and Treasury requirements.

The Director of Finance ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meets it statutory and legal responsibilities relating to finance, financial management and financial controls. He ensures that the Trust has in place Standing Orders and Standing Financial Instructions, including Reservation of Powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

The Medical Director – Lead Director responsible for Integrated Governance and Risk Management, including Clinical Governance

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management and excluding finance. This responsibility is shared with the Director of Nursing, Director of Social Work and Director of Finance.

He ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet its statutory and legal responsibilities relating to his area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on the Board's ability to fulfil its governance responsibilities. As part of the Trust's performance and assurance process, the Director of Performance and Service Delivery and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Director of Nursing and User Experience

The Director of Nursing is responsible for all issues relating to nursing and midwifery policy, statutory and regulatory requirements and functions, professional practice and workforce requirements. She is responsible for providing strong professional leadership and for ensuring high standards of nursing and patient/client experience in all health and social care services.

The Director of Social Work – Lead Director for Governance in Social Services

The Director of Social Work is responsible for ensuring the effective discharge of statutory functions across all Service Sectors and the establishment of organisational arrangements and structures to facilitate same. She/he is required to report directly to Trust Board on the discharge of these functions, including the presentation of the annual Statutory Functions Report and six-monthly Corporate Parenting reports.

The Director of Social Work provides professional leadership to and is responsible for the maintenance of professional standards and all regulatory issues pertaining to the Trust's social work and social care workforce.

The Director of Planning and Redevelopment

The Director of Planning and Redevelopment is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to the Board of Directors.

The Director of Performance and Service Delivery

The Director of Performance and Service Delivery is accountable to the Chief Executive for ensuring that a performance and accountability framework suitable for the delivery of the Trust Delivery Plan and Corporate Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

Service Directors

The Service Directors are:-

- Director of Cancer and Specialist Services;
- Director of Specialist Hospitals and Child Health;
- Director of Social and Primary Care;
- Director of Acute Services.

The Service Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance. Each Directorate will establish a Directorate Assurance Committee and develop systems and structures to support the various governance strategies, policies and procedures and ensure these are audited and monitored. Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management and the assurance framework, the Directorate Directors agree with the Chief Executive and the Director of Planning and Service Delivery, the objectives and targets for their Directorate, based upon the management plan agreed by the Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Directorate performance reviews.

The Directorates are supported and facilitated to meet their governance requirements by their dedicated governance leads and the risk and governance staff of the Medical Director's office.

8. Board Reporting

It is important that key information is reported to the Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow the Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Chief Executive, Director of Finance, Medical Director and Director of Performance and Service Delivery will be responsible for providing the monitoring and support for the Assurance Framework and providing an updated position on performance and governance, the effectiveness of the Trust's system of internal control; providing details of positive assurances on principal risks where controls are effective and objectives are being met; where the organisation's achievement of its objectives is at risk through significant gaps in control; and where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It will be important for the quality and robustness of this Assurance Framework to be evaluated by the Board annually.

Appendix A

RISK MANAGEMENT POLICY STATEMENT (INCORPORATING A DEFINITION OF ACCEPTABLE RISK)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

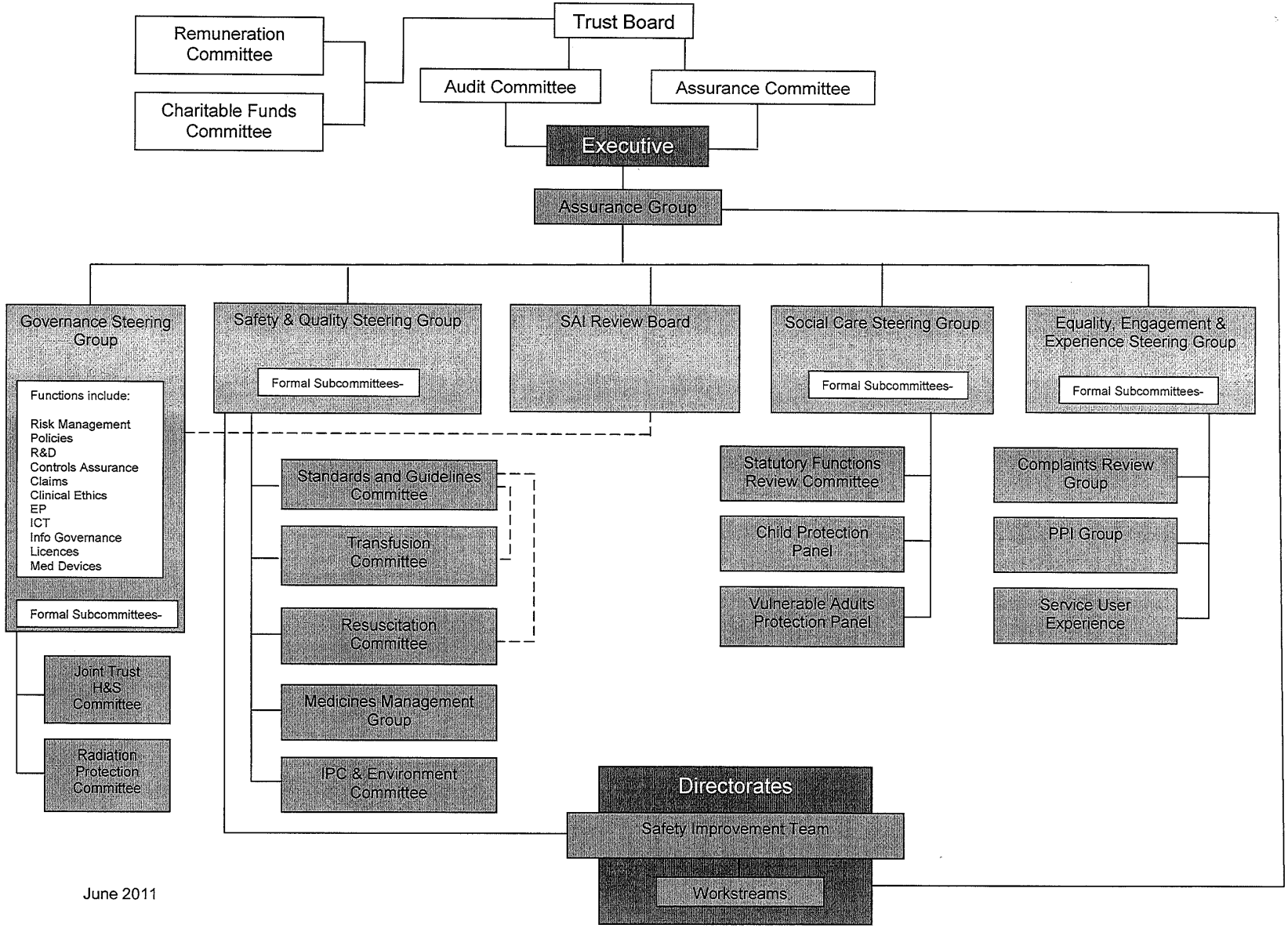
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

ASSURANCE COMMITTEE
SUB-COMMITTEE STRUCTURE



June 2011