Muckamore Abbey Hospital Inquiry

Organisational Module 9 – Trust Board

WITNESS STATEMENT OF MARTIN DILLON

I, Martin Dillon, former Chief Executive Officer within the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on my own behalf in response to a request for evidence from the MAH Inquiry Panel dated 13 March 2024. The statement addresses three different sets of questions posed to me relating to:

    a. the Trust Board of the Belfast Trust (the Trust Board);
    b. the 2018 "Way to Go" Report; and
    c. steps taken by the Belfast Trust in response to the "Way to Go" Report

2. This is my third witness statement to the MAH Inquiry. I endeavoured to assist the MAHI Inquiry previously as the witness statement maker on behalf of the Belfast Trust in respect of two MAHI Evidence Modules. I provided, with the assistance and contributions of others, the witness statement dated 28 March 2023 dealing with Module 5: Regulation and Other Agencies, and the witness statement dated 26 April 2023 dealing with Module 6: MAH Reports and Responses.

3. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "MD3".

4. The 13 March 2024 MAH Inquiry request for evidence, with the accompanying questions, can be found at Tab 1 in the exhibit bundle.

Qualification, Experience and Position of the Statement Maker

5. As I explained in my previous statements, I am an Economics Graduate and Qualified Accountant by academic background.

6. I was Chief Executive of the Belfast Trust between February 2017 and my retirement in February 2020. Prior to this I held the following roles within the Belfast Trust; Deputy Chief Executive and Executive Director of Finance (January 2015 - January 2017), Executive Director of Finance (October 2010 – June 2014) and Interim Chief Executive (June 2014 – December 2014). In these roles I was a member of the Executive Team and the Trust Board.

<u>Questions for Trust Board Members</u>

Question 1

Please identify:

- **i. The time period in which you were a member of the Trust Board.**
- **ii. Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub-committee(s).**

The time period during which I was a member of Trust Board

7. I was an Executive Member of the Trust Board of the Belfast Trust in the period October 2010 (when I became Director of Finance) to February 2020 (when I retired from my then role as Chief Executive).

The sub-committees of Trust Board of which I was a member

8. To the best of my recall, I was a member of the Charitable Funds Committee, which was a sub-committee of the Trust Board of the Belfast Trust.

The composition and remit of each of the sub committees of Trust Board of which I was a member

9. The Charitable Funds Committee was comprised of a small number of Non-Executive and Executive directors. Its role, during my time as a member, was to oversee the Belfast Trust's charitable trust funds in line with guidance in the Belfast Trust's Standing Financial Instructions, departmental guidance and legislation. This included, amongst other tasks, ensuring that the funds were not unduly or unnecessarily allowed to accumulate, and ensuring that expenditure from the funds were subject to value for money considerations.

10. To the best of my recall, the membership of all other sub-committees of the Board were comprised solely of non-executive Directors, with relevant Executive Directors being in attendance to present or speak to papers on the agenda and to answer any questions the members might have. The governance structures of the Trust are set out in the attached Board Assurance Frameworks that cover my time on the Trust Board; they are exhibited behind Tab 2 in the exhibit bundle. The Assurance Framework was a dynamic framework that was updated on a "needs arises" basis in light of any changed guidance or directives from the Northern Ireland Department of Health ("DoH") and/or in response to any governance changes made by the Belfast Trust. The minutes of all Sub-Committees of the Board are tabled for approval at meetings of Trust Board. This provides the relevant committee Chair with the means to escalate or make the Trust Board aware of any issues or concerns that require visibility at Trust Board, and to allow any action required on the part of the Trust Board to be discussed at Trust Board level. In this way the Trust Board gains assurance that appropriate action is being taken in respect of the matters under the remits of the various sub-committees, with a

mechanism for specific issues to then be raised with the Trust Board itself as necessary.

11. While not a member, I was also in regular attendance at meetings of the Audit Committee and Assurance Committee. This was for the purposes of presenting or speaking to papers, answering committee members' questions and queries, and ensuring follow up, where that fell to me, of agreed actions on behalf of the Committee.

Question 2

Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Trust Board level?

The structures and processes that were in place at Trust Board level for the oversight of MAH

12. The structures and processes that were in place at Trust Board level for oversight of Muckamore Abbey Hospital were the same structures and processes that were in place for the oversight of all other areas of the Belfast Trust, including the various different services within Learning Disability.

13. The Belfast Trust was and is a huge organisation with circa 22,000 staff and a current budget of circa £1.9 billion. My recall is that during my time in the organisation it was one of the biggest provider Trusts across the United Kingdom. It had a huge span of control to be managed, covering a huge range of services across many Directorates, ranging from very complex regional hospital services in Acute Hospital Services including transplant services, to Mental Health and Learning Disability Services, which ranged from complex regional services including secure forensic units to local services, to domiciliary practical and personal care services provided to people in their own homes. The Belfast Trust

provided services and support services from over 700 buildings. From recall during my time as Finance Director, Muckamore Abbey Hospital would have accounted for about, on average, 1% to 1.5% of the total Belfast Trust budget.

14. As a vast and complex organisation the Belfast Trust had in place comprehensive and necessarily complex governance structures and accountability arrangements, both to run the organisation and to provide the Trust Board with assurance that the organisation was being effectively run, and to allow it to monitor performance. The Belfast Trust ran on a model of delegated and distributed leadership. The structures and processes that were in place within the Trust for the oversight of the whole Trust are set out in the Board Assurance Framework referred to above.

15. Due to the size of the Belfast Trust which has at least, from memory, eight large service-facing Directorates, which themselves were the equivalent size of many NHS Trusts found in England, individual Directorates were expected to be managed and overseen internally in the first instance, with reporting procedures put in place to allow matters of sufficient note or concern to be raised up to Board level as necessary.

16. The structures and processes that were in place for the management and oversight of Muckamore Abbey Hospital (MAH) were the same as for other hospitals being managed by Belfast Trust. They were first and foremost managed at Directorate level. During my time in the Belfast Trust, MAH was within the Directorate of Adult Social and Primary Care. The relevant Director of Adult Social and Primary Care would had overall responsibility and accountability for operations within the Directorate, and would report to, and be accountable to, the Chief Executive for the services for which they were responsible.

17. As with the Directors of other Directorates, the Director of Adult Social and Primary Care had an extensive portfolio covering a huge range of services. Reporting to the Director of Adult Social and Primary Care were a number of Co-

Directors, one of whose portfolios included responsibility for Muckamore Abbey Hospital. That Co-Director's role therefore included ensuring that there was effective management and oversight of Muckamore Abbey Hospital, and in turn reporting to the Director. To the best of my recall of the managerial structures, a Service Manager, whose responsibilities included Muckamore Abbey Hospital, would have reported to the Co-Director, and below that was organisational site management.

18. Over and above the Directorate's operational and line management arrangements for the effective management and oversight of Muckamore Abbey Hospital, and as with other hospitals managed by the Belfast Trust, others would have had professional responsibility for various staff groups working within MAH. For example, the Director of Nursing would have professional responsibility for Registered Nurses across the Belfast Trust, including those in Muckamore Abbey Hospital. The Nursing Directorate was represented at Board level, and any matter of concern involving nursing care at Muckamore Abbey Hospital could be referred from directorate level up to Trust Board level as necessary.

19. In summary, given the size, scale and enormous scope of the Belfast Trust, it was primarily for the Director of Adult Social and Primary Care to have in place the structures and processes for the effective oversight of Muckamore Abbey Hospital in line with the Belfast Trust's overall Assurance and Governance arrangements. Those arrangements made provision for matters of concern to be raised to Trust Board level. As with the other Directorates within the Belfast Trust, the Directorate would have accounted for and provided assurance on the effective management and oversight of services operating within the Directorate by a variety of means, including through internal senior leadership meetings, Trust level and external accountability meetings and from the inspection reports from regulatory and other bodies such as RQIA.

20. As with any major matters of concern occurring within other Directorates within the Belfast Trust, it was a responsibility of the Director of Adult Social and Primary Care to raise or escalate any significant or major matters of concern, including any relating to Muckamore Abbey Hospital, to the Chief Executive in line with the Trust's Governance and Assurance arrangements. There were no restrictions on what could be escalated. Escalation was not discouraged in any way. It was a matter of judgment. Means of escalation could include informing the Chief Executive directly in cases of significant or major concerns, or raising a matter at the Executive Team under the relevant agenda heading, elevating a risk to the Principal Risk Register, informing relevant officers in the Regional Health and Social Care Board and/or the Department of Health, or with regulatory bodies such as the RQIA or MHRA (the Medicines and Healthcare Products Agency).

21. While, as has been said, the management and oversight of Muckamore Abbey Hospital was principally a matter for the Director and Directorate, they were supported in their endeavours to manage and oversee the whole Directorate by embedded internal 'business partners' from other Directorates; finance, planning and Human Resources. They were also supported by a range of corporate functions including corporate medical, nursing and social work teams. These supports included the provision of information and analysis in relation to the Directorate's financial performance, both in summary and in relation to individual budget areas, its performance against a wide range of commissioned activity and ministerial targets, including a range of governance and patient safety metrics. While it was expected that areas of significant concern would be specifically raised through Executive Team, Assurance Committee and Trust Board, other parts of the Belfast Trust, and external organisations, had functions that were capable of triangulating information, thereby highlighting problems or other issues which could be picked up at Board level. This included the presentation of key performance indicators/information in Trust-wide reports on Finance and Performance tabled at Executive Team and at Trust Board, Assurance Committee reports which included information or trends on SAIs, complaints process

measures, early alerts, incidents, progress with implementation of RQIA Inspection findings would also have helped identify concerns at ward/service/area level. Furthermore, during my time as Chief Executive, I regularly told individuals I met when I was at ward level that I was available to discuss any serious concerns raised at that level.

22. Additionally, the required Departmental Statutory Functions report, tabled annually at Trust Board by the Executive Director of Social Work, and Internal Audits reports presented at Audit Committee, would have provided additional oversight and assurance at Board level. The annual Statutory Functions report was a report in which the Belfast Trust (as with other health and social care trusts) set out how it had discharged the Statutory Functions and responsibilities delegated to it by the Department of Health and Regional Health and Social Care Board. The report covered areas such as the nature and scope of interventions in matters of personal liberty, the protection of vulnerable adults and children, how the Belfast Trust discharged its corporate parenting responsibilities and on the discharge of its regulatory function for certain services.

My view of how effective those structures and processes were in ensuring adequate oversight of MAH at Trust Board level

23. During the time I served on the Trust Board I did regard the complex governance structures that the Belfast Trust had in place as providing adequate oversight by Trust Board of the many services provided by the Belfast Trust. This included MAH. If I, and my colleagues, had thought the structures and processes were not adequate to give proper oversight to the Trust Board, then we would have taken steps to try to address that. Governance is always evolving and changing. It did so during my time on Trust Board. Changes are made in the belief they will make oversight better and more effective.

24. To the best of my recollection, which I accept be may be impaired with the passage of time, until the serious Adult Safeguarding concerns surfaced in 2017, during my time in the Belfast Trust, I do not recall any significant or major concerns about the management or oversight of Muckamore Abbey Hospital, or patient safety issues from MAH, being escalated to, or raised at, Executive Team or at Trust Board level.

25. To assist with preparing this witness statement I sought from the Belfast Trust and received access to Trust Board documents that I would have had access to during my employment. This was to refresh my memory of what matters were being discussed at Trust Board. While I do not have any recall of this matter at this distance in time, I note that in the minutes of the Trust Board in confidential session on the 11 April 2013, under the reference 09/13(f), the then director of Adult Social and Primary Care briefed Trust Board members that the PSNI had investigated an alleged case of ill treatment of patients at Muckamore Abbey by two members of staff and that they had recommended prosecution to the Public Prosecution Service. This would be in keeping with what I would expect to happen on the thankfully reasonably rare occasions when staff of the Belfast Trust face criminal prosecution. The relevant Director of the Directorate in which the staff worked would inform the Trust Board. It would not have required the Trust Board to do anything, rather it was for information. The expectation of the members of Trust Board would be that the issues that gave rise to the matter were being addressed in the relevant Directorate, unless the relevant Director considered that some specific issue required the attention of, and assistance of, the Trust Board.

26. Prior to 2017, I had no reason to believe that the structures and processes for the management and oversight of Muckamore at Directorate level were other than effective. Governance structures obviously require staff to use them appropriately. Now, with the benefit of hindsight, and through the findings of the likes of the Level 3 SAI Review report 'A Way to Go', it seems clear to me that the governance system was not being used appropriately by some staff, in that staff who were

aware of their responsibilities through their training, job description, through Trust Codes of Conduct, and associated values and behaviours statements and through their professional codes of conduct (and who would or should have been aware of the Trust's focus on seeking continuous improvement in patient safety) were not speaking up and out, either to line or professional management, about unacceptable behaviours of some staff at Muckamore Abbey Hospital.

27. The reviewing of CCTV revealed incidents of abuse and neglect which were not reported or referred as Adult Safeguarding Incidents in the way the governance structure and processes required. I do not know if this was because the individuals concerned felt unable, or were unwilling, to do so, or both. I cannot believe it was for lack of opportunity either, as provision was made in the Belfast Trust for whistleblowing or other means of escalation. This reticence to speak up, whatever the reason, prevented abuse from being exposed to the light of day, and stopped, and from appropriate action being taken. If the MAH Inquiry can, through its work, gather insight as to why some staff at Muckamore Abbey Hospital failed to speak up and to escalate matters, and gather insight as to how a culture embeds itself whereby unacceptable practice becomes 'socialised' or 'normalised' or shrugged off by certain staff, it will be of great help in improving the future safety of care. I believe the Belfast Trust had appropriate whistleblowing arrangements in place that were highly visible and other channels including escalating to line or professional management existed for staff, but they were not being used as they should have been by some staff in MAH in 2017.

Question 3

To your recollection, how often was MAH included on the agenda of:

i. **Meetings of the Trust Board.**
ii. **Meetings of the Executive Team.**

Meetings of the Trust Board

28. The role of a Trust Board is set out in the Department of Health Management Statement Document, in particular at Section 3.4.2. A copy is included behind Tab 3 in the exhibit bundle. It is also summarised in the Board Assurance Framework. Copies have been included behind Tab 2. The Trust Board is concerned with directing and supervising the Trust's affairs and this is done through reviewing and managing Trust or Directorate performance.

29. Thus, the Trust Board agenda is not facility/building driven, but rather driven by a focus on discharging the Trust Board's functions, with the focus being on setting strategic direction within the policy and resources framework set by the Department of Health, with a focus patient and service user safety, to ensure quality in line with its overall statutory duty of quality, to ensure the provision of safe and effective services, identifying and managing risk and performance against a range of targets, including ministerial targets, and the delivery of agreed levels of activity commissioned by the Health and Social Care Board and against a range of safety metrics, ensuring it receives regular reports on the financial management and financial stewardship of the Trust in line with statutory duties, and constructively challenging the Executive Team in their planning, target setting and delivery of performance.

30. Thus Muckamore Abbey Hospital *per se* would not normally appear on a Trust Board agenda. The same applies to other hospitals and facilities across the Belfast Trust. An individual service or facility would only appear on the Agenda if the Director in question or the Chief Executive were aware of significant concerns that merited review at Trust Board level. If a matter of concern pertaining to Muckamore Abbey Hospital was elevated to Trust Board level, it would have been included under the likes of the Chief Executive's report or under a relevant agenda heading, depending on the nature of the issue.

31. Following the events of 2017, the matter became a standing agenda item under the heading of 'Chief Executive's Report'. That reflects the fact a serious problem or

problems were found to exist, and which the management of has continued to present difficulty for the safe running of this hospital. Consequently, it is something about which the Trust Board would need to be aware.

Meetings of Executive Team

32. As with the Trust Board, a discrete service area such as Muckamore Abbey Hospital would not usually appear as a freestanding agenda item unless concerns about it had been raised to Executive Team level. It was principally for Directorates to identify and escalate concerns to this level as necessary.

33. I do not recall Muckamore Abbey being raised as a freestanding agenda item at the Executive Team before 2017. When issues about Adult Safeguarding became apparent in late 2017, Muckamore Abbey Hospital became a standing agenda item. This was done at my request, as Chief Executive, in November 2017 due to the seriousness with which I took the Adult Safeguarding issues that were emerging. Muckamore Abbey Hospital remained a standing agenda item until after my retirement in February 2020. Accordingly, the Executive Team was receiving weekly updates on Muckamore Abbey Hospital after it became aware of serious Adult Safeguarding concerns in late 2017.

Question 4

Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

34. During my time on the Trust Board, I had the opportunity to visit Muckamore Abbey Hospital a number of times. It is not possible to be precise about all the dates I visited as it is no longer possible for the Belfast Trust to access my old diary.

35. The Executive Team held a number of peripatetic meetings at various sites throughout the Belfast Trust. I attended two such meetings at Muckamore Abbey

Hospital, one on 3 February 2016 and the other on 2 August 2017. I was present in my role as Deputy Chief Executive and Executive Director of Finance at the former, and in my role as Chief Executive at the latter. At that time the Executive Team was holding some of its meetings away from Trust headquarters in differing venues, such as Hospitals and Health and Care Centres, so as to increase the visibility of the Executive Team and to facilitate a 'meet and greet' with staff following the meetings. It also permitted Executive Team members to visit wards and service areas to hear more, at first hand, of the work staff were doing, and, probably most importantly of all, taking the opportunity to thank staff for the work they do. To the best of my recollection, at the end of these meetings, Directors went to visit various wards to meet patients and staff. It is my recollection that at the end of the meeting held in MAH in August 2017, and after my MAH ward visits with the Director of Nursing that were conducted on that occasion, we attended a staff recognition/thank you event in the staff canteen where I had the opportunity to pay tribute to, and thank, a number of MAH staff.

36. The Trust Board also held a Workshop meeting at Muckamore Abbey on the 2 July 2015. The Trust Board held Workshops every second month or so, to allow it to hear Patient/Service User stories directly from patients and service users and to receive presentations from various service areas on their work. My recall is that there was a schedule of MAH ward visits after the Workshop, although I do not now recall which ward or wards I was assigned to visit.

37. I also recall undertaking a visit to the Psychiatric Intensive Care Unit (PICU) with the Chairman of the Belfast Trust. I cannot be precise about the date, but I believe this was sometime in 2017. The purpose of that visit was to allow the Chairman to meet with patients and staff in the PICU and to help deepen his insight into the nature of the service provision at Muckamore Abbey Hospital, and of the patient population and the challenges associated with resettling the remaining patient population.

38. On becoming Chief Executive in 2017, part of my proposition for taking the Belfast Trust forward was that we would, as a Trust, strengthen our focus on improving patient and service user safety without neglecting our performance, financial stewardship or other responsibilities. I set the Belfast Trust an ambitious target of being in the top 20% of Trusts in the UK in this area of patient and service user safety by 2020. I supported this agenda by introducing and investing in new managerial arrangements which devolved a greater role, power, responsibility and accountability for the patient and service user safety and quality improvement agenda to Senior Clinicians, as I believed that unless they took the principal lead for, and ownership of, this agenda, and were given dedicated time to pursue it (alongside appropriate support from management), that the necessary progress would not be achieved. The new arrangements included introducing the new role of Divisional Chairs (all of whom were senior doctors), whose job description set out clearly, *inter alia,* their role in driving forward improvements in the safety of care provision. One such Divisional Chair's responsibilities included Muckamore Abbey Hospital.

39. As part of this drive for improved patient safety, I embarked, as Chief Executive, on a series of visits across the Belfast Trust to as many service areas as I could to meet with as many staff as possible. I wanted to make myself visible to staff and to directly bring my message about the Trust's focus on improving safety to staff groups. These visits were about walking in staff's shoes and shadowing them at work. Given the huge breadth of the Belfast Trust's work, I wanted to experience as wide a range of services as I could across a range of Directorates. I met with Ward Sisters and Charge Nurses across a range of Belfast Trust facilities, including Muckamore Abbey Hospital. As my diary is no longer accessible, I unfortunately cannot be precise as to the date, save to say that it was during my time as Chief Executive.

40. I made a point of speaking to Charge Nurses and Ward Sisters because I believe that they play a pivotal role in driving and ensuring patient safety improvements

within their wards. The purpose of these informal visits was to introduce myself, make myself visible to this group of staff, to speak about the Trust's safety improvement agenda and to highlight that my inbox, door and phoneline was open to them if they felt the need to escalate any safety issues or concerns they had that they felt were not being addressed up their line management channels.

41. From memory about 12-14 Ward Sisters/Charge Nurses attended the meeting at Muckamore Abbey Hospital which was held in the Boardroom in the administrative Block. I do not recall any issues or concerns around patient safety being raised with me, either in the meeting, or privately with me after the meeting concluded. This was similar with other sites, where the main concerns raised related to recently-introduced HR and Finance systems and challenges associated with managing the impact of unfilled staff vacancies. I took reassurance from this, as my experience has been that Ward Sisters and Charge Nurses are not afraid to speak up where they see problems.

42. I also visited Muckamore Abbey Hospital again sometime in 2018 or 2019 during the time when the Director of Adult Social and Primary Care was largely based there so that she could provide a visible very senior leadership presence and to progress actions being taken to improve the lived experience of the patients.

43. In summary, my recall is that I made multiple visits to Muckamore Abbey Hospital during my time on the Trust Board. I recall visits (some multiple times) to PICU, Cranfield, Sixmile, Donegore, Killead, Day therapy/day centre unit, the staff canteen, and the Administrative Building.

Question 5

Did the Trust Board receive reports on the following (and if so, please indicate how often):

i. **Safeguarding of patients at MAH.**
ii. **Seclusion rates at MAH.**

iii. Complaints relating to MAH.

iv. Resettlement of patients from MAH.

v. Staffing (both establishments and vacancies) at MAH.

Reports on the Safeguarding of patients at MAH

44. To the best of my recollection, prior to the events that surfaced in 2017, no reports on safeguarding at Muckamore Abbey Hospital were tabled at Trust Board. As referenced earlier in my response to question 2, the confidential minutes of the Trust Board meeting on 11 April 2013 do reference the Trust Board being informed of a safeguarding matter at MAH.

45. I say this in the wider context that my recollection is that Safeguarding Reports, from any service area in the Trust, were not things provided either to the Executive Team or the Trust Board. Rather, in line with its role and functions, the Trust Board's focus would have been on monitoring performance and receiving assurance through its sub-committee structure (in particular, in the context of adult safeguarding, from the Social Care Committee) and from the annual Statutory Functions Report, that its safeguarding arrangements were in line with regional requirements, that policies were up to date and that policies and processes were operating effectively.

46. My recollection is that the management and oversight of safeguarding processes and investigations, in line with extant Trust policy, was managed at Directorate level, with monitoring, oversight and the evaluation of the arrangements overseen by Safeguarding Steering Groups who provided reports to the Social Care Committee for scrutiny and challenge. From recall, I believe that a section on how the Belfast Trust discharged its Safeguarding responsibilities would have been included in the annual Statutory Functions Report. If required, the Trust's Director of Social Work and/or the Trust's Governance Lead would be in a position to provide the Inquiry with greater detail on this aspect of Safeguarding governance.

Reports on seclusion rates at MAH

47. To the best of my recollection, prior to the events that surfaced in 2017, no reports on seclusion at Muckamore Abbey Hospital were tabled at Trust Board. Again, I say this in the wider context that reports on seclusion were not provided to the Board from any service area in the Trust as the Board's functions were focussed on monitoring performance and receiving assurance, and the Trust had procedures in place to ensure that matters such a seclusion were dealt with at Directorate level, with assurance being given to the Trust Board through its sub-committees.

48. I cannot recall, at this remove, which sub-group in the Board Assurance Framework considered reports on the use of seclusion in relevant Trust facilities. The Trust's governance manager could help the Inquiry with this if required.

Reports on Complaints relating to MAH

49. To the best of my recollection, prior to the events that surfaced in 2017, no reports on complaints relating to Muckamore Abbey Hospital were tabled at Trust Board. I make the same observation as above in relation to the sorts of issues that would be raised at the Trust Board. So far as complaints are concerned, the Trust Board would be concerned with monitoring complaints handling at a Directorate or Trust-wide level and seeking assurance through its sub-committee structure that complaints were being handled in line with policy and targets. This would include considering the proportion of complaints being resolved. At Trust Board level, this would not be done on a site-specific basis. My recollection is that it was for each directorate to manage and respond to complaints within the target timescales prescribed by the Department of Health. The Governance Department would have provided high summary information on Complaints (e.g. overall numbers, trends, category of complaint , and information on whether they were considered resolved etc.) by Directorate for scrutiny and challenge by sub committees of the Board. My

recall is that two of the non-executive Directors of the Board were on the Complaints Committee.

Reports on Resettlement of patients from MAH

50. To the best of my recall, prior to the events that surfaced in 2017, no specific or detailed reports on resettlement from Muckamore Abbey Hospital were tabled at Trust Board. The Board's focus would have been on monitoring performance against any resettlement targets set by the HSCB and subsequently set out in the Trust Delivery Plan (TDP). I cannot recall with any accuracy, at this remove, what targets were set for what years with regard to resettlement of patients from Muckamore Abbey Hospital. The Board would have been aware of resettlement targets in the relevant year's TDP as it would have approved the TDP ahead of submission to the regional Health and Care Board and would have received updates from the Director of Planning and Performance on performance against such targets, although not with a degree of specificity relating to any particular site.

Staffing (both establishments and vacancies) at MAH

51. To the best of my recall, prior to the events that surfaced in 2017, no reports on staffing at MAH were tabled at Trust Board. This would have been the same for other hospitals and services within the Belfast Trust. The management of staffing at Muckamore Abbey Hospital was managed at Directorate level, with support from other relevant Trust Departments such as Human Resources and Central Nursing.

Question 6

If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:

i. Who prepared those reports?

ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?

iii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?

52. For the period prior to 2017, please refer to the answer at 5 above. For the period following 2017, please see the answer at 7 below.

Question 7

Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.

53. Prior to the events that surfaced in 2017, I have no recall of being made aware of concerns relating to the matters set out in Question 5, (i) –(v). My recall is that I was first made aware of a specific safeguarding concern relating to MAH on the 20 October 2017 when I received correspondence from the Chief Social Work Officer and the Chief Nursing Officer in the Department of Health about a safeguarding incident at Muckamore Abbey Hospital. A copy of that letter, together with its response and subsequent correspondence, is exhibited behind Tab 4 in the exhibit bundle.

54. In the 20 October 2017 letter the Chief Officers stated their concerns regarding a delay by the Belfast Trust in submitting an Early Alert in relation to an alleged assault on a patient in PICU at Muckamore Abbey Hospital on the 12 August 2017. The Early Alert was sent to the DoH on the 7 September 2017 when it should have been submitted promptly, normally within 48 hours of the incident occurring. The letter also raised concerns about a lack of detail in the update to the Alert submitted on the 26 September 2017, and the fact that an Early Alert had not yet been submitted in relation to the precautionary suspension of another member of staff relating to a safeguarding concern in another ward. The letter asked for written

accounts of both incidents and explanations for the delays in notifying the DoH via the early alerts. I provided the response by letter dated 3 November 2017.

55. Following receipt of the correspondence from the DoH Chief Officers I requested a full briefing from the then Director of Adult Social and Primary Care, including an update on all the actions being pursued to investigate the complaint and of the engagement with affected families and actions being taken to ensure the safety of all patients. As part of this briefing I was advised that the contractor which had installed CCTV at Muckamore Abbey Hospital had advised that CCTV footage in relation to the 12 August 2017 incident was available to view, because, although the system was not due to go live until the 11 September 2017, recording for trialling and testing purposes had been going on for a number of months in 2017. The Director advised me that after legal advice had been sought the footage had been viewed and that this had led to a further precautionary suspension of another member of staff and actions against others.

56. I briefed the Trust Chairman on this issue just as soon as I became aware of it and provided him with a copy of the DoH correspondence referred to earlier. Subsequently a full verbal update was provided to the Trust Board in confidential session on the 2 November 2017. In this update, the Director of Adult Social and Primary Care referenced the incidents and the precautionary suspension of two members of staff. The update referenced the establishment of a Director-led Oversight Group, consisting of the Deputy Chief Executive/Medical Director, the Director of Adult Social and Primary Care, the Director of Nursing and the Director of Human Resources. This Oversight group would meet weekly with Muckamore Abbey teams to oversee progress with agreed actions introduced.

57. The Chair requested a paper on the actions being taken be presented to the Assurance Sub-Committee of the Trust Board at its meeting on the 14 November 2017. This was duly done.

58. Since we had learned that CCTV footage was available to view, this led to other recent incidents being viewed and further examples of unacceptable practice surfaced. My recall, at this remove from events, of the key initial and subsequent actions taken is set out below. It is largely based, given the passage of time, on re-reading Trust Board minutes. I should say that it was primarily the responsibility of the Executive arm of the Belfast Trust to develop and implement the appropriate actions to safeguard patients in response to the unfolding events at Muckamore Abbey Hospital, and to keep the Trust Board fully sighted on these matters so that it could exercise its challenge and assurance functions. The role of the Trust Board was to provide oversight and challenge, and to scrutinise actions for their comprehensiveness and appropriateness, or to highlight any other actions the Trust Board wished to see taken. It would not be the Trust Board itself taking the actions.

59. From November 2017 onwards, Trust Board members were updated every month, either by means of a verbal or written update, of the various actions being taken to ensure the safety of all patients at Muckamore Abbey Hospital, and to improve their daily lived experience. The Trust Board minutes for the period of my tenure as Chief Executive reflect these updates and record questions, follow up actions, and assurances asked for by the Chair and Non-Executive members following these updates. These updates were either provided by me in my role as Chief Executive, based on material provided to me by Directors, or through me, by the relevant Director or Directors. Some updates may have also been provided at the Social Care Committee.

60. From the outset the actions were first and foremost focussed on ensuring all patients at Muckamore Abbey Hospital were being safely cared for, and to drive improvements in the quality of the patients' daily lives. As stated earlier, in response to unfolding events, a Director-led oversight group was established which met weekly to oversee the implementation of actions, including enhanced monitoring on the Muckamore Abbey Hospital site.

61. My recall is these actions included an increased managerial presence, particularly nursing, on the wards at Muckamore Abbey Hospital, to observe care, and to provide visible leadership; staggered night time visits and unannounced leadership visits; and meetings with affected families and other key stakeholders. As further incidents of unacceptable practice emerged, oversight and actions were strengthened and deepened as appropriate, with the Director for Adult Social and Primary Care being a frequent presence on site, offering an open door to all staff to come and see her to air and discuss any concerns they might have.

62. Other key actions included commissioning an independent level 3 SAI review into safeguarding at Muckamore Abbey Hospital. Its Terms of Reference were contributed to, and agreed by, the DoH and the HSCB. This resulted in the SAI panel producing the 'A Way to Go' Report, and ensuring that its findings and recommendations were reflected in the action plans if not already there.

63. The Belfast Trust also commissioned an External Support Team to review the appropriateness of the Trust's actions in response to events. Over time, the oversight arrangements were strengthened as the need arose. With effect from March 2019, under my direction, given the huge and complex tasks associated with ongoing family communication and engagement; managing the retrospective viewing of a huge volume of CCTV footage; ongoing liaison with the PSNI and RQIA; and in light of growing workforce issues, the responsible Director was freed from all their responsibilities bar those relating to Muckamore Abbey Hospital.

64. In addition to this, an Assurance Group chaired by the deputy Chief executive and Medical Director, which had the Director of Nursing, the Director of Adult and Primary Care and HR Directors as members, was established to oversee all the various actions being pursued under various workstreams. This included considering actions being pursued on a regional basis around admissions to, and

discharges from, Muckamore Abbey Hospital, and on the need for ongoing resettlement of patients by all Trusts.

65. During all of this time I kept the Board Chairman fully briefed through weekly one to one meetings, and very regular updates were given to the Trust Board to allow it to exercise its challenge and scrutiny function. At this remove, I cannot recall the exact sequencing of events, nor all of the fine detail of the various actions, but others such as the then Director of Adult Social and Primary Care, the current Chief and deputy Chief Executive and the current Director of Nursing may be able to provide some further information on the detail of actions taken.

66. I believe that, once incidents of abuse identified from CCTV began to surface in the second half of 2017, the Belfast Trust responded quickly to these matters, endeavoured to put in place appropriate safeguarding arrangements, and took a host of actions to try to ensure it had a firm grip on the situation. The intended focus was on ensuring the safety of patients and on improving their daily lived experience. There were significant challenges, for example in relation to workforce stabilisation. The Trust Board members were kept informed of developments and wanted to be assured that appropriate steps were being taken in what was a very difficult situation.

Question 8

What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH?

Please also describe your recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

The arrangements in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH?

67. The arrangements for workforce monitoring, planning and implementation to ensure appropriate staffing levels and skill mix fell to the Directorate, supported by Central Nursing and Human Resources partners. The Trust Board would not have a direct involvement in monitoring in this area unless matters of specific concern were escalated to it. Following the events of 2017, the Trust Board would have been updated on workforce issues at MAH as they arose, as part of the general updating that occurred on actions being taken to address matters occurring at MAH.

68. With regard to workforce monitoring generally throughout the huge organisation that the Belfast Trust was, the Trust Board would have been made aware, at a high level, through Finance, Performance and HR reports, and through the Directors of Nursing and Social work and the Medical Director, of general workforce concerns. For example, areas of staffing gaps from unfilled vacancies or sickness which might impact on commissioned activity and other service provision, and of the actions taken by the Belfast Trust to try to mitigate such risks (such as the use of bank staff, overtime and locum tenens appointments).

My recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

69. The actions would have been for the Directorate to manage, and this issue would only have been dealt with by the Trust Board if it were escalated by the Director in question. To the best of my recollection, this did not happen.

70. Following the events of 2017, the Board was regularly updated on actions being pursed to ensure that staff skills at MAH met patient needs. I recall that this

included the Belfast Trust ensuring that there were at least two registered Nurses on each shift. As the number of precautionary suspensions grew, creating workforce sustainability challenges, I recall meeting with the then Department of Health Permanent Secretary to enlist his help in encouraging other Trusts to release suitable nursing staff to help, and to consider a pay premium for staff working on the Muckamore Abbey Hospital site to aid with recruitment and retention. The former directors of Adult Social and Primary Care and the current Director of Nursing would be in a better place to answer the Inquiry's questions in relation to the specific actions taken.

Question 9

Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

71. From my recollection, the answer to this question is no. In my time in the Belfast Trust, the Trust's approach to dealing with annual Pharmacy and General savings targets issued by the Department of Health was through its MORE Programme (Managing Outcome, Resources and Efficiencies). This was a vehicle for looking at this agenda on a Trust-wide basis, as all Directors were normally in attendance. It also served as an accountability forum for delivery of savings. This would usually be chaired by the Chief Executive.

72. Through MORE, Directors were asked to identify savings proposals based on benchmarking, best practice examples from elsewhere in the Trust, and indeed from outside the Trust. When savings proposals were approved, Directorates were then expected to put plans in place to achieve the savings. Monitoring of delivery happened through Finance Reporting and through MORE. This approach was adopted Trust-wide. Thus, the Directorate in which Muckamore Abbey Hospital sat was treated no differently from any other Directorate. In fact, it is my recall from my time as Finance Director that, in relation to Muckamore Abbey Hospital,

the Belfast Trust succeeded each year in receiving non-recurring bridging finance to compensate the Trust for the fact that bed closures did not fall neatly into line with re-settlements owing to the needs of the remaining population as well as funding for increased agency and 'specialing costs'. The resettlement process, from my recollection, was a robust process which was agreed between the Belfast Trust and Regional Health Board Staff and overseen by the HSCB. The plan revolved around withdrawing budgets from Muckamore Abbey Hospital as wards closed so that that funding could be used as a contribution towards the costs of patients resettled into community placements. Where the withdrawal plans resulted in overspending at Muckamore Abbey Hospital against budget, for example when wards could not be closed or bed numbers fall in line with agreed timescales because of the complex care needs of the remaining patients, or where resettlement packages cost more than estimated, the Regional Board provided bridging and/or non-recurring support to offset the overspends. At no stage was Muckamore Abbey Hospital, to the best of my recollection, asked by the Directorate to cover such cost pressures through savings at MAH. I understand from speaking to the current Director of Finance that this remains the case.

Question 10

From 2010 onwards, following bed closures at MAH:

i. **How did the Trust Board assure itself that the reorganisation of wards was safe?**
ii. **Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.**

73. It was principally for the Directorate managing Muckamore Abbey Hospital to ensure that the ward reorganisations, following resettlements, was safe, and to escalate to the Executive Team and to the Trust Board any major issues of concern that the Executive Team or the Trust Board needed to be aware of. In the same

way, it was for other Directorates within the Trust to manage the restructuring and reorganisation of services within the Directorate in question. For example, there was major restructuring in a number of services in the Trust e.g. Cardiology, and it was the role and responsibility of those Directors and Directorates to manage the reorganisations following resettlements safely, and to escalate any issues or concerns appropriately. I have no recall of any concerns or issues in relation to Muckamore Abbey Hospital and ward reorganisations being escalated to Trust Board. Following the events of 2017 the Trust Board, as has been stated earlier, received regular updates on staffing issues and how they were being managed.

Question 11

Were any issues relating to MAH ever included in:

i. **The Delegated Statutory Functions Report?**
ii. **The Corporate Risk Register?**

If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.

74. I do not recall at this remove whether issues relating to MAH were included in the Delegated Statutory Functions Report or the Corporate Risk Register. My recollection is that the Delegated Statutory functions report was a document that reported on the exercise of statutory functions at an organisational level, and that it did not provide an assessment of how individual sites or services performed those functions. That being said, it was a report that would have commented on adult safeguarding or learning disability services and it is possible that an issue relating to MAH may have been mentioned. I am unable to recall whether any issues relating to MAH were included in any Delegated Statutory Functions Report.

75. Similarly, at this remove, I am unable to recall whether any issue relating to MAH was ever included on the Corporate Risk Register.

Question 12

Were SAIs which occurred at MAH always reported to the Trust Board? If so:

i. **What information did the Trust Board receive in respect of SAIs?**
ii. **Were SAIs discussed at Trust Board meetings?**
iii. **What actions did the Trust Board take in response to SAIs?**

76. The Trust Board would not normally consider SAI reports from any service. SAIs were managed by the Directorate in which they occurred, in line with a Framework issued by the Regional Health and Social Care Board. The Assurance Committee of the Trust Board, to the best of my recollection, was provided with information on SAIs. From memory this would have included information, for example, on numbers and the nature of SAIs by Directorate or service area, on the number of SAI review reports beyond their expected report date. The Belfast Trust's head of Governance would be able to provide the MAH Inquiry with further information on the nature of these performance monitoring reports.

Question 13

How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

77. The RQIA Inspection reports relating to MAH, as with all inspection reports relating to Belfast Trust facilities, would have been addressed by the Directorate to which they related. My recall is that the Board's Assurance Committee would have received performance reports on RQIA inspections, both thematic and on regulated services, for the Committee to scrutinise. These reports would have included, from memory, updates on progress with the implementation of recommendations. The Trust's head of Governance would be best placed to provide further information on the nature of these reports if the MAH Inquiry wished to have it.

Question 14

Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

78. I have no recollection of the issues referred to above being escalated by the Trust Board to the DoH. It would have been for the Director to escalate to the Trust Board in the first instance. It was open to the Director to ask for a matter of concern to be escalated by the Chief Executive if his/her escalation was not achieving the desired objective or outcome. In my experience it would be rare for a Chief Executive to ask the Chair of the Trust Board to escalate a matter (Chairs, as ministerial appointees, would escalate matters to the Minister) as they were normally dealt with before that level of escalation would be required. It was for each Director supported by other relevant Directors such as the Director of Human Resources and the Director Nursing to escalate to the HSCB and/or the DoH any issues relating to workforce issues or resettlement challenges that they believed required visibility at that level or indeed required action on the part of those external bodies. Regular meetings with the HSCB by Programme of Care or Speciality would have provided Directors with the opportunity to escalate matters that they wished to do so.

Question 15

Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.

79. I have no recollection of the Trust Board discussing the installation and operation of CCTV at Muckamore Abbey Hospital, or indeed anywhere else on Belfast Trust premises.

Question 16

Other than as addressed in responses to the questions above, please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Trust Board level to address such concerns?

80. Other than that addressed in previous answers, I do not recall being made aware of concerns over the abuse of patients by staff at Muckamore Abbey Hospital.

Question 17

Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

81. I was personally aware of the Winterbourne scandal from press reports at the time. In relation to the applicability or relevance to Northern Ireland of any of the learning and actions being taken by the NHS in England, my view is that I would have expected Regional Professional Officers in regional bodies such as the DoH or the HSCB in Northern Ireland to take a lead on determining what learning or initiatives should be implemented in Northern Ireland. This would ensure that such were properly commissioned and that appropriate regional oversight arrangements applied. It may well also be that there was more specific consideration of these issues within Learning Disability within the Belfast Trust, but appropriate individuals from the Belfast Trust would need to be asked about that.

Question 18

Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

82. I regret that a public inquiry is necessary, but look forward to seeing recommendations focussed on how to avoid any repeat of the abuse, and problems that have occurred at Muckamore Abbey Hospital. During my time as interim Chief Executive, Deputy Chief Executive and Chief Executive in the Belfast Trust, I put a huge emphasis on improving patient and service user safety and invested in this agenda. When the level of abuse at Muckamore Abbey Hospital was uncovered, and all the consequent difficulties that arose for the patients and the hospital as a result, I was shocked and saddened because I knew the devastating impact it would have on families who had entrusted their loved ones to the Belfast Trust's care, and because what happened was the vey antithesis of the values of the organisation and of the patient/service user safety agenda I was promoting. I was very grateful therefore to have had the opportunity on the 18 February 2019 to be able to humbly and unreservedly apologise in person to families at a meeting the Trust Chairman and I attended to hear the views of families as to how the recommendation of the 'A Way to go Report' might be taken forward. This personal apology followed up on previous unreserved and unequivocal apologies to patients and their families made by the Belfast Trust,

83. Institutions such as a Muckamore Abbey Hospital, where patients who are originally admitted for short stay assessment and treatment end up unintentionally staying for lifetimes, for want of suitable alternative community placements, have, in my view, no place in future service provision.

84. Trusts can put in place best in class governance, managerial and oversight arrangements but they will only be as good as their weakest link, that is to say, human beings, and they can be defeated by those who collude to do so. It is also a

reality that well-meaning people with the right values are also human, will make mistakes, and we can often put staff into environments and situations that increase the risk of mistakes and error on their part. We have to try to minimise those risks as much as possible. It is important that Trusts continue to focus greatly on Patient Safety and to ensure that Clinicians are properly engaged in, and taking a lead on, this agenda. Trusts need to work tirelessly to create a blame-free culture wherein staff feel empowered to report incidents and mistakes so that they can be reviewed in context, root causes properly identified and relevant learning taken and applied so that safety improves. We need to strengthen our arrangements to support staff who bravely 'whistleblow' and refuse to walk past on the other side of the ward when they see something that is not right. We should never lose sight of the fact that the vast, vast majority of staff come to work to do their best for patients and care for them with compassion like they were their own kin. I believe that, down the years, the overwhelming majority of staff in Muckamore Abbey Hospital will have looked after their patients with skill, kindness, compassion and empathy and it is important that this is remembered.

85. In my view 'best in class' governance arrangements can go a long, long way, but can probably never fully protect patients who lack a voice and/or capacity from staff who seek to abuse them and who keep their wrongdoing masked from those who would take action to stop it, and those who aid them through their wilful silence. I hope the MAH Inquiry is able to gain insight, through its work, as to why staff were either unable, unwilling, or both, to speak up and to escalate concerns and incidents despite the means being available to them, and that the MAH Inquiry is able to gain insight into why staff go 'rogue', and how a culture in which bad practice became socialised or normalised on certain wards on certain shifts, is created, survives, and is hidden from view. If so, this will provide invaluable learning for future improvement.

86. We need to find a way, through increased vigilance, of nipping in the bud any culture or behaviours that run contrary to the values of the Belfast Trust. This

should be a feature of specific leadership training for leaders in environments caring for patients who lack capacity, whereby the leaders' antennae must always be up through a frequent on-the-ground presence, and through promoting a zero tolerance culture in respect of poor behaviour to patients, and by truly listening to the patient and family voice. It may be, given repeated incidences of abuse at scale across the United Kingdom, that CCTV may have to be a feature of future oversight, and be part of the patient's voice, and indeed offer protection for staff in what are challenging roles. How to make best use of CCTV, so as to be fair, will be very important. It may be relatively easy to identify obvious instances of abusive practices. However, issues at the opposite end of the scale have the potential to damage well-meaning staff who have no intent to abuse. Perhaps the availability of sound may be important in this regard, so that better context may be available. I wish the MAH Inquiry well in its endeavours and look forward to its recommendations for safer care in the future.

Questions relating to the "Way to Go" Report

Question 1

In relation to the Terms of Reference of the November 2018 report, "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital" ("the Way to Go report"):

i. **Who wrote the Terms of Reference?**
ii. **How were the Terms of Reference determined?**
iii. **Why was the time period 2012 - 2017 selected for the investigation of adult safeguarding and subsequent investigations?**
iv. **Why was the time period August 2017 – October 2017 selected for the investigation of incidents occurring at PICU and Six Mile?**
v. **Why was the time period 2012 - 2017 selected for the investigation of governance and quality assurance controls?**

87. By way of contextual background, the framework for SAI reporting is provided in a document entitled 'Health and Social Care Board Procedure for the Reporting and Follow up of Serious Adverse Incidents.' The Belfast Trust followed this procedure in 2017 when commissioning the Independent Level 3 SAI Review into Safeguarding incidents at Muckamore Abbey Hospital. The purpose of SAI reviews is to identify learning and to ensure that any learning elicited can be taken and applied to minimise the potential for incident recurrence. SAI reviews are neither investigatory nor accountability vehicles, but reviews, whose aims are to identify learning for the improvement of services.

(i) Who wrote the Terms of Reference?

88. As responsibility for the Terms of Reference sat with the then Director of Adult Social and Primary Care, Ms Heaney is likely to best placed to answer this question, alongside any available documentary material that records what occurred. The then Director of Adult Social and Primary Care may have had assistance from other colleagues within the Belfast Trust in relation to drafting the Terms of Reference. I know I did ask the then Director of Adult Social and Primary Care to ensure that the Terms of Reference included two items that the Chief Social Worker and the Chief Nursing Officer of the Department of Health had directed to be included in their letter to me dated 30 November 2017. However, I do not believe I was involved in the actual drafting.

89. My understanding of the procedure for Level 3 SAIs is that the Health and Social Care Board/Public Health Agency appoint an appropriate Designated Review Officer for each SAI, whose responsibilities include agreeing the Terms of Reference, the membership of the Review Panel, setting timescales for the completion of reviews, receiving and reviewing completed reports, monitoring follow-up action plan delivery and disseminating learning regionally, if applicable.

90. Consequently, the Terms of Reference may have been drafted by the Director in question in the first instance, though they would have to be agreed and signed off by the Health and Social Care Board.

(ii) How were the Terms of Reference determined?

91. I was not involved in determining the Terms of Reference save that I passed on the request made to me by the DoH as set out above. To the best of my understanding, the Terms of Reference were determined by a combination of the DoH, the Belfast Trust and the Health and Social Care Board. So far as I understand, the Terms of Reference were ultimately signed off by the Health and Social Care Board. I believe that the former Director of Adult Social and Primary Care may be able to assist the Inquiry further with this question.

(iii) Why was the time period 2012-2017 selected for the investigation of adult safeguarding and subsequent investigations?

92. In the correspondence from the DoH to me dated 30 November 2017, the DoH stated that it believed the Trust "*now needs to review all allegations of abuse by staff over the last five years and the action taken by the Trust as part of its investigation. We therefore ask that this is now incorporated into the Terms of Reference for the 'Level 3' SAI investigation.*" I assume, in view of this, that is why the period 2012-2017 was selected, but, again, Ms Heaney may be better able to assist.

(iv) Why was the time period August 2017 to October 2017 selected for the investigation of incidents occurring at PICU and Six Mile?

93. Although I was not involved in the identification or selection of this time period, I believe that this period was selected because that was the time period in which the incidents to be reviewed as part of the Level 3 SAI Review occurred.

(v) Why was the time period 2012-2017 selected for the investigation of governance and quality assurance controls?

94. I do not believe I had any involvement in selecting this period. The then Director of Adult Social and Primary Care would be better placed to answer this question. My instinct is that this period was selected so as to be co-terminus with the period selected for the review of safeguarding incidents.

Question 2

In relation to the 69 patient safeguarding files provided to the Review Team for the Way to Go report:

i. How, by whom and on what basis were the 69 patient files selected?

ii. Were the entire files provided, or some portion of them? If the latter, please provide an explanation of the documents which were included and excluded, and the reason(s) therefor.

(i) How, by whom and on what basis were the 69 patient files selected?

95. As I have set out above, I did not have direct involvement with the Level 3 SAI; the Belfast Trust's then Director of Adult Social and Primary Care was leading on the commissioning of the Level 3 review and was working alongside the Health and Social Care Board's Designated Review Officer. The Director was leading on engagement with the SAI panel in relation to accommodating their preferred ways of working and methodology and the then Director and her team had the responsibility to ensure that the Review Team had access to any and all material the Level 3 SAI panel considered necessary to assist them in fulfilling the Terms of Reference. I believe it would have been for the Review Team to make sure that they obtained everything they considered necessary for the discharge of the Terms of Reference, and to escalate to the Director if they had any concerns about access to whatever they required. I do not recall the Director ever raising with me anything

of this nature. I believe, again, that the then Director of Adult Social and Primary Care may be better-placed to answer this question.

(ii) Were the entire files provided, or some portion of them? If the latter, please provide an explanation of the documents which were included and excluded, and the reason(s) therefore.

96. Answer, as per (i) above.

Question 3

In relation to the 61 RQIA reports provided to the Review Team for the Way to Go report, how, by whom and on what basis were those reports selected? Were they complete reports?

97. Please see the answers to question 1 and 2 above. I am afraid I cannot answer this question.

Question 4

In relation to the 12 patient experience interviews provided to the Review Team for the Way to Go report, conducted pursuant to an RQIA questionnaire:

i. Was this the total number of such interviews or a selection?

ii. Were the entire contents of the 12 interviews provided, or selected parts of them?

iii. How, by whom and on what basis were those interviews (or parts of them, if applicable) selected?

98. I am unable to answer this question for the reasons appearing in my responses to questions 1 and 2 above.

Question 5

How, by whom and on what basis were the 20 minutes of CCTV footage, shown to the Review Team, selected (see page 8 of the report)?

99. I am unable to answer this question for the reasons appearing in my responses to questions 1 and 2 above.

Question 6

Paragraph 17 of page 9 of the Way to Go report refers to an undated "Business Case" for MAH:

i. Are you aware of when and by whom this document was written?

100. It is not clear to what Business Case is being referred to, and consequently I do not know when or by whom it was written.

ii. Do you know how the number of beds said to be needed (115) was calculated?

101. As it is not clear what Business Case is being referred to, I am afraid I do not know how the number of beds said to be needed was calculated.

iii. Can the number of beds said to be needed be reconciled with the view expressed in the Bamford Review and Equal Lives that learning disability services should be community based?

102. I am unable to comment on the above as I do not know what Business Case is being referred to.

Question 7

Dr Flynn gave oral evidence to the Inquiry on 25 May 2023 that the data at paragraph 55 of the Way to Go report was taken from information supplied by MAH (see the transcript of 25 May 2023 at page 43). How and by whom was this data compiled and calculated?

103. I do not know and am unable to comment for the reasons appearing in my responses to questions 1 and 2 above.

Question 8

On the same date, Dr Flynn gave oral evidence to the Inquiry that the Review Team believed that the Report would be published (see the transcript of 25 May 2023 at pages 10-11). In relation to the issue of publication of the Way to Go report:

i. What was the Trust's view regarding publication of the report at the time of engaging the Review Team?

104. The Belfast Trust was commissioning, in line with the HSCB Procedure, a Level 3 SAI Review, whose Terms of Reference, panel membership, reporting timescales, and action plan follow-up arrangements would all be agreed with the Health and Social Care Board's Designated Review Officer under the applicable procedure. As I have set out above, the purpose of SAI Reviews is to elicit and apply learning to eliminate or minimise the potential for incident recurrence. SAI review reports are sent to the Health and Social Care Board for consideration and sign-off and are then shared internally with relevant staff, and the outcomes are shared with patient/service user/families involved in line with the Health and Social Care Board procedure.

105. SAI Reviews often contain significant information about the nature of a particular incident and a detailed review of all the relevant care given. Personal information which could identify patients or staff in question would be contained in the review. My recollection is that patient information is redacted before transmission to the Health and Social Care Board for approval. The presence of personal information is a reason these reports are not published. The Belfast Trust views SAI reviews as a very important source of learning for improving the safety and effectiveness of patient or service user care. They are essential to promoting a culture of continuous improvement that staff feel safe in reporting incidents, accidents and near misses so that these can be properly reviewed in a no blame,

non-punitive way. If staff feel safe and assured about a 'no unfair blame' ethos, they are more disposed to incident reporting so that learning can be applied for the improvement of services.

106. On some occasions in the past, I believe reports, suitably redacted for staff names or other sensitive data, were shared with Patients or Service Users affected by the SAI.

107. As SAI Reviews are often focussed on single adverse events and contain sensitive personal information, and because they are not public-interest investigations or accountability vehicles, these Reviews are simply not published to the public at large. Leaving aside concerns about personal information, the concern would be that if health and social care staff felt that a SAI Review report would be published by Trusts, they might refuse to participate and stop openly reporting incidents because they fear that unfair blame or public recrimination might ensue.

108. Given that SAI Reviews are never published it was never a matter of the Belfast Trust taking a particular view on publication. The question simply did not arise. I do not recall the matter of possible publication ever being discussed or escalated to me. Publication would have set a difficult precedent and I believe that any publication would have required the agreement of the Health and Social Care Board, and, in all likelihood, the DoH.

ii. Did this view change? If it did, why?

109. Please see the response to question 8(i) above.

iii. When and how was the Trust view regarding publication communicated to the Review Team?

110. As these reviews are not published, it was not a matter of the Belfast Trust having a view. The then Director who was leading on engagement with the Review Team never, to the best of my recollection, discussed with me any views that the Review Team, or its Chair, had on publication.

iv. When, if at all, was a decision taken by the Trust to leave the report unpublished?

111. For the reasons set out above, I do not consider that the Belfast Trust made a positive decision not to publish this particular report; rather, the practice was that such reports were not published and so this matter was simply not considered by the Belfast Trust.

v. Who made this decision?

112. Please see the responses above; no positive decision was made by any individual, rather the established practice was not to publish these reports. What occurred over this report, occurs over every such report.

vi. When and how was this decision communicated to the Review Team?

113. Because it was never a matter of taking a positive decision not to publish, there was nothing to communicate to the Review Team.

vii. For what reason(s) was the report left unpublished?

114. Please see the responses above.

Question 9

In relation to the shorter Way to Go "summary" report, which was published in or around February 2019, Dr Flynn has given evidence to the Inquiry that she did not write it (MAHI-STM-130-1). In relation to this summary report:

i. Who compiled it?

115. I believe the summary, in terms of the content, was in large part compiled by the Chair of the Level 3 SAI Review. This was publicly explained by the Belfast Trust at the time of publication on 15 February 2019; please see https://belfasttrust.hscni.net/2019/02/15/summary-of-a-review-of-safeguarding-at-muckamore-abbey-hospital-a-way-to-go/

ii. What were the circumstances leading to its compilation?

116. Please see the explanation publicly provided by the Belfast Trust on 15 February 2019. It is available through the above link, but a copy of the relevant Belfast Trust webpage can be found behind Tab 5 in the exhibit bundle. As I have set out above, SAI Reports are never published. Of primary importance was the intention of the Belfast Trust, from the outset of the review, to ensure that the families affected by the incidents that occurred in PICU and Sixmile and were the subject of the SAI were notified of the Terms of Reference; that they were fully engaged with throughout the process; and that they were kept fully up to date on progress with the Review. I have some recollection of the then Director leading on all this, briefing me about workshops with affected families, hosted by the SAI Panel members, in the Summer of 2018 to discuss and take feedback on emerging findings and learning. To the best of my recollection, it was the intention from the outset to ensure that affected families were provided with copies of the SAI review Report once finalised and signed-off by the Health and Social Care Board. This was duly done in December 2018, when the SAI Panel Chair and the then Director hand delivered copies of the report and discussed its content with affected families.

117. My recollection is that, following these meetings, there were media requests for the finalised Review Report and growing calls for publication in the public interest. Given that SAI reports are not published for the reasons stated earlier, and in order to avoid causing potential further distress to affected families through the possible public identification of their family members, and to avoid setting a difficult precedent which may have required Health and Social Care Board, and possibly DoH, approval, the then Director suggested the publication of a summary version that could be published and which would focus on the key findings, the learning, and recommendations. The Trust Board believed that this represented a reasonable course of action that promoted openness and transparency whilst also protecting families.

Steps taken in response to the Way to Go Report

Please explain any actions taken by the Belfast Trust in relation to:

Question 1
The conclusions of the Way to Go Report, at pages 33-35.

118. It is unclear if this question is posed having considered what I had to say on behalf of the Belfast Trust in paragraph 190 to 235 in the Belfast Trust Module 6 statement dated 26 April 2023. I repeat paragraphs 190 to 235 in the Belfast Trust Module 6 statement dated 26 April 2023 in full in this regard.

119. By the time the report was presented to the Belfast Trust and Health and Social Care Board in December 2018, a whole range of actions were already being taken including, to the best of my recollection, some actions in pursuit of the conclusions, learning and recommendations. These were known about from previous Trust Board Workshops on the draft report. I cannot at this remove remember the exact chronology of events, but I do know that the Belfast Trust was also working with

the East London Trust to learn about their practice and to ensure that the Belfast Trust was learning quickly from elsewhere.

120. Following receipt of the Level 3 SAI Report, often known as the "A Way to Go" report, I asked the then Director of Adult Social and Primary Care to ensure that any actions the Belfast Trust needed to take in respect of its conclusions and recommendations, which were not already reflected in existing action plans, were included in plans going forward, and to provide monitoring reports to the Executive Team and Trust Board. I recall that important actions were taking place (though not necessarily conclusions or recommendations arising from the Level 3 SAI report); the further roll out of CCTV to other MAH wards; improvements to safeguarding procedures; the recruitment of behavioural nurses; strengthening of patient advocacy arrangements; updating the seclusion policy; and placing a focus, along with other Trusts, on admission avoidance and ensuring patients were discharged promptly upon completion of their assessment. The then Director may be better placed to provide the Inquiry with the full details of steps taken at this time.

Question 2

The learning identified in the Way to Go Report, at page 36.

121. Please see the response to question 1 above.

Question 3

The recommendations made in the Way to Go Report, at page 47.

122. See the answer to question 1 above. The two recommendations were more regional in nature, and I believe it would have been for the Health and Social Care Board and DoH to lead on making regional changes. In terms of matters within the Belfast Trust's remit, I recall that the Belfast Trust placed a renewed focus on resettlement of patients, although I am afraid I do not now recall the full nature of

the steps undertaken by the Belfast Trust in response to the "A Way to Go" Report. The then Director of Adult Primary and Social Care may be able to assist the MAH Inquiry more fully in this regard.

Question 4

Each of the workforce issues identified in the Way to Go Report, at pages 59-64 of Appendix 4, including but not limited to the recommendation that more RNLD nursing places be made available to meet service demand.

123. I am not able to answer this question. I believe the Belfast Trust's Director of Nursing took the lead on the actions not already being addressed and that were capable of being addressed by the Belfast Trust. However, the specific question posed by the MAH Inquiry, about more RNLD nursing places, was not a matter the Belfast Trust could resolve.

Question 5

Any other action(s) taken by the Trust in response to the Way to Go Report.

124. I have set out in paragraphs 190 to 235 in the Belfast Trust Module 6 statement dated 26 April 2023, and in response to question 1, that the Belfast Trust was already pursuing a broad range of action ahead of the receipt of the Level 3 SAI "A Way to Go" Report, and sought to include any suggestions made by that Report which were not already underway in its plans going forward.

Declaration of Truth

125. The contents of this witness statement are true to the best of my knowledge and belief. I have, to the best of my ability, either exhibited or referred to the documents which, collectively, I believe are necessary to address the matters on which the MAH Inquiry Panel has requested me to give evidence.

Signed: Martin Dillon

Dated: 30th May 2024.

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MAHI Muckamore Abbey Hospital Inquiry

MAHI Team
1st Floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

13 March 2024

By Email Only
Mr Martin Dillon
Former Chief Executive Officer BHSCT

Dear Mr Dillon

Re MAHI Organisational Modules 2024: Request for Witness Statement

The Inquiry is currently preparing for the final phase of evidence. Please see enclosed a document summarising the ten organisational modules to be heard in this phase: Organisational Modules 2024.pdf (mahinquiry.org.uk).

It is anticipated that the Inquiry will hear evidence in respect of these modules in September and October 2024.

The purpose of this correspondence is to issue a request, in the first instance, for a statement from you that will assist the Inquiry in this phase of evidence. It should be regarded as a request by the Inquiry Panel for the purposes of Rule 9 of the Inquiry Rules 2006.

The Inquiry understands that you were Chief Executive for BHSCT between 2017 and 2020.

You are asked to make a statement for the following module:

M9: Trust Board

I have also enclosed for your attention a copy of the Inquiry's Terms of Reference. You will note that the module in respect of which you are asked to make a statement is primarily concerned with the evidence of those in key positions of responsibility for MAH, past and present, at Trust Board level.

Please find enclosed two sets of questions that the Panel wish to be addressed in your statement ("Questions for Trust Board Members" and "Questions relating to Way To Go Report"). It would be helpful if you could address those questions in sequence in

your statement. If you do not feel that you are in a position to assist with a particular question, you should indicate accordingly and explain why that is so.

The Inquiry is grateful for the information which you have already provided on BHSCT's response to the Way to Go report, in the statement which you made to the Inquiry dated 26 April 2023 (MAHI-STM-107). That statement was made for the purpose of Evidence Modules 2023 which were heard by the Inquiry from March to May 2023. It is noted that, at paragraph 213 of that statement, you describe the information provided as a "broad overview" and you refer to BHSCT's desire to, in due course, provide "a comprehensive account to the MAH Inquiry about all the steps taken". The Inquiry Panel requests that you provide further information on the steps taken by BHSCT in response to the Way to Go Report in the statement which is now requested. In particular, please explain any actions taken by BHSCT in relation to the following:

1. The conclusions of the Way to Go Report, at pages 33-35.

2. The learning identified in the Way to Go Report, at page 36.

3. The recommendations made in the Way to Go Report, at page 37.

4. Each of the workforce issues identified in the Way to Go Report, at pages 59-64 of Appendix 4, including but not limited to the recommendation that more RNLD nursing places be made available to meet service demand.

5. Any other action(s) taken by the Trust in response to the Way to Go Report.

Please note that, while the Inquiry has received and heard a considerable body of evidence about the relevant systems and processes that were in place during the timeframe of the Terms of Reference, the Inquiry will now be focusing primarily on the *adequacy and effectiveness* of those systems and processes.

Please see enclosed a Statement Format Guide that will assist with the presentation of your statement. It is important that statements made for Inquiry purposes should be consistent in format. It is appreciated that the number of required sections will depend on the range and breadth of issues to be covered and that some flexibility will be needed to ensure the most effective presentation, but you are asked to adhere to the Guide to the extent that is possible.

You are requested to furnish the Inquiry with your completed statement by 27 April 2024. Your statement should be uploaded to the Inquiry's document management platform BOX via the following link:

https://mahinquiry.box.com/s/5l2suuwj8xp81hufe763t8y3msyur1rl

Should you have any issues accessing BOX please email info@mahinquiry.org.uk and a member of the team will assist you.

Statements made for the purpose of the organisational modules will be published on the Inquiry's website.

As noted above, it is anticipated that evidence in these modules will be heard by the Inquiry in September and October 2024. If there are any dates in those months on which you will be unavailable to attend the Inquiry to give evidence, please inform the Inquiry as soon as possible by emailing the Inquiry Secretary jaclyn.richardson@mahinquiry.org.uk.

If you have any queries about this correspondence, please do not hesitate to contact me.

Yours faithfully,

Lorraine Keown
Solicitor to the Inquiry

Encs:

1. Outline of Organisational Modules April – June 2024 Organisational Modules 2024.pdf (mahinquiry.org.uk).
2. MAHI Terms of Reference.
3. OM2024 Statement Format Guide.
4. Questions for Trust Board Members.
5. Questions relating to Way To Go Report.

MAHI Muckamore Abbey Hospital Inquiry

M9: Trust Board
Questions to be Addressed in Witness Statement

Questions for Trust Board members

1. Please identify:

   i. The time period in which you were a member of the Trust Board.
   ii. Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub-committee(s).

2. Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Trust Board level?

3. To your recollection, how often was MAH included on the agenda of:

   i. Meetings of the Trust Board.
   ii. Meetings of the Executive Team.

4. Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

5. Did the Trust Board receive reports on the following (and if so, please indicate how often):

   i. Safeguarding of patients at MAH.
   ii. Seclusion rates at MAH.
   iii. Complaints relating to MAH.
   iv. Resettlement of patients from MAH.
   v. Staffing (both establishments and vacancies) at MAH.

6. If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:

   i. Who prepared those reports?
   ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?
   iii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?

7. Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.

8. What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also describe your recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

9. Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

10. From 2010 onwards, following bed closures at MAH:

    i. How did the Trust Board assure itself that the reorganisation of wards was safe?
    ii. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.

11. Were any issues relating to MAH ever included in:

    i. The Delegated Statutory Functions Report?
    ii. The Corporate Risk Register?

    If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.

12. Were SAIs which occurred at MAH always reported to the Trust Board? If so:

    i. What information did the Trust Board receive in respect of SAIs?
    ii. Were SAIs discussed at Trust Board meetings?
    iii. What actions did the Trust Board take in response to SAIs?

13. How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

14. Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

15. Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.

16. Other than as addressed in responses to the questions above, please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Trust Board level to address such concerns?

17. Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

18. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

Muckamore Abbey Hospital Inquiry

Organisational Modules 2024

M9: Trust Board
Questions relating to Way to Go Report

1. In relation to the Terms of Reference of the November 2018 report, "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital" ("the Way to Go report"):

   i. Who wrote the Terms of Reference?
   ii. How were the Terms of Reference determined?
   iii. Why was the time period 2012 - 2017 selected for the investigation of adult safeguarding and subsequent investigations?
   iv. Why was the time period August 2017 – October 2017 selected for the investigation of incidents occurring at PICU and Six Mile?
   v. Why was the time period 2012 - 2017 selected for the investigation of governance and quality assurance controls?

2. In relation to the 69 patient safeguarding files provided to the Review Team for the Way to Go report:

   i. How, by whom and on what basis were the 69 patient files selected?
   ii. Were the entire files provided, or some portion of them? If the latter, please provide an explanation of the documents which were included and excluded, and the reason(s) therefor.

3. In relation to the 61 RQIA reports provided to the Review Team for the Way to Go report, how, by whom and on what basis were those reports selected? Were they complete reports?

4. In relation to the 12 patient experience interviews provided to the Review Team for the Way to Go report, conducted pursuant to an RQIA questionnaire:

   i. Was this the total number of such interviews or a selection?
   ii. Were the entire contents of the 12 interviews provided, or selected parts of them?
   iii. How, by whom and on what basis were those interviews (or parts of them, if applicable) selected?

5. How, by whom and on what basis were the 20 minutes of CCTV footage, shown to the Review Team, selected (see page 8 of the report)?

6. Paragraph 17 of page 9 of the Way to Go report refers to an undated “Business Case” for MAH:

   i. Are you aware of when and by whom this document was written?
   ii. Do you know how the number of beds said to be needed (115) was calculated?
   iii. Can the number of beds said to be needed be reconciled with the view expressed in the Bamford Review and Equal Lives that learning disability services should be community based?

7. Dr Flynn gave oral evidence to the Inquiry on 25 May 2023 that the data at paragraph 55 of the Way to Go report was taken from information supplied by MAH (see the transcript of 25 May 2023 at page 43). How and by whom was this data compiled and calculated?

8. On the same date, Dr Flynn gave oral evidence to the Inquiry that the Review Team believed that the Report would be published (see the transcript of 25 May 2023 at pages 10-11). In relation to the issue of publication of the Way to Go report:

   i. What was the Trust’s view regarding publication of the report at the time of engaging the Review Team?
   ii. Did this view change? If it did, why?
   iii. When and how was the Trust view regarding publication communicated to the Review Team?
   iv. When, if at all, was a decision taken by the Trust to leave the report unpublished?
   v. Who made this decision?
   vi. When and how was this decision communicated to the Review Team?
   vii. For what reason(s) was the report left unpublished?

9. In relation to the shorter Way to Go “summary” report, which was published in or around February 2019, Dr Flynn has given evidence to the Inquiry that she did not write it (MAHI-STM-130-1). In relation to this summary report:

   i. Who compiled it?
   ii. What were the circumstances leading to its compilation?

BOARD ASSURANCE FRAMEWORK

2010/11

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 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 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:

- 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 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 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 the HPSS (NI) Order 1991[4] (augmented by the HPSS (NI) Order 1994[5]) led to

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

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 (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 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 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.

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

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.

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.

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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.

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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.

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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 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 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

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

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.

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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 Chief Operating Officer 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.

Directorate Directors

The Directorate 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 Directorate 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 Chief Operating Officer, 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 Deputy 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.

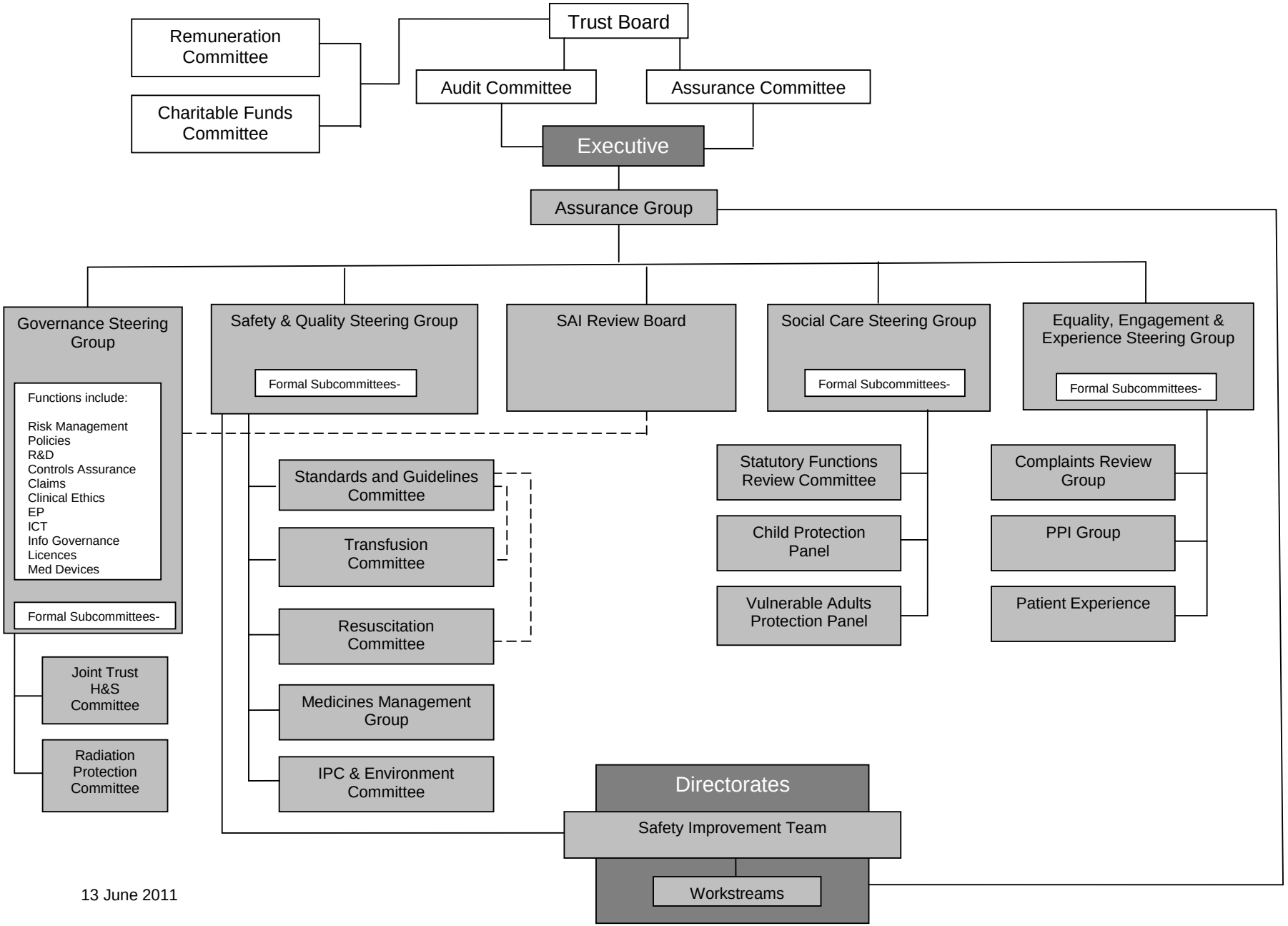
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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.

MAHI - STM - 272 - 73
ASSURANCE COMMITTEE
SUB-COMMITTEE STRUCTURE



13 June 2011

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'

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

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 (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.

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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. They 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.

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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.

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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.

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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.

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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.

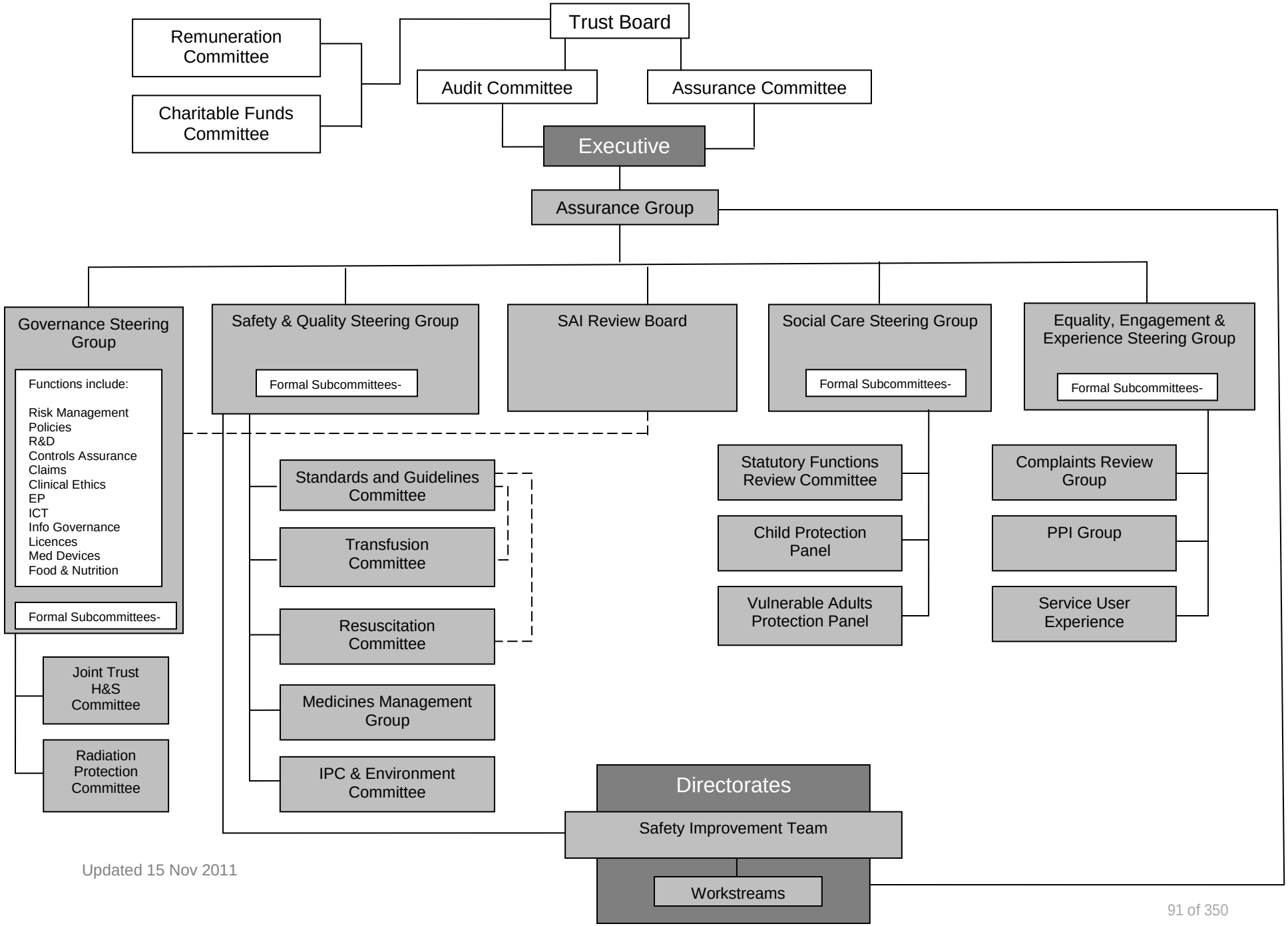
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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



Updated 15 Nov 2011

Belfast Health and Social Care Trust

BOARD ASSURANCE FRAMEWORK

2012-2013

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 Principal Risk Document.

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 ***Transforming Your Care***[a] together with the ***Commissioning Plan Direction and Indicators of Performance Direction*** and the HSCB/PHA annual Commissioning Plan reflect the 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.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators 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, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards'

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

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 (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 o 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 [5]. 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.

[5] 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. The Trust has been identified as a designated body by the General Medical Council and will ensure that this Framework supports the effective delivery of medical revalidation.

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 red risk register and Principal Risk Document 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 Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

The Expert Advisory Committees (Appendix B)

These committees report through the Steering Group to the Assurance Group of the 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 Chairman has a key leadership role in the assurance framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chairman and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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/she is responsible for the Statutory Duty of Quality. He/she 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/her 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 & Estates

The Director of Finance and Estates 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 the Department of Health and Treasury requirements.

The Director of Finance and Estates 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/she 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 Director of Finance and Estates 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 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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he are responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, continence, carers, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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.

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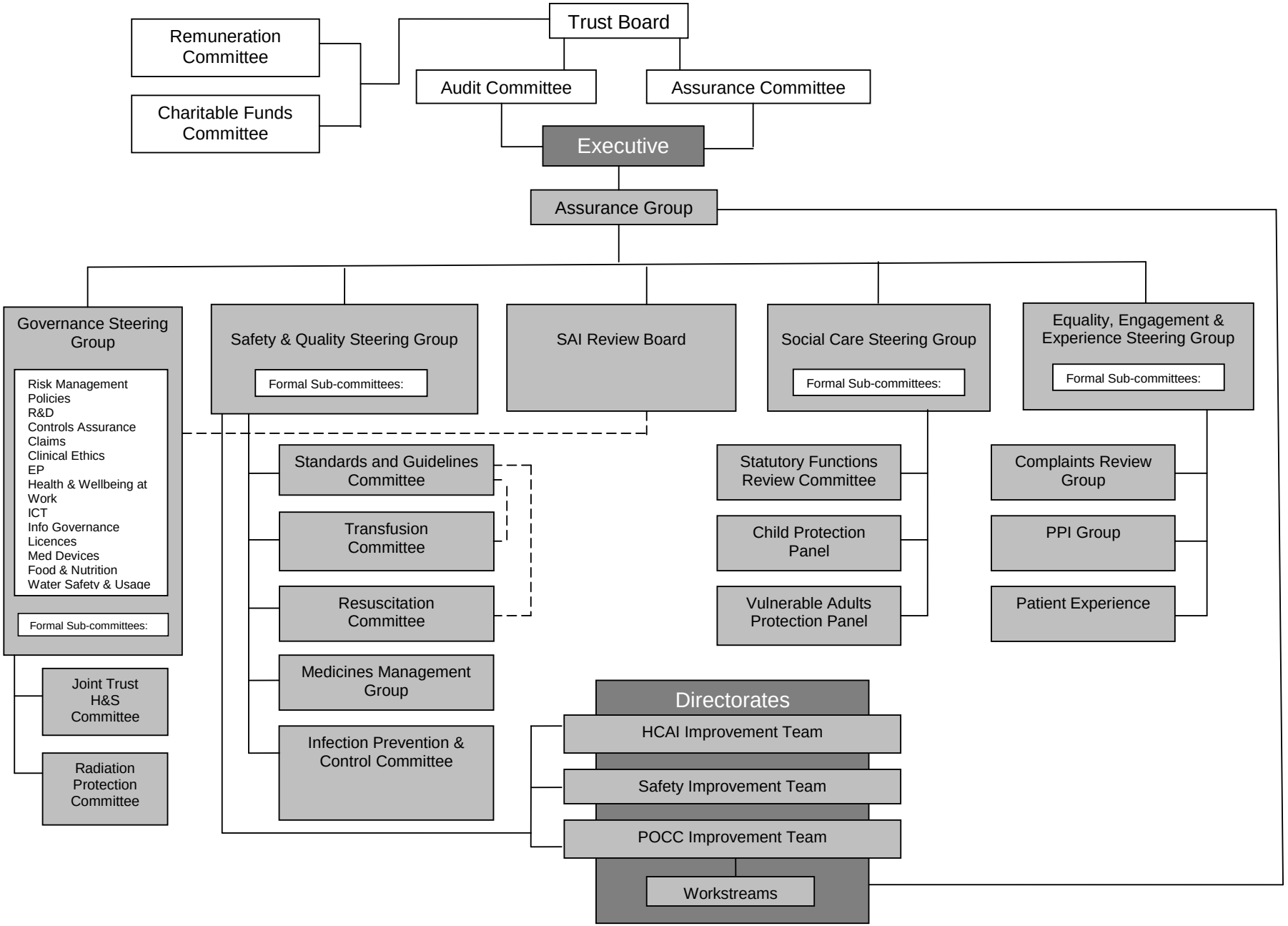
ASSURANCE COMMITTEE
SUB-COMMITTEE STRUCTURE



Belfast Health and Social Care Trust

BOARD ASSURANCE FRAMEWORK

2013-2014

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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 Principal Risk Document.

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 ***Transforming Your Care***[a] together with the ***Commissioning Plan Direction and Indicators of Performance Direction*** and the HSCB/PHA annual Commissioning Plan reflect the 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.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators 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, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards'

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

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 (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 o 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 [5]. 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.

[5] 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. The Trust has been identified as a designated body by the General Medical Council and will ensure that this Framework supports the effective delivery of medical revalidation.

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 red risk register and Principal Risk Document 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 Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

The Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the 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 values 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 Chair

The Chair has a key leadership role in the assurance framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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/she is responsible for the Statutory Duty of Quality. He/she 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/her 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 & Estates

The Director of Finance and Estates 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 the Department of Health and Treasury requirements.

The Director of Finance and Estates 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/she 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 Director of Finance and Estates 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 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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, continence, carers, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social and Primary Care;
- Director of Acute Services;
- Interim Director of Unscheduled Care.

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 Performance, Planning and Informatics, 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 and Estates, Medical Director and Director of Planning, Performance and Informatics 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.

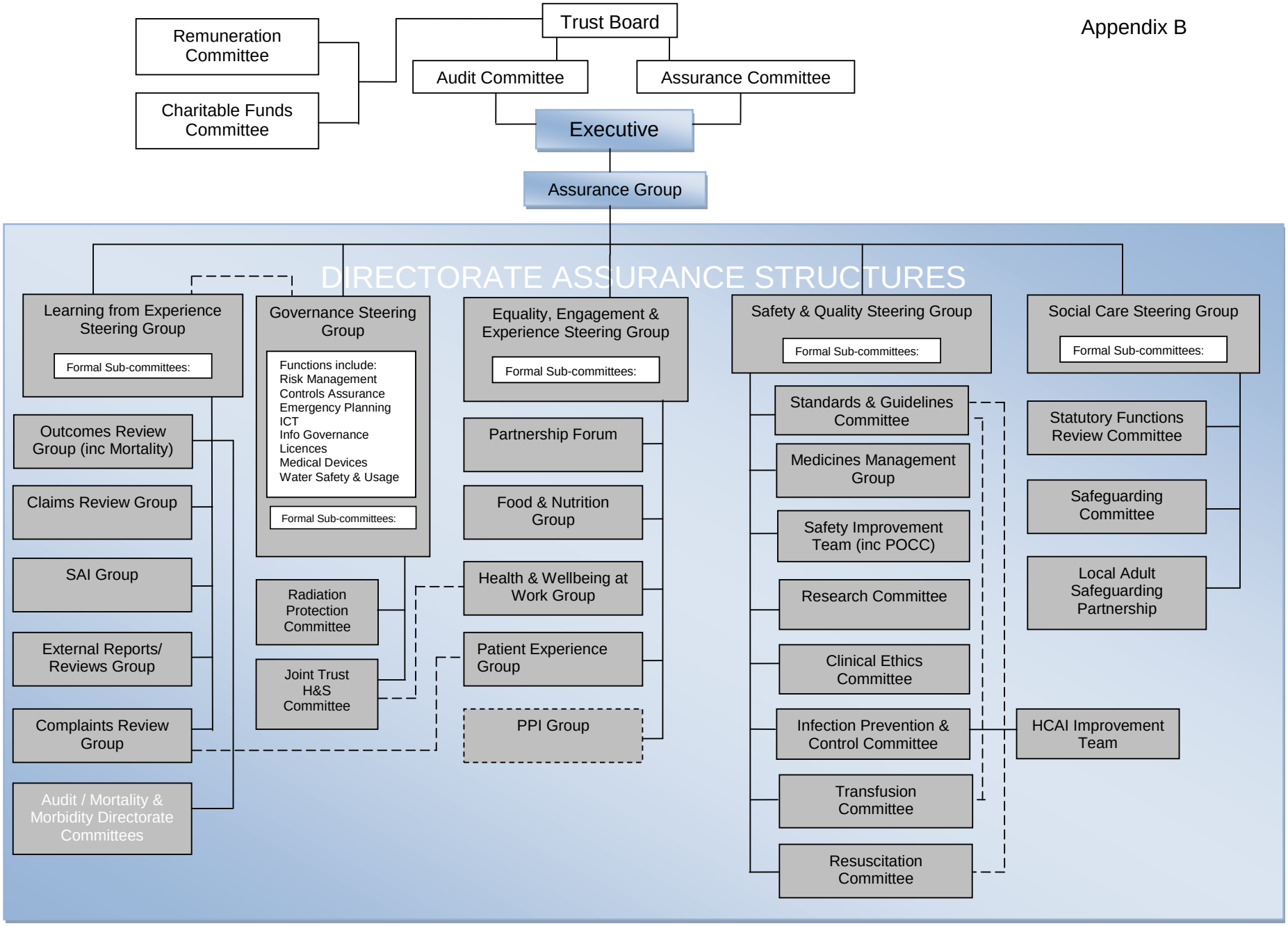
The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through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

MAHI - STM - 272 - 129
ASSURANCE SUB-COMMITTEE STRUCTURE

Appendix B



Belfast Health and Social Care Trust

BOARD ASSURANCE FRAMEWORK

2014-2015

Index

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- 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 – Trust Vision & Corporate Plan 2013/4-2015/6; Corporate Management Plan 2014/5 & Trust Delivery Plan 2014/5

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 Principal Risk Document.

2. Strategic Context

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The Trust Vision & Corporate Plan 2013/4-2015/6 affirms the Trust Vision and Values and sets out the three year commitment for Trust services with identified outcomes. The Trust Vision is to:

'continuously improve health and social care delivery and foster innovation in pursuit of this goal. We will seek to achieve the right balance between providing more health and social care in, or closer to, people's homes and supporting the specialist delivery of acute care, thereby delivering positive outcomes for the people who use our services.'

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 Annual Corporate Management Plan, supported by Directorate Management Plans, identifies the annual objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan.

The Trust has five strategic objectives. These are:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.

- Continuous Improvement - Our commitment: to work in partnership across the community, voluntary, statutory, public and private sections to deliver

improvements in service, quality and experience to the people who use our services

- Partnerships - Service Commitment: -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion

- Our People - Service Commitment: we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce

- Resources - Service Commitment: we will work to optimise the resources available to us to achieve shared goals.

Directorate Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

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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).

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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, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards'

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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 (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).

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- 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 [5]. 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.

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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. The Trust has been identified as a designated body by the General Medical Council and will ensure that this Framework supports the effective delivery of medical revalidation.

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 red risk register and Principal Risk Document 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 Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

The Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the 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 values 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 Chair

The Chair has a key leadership role in the assurance framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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/she is responsible for the Statutory Duty of Quality. He/she 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/her 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 & Estates

The Director of Finance and Estates 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 the Department of Health and Treasury requirements.

The Director of Finance and Estates 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/she 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 Director of Finance and Estates 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 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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, continence, carers, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social and Primary Care;
- Director of Unscheduled & Acute Care

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 Performance, Planning and Informatics, 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 and Estates, Medical Director and Director of Planning, Performance and Informatics 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.

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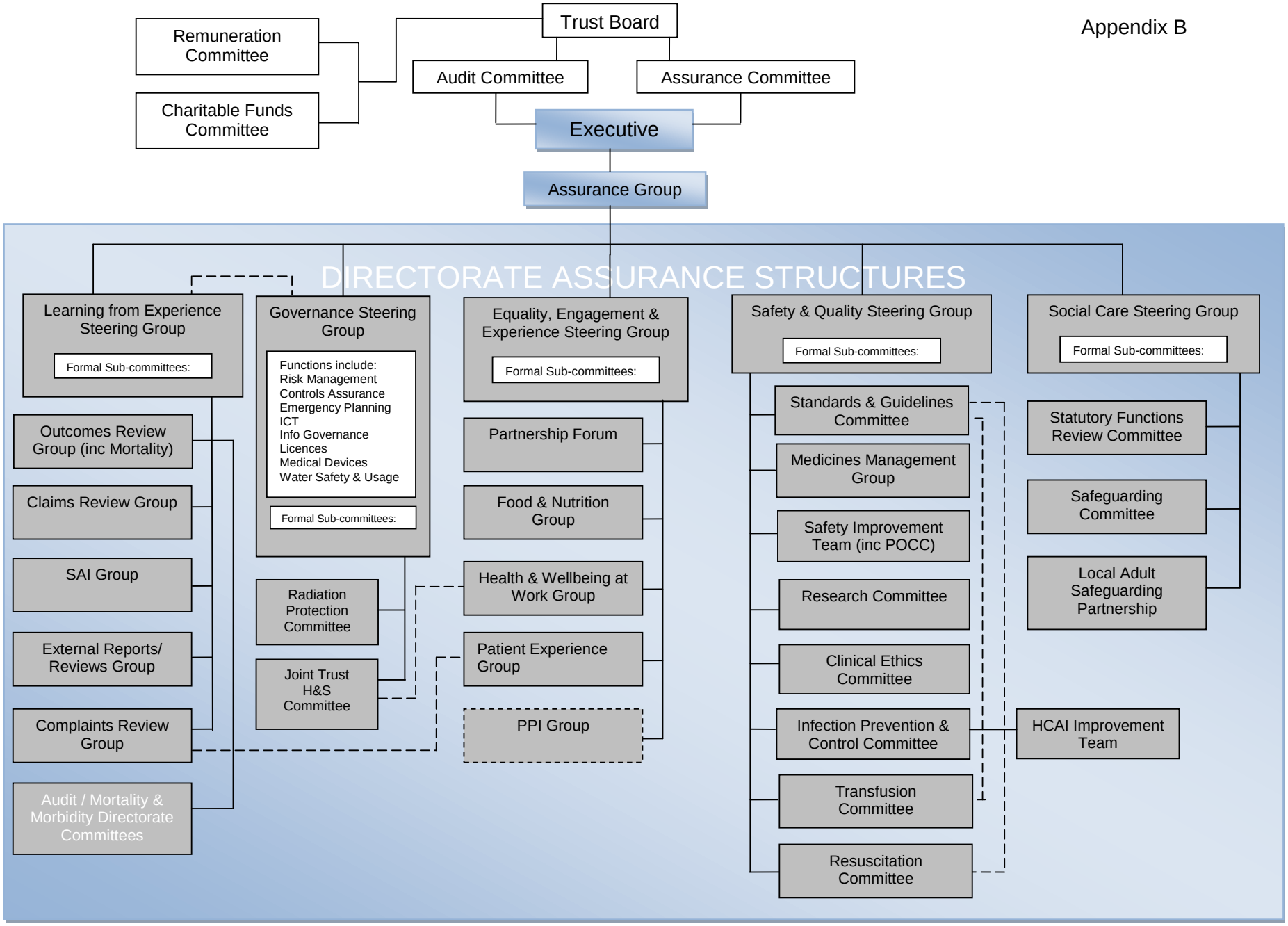
ASSURANCE SUB-COMMITTEE STRUCTURE

Appendix B



Belfast Health and Social Care Trust

BOARD ASSURANCE FRAMEWORK

2015-2016

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 Trust Vision and Corporate Plan 2013/14 – 2015/16.

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 outlines 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 – Trust Vision & Corporate Plan 2013/4-2015/6; Corporate Management Plan 2015/6 & Trust Delivery Plan 2015/16

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 Principal Risk Document.

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 Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

The Trust Vision & Corporate Plan 2013/4-2015/6 affirms the Trust Vision and Values and sets out the three year commitment for Trust services with identified outcomes. The Trust Vision is to:

'continuously improve health and social care delivery and foster innovation in pursuit of this goal. We will seek to achieve the right balance between providing more health and social care in, or closer to, people's homes and supporting the specialist delivery of acute care, thereby delivering positive outcomes for the people who use our services.'

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 Annual Corporate Management Plan, supported by Directorate Management Plans, identifies the annual objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan.

The Trust has five strategic objectives. These are:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.

- Continuous Improvement - Our commitment: to work in partnership across the community, voluntary, statutory, public and private sections to deliver improvements in service, quality and experience to the people who use our services

- Partnerships - Service Commitment: -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion

- Our People - Service Commitment: we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce

- Resources - Service Commitment: we will work to optimise the resources available to us to achieve shared goals.

Directorate Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Directions and the HSCB/PHA Commissioning Plan.
While the Corporate Management 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 Management 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.

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Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, 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.

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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, for example when applying for a child care order.

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The Belfast Trust has and continues to develop 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 are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust's Being Open Policy.

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 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 Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the Remuneration Committee is to provide advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

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 the Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

The Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the 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 across the Trust.

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, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

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 the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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/her leadership creates the vision for the Board and the Trust to modernise and improve services. He/she is responsible for the Statutory Duty of Quality. He/she 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/her

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 Finance & Estates

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

The Director of Finance and Estates 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 the Department of Health and Treasury requirements.

The Director of Finance and Estates 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/she 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 Director of Finance and Estates 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 Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development 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 of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety. She/he will lead implementation for the revalidation of nurses and midwives, which is due to commence nationally in 2015-2016.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Management

Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

Service Directors

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social and Primary Care;
- Director of Unscheduled & Acute Care

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 Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, 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 and Estates, Medical Director, and Director of Planning, Performance and Informatics 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 is important for the quality and robustness of this Assurance Framework that it is 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.

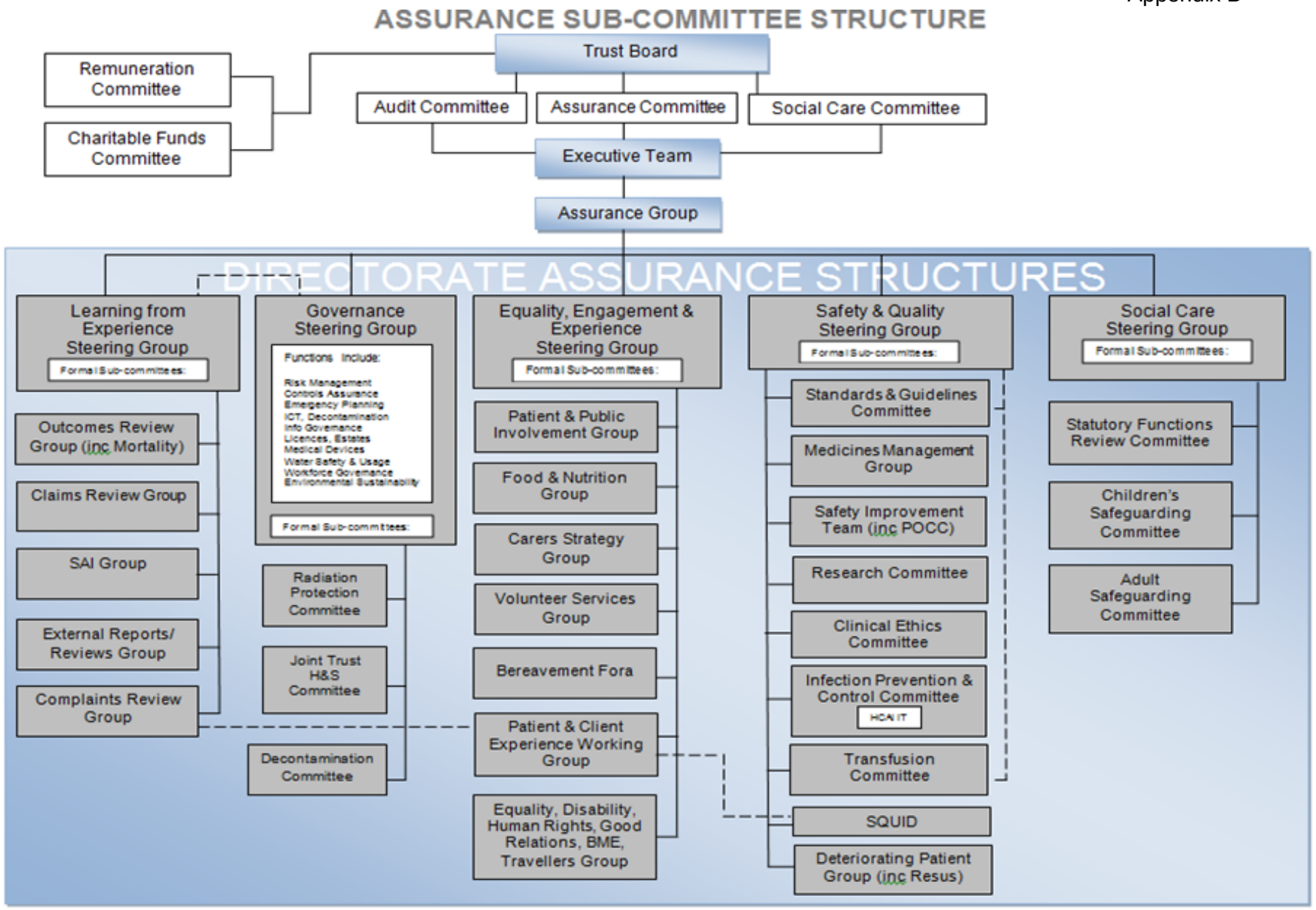
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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 Sub-Committee STRUCTURE Feb 2016 fv Approved

BOARD ASSURANCE FRAMEWORK

2016-2017

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 Trust Corporate Management Plan 2016-2017.

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 outlines 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 – Trust Vision & Corporate Plan 2013/4-2015/6; Corporate Management Plan 2015/6 & Trust Delivery Plan 2015/16

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 Principal Risk Document.

2. Strategic Context

In order to produce the outcomes for which the Department of Health (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 Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

New Directions 'A blueprint for future health and social care delivery in Belfast Trust' , which will determine the future shape of services within Belfast Trust, is currently under development. The existent 3-year Trust Vision & Corporate Plan affirms the Trust Vision and Values, and sets out the three-year commitment for Trust services with identified outcomes. The Trust Vision is to:

'continuously improve health and social care delivery and foster innovation in pursuit of this goal. We will seek to achieve the right balance between providing more health and social care in, or closer to, people's homes and supporting the specialist delivery of acute care, thereby delivering positive outcomes for the people who use our services.'

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 Annual Corporate Management Plan, supported by Directorate Management Plans, identifies the annual objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan.

The Trust has identified six Key cross-Directorate Themes this year, each led by a Lead Director, working across Directorates. These 'Big 6' themes are:

- Build the will and the capacity to ensure that continuous quality improvement and the relentless reduction of patient harm becomes our greatest focus.
- Improving care to support more people to live well at home.
- Improving Elective Care with an emphasis on Cancer Care improvement. Develop and deliver an Improvement Plan for Elective Care including Cancer performance.
- Improving Unscheduled Care – Identify, resource and deliver the Unscheduled Care Plan for 2016/17 including Escalation Arrangements.
- Implement the Organisational Development Framework to realise our ambition of being recognised as a world leader in the provision of health and social care.
- Develop an integrated plan for the people of Belfast with a range of partners and agencies.

Each Key theme links to the Trust's five strategic objectives, which remain as:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.
- Continuous Improvement - Our commitment: to work in partnership across the community, voluntary, statutory, public and private sections to deliver improvements in service, quality and experience to the people who use our services

- Partnerships -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion

- Our People - we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce

- Resources - we will work to optimise the resources available to us to achieve shared goals.

Directorate Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Directions and the HSCB/PHA Commissioning Plan.

While the Corporate Management 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 Management 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

Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) 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 (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 HSC 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.

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

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 [5]. 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.

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

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

governance or financial control. The Trust has been identified as a designated body by the General Medical Council and the Nursing and Midwifery Council and will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

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.

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Quality Improvement

The Trust is continually aiming to improve the quality of services we deliver to our patients and clients and to improve the working environment for our staff. We recognise that we cannot provide high-quality care consistently across all our services without having a fundamental all-embracing approach to quality improvement (QI) that runs throughout the organisation. The three landmark reports in 2013 on quality and safety in the NHS (Francis Report, Keogh Review and the Berwick Report) all recommended the development of an organisational culture which prioritises patients and quality care above all else with clear values embedded throughout all aspects of organisational behaviour and a relentless pursuit of high-quality care through continuous improvement. The Trust is developing a new five-year Quality Improvement Strategy to build QI capacity throughout the organisation and to ensure integration with the Assurance Framework.

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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 Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the Remuneration Committee is to provide advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

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 the Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the 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 across the Trust.

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, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

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 the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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/her leadership creates the vision for the Board and the Trust to modernise and improve services. He/she is responsible for the Statutory Duty of Quality. He/she 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/her 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 Finance & Estates

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

The Director of Finance and Estates 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 the Department of Health and Treasury requirements.

The Director of Finance and Estates 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/she 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 Director of Finance and Estates 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 Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development 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 of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

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

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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and

User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

Service Directors

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social & Primary Care;
- Director of Unscheduled & Acute Care

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 Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, 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 and Estates, Medical Director, and Director of Planning, Performance and Informatics 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 is important for the quality and robustness of this Assurance Framework that it is 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.

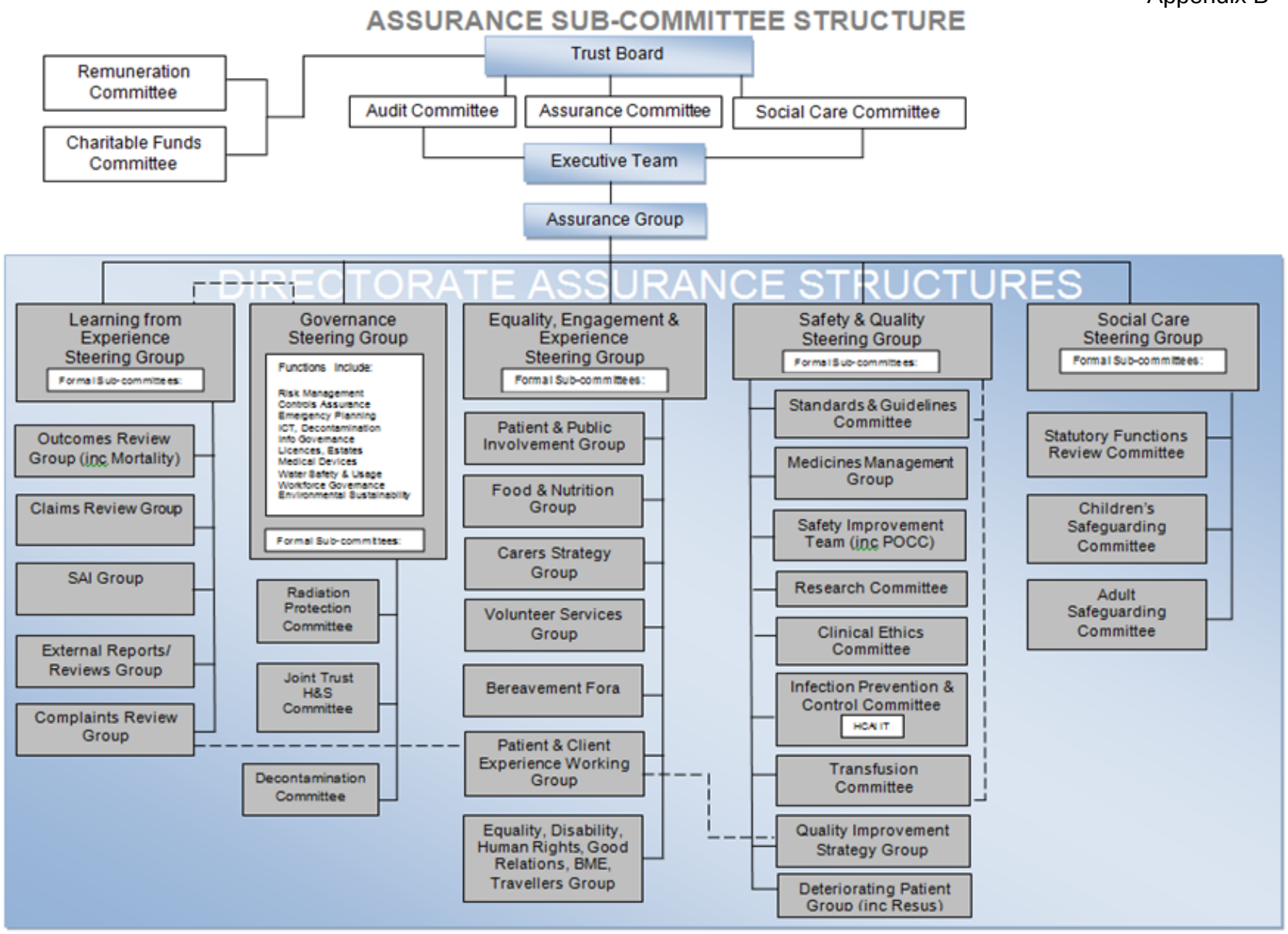
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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 SUB-COMMITTEE STRUCTURE
Trust Board
Remuneration Committee
Charitable Funds Committee
Audit Committee
Assurance Committee
Social Care Committee
Executive Team
Assurance Group
DIRECTORATE ASSURANCE STRUCTURES
Learning from Experience Steering Group
Formal Sub-committees:
Outcomes Review Group (inc Mortality)
Claims Review Group
SAI Group
External Reports/ Reviews Group
Complaints Review Group
Governance Steering Group
Functions Include:
Risk Management
Controls Assurance
Emergency Planning
ICT, Decontamination
Info Governance
Licences, Estates
Medical Devices
Water Safety & Usage
Workforce Governance
Environmental Sustainability
Formal Sub-committees:
Radiation Protection Committee
Joint Trust H&S Committee
Decontamination Committee
Equality, Engagement & Experience Steering Group
Formal Sub-committees:
Patient & Public Involvement Group
Food & Nutrition Group
Carers Strategy Group
Volunteer Services Group
Bereavement Fora
Patient & Client Experience Working Group
Equality, Disability, Human Rights, Good Relations, BME, Travellers Group
Safety & Quality Steering Group
Formal Sub-committees:
Standards & Guidelines Committee
Medicines Management Group
Safety Improvement Team (inc POCC)
Research Committee
Clinical Ethics Committee
Infection Prevention & Control Committee
HCAI T
Transfusion Committee
Quality Improvement Strategy Group
Deteriorating Patient Group (inc Resus)
Social Care Steering Group
Formal Sub-committees:
Statutory Functions Review Committee
Children's Safeguarding Committee
Adult Safeguarding Committee

Appendix C

Belfast Health and Social Care Trust
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Assurance Group & Committee Annual Schedule of Reports 2016

Assurance Committee	9 Feb	26 Apr	25 Jul	8 Nov
Assurance Group	27 Jan	13 Apr	22 Jun	12 Oct
Assurance Framework Principal Risk Document	✓	✓	✓	✓
Risk Management Strategy (every 3 years latest 2013-16)	✓			✓
Board Assurance Framework (Annual Revision)		✓		
Legal Services Quarterly Report	✓	✓	✓	✓
Legal Services Annual Report			✓	
Serious Adverse Incidents Quarterly Report	✓	✓	✓	✓
Serious Adverse Incidents Annual Report			✓	
Incident Quarterly Report	✓	✓	✓	✓
Incident Annual Report			✓	
Complaints Quarterly Report	✓	✓	✓	✓
Complaints Annual Report			✓	
Health & Safety Annual Report				✓
Information Governance Annual Report			✓	
Controls Assurance Compliance Annual Report		✓		
Fire Safety Annual Report			✓	
Infection and Prevention Control Annual Report			✓	
RQIA Thematic Reviews	✓	✓	✓	✓
RQIA Regulated Providers Inspections Summary	✓	✓	✓	✓
Trust Quality Improvement Plan (inc Graph Set)	✓	✓	✓	✓
Medical & Dental Revalidation Report		✓		
Professional Nursing Report	✓		✓	
Mater Trustee Meeting Minutes	✓	✓	✓	✓

Belfast Health and Social Care Trust

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BOARD ASSURANCE FRAMEWORK

2017-2018

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 Trust Corporate Management Plan 2017-2018.

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 outlines 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;

On an ongoing basis the Board will:

[1] Belfast Health and Social Care Trust – Corporate Plan 2017/8

- 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 Principal Risk Document.

2. Strategic Context

In order to produce the outcomes for which the Department of Health (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 Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

New Directions 'A blueprint for future health and social care delivery in Belfast Trust' , which will determine the future shape of services within Belfast Trust, is currently under development. The existent 3-year Trust Vision & Corporate Plan affirms the Trust Vision and Values, and sets out the three-year commitment for Trust services with identified outcomes. The Trust Vision is to:

'continuously improve health and social care delivery and foster innovation in pursuit of this goal. We will seek to achieve the right balance between providing more health and social care in, or closer to, people's homes and supporting the specialist delivery of acute care, thereby delivering positive outcomes for the people who use our services.'

The Trust Delivery Plan (TDP) is the Trust's response to the DOH Commissioning Plan Direction and the HSCB Commissioning Plan. It 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 Annual Corporate Management Plan, supported by Directorate Management Plans, identifies the annual objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan.

The Trust has identified five overarching corporate objectives:

A Culture of Safety and Excellence - Open and learning culture and robust systems to provide safe, high quality effective care

Continuous Improvement - Be a leading edge Trust through improvement

Partnerships - Work collaboratively with all stakeholders and partners to deliver our purpose

Our People - Show leadership and excellence through organisation and workforce development

Resources - Make the best use of resources by improving performance and productivity

There are annual objectives attached to each of these overarching objectives. Directorate Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Plan Direction and the HSCB/PHA Commissioning Plan.

While the Corporate Management 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 Management 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

Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) 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 (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 HSC 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

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

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 [5]. 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.

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

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

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. The Trust has been identified as a designated body by the General Medical Council and the Nursing and Midwifery Council and will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

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, for example when applying for a child care order.

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.

The Assurance Framework is being reviewed through the summer of 2017 with a view to being updated by October 2017. The review is to update the Assurance Framework in line with reorganisation of Directorates into Divisions and Care Delivery Units.

Risk Management

The Belfast Trust has a risk management strategy that underpins its policy on risk (see Appendix A) and explains its approach to acceptable risk.

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the principal risks to achieving these objectives. These are encapsulated as the Principal Risk Document. There are systems in place to monitor and review risks which are delegated below Corporate level.

Controls Assurance remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard. The results will be reflected in the Trust's Corporate Risk Register.

The Belfast Trust has and continues to develop 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 are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust's Being Open Policy.

Quality Improvement

The Trust has developed a Quality Improvement Strategy 2017-2020 (QIS) which outlines how it will create the conditions for the Belfast Health and Social Care Trust to become a leader in providing safe, high quality and compassionate care in the UK.

Delivering safe, high quality and compassionate care is the first order priority for the Belfast Trust. We will realise this ambition by developing a culture of excellence in safety and quality by engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those in our care.

To realise and embed this culture and to support our staff, we have identified five key principles to focus our safety and quality efforts:

1. Placing the **person** clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation;
2. Ensuring a **relentless focus on safety and quality improvement** through the implementation of our Quality Improvement Plan, aligned to our corporate objectives and assurance framework;
3. Ensuring th**at we are an open, transparent and supportive organisation** that is continually learning and sharing both within and beyond the organisation;

4. Using **measurement and real time data, linked to goals, to learn and improve at every lev**el;
5. Enhancing our **will, capability and structures** to undertake quality improvement consistently, everywhere and everyday.

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 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 Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the Remuneration Committee is to provide advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

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 the Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the 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 across the Trust.

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, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

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 the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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/her leadership creates the vision for the Board and the Trust to modernise and improve services. He/she is responsible for the Statutory Duty of Quality. He/she 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/her 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 Director of Finance & Estates

The Director of Finance and Estates 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 the Department of Health and Treasury requirements.

The Director of Finance and Estates 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/she 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 Director of Finance and Estates 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 Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development 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 of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

The Director of Human Resources and Organisational Development is leading a reorganisation of Directorates into Divisions and Care Delivery Units to support a collective leadership model of care delivery. This will support the Trust's aim to be in the top 20% of NHS organisations for safety and quality by 2020.

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

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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

Service Directors

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social & Primary Care;
- Director of Unscheduled & Acute Care

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 Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, 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 and Estates, Medical Director, and Director of Planning, Performance and Informatics 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 is important for the quality and robustness of this Assurance Framework that it is 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.

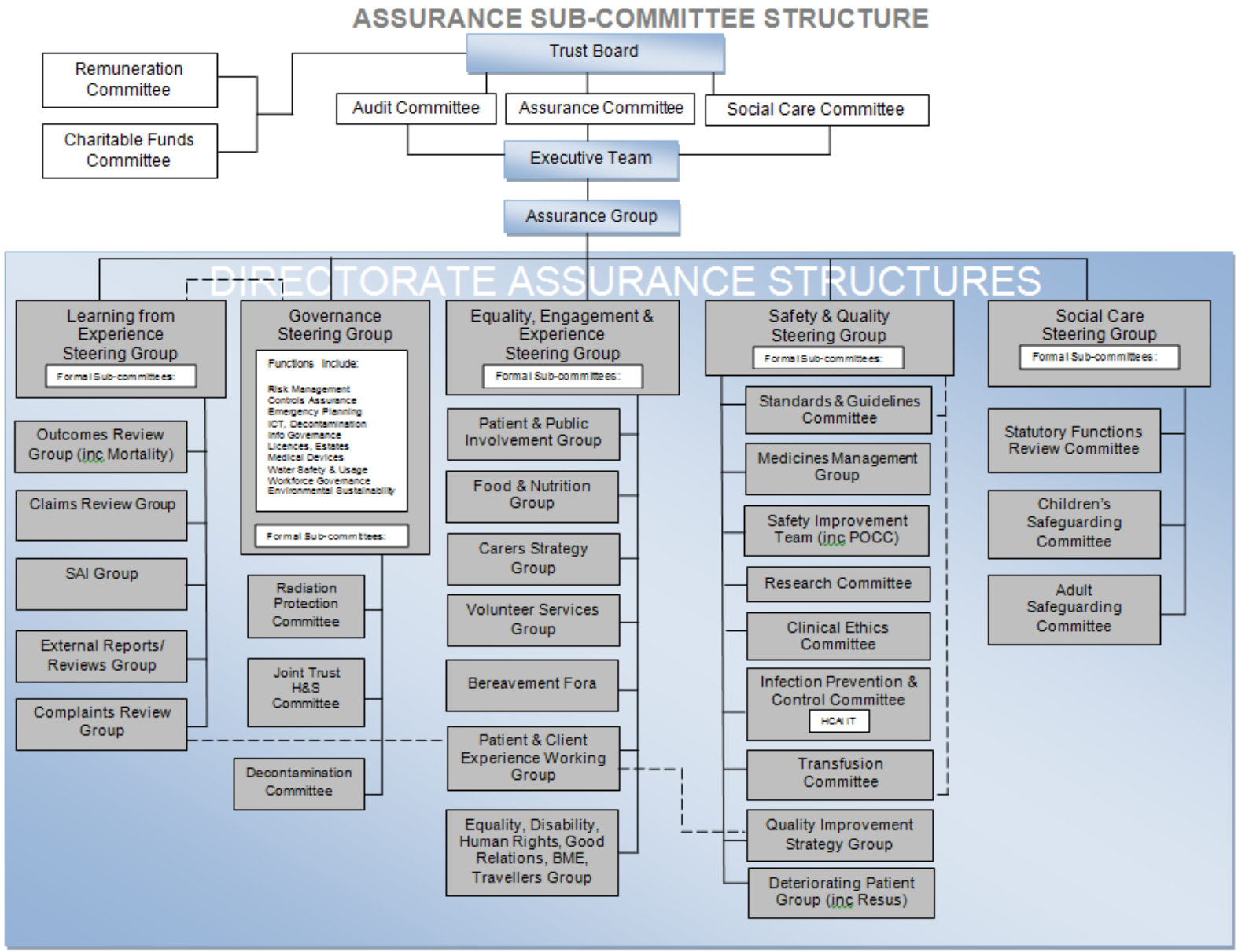
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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 SUB-COMMITTEE STRUCTURE
Trust Board
Remuneration Committee
Charitable Funds Committee
Audit Committee
Assurance Committee
Social Care Committee
Executive Team
Assurance Group
DIRECTORATE ASSURANCE STRUCTURES
Learning from Experience Steering Group
Formal Sub-committees:
Outcomes Review Group (inc Mortality)
Claims Review Group
SAI Group
External Reports/ Reviews Group
Complaints Review Group
Governance Steering Group
Functions Include:
Risk Management
Controls Assurance
Emergency Planning
ICT, Decontamination
Info Governance
Licences, Estates
Medical Devices
Water Safety & Usage
Workforce Governance
Environmental Sustainability
Formal Sub-committees:
Radiation Protection Committee
Joint Trust H&S Committee
Decontamination Committee
Equality, Engagement & Experience Steering Group
Formal Sub-committees:
Patient & Public Involvement Group
Food & Nutrition Group
Carers Strategy Group
Volunteer Services Group
Bereavement Fora
Patient & Client Experience Working Group
Equality, Disability, Human Rights, Good Relations, BME, Travellers Group
Safety & Quality Steering Group
Formal Sub-committees:
Standards & Guidelines Committee
Medicines Management Group
Safety Improvement Team (inc POCC)
Research Committee
Clinical Ethics Committee
Infection Prevention & Control Committee
HCAI IT
Transfusion Committee
Quality Improvement Strategy Group
Deteriorating Patient Group (inc Resus)
Social Care Steering Group
Formal Sub-committees:
Statutory Functions Review Committee
Children's Safeguarding Committee
Adult Safeguarding Committee

Appendix C

Belfast Health and Social Care Trust
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Assurance Group & Committee Annual Schedule of Reports 2017

Assurance Committee	7 Feb	2 May	25 Jul	14 Nov
Assurance Group	**25 Jan**	**5 Apr**	**21 Jun**	**18 Oct**
Assurance Framework Principal Risk Document	✓	✓	✓	✓
Risk Management Strategy (every 3 years latest 2017-19)	✓			✓
Board Assurance Framework (Annual Revision)		✓		
Legal Services Quarterly Report	✓	✓	✓	✓
Legal Services Annual Report			✓	
Serious Adverse Incidents Quarterly Report	✓	✓	✓	✓
Serious Adverse Incidents Annual Report			✓	
Incident Quarterly Report	✓	✓	✓	✓
Incident Annual Report			✓	
Complaints Quarterly Report	✓	✓	✓	✓
Complaints Annual Report			✓	
Health & Safety Annual Report				✓
Information Governance Annual Report			✓	
Controls Assurance Compliance Annual Report		✓		
Medical Devices Annual Report			✓	
Fire Safety Annual Report			✓	
Infection and Prevention Control Annual Report			✓	
Water Safety Annual Report			✓	
RQIA Thematic Reviews	✓	✓	✓	✓
RQIA Regulated Providers Inspections Summary	✓	✓	✓	✓
Trust Quality Improvement Plan (inc Graph Set)	✓	✓	✓	✓
Medical & Dental Revalidation Report		✓		
Professional Nursing Report	✓		✓	
Mater Trustee Meeting Minutes	✓	✓	✓	✓

Belfast Health and Social Care Trust

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BOARD ASSURANCE FRAMEWORK

2018-2019

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 Trust Corporate Management Plan 2018-2021.

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 outlines 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 Assurance Standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast HSC Trust Corporate Management Plan 2018-21

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 Principal Risk Document.

2. Strategic Context

In order to produce the outcomes for which the Department of Health (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 Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

New Directions 2 'A blueprint for future health and social care delivery in Belfast Trust' , which will outline the future delivery of services within Belfast Trust, is currently under development. The 3-year Trust Corporate Management Plan (2018-2021) affirms the Trust Vision and Values, and sets out the three-year commitment for Trust services with identified outcomes. The Trust Vision is:

> *'..to be one of the safest, most effective and compassionate health and social care organisations.'* (Corporate Management Plan 2018-2021)

The Trust Delivery Plan (TDP) is the Trust's response to the DoH Commissioning Plan Direction and the HSCB Commissioning Plan. It 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 service transformation agenda and for effective and efficient management of resources.

3. Objective Setting

The Trust's 3-year Corporate Management Plan (2018-2021), supported by Divisional Management Plans, identifies our objectives to support the delivery of

the Corporate Plan and the Trust Delivery Plan within the context of the overall regional priorities, ie – improving the health of the population; improving the quality and experience of care; ensuring the sustainability of the services delivered and supporting and empowering our staff.

The Trust has identified five overarching corporate objectives:

Safety, Quality and Experience - Work with service users and carers to continuously improve Safety, Quality and Experience for those who access and deliver our services;

Service Delivery - Drive improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors;

People and Culture - Support a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams;

Strategy and Partnerships - Innovate and develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors;

Resources - Work together to make the best use of available resources and reduce variation in care for the benefit of those we serve.

There are objectives attached to each of these overarching objectives. Divisional Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Plan Direction and the HSCB/PHA Commissioning Plan.

While the Corporate Management 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:

- Divisional Annual Management 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 Department of Health

Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) 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 (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 HSC 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

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

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.

The DoH Draft HSC Performance Management Framework (issued June 2017) sets out an enhanced framework for managing performance and accountability for HSC with the primary performance management role undertaken within Trusts (including by Trust Board). The key regional forum for holding Trusts to account will be through the DoH accountability review meetings under the new PMF. The PHA (and HSCB currently) is expected to provide advice to the DoH with regards to performance management and support to the Trusts within an overall cycle of continuous engagement and improvement.

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.

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. The Trust has been identified as a designated body by the General Medical Council and the Nursing and Midwifery Council and will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

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, for example when applying for a child care order.

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 has a risk management strategy that underpins its policy on risk (see Appendix A) and explains its approach to acceptable risk.

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the principal risks to achieving these objectives. These are encapsulated as the Principal Risk Document. There are systems in place to monitor and review risks, which are delegated below Corporate level.

Assurance (formerly the Controls Assurance process) remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard. The results will be reflected in the Trust's Corporate Risk Register.

The Belfast Trust has and continues to develop 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 are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust's Being Open Policy.

Quality Improvement

The Trust has developed a Quality Improvement Strategy 2017-2020 (QIS) which outlines how it will create the conditions for the Belfast Health and Social Care Trust to become a leader in providing safe, high quality and compassionate care in the UK.

Delivering safe, high quality and compassionate care is the first order priority for the Belfast Trust. We will realise this ambition by developing a culture of excellence in safety and quality by engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those in our care.

To realise and embed this culture and to support our staff, we have identified five key principles to focus our safety and quality efforts:

1. Placing the **person** clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation;
2. Ensuring a **relentless focus on safety and quality improvement** through the implementation of our Quality Improvement Plan, aligned to our corporate objectives and assurance framework;
3. Ensuring th**at we are an open, transparent and supportive organisation** that is continually learning and sharing both within and beyond the organisation;
4. Using **measurement and real time data, linked to goals, to learn and improve at every level**;
5. Enhancing our **will, capability and structures** to undertake quality improvement consistently, everywhere and every day.

Organisational Arrangements

Proposed organisational arrangements for governance and assurance are set out in Appendix B and C. 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 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.

Appendix D outlines the Schedule of Key Documents to be presented (Including Annual Reports)

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 Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the

Remuneration Committee is to provide advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

The Social Care Committee

The Social Care Committee (a standing committee of Trust Board) is comprised of Non-Executive Directors. Its role is to assist the Trust Board in assuring the Trust's discharge of its delegated statutory functions with regard to the delivery of social care services. This involves its scrutiny of the suite of reports and related data which are included in the Trust's Annual and Interim Statutory Functions Reports.

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 the Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix C)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

Formal Sub-Committees (Appendix C)

These committees report through a Steering Group to the Assurance Group of the 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 across the Trust.

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, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

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 the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. They provide leadership through his/her chairmanship of the Board and Assurance Committee. They work closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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 leadership creates the vision for the Board and the Trust to modernise and improve services. They are responsible for the Statutory Duty of Quality. They are 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/her 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 Director of Finance & Estates

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. They, with the Chief Executive, are 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 and Estates 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. They 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 Director of Finance and Estates 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 Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development 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 they 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, they work with relevant Directors to ensure the system of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

The Director of Human Resources and Organisational Development is leading a reorganisation of Directorates into Divisions and Care Delivery Units to support a collective leadership model of care delivery. This will support the Trust's aim to be in the top 20% of NHS organisations for safety and quality by 2020.

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

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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. They 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. They are responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. They have specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. They have specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. They have lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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. They are 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

Service Directors

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social & Primary Care;
- Director of Unscheduled & Acute Care

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 Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, 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 and Estates, Medical Director, and Director of Planning, Performance and Informatics 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 is important for the quality and robustness of this Assurance Framework that it is 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.

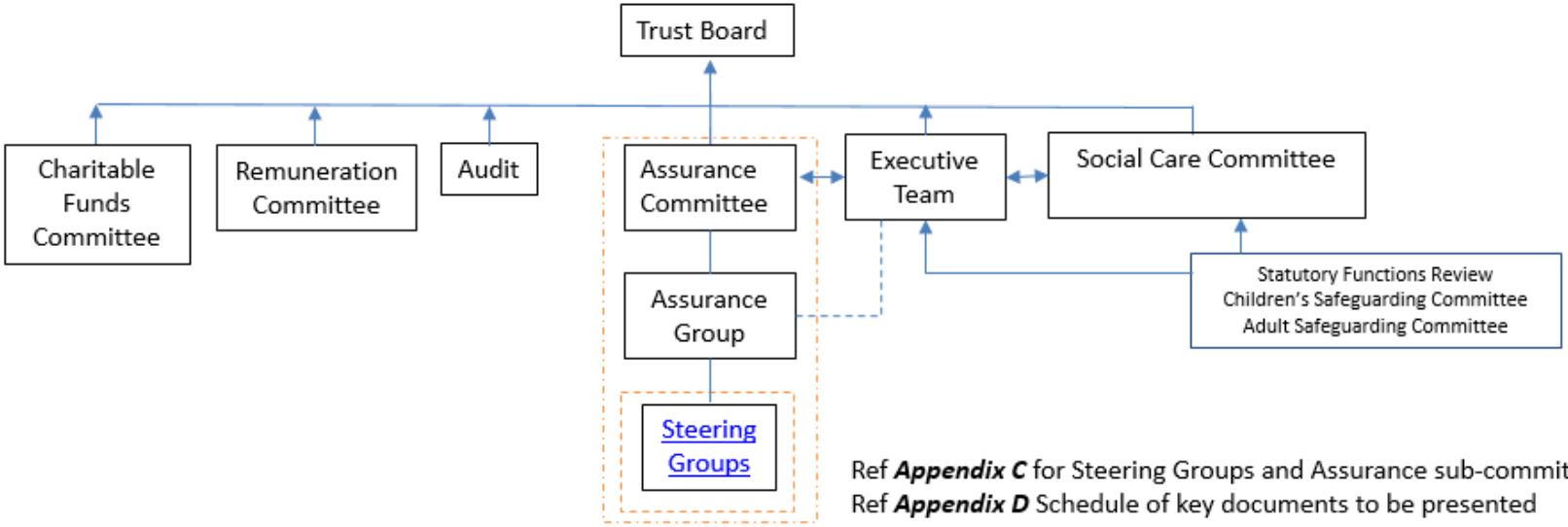
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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.

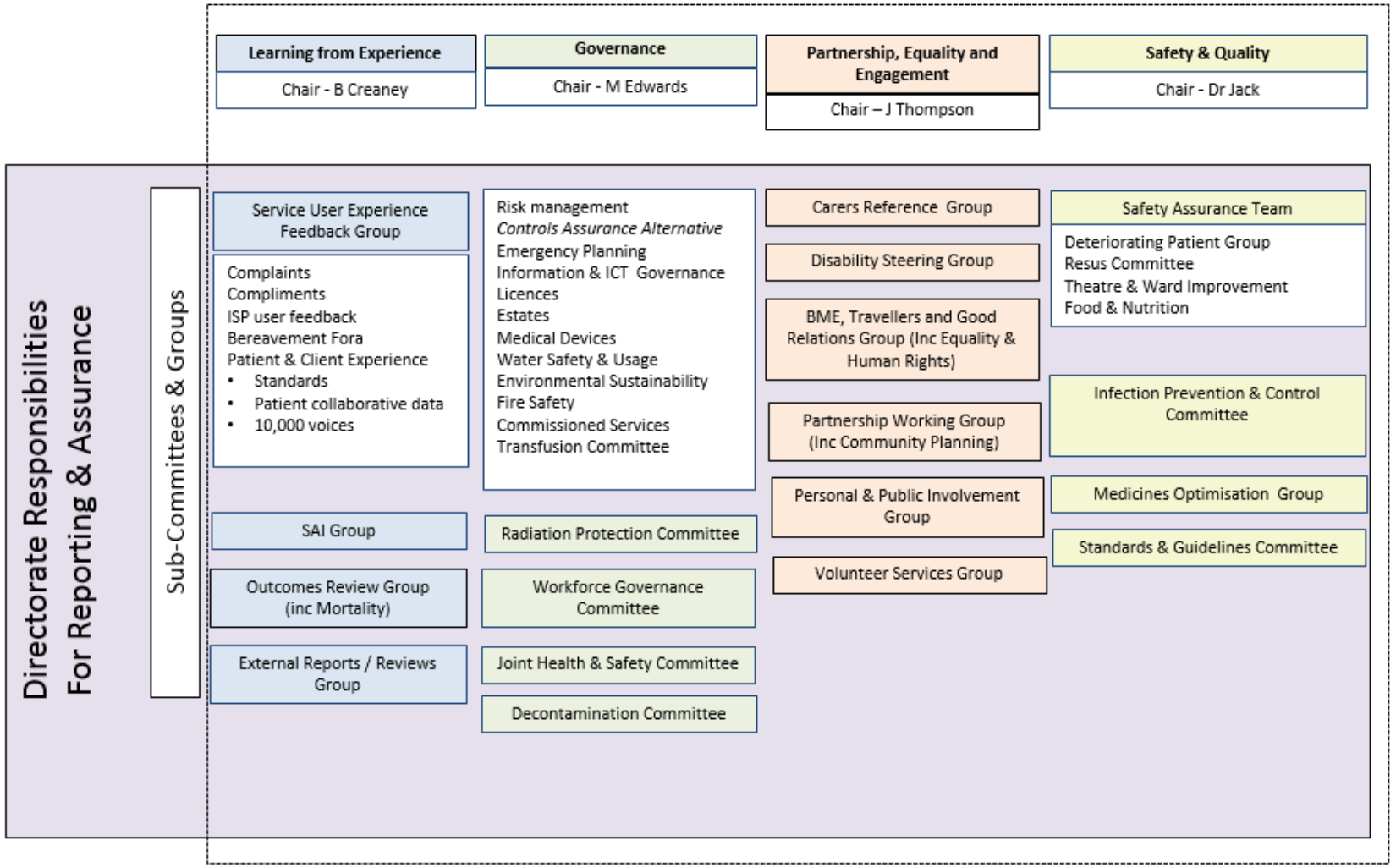
Appendix B - Trust Assurance & Accountability Organisational Overview



Ref ***Appendix C*** for Steering Groups and Assurance sub-committees
Ref ***Appendix D*** Schedule of key documents to be presented

Five Corporate Themes				
Safety, Quality & Experience	Service Delivery	Strategy	People & Culture	Resources
Key Objectives				
Deliver Quality Improvement Plan 2017-2020, linked to Experience	Drive Improvement across elective care, unscheduled and community services	Develop and deliver strategic change with partners	Implement Collective Leadership and Culture Strategy	Build Infrastructure fit for purpose

Appendix C Steering Groups and Assurance subcommittees



Appendix D Schedule of Key Documents to be presented (Including Annual Reports)

		Assurance Group presentation (pre Assurance Committee)				Assurance Committee
Group Involved in the review	Steering Group	January	April	June	October	
Assurance Framework Principal Risk Document	N/A	√	√	√	√	√
Risk Management Strategy	N/A			√		√
Board Assurance Framework	N/A			√		√
Whistleblowing Annual report	N/A			√		√
Legal Services Quarterly Report	Learning from Experience	√	√	√	√	√
Legal Services Annual report	Learning from Experience			√		√
Incident & Serious Adverse Incident Quarterly Report	Learning from Experience	√	√	√	√	√
Complaints & Compliments Quarterly Report	Learning from Experience	√	√	√	√	√
Complaints & Compliments Annual report	Learning from Experience			√		√
RQIA Thematic Review	Learning from Experience	√	√	√	√	√
RQIA Regulated Providers Inspections Summary	Learning from Experience	√	√	√	√	√
Research Committee Annual Report	Learning from Experience			√		√
Health & Safety Annual report	Governance				√	√
Information Governance Annual Report	Governance			√		√
(Controls) Assurance Compliance Report	Governance		√			√
Medical Devices Annual Report	Governance			√		
Emergency Preparedness Annual Report	Governance			√		√
Fire Safety Annual Report	Governance			√		√
Water Safety Annual Report	Governance			√		√
Commissioned Services Report (Acute)	Governance			√		√
Commissioned Services Report (Community)	Governance			√		√
Transfusion Committee Annual Report	Governance				√	√
Food & Nutrition	Governance				√	√
Infection and Prevention Control Annual Report	Safety & Quality			√		√
Trust Quality Improvement Plan (inc Graph Set)	Safety & Quality	√	√	√	√	√
Organ Donation Annual Report	Safety & Quality			√		√
Standards & Guidelines Annual Report	Safety & Quality			√		√
Partnership, Equality and Engagement Steering Group Annual Report	Partnership, Equality and Engagement			√		√
Professional Nursing Report	N/A					√
Medical & Dental Revalidation Report	N/A					√
Mater Trustee meeting Minutes	N/A		√		√	√
Workforce Governance Group	Governance			√		√
Learning & Development Group	Governance			√		√
Health & Wellbeing Group Annual Report	Governance			√		√
Statutory & Mandatory Training Group	Governance			√		√
Discharge of Statutory Functions	N/A				√	Trust Board
Corporate Parenting	N/A				√	Trust Board
Annual Adoption Services	N/A		√			Trust Board
Annual Residential Children's	N/A		√			Trust Board
Annual Regional Emergency SWS	N/A		√			Trust Board

Belfast Health and Social Care Trust

caring supporting improving together

BOARD ASSURANCE FRAMEWORK

2019-2020

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 Trust Corporate Management Plan 2018-2021.

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 outlines 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 Assurance Standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast HSC Trust Corporate Management Plan 2018-21

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 Principal Risk Document.

2. Strategic Context

In order to produce the outcomes for which the Department of Health (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 DoH Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

The 3-year Trust Corporate Management Plan (2018-2021) affirms the Trust Vision and Values, and sets out the three-year commitment for Trust services with identified outcomes. The Trust Vision is:

> *'..to be one of the safest, most effective and compassionate health and social care organisations.'* (Corporate Management Plan 2018-2021)

The Trust Delivery Plan (TDP) is the Trust's response to the DoH Commissioning Plan Direction and the HSCB Commissioning Plan. It 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 service transformation agenda and for effective and efficient management of resources.

3. Objective Setting

The Trust's 3-year Corporate Management Plan (2018-2021), supported by Divisional Management Plans, identifies our objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan within the context of the overall regional priorities, ie – improving the health of the population; improving the

quality and experience of care; ensuring the sustainability of the services delivered and supporting and empowering our staff.

The Trust has identified five overarching corporate objectives:

Safety, Quality and Experience - Work with service users and carers to continuously improve Safety, Quality and Experience for those who access and deliver our services;

Service Delivery - Drive improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors;

People and Culture - Support a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams;

Strategy and Partnerships - Innovate and develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors;

Resources - Work together to make the best use of available resources and reduce variation in care for the benefit of those we serve.

There are objectives attached to each of these overarching objectives. Divisional Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Plan Direction and the HSCB/PHA Commissioning Plan.

While the Corporate Management 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:

- Divisional Annual Management 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 Department of Health

Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) 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 (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 HSC 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

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

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.

The DoH HSC Performance Management Framework (issued June 2017) sets out an enhanced framework for managing performance and accountability for HSC with the primary performance management role undertaken within Trusts (including by Trust Board). The key regional forum for holding Trusts to account will be through the DoH accountability review meetings under the PMF. The PHA (and HSCB currently) is expected to provide advice to the DoH with regards to performance management and support to the Trusts within an overall cycle of continuous engagement and improvement.

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.

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. The Trust has been identified as a designated body by the General Medical Council and the Nursing and Midwifery Council and will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

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, for example when applying for a child care order.

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 has a risk management strategy that underpins its policy on risk (see Appendix A) and explains its approach to acceptable risk.

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the principal risks to achieving these objectives. These are encapsulated as the Principal Risk Document. There are systems in place to monitor and review risks, which are delegated below Corporate level.

Assurance (formerly the Controls Assurance process) remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard. The results will be reflected in the Trust's Corporate Risk Register.

The Belfast Trust has and continues to develop 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 are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust's Being Open Policy.

Quality Improvement

The Trust has developed a Quality Improvement Strategy 2017-2020 (QIS) which outlines how it will create the conditions for the Belfast Health and Social Care Trust to become a leader in providing safe, high quality and compassionate care in the UK.

Delivering safe, high quality and compassionate care is the first order priority for the Belfast Trust. We will realise this ambition by developing a culture of excellence in safety and quality by engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those in our care.

To realise and embed this culture and to support our staff, we have identified five key principles to focus our safety and quality efforts:

1. Placing the **person** clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation;
2. Ensuring a **relentless focus on safety and quality improvement** through the implementation of our Quality Improvement Plan, aligned to our corporate objectives and assurance framework;
3. Ensuring th**at we are an open, transparent and supportive organisation** that is continually learning and sharing both within and beyond the organisation;
4. Using **measurement and real time data, linked to goals, to learn and improve at every level**;
5. Enhancing our **will, capability and structures** to undertake quality improvement consistently, everywhere and every day.

Organisational Arrangements

Proposed organisational arrangements for governance and assurance are set out in Appendix B and C. 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 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.

Appendix D outlines the Schedule of Key Documents to be presented (Including Annual Reports)

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 Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the

Remuneration Committee is to provide advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

The Social Care Committee

The Social Care Committee (a standing committee of Trust Board) is comprised of Non-Executive Directors. Its role is to assist the Trust Board in assuring the Trust's discharge of its delegated statutory functions with regard to the delivery of social care services. This involves its scrutiny of the suite of reports and related data which are included in the Trust's Annual and Interim Statutory Functions Reports.

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 the Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny 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.

Assurance Steering Groups (Appendix C)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

Formal Sub-Committees (Appendix C)

These committees report through a Steering Group to the Assurance Group of the 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 across the Trust.

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, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

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 the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. They provide leadership through his/her chairmanship of the Board and Assurance Committee. They work closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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 leadership creates the vision for the Board and the Trust to modernise and improve services. They are responsible for the Statutory Duty of Quality. They are 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/her 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 Director of Finance & Estates

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. They, with the Chief Executive, are 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 and Estates 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. They 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 Director of Finance and Estates 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 Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development 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 they 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, they work with relevant Directors to ensure the system of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

The Director of Human Resources and Organisational Development is leading a reorganisation of Directorates into Divisions and Care Delivery Units to support a collective leadership model of care delivery. This will support the Trust's aim to be in the top 20% of NHS organisations for safety and quality by 2020.

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

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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. They 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. They are responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. They have specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. They have specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. They have lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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. They are 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

Service Directors

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social & Primary Care;
- Director of Unscheduled & Acute Care

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 Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, 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 and Estates, Medical Director, and Director of Planning, Performance and Informatics 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 is important for the quality and robustness of this Assurance Framework that it is 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.

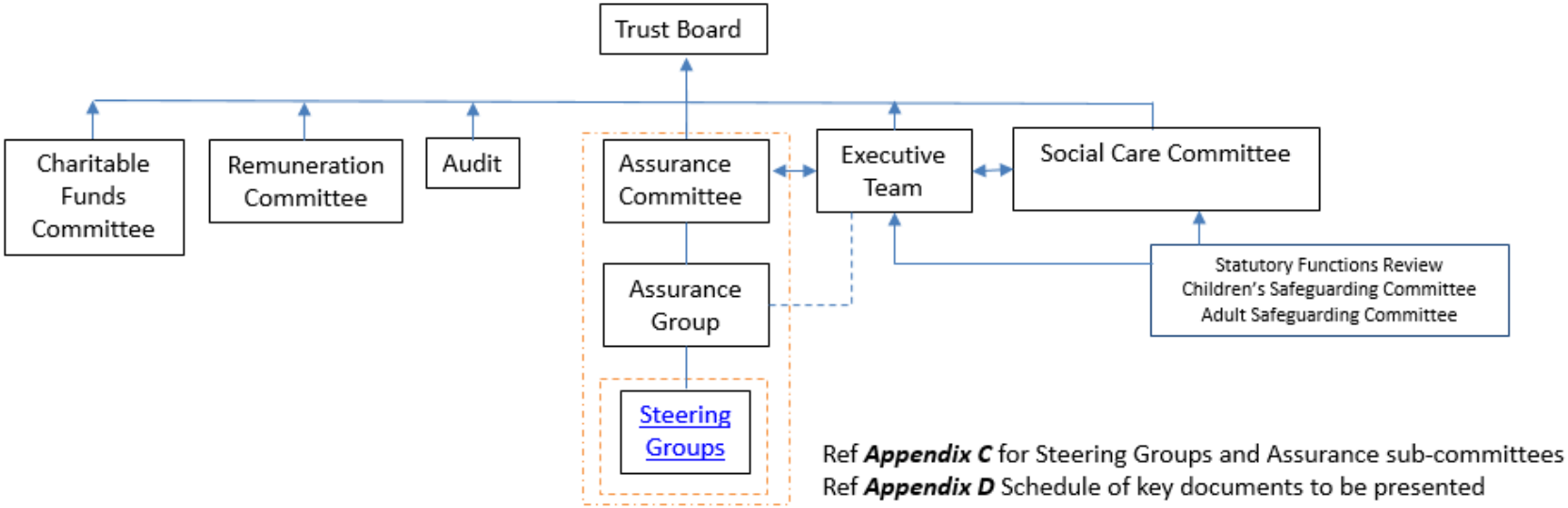
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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.

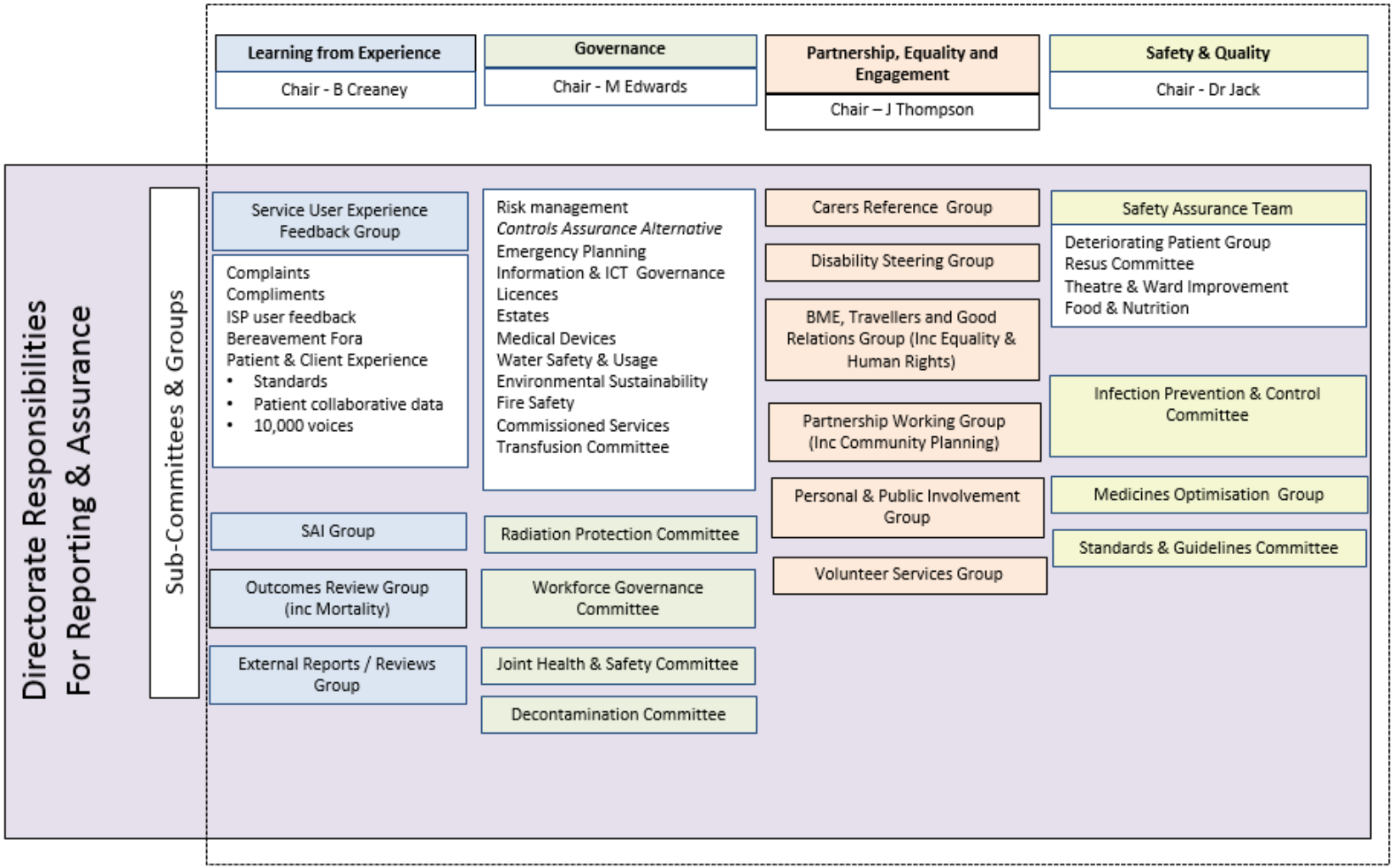
Appendix B - Trust Assurance & Accountability Organisational Overview



Ref ***Appendix C*** for Steering Groups and Assurance sub-committees
Ref ***Appendix D*** Schedule of key documents to be presented

Five Corporate Themes				
Safety, Quality & Experience	Service Delivery	Strategy	People & Culture	Resources
Key Objectives				
Deliver Quality Improvement Plan 2017-2020, linked to Experience	Drive Improvement across elective care, unscheduled and community services	Develop and deliver strategic change with partners	Implement Collective Leadership and Culture Strategy	Build Infrastructure fit for purpose

Appendix C Steering Groups and Assurance subcommittees



Appendix D Schedule of Key Documents to be presented (Including Annual Reports)

		Assurance Group presentation (pre Assurance Committee)				Assurance Committee
Group Involved in the review	Steering Group	January	April	June	October	
Assurance Framework Principal Risk Document	N/A	√	√	√	√	√
Risk Management Strategy	N/A			√		√
Board Assurance Framework	N/A			√		√
Whistleblowing Annual report	N/A			√		√
Legal Services Quarterly Report	Learning from Experience	√	√	√	√	√
Legal Services Annual report	Learning from Experience			√		√
Incident & Serious Adverse Incident Quarterly Report	Learning from Experience	√	√	√	√	√
Complaints & Compliments Quarterly Report	Learning from Experience	√	√	√	√	√
Complaints & Compliments Annual report	Learning from Experience			√		√
RQIA Thematic Review	Learning from Experience	√	√	√	√	√
RQIA Regulated Providers Inspections Summary	Learning from Experience	√	√	√	√	√
Research Committee Annual Report	Learning from Experience			√		√
Health & Safety Annual report	Governance				√	√
Information Governance Annual Report	Governance			√		√
(Controls) Assurance Compliance Report	Governance		√			√
Medical Devices Annual Report	Governance			√		
Emergency Preparedness Annual Report	Governance			√		√
Fire Safety Annual Report	Governance			√		√
Water Safety Annual Report	Governance			√		√
Commissioned Services Report (Acute)	Governance			√		√
Commissioned Services Report (Community)	Governance			√		√
Transfusion Committee Annual Report	Governance				√	√
Food & Nutrition	Governance				√	√
Infection and Prevention Control Annual Report	Safety & Quality			√		√
Trust Quality Improvement Plan (inc Graph Set)	Safety & Quality	√	√	√	√	√
Organ Donation Annual Report	Safety & Quality			√		√
Standards & Guidelines Annual Report	Safety & Quality			√		√
Partnership, Equality and Engagement Steering Group Annual Report	Partnership, Equality and Engagement			√		√
Professional Nursing Report	N/A					√
Medical & Dental Revalidation Report	N/A					√
Mater Trustee meeting Minutes	N/A		√		√	√
Workforce Governance Group	Governance			√		√
Learning & Development Group	Governance			√		√
Health & Wellbeing Group Annual Report	Governance			√		√
Statutory & Mandatory Training Group	Governance			√		√
Discharge of Statutory Functions	N/A				√	Trust Board
Corporate Parenting	N/A				√	Trust Board
Annual Adoption Services	N/A		√			Trust Board
Annual Residential Children's	N/A		√			Trust Board
Annual Regional Emergency SWS	N/A		√			Trust Board

Belfast Health and Social Care Trust

caring supporting improving together

BOARD ASSURANCE FRAMEWORK

2020-2021

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 Trust Corporate Management Plan 2018-2021.

The Assurance Framework (formerly 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 outlines 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 Assurance Standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast HSC Trust Corporate Management Plan 2018-21

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, regularly reviewed Principal Risks.

2. Strategic Context

In order to produce the outcomes for which the Department of Health (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 DoH Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

The 3-year Trust Corporate Management Plan (2018-2021) affirms the Trust Vision and Values, and sets out the three-year commitment for Trust services with identified outcomes. The Trust Vision is:

> *'..to be one of the safest, most effective and compassionate health and social care organisations.'* (Corporate Management Plan 2018-2021)

The Trust Delivery Plan (TDP) is the Trust's response to the DoH Commissioning Plan Direction and the HSCB Commissioning Plan. It 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 service transformation agenda and for effective and efficient management of resources.

3. Objective Setting

The Trust's 3-year Corporate Management Plan (2018-2021), supported by Divisional Management Plans, identifies our objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan within the context of the overall regional priorities, i.e., – improving the health of the population; improving the

quality and experience of care; ensuring the sustainability of the services delivered and supporting and empowering our staff.

The Trust has identified five overarching corporate objectives:

Safety, Quality and Experience - Work with service users and carers to continuously improve Safety, Quality and Experience for those who access and deliver our services;

Service Delivery - Drive improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors;

People and Culture - Support a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams;

Strategy and Partnerships - Innovate and develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors;

Resources - Work together to make the best use of available resources and reduce variation in care for the benefit of those we serve.

There are objectives attached to each of these overarching objectives. Divisional Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Plan Direction and the HSCB/PHA Commissioning Plan.

While the Corporate Management 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:

- Divisional Annual Management 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 Department of Health

Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, 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[2] (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[3] (augmented by the HPSS (NI) Order 1994[4]) 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 (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 HSC 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

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

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.

The DoH HSC Performance Management Framework (issued June 2017) sets out an enhanced framework for managing performance and accountability for HSC with the primary performance management role undertaken within Trusts (including by Trust Board). The key regional forum for holding Trusts to account will be through the DoH accountability review meetings under the PMF. The PHA (and HSCB currently) is expected to provide advice to the DoH with regards to performance management and support to the Trusts within an overall cycle of continuous engagement and improvement.

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.

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. The Trust has been identified as a designated body by the General Medical Council and the Nursing and Midwifery Council and will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

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, for example when applying for a child care order.

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 has a risk management strategy that underpins its policy on risk (see Appendix A) and explains its approach to acceptable risk.

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the principal risks to achieving these objectives. These are encapsulated within the Assurance Framework. There are systems in place to monitor and review risks, which are delegated below Corporate level.

Organisational Assurance (formerly the Controls Assurance process) remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard. The results will be reflected in the Trust's Corporate Risk Register.

The Belfast Trust has and continues to develop 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 are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust's Being Open Policy.

Quality Improvement

The Trust has developed a Quality Improvement Strategy 2017-2020 (QIS) which outlines how it will create the conditions for the Belfast Health and Social Care Trust to become a leader in providing safe, high quality and compassionate care in the UK.

Delivering safe, high quality and compassionate care is the first order priority for the Belfast Trust. We will realise this ambition by developing a culture of excellence in safety and quality by engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those in our care.

To realise and embed this culture and to support our staff, we have identified five key principles to focus our safety and quality efforts:

1. Placing the **person** clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation;

2. Ensuring a **relentless focus on safety and quality improvement** through the implementation of our Quality Improvement Plan, aligned to our corporate objectives and assurance framework;
3. Ensuring th**at we are an open, transparent and supportive organisation** that is continually learning and sharing both within and beyond the organisation;
4. Using **measurement and real time data, linked to goals, to learn and improve at every level**;
5. Enhancing our **will, capability and structures** to undertake quality improvement consistently, everywhere and every day.

Organisational Arrangements

Proposed organisational arrangements for governance and assurance are set out in Appendix B and C. 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 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.

Appendix D outlines the Schedule of Key Documents to be presented (Including Annual Reports)

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 Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the

Remuneration Committee is to provide advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

The Social Care Committee

The Social Care Committee (a standing committee of Trust Board) is comprised of Non-Executive Directors. Its role is to assist the Trust Board in assuring the Trust's discharge of its delegated statutory functions with regard to the delivery of social care services. This involves its scrutiny of the suite of reports and related data which are included in the Trust's Annual and Interim Statutory Functions Reports.

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 the Assurance Framework Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny committees. The Assurance Group will be responsible on behalf of the Executive Team for developing and maintaining the Assurance Framework. It will be responsible for maintaining a programme of self-

assessment and independent audit/verification against required standards, other than finance.

Assurance Steering Groups (Appendix C)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

Formal Sub-Committees (Appendix C)

These committees report through a Steering Group to the Assurance Group of the 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 across the Trust.

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, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

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 the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. They provide leadership through his/her chairmanship of the Board and Assurance Committee. They work closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of 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 Audit Committee and Assurance Committee and 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 leadership creates the vision for the Board and the Trust to modernise and improve services. They are responsible for the Statutory Duty of Quality. They are 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/her 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 Director of Finance & Estates

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. They, with the Chief Executive, are 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 and Estates 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. They ensure 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 Director of Finance and Estates 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 Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development 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 they 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, they work with relevant Directors to ensure the system of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

The Director of Human Resources and Organisational Development is leading a reorganisation of Directorates into Divisions and Care Delivery Units to support a collective leadership model of care delivery.

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

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 & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director 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 their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. They 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 Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. They are responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. They have specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. They have specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. They have lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services 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. They are 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/Children's Community Services 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 Performance, Planning and Informatics

The Director of Performance, Planning and Informatics 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 Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

The Director of Performance, Planning and Informatics leads on statutory compliance for Equality. Personal and Public Involvement and GDPR.

Service Directors

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Unscheduled Care & Older People's Services
- Director of Neurosciences & Imaging Services
- Director of Social Work / Children's Community Services;
- Director of Adult Social & Primary Care

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 Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, 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 and Estates, Medical Director, and Director of Planning, Performance and Informatics 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 is important for the quality and robustness of this Assurance Framework that it is 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.

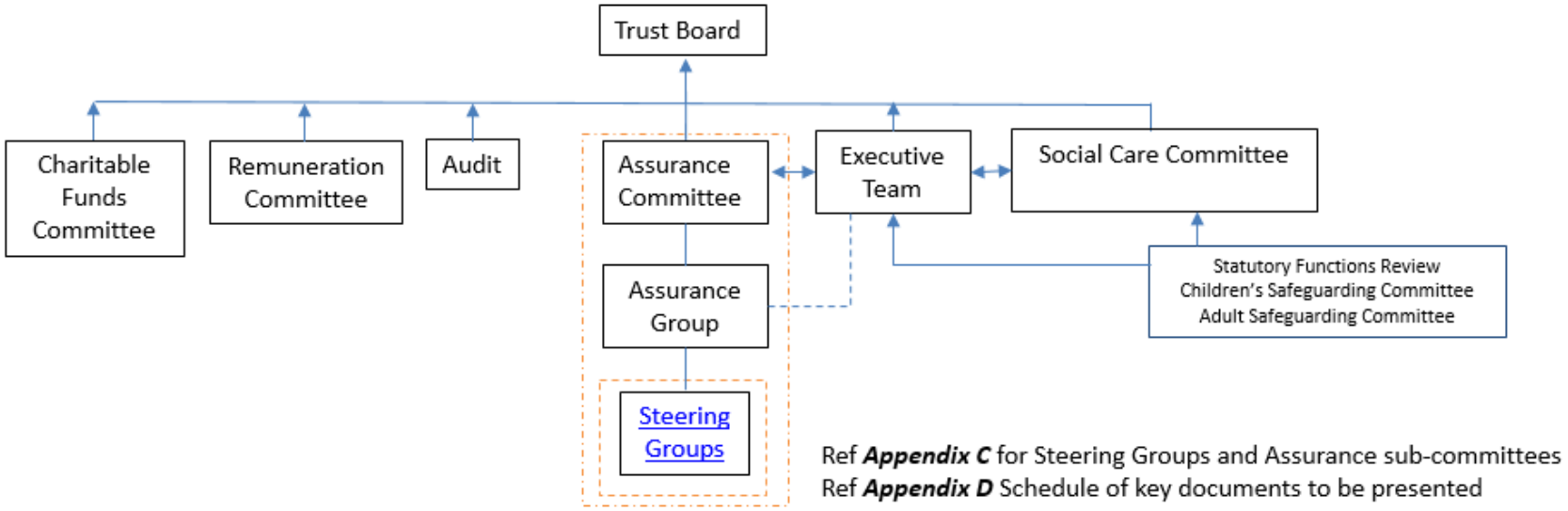
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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.

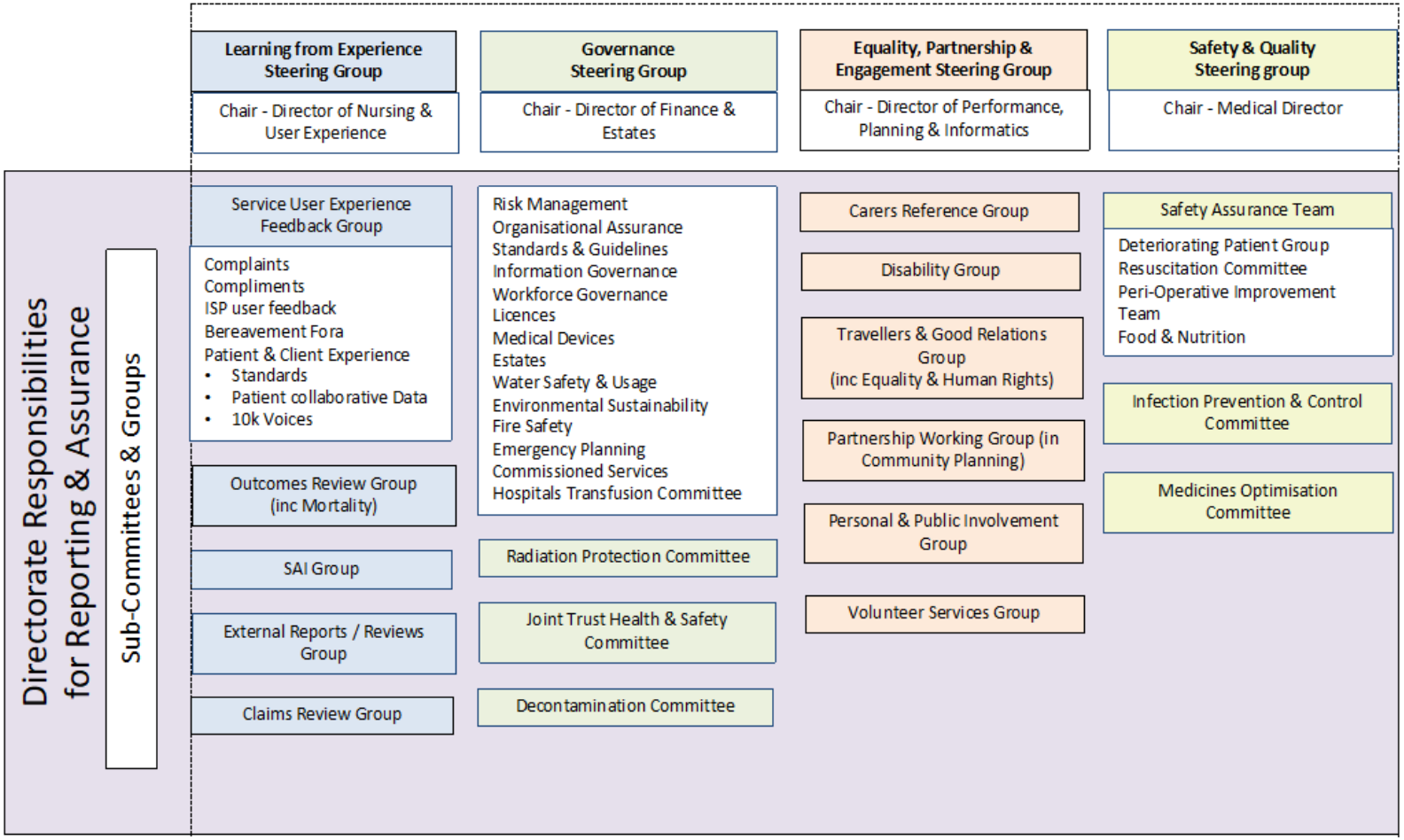
The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk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

Appendix B - Trust Assurance & Accountability Organisational Overview



Five Corporate Themes				
Safety, Quality & Experience	Service Delivery	Strategy	People & Culture	Resources
Key Objectives				
Deliver Quality Improvement Plan 2017-2020, linked to Experience	Drive Improvement across elective care, unscheduled and community services	Develop and deliver strategic change with partners	Implement Collective Leadership and Culture Strategy	Build Infrastructure fit for purpose

Appendix C Steering Groups and Assurance subcommittees



Appendix D Board Assurance Framework Schedule of Reports

Report	Jan	Apr	Jun	Oct	Assurance Committee	Trust Board
Assurance Framework (formally Principal Risk Document - inc Corporate Risk Register)	✓	✓	✓	✓	✓	
Service & Corporate Directorate Extreme & High-Risk Registers	✓	✓	✓	✓		
Incident & SAI Rolling Year Report	✓	✓		✓		
Incident & SAI Annual Report*			✓		✓	
Legal Services Quarterly Report	✓	✓		✓	✓	
Legal Services Annual Report			✓		✓	
Coroner's Services Quarterly Report	✓	✓		✓	✓	
Coroner's Services Annual Report			✓		✓	
Complaints Quarterly Report	✓	✓	✓	✓	✓	
Complaints Annual Report				✓	✓	
Governance Informatics Reports	✓	✓	✓	✓	✓	
Board Assurance Framework			✓		✓	
Risk Management Strategy			✓		✓	
Whistleblowing Annual Report				✓	✓	
RQIA Thematic Review Summary Report*	✓	✓	✓	✓	✓	
RQIA ASPC Regulated Inspections Report*	✓	✓	✓	✓	✓	
GMC Quarterly Report	✓	✓	✓	✓	✓	
Medical & Dental Assurance Annual Report				✓	✓	
Nursing Assurance Annual Report				✓	✓	
Health & Safety Annual Report				✓	✓	
Information Governance Annual Report				✓	✓	
Fire Safety Annual Report				✓	✓	
Water Safety Annual Report				✓	✓	
AHP Annual Report				✓	✓	
IPC Annual Report				✓	✓	
Hospitals Transfusion Committee Annual Report				✓	✓	
Standards & Guidelines Annual Report				✓	✓	
ISP Acute Annual Report			✓		✓	
ISP Community Annual Report			✓		✓	
Mater Trustee Meeting Minutes		✓		✓	✓	
Annual Quality Report (Corporate Comms)						✓
Emergency Planning Annual Report						✓
Corporate Parenting Report						✓
Statutory Functions Report						✓
RESW Annual Report						✓
Adoption Services Annual Report						✓
Residential Children's Annual Report						✓
Clinical Ethics Annual Report	✓					✓
Organ Donation Annual Report			✓			✓
Research Committee Annual Report			✓			✓

MANAGEMENT STATEMENT

BETWEEN

DEPARTMENT OF HEALTH FOR NORTHERN IRELAND

&

BELFAST HEALTH & SOCIAL CARE TRUST

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

HSC Belfast Health and Social Care Trust
caring supporting improving together

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Management Statement

Belfast Health & Social Care Trust

1. INTRODUCTION

1.1 This document

1.1.1 This *Management Statement* and *Financial Memorandum* (MS/FM) has been drawn up by the sponsor Department, the Department of Health, in consultation with the Belfast Health & Social Care Trust (referred to in this document as BHSCT or the Trust), Belfast Trust Headquarters, A Floor, Belfast City Hospital, Lisburn Road, Belfast, BT9 7AB. The document is based on a model prepared by the Department of Finance (DoF).

1.1.2 The terms and conditions set out in the combined M*anagement Statement* and *Financial Memorandum* may be supplemented by guidelines or directions issued by the sponsor Department/Minister in respect of the exercise of any individual functions, powers and duties of the BHSCT.

1.1.3 A copy of the MS/FM for the BHSCT should be given to all newly appointed Trust Board Members, senior Trust executive staff and departmental sponsor staff on appointment. Additionally the MS/FM should be tabled for the information of Trust Board Members at least annually at a full meeting of the Board. Amendments made to the MS/FM should also be brought to the attention of the full Board on a timely basis.

1.1.4 Subject to the legislation noted below, this *Management Statement* sets out the broad framework within which the Trust will operate, in particular:

- the Trust's overall aims, objectives and targets in support of the sponsor Department's wider strategic aims and the outcomes and targets contained in the Programme for Government (PfG) and in the Commissioning Plan Direction (CPD);
- the rules and guidelines relevant to the exercise of the Trust's functions, duties and powers;
- the conditions under which any public funds are paid to the Trust; and
- how the Trust is to be held to account for its performance.

1.1.5 The associated *Financial Memorandum* sets out in greater detail certain aspects of the financial provisions which the BHSCT shall observe. However, the *Management Statement* and *Financial Memorandum* do not convey any legal powers or responsibilities.

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1.1.6 The document shall be periodically reviewed by the sponsor Department in line with the reviews referred to in Section 7 below.

1.1.7 BHSCT, the sponsor Department, or the Minister, may propose amendments to this document at any time. Any such proposals by the Trust shall be considered in the light of evolving departmental policy aims, operational factors and the track record of the Trust itself. The guiding principle shall be that the extent of flexibility and freedom given to the Trust shall reflect both the quality of its internal controls to achieve performance and its operational needs. The sponsor Department shall determine what changes, if any, are to be incorporated in the document. Legislative provisions shall take precedence over any part of the document. Significant variations to the document shall be cleared with DoF Supply after consultation with the Trust, as appropriate. (The definition of "significant" will be determined by the sponsor Department in consultation with DoF).

1.1.8 The *MS/FM* is approved by DoF Supply, and signed and dated by the sponsor Department and BHSCT's Chief Executive.

1.1.9 Any question regarding the interpretation of the document shall be resolved by the sponsor Department after consultation with the BHSCT and, as necessary, with DoF Supply.

1.1.10 BHSCT should provide the documents detailed in Appendix 1 to the sponsor Department with the frequency described therein.

1.1.11 Copies of this document and any subsequent substantive amendments shall be placed in the Library of the Assembly. (Copies shall also be made available to members of the public on BHSCT's website).

1.2 Founding legislation: status

1.2.1 BHSCT is established by means of an Establishment Order made under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (the 1991 Order). The Establishment Order is the Belfast Health & Social Services Trust (Establishment) Order (Northern Ireland) 2006 (the 2006 Establishment Order). BHSCT does not carry out its functions on behalf of the Crown.

1.3 The functions, duties and powers of BHSCT

1.3.1 BHSCT is established for the purposes specified in Article 10(1) of the 1991 Order. http://www.legislation.gov.uk/nisi/1991/194/article/10 . These include any functions of the Department with respect to administration of health and social care that the Department may direct. The Trust's general powers are listed in the Schedule to the 2006 Establishment Order -

http://www.legislation.gov.uk/nisr/2006/294/schedule/made

1.4 Classification

1.4.1 For policy/administrative purposes BHSCT is classified as a health and social care body (akin to an executive non-departmental public body).

1.4.2 For national accounts purposes BHSCT is classified to the public corporations sector.

1.4.3 References to BHSCT include, where they exist, all its subsidiaries and joint ventures that are classified to the public sector for national accounts purposes. If such a subsidiary or joint venture is created, there shall be a document setting out the arrangements between it and BHSCT.

2. AIMS, OBJECTIVES AND TARGETS

2.1 Overall aim

2.1.1 The approved overall aim for BHSCT is to improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, by providing effective, high quality, equitable and efficient health and social care.

2.2 Objectives and key targets

2.2.1 The Department determines BHSCT's performance framework in light of the Department's wider strategic aims, current PfG objectives and targets and the CPD.

3. RESPONSIBILITIES AND ACCOUNTABILITY

3.1 The Minister

3.1.1 The Minister is accountable to the NI Assembly for the activities and performance of BHSCT.

His/her responsibilities include:

- keeping the Assembly informed about the Trust's performance, as part of the HSC system;
- carrying out responsibilities specified in the founding legislation including appointments to the Trust Board (including its Chairman) and laying of the annual report and accounts before the Assembly; and

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- approving the remuneration scheme for Non-Executive Board members and setting the annual pay settlement each year under these arrangements.

3.2 The Accounting Officer of the sponsor Department

3.2.1 The Permanent Secretary, as the sponsor Department's principal Accounting Officer (the 'Departmental Accounting Officer'), is responsible for the overall organisation, management and staffing of the sponsor Department and for ensuring that there is a high standard of financial management in the Department as a whole. The Departmental Accounting Officer is accountable to the Assembly for the issue of any grant-in-aid (GIA) to the BHSCT. The Departmental Accounting Officer designates the Chief Executive of the BHSCT as its Accounting Officer, and may withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role.

3.2.2 In particular, the Departmental Accounting Officer of the sponsor Department shall ensure that:

- BHSCT's strategic aim(s) and objectives support the sponsor Department's wider strategic aims, current PfG objectives and targets and the CPD;

- the financial and other management controls applied by the sponsor Department to BHSCT are appropriate and sufficient to safeguard public funds and for ensuring that the Trust's compliance with those controls is effectively monitored ("public funds" include not only any funds granted to the Trust by the Assembly but also any other funds falling within the stewardship of the Trust);

- the internal controls applied by BHSCT conform to the requirements of regularity, propriety and good financial management; and

- any GIA to BHSCT is within the ambit and the amount of the Request for Resources and that Assembly authority has been sought and given.

3.2.3 The Departmental Accounting Officer is also responsible for ensuring that arrangements are in place to:

- continuously monitor BHSCT's activities to measure progress against approved targets, standards and actions, and to assess compliance with safety and quality, governance, risk management and other relevant requirements placed on the organisation;

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- address significant problems in the Trust, making such interventions as he/she judges necessary to address such problems;
- periodically carry out an assessment of the risks both to the Department's and the Trust's objectives and activities;
- inform the Trust of relevant Government policy in a timely manner; and
- bring concerns about the activities of the Trust to the full BHSCT Board, requiring explanations and assurances that appropriate action has been taken.

3.2.4 The responsibilities of a Departmental Accounting Officer are set out in more detail in Chapter 3 of Managing Public Money Northern Ireland (MPMNI).

3.3 The DoH Executive Board Member, the sponsor team and Finance Directorate

3.3.1 Sponsorship of BHSCT is the responsibility of DoH as a whole. The Department has allocated an Executive Board Member (EBM) Sponsor to each Arms Length Body (ALB). The EBM Sponsor has primary responsibility for overseeing sponsorship of the ALB. In particular the EBM supports the Permanent Secretary in ensuring sponsorship is applied systematically; provides an assurance that a proportionate approach to assurance and accountability is in place; manages the ALB's business planning process; and ensures that significant governance, risk management or internal control issues are escalated within the Department. The EBM sponsor also undertakes end-year appraisals for ALB Chairs and participates in ground-clearing and accountability meetings as required.

3.3.2 HSC Sponsorship Branch is the sponsor team for the BHSCT. The sponsor team, in consultation as necessary with the Departmental Accounting Officer, is the primary source of advice to the Minister on the discharge of his/her responsibilities in respect of the BHSCT, and, subject to paragraph 3.3 4, is the primary point of contact for the Trust in dealing with the sponsor Department. The sponsoring team carries out its duties under the management of the EBM.

3.3.3 The sponsor Department shall advise the Minister on an appropriate framework of objectives and targets for BHSCT in the light of the Department's wider strategic aims, current PfG objectives and targets and the CPD;

3.3.4 On financial matters, the primary point of Departmental contact for the Trust is the Department's Finance Directorate. The Directorate supports the Departmental Accounting Officer on his / her responsibilities towards the Trust regarding accounting arrangements, budgetary control and other financial matters, including procurement. In doing so, Finance Directorate shall liaise as appropriate with the sponsor team.

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3.4 The BHSCT Board

3.4.1 Non Executive Board Members are appointed by the Minister following an open and transparent public appointment competition carried out in line with the Code of Practice issued by the Commissioner for Public Appointments NI. The Trust Board comprises a Non-Executive Chair and seven Non-Executive Members. The Non-Executive Members include 6 Lay Members and a Lay Member with Financial experience. Appointments are normally for a four year term and are restricted to 2 terms. Notwithstanding the length of individual appointment terms, the maximum period in post must not exceed 10 years. Appointments are made in line with appropriate legislation; Health and Social Services Trusts (Membership and Procedure) Regulations (NI)1994.

3.4.2 The BHSCT Board has corporate responsibility for ensuring that BHSCT fulfils the aims and objectives set by the sponsor Department and approved by the Minister in the light of the Department's wider strategic aims, current PfG objectives and targets and the CPD, and for promoting the efficient, economic and effective use of staff and other resources by the Trust. To this end, and in pursuit of its wider corporate responsibilities, BHSCT Board shall:

- establish the overall strategic direction of the Trust within the policy and resources framework determined by the sponsor Minister and Department;

- constructively challenge the Trust's executive team in their planning, target setting and delivery of performance;

- ensure that the sponsor Department (through the Health & Social Care Board (HSCB)) is kept informed of any changes which are likely to impact on the strategic direction of the Trust or on the attainability of its targets, and determine the steps needed to deal with such changes;

- ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Trust Board operates within the limits of its statutory authority and any delegated authority agreed with the sponsor Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Trust Board takes into account all relevant guidance issued by DoF and the sponsor Department;

- ensure that the Trust Board receives and reviews regular financial information concerning the management of the Trust; is informed in a timely manner about any concerns about the activities of the Trust; and provides positive assurance to the sponsor Department that appropriate action has been taken on such concerns;

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- demonstrate high standards of corporate governance at all times, including using the independent Audit Committee, (see paragraph 4.7) to help the Trust Board to address the key financial and other risks facing the Trust; and

- in accordance with the latest Departmental guidance, appoint a Chief Executive to the BHSCT and, in consultation with the sponsor Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive, which give due weight to the proper management and use of public monies.

3.4.3 Individual Trust Board Members shall act in accordance with their wider responsibilities as Members of the Board – namely to:

- comply at all times with the Code of Conduct and Accountability (see paragraph 3.5.5) that is adopted by BHSCT and with the rules and guidance relating to the use of public funds and to conflicts of interest;

- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organisations; and to declare publicly and to the Trust Board any private interests that may be perceived to conflict with their public duties;

- comply with the Trust Board's rules on the acceptance of gifts and hospitality, and of business appointments; and

- act in good faith and in the best interests of the Trust.

3.4.4 The Trust Board shall provide the sponsor Department with access to all Trust Board meeting minutes. These should be provided to the sponsor team in draft form at the same time as they are circulated to Board Members. The Trust shall provide final agreed minutes to the sponsor team in a timely way.

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3.5 The Chairman of the BHSCT

3.5.1 The Chairman is appointed by the Minister following an open and transparent public appointment competition as outlined in paragraph 3.4.1. Appointments are made in line with appropriate legislation; Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994 http://www.legislation.gov.uk/nisr/1994/63/pdfs/nisr_19940063_en.pdf .

3.5.2 The Chairman is accountable to the Minister of the sponsor Department. The Chairman shall ensure that BHSCT's policies and actions support the wider strategic policies of the Minister; and that the Trust's affairs are conducted with probity. The Chairman shares with other Trust Board members the corporate responsibilities set out in paragraph 3.4.2, and in particular for ensuring that the Trust fulfils the aims and objectives set by the sponsor Department and approved by the Minister.

3.5.3 The Chairman has a particular leadership responsibility on the following matters:

- formulating the Trust Board's strategy for discharging its duties;
- ensuring that the Trust Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor Department, the HSCB or the PHA;
- promoting the efficient, economic and effective use of staff and other resources;
- encouraging and delivering high standards of regularity and propriety;
- representing the views of the Trust Board to the general public;
- ensuring that risk management is considered regularly and formally at Board meetings; and
- ensuring that the Trust Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board Members. Meetings must be open to the public, the public should be advised in advance of meetings through the press or other media such as the Trust's website and the minutes must be placed on the Trust's website after formal approval.

3.5.4 The Chairman shall also:

- ensure that all members of the Trust Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;

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- advise the Department of the needs of BHSCT when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise; and

- assess the performance of individual Trust Board Members. Trust Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed in consultation with Trust Committee Chairs as appropriate by the Chair of the Board at the end of each year and prior to any proposed re - appointment or extension of the term of appointment of individual members taking place. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the Departmental EBM.

- ensure the completion of the Board Governance Self Assessment Tool on an annual basis. Assurance will be provided through the mid-year assurance statement that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department.

3.5.5 The Chairman shall also ensure that Trust Board Members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) which reflects the Cabinet Office's *Code of Practice for Board Members of Public Bodies,* (FD (DFP) 03/06), including the Nolan "seven principles of public life", and also including a requirement for a comprehensive and publicly available register of Trust Board Members' interests.

3.5.6 Communications between the Board, the Minister and the Department shall normally be through the Chairman. The Chairman shall ensure that the other Trust Board Members are kept informed of such communications on a timely basis.

3.6 The Chief Executive's role as Accounting Officer

3.6.1 The Chief Executive of BHSCT is designated as the Trust's Accounting Officer by the Departmental Accounting Officer of the sponsor Department.

3.6.2 The Accounting Officer of BHSCT is personally responsible for safeguarding the public funds for which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day-to-day operations and management of the Trust. The Chief Executive should aim to attend the training course 'An Introduction for Accounting Officers' within 3 months of appointment.

3.6.3 As Accounting Officer, the Chief Executive shall exercise the following responsibilities in particular:

on planning and monitoring -

- establish, with approval of the sponsor Department, as appropriate, the BHSCT's corporate and business plans in support of the Department's wider strategic aims and current PfG objectives and targets;

- inform the HSCB and the sponsor Department as appropriate of the Trust's progress in helping to achieve the Department's policy objectives and in demonstrating how resources are being used to achieve those objectives;

- ensure that timely forecasts and monitoring information on performance and finance are provided to the HSCB and the sponsor Department as appropriate, including prompt notification if overspends or underspends are likely and that corrective action is taken;

- that any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, are notified to the HSCB or the sponsor Department as appropriate in a timely fashion;

on advising the Board -

- advise the Trust Board on the discharge of its responsibilities as set out in this document, in the founding legislation and in any other relevant instructions and guidance that may be issued from time to time by DoF or the sponsor Department;

- advise the Trust Board on BHSCT's performance compared with its aims and objectives;

- ensure that financial considerations are taken fully into account by the Trust Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed appropriately;

- take action in line with Section 3.8 of MPMNI if the Trust Board, or its Chairman, is contemplating a course of action involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity, or does not represent prudent or economical administration, efficiency or effectiveness;

on managing risk and resources –

- ensure that a system of risk management is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets;

- ensure that an effective system of programme and project management and contract management is maintained;

- ensure compliance with the Northern Ireland Public Procurement Policy;

- ensure that all public funds made available to BHSCT, including any income or other receipts, are used for the purpose intended by the Assembly, and that such monies, together with the Trust's assets, equipment and staff, are used economically, efficiently and effectively;

- ensure that adequate internal management and financial controls are maintained by BHSCT, including effective measures against fraud and theft;

- maintain a comprehensive system of internal delegated authorities that are notified to all staff, together with a system for regularly reviewing compliance with these delegations;

- ensure that effective personnel management policies are maintained;

on accounting for BHSCT's activities –

- sign the accounts and be responsible for ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with any directions issued by the Minister, the sponsor Department, or DoF;

- sign a Statement of Accounting Officer's responsibilities, for inclusion in the annual report and accounts;

- sign a Governance Statement regarding BHSCT's system of internal control, for inclusion in the annual report and accounts, which details significant internal control divergences;

- sign a mid-year assurance statement on the condition of the Trust's system of internal control which details significant internal control divergences;

- ensure that effective procedures for handling complaints about BHSCT are established and made widely known within the Trust;

- act in accordance with the terms of this document and with the instructions and relevant guidance in *MPMNI* and other instructions and guidance issued from time to time by the sponsor Department and DoF - in particular, Chapter 3 of MPMNI and the Treasury document *Regularity and Propriety and Value for Money* (a copy of which the Chief Executive shall receive on appointment). Section IX of the *Financial Memorandum* refers to other key guidance;

- give evidence, normally with the Accounting Officer of the sponsor Department, if summoned before the Public Accounts Committee on the use and stewardship of public funds by BHSCT;

- ensure that an Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and The Executive Office;

- ensure that Lifetime Opportunities is taken into account;

- ensure that the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 are complied with;

- report on compliance with controls assurance and quality standards to the sponsor Department;
- ensure that a business continuity plan is developed and maintained;
- ensure that copies of adverse inspection reports are shared with the relevant policy lead in the Department;
- ensure full compliance with the requirements of relevant statutes, court rulings and departmental directions; and
- ensure that a policy on acceptance and provision of Gifts and Hospitality is in place, which sets out the principles and requirements under which gifts and hospitality can be received and in turn when such offers can be made.

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3.7 The Chief Executive's role as Consolidation Officer

3.7.1 For the purposes of Whole of Government Accounts, the Chief Executive of BHSCT is normally appointed by DoF as the Trust's Consolidation Officer.

3.7.2 As the Trust's Consolidation Officer, the Chief Executive shall be personally responsible for preparing the consolidation information, which sets out the financial results and position of the BHSCT; for arranging for its audit; and for sending the information and the audit report to the Principal Consolidation Officer nominated by DoF.

3.7.3 As Consolidation Officer, the Chief Executive shall comply with the requirements of the BHSCT Consolidation Officer Letter of Appointment as issued by DoF and shall, in particular:

- ensure that the Trust has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and

- prepare the consolidation information (including the relevant accounting and disclosure requirements and all relevant consolidation adjustments) in accordance with the consolidation instructions and directions ["Dear Consolidation Officer" (DCO) and "Dear Consolidation Manager" (DCM) letters] issued by DoF on the form, manner and timetable for the delivery of such information.

3.8 Delegation of duties

3.8.1 The Chief Executive may delegate the day-to-day administration of his/her Accounting Officer and Consolidation Officer responsibilities to other employees in BHSCT. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in this document.

3.9 The Chief Executive's role as Principal Officer for Ombudsman cases

3.9.1 The Chief Executive of BHSCT is the Principal Officer for handling cases involving the Northern Ireland Commissioner for Complaints. As Principal Officer, he/she shall inform the Permanent Secretary of the sponsor Department of any complaints about the Trust accepted by the Ombudsman for investigation, and about the Trust's proposed response to any subsequent recommendations from the Ombudsman.

3.10 Consulting customers

3.10.1 BHSCT will work in partnership with its stakeholders and customers, patients, other service users and carers to deliver the services/programmes for which it has responsibility, to agreed standards. It will consult regularly, within the parameters of the Trust's Consultation Scheme, to develop a

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clear understanding of citizens' needs and expectations of its services, and to seek feedback from both stakeholders and customers, patients, other service users and carers and will work to deliver a modern, accessible service.

3.10.2 BHSCT shall comply with the duties and requirements relating to the duty to co-operate with the Patient and Client Council, public involvement and consultation schemes in Sections 18, 19 and 20 of the Health and Social Care (Reform) Act (Northern-Ireland) 2009 - http://www.legislation.gov.uk/nia/2009/1/pdfs/nia_20090001_en.pdf .

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4. PLANNING, BUDGETING AND CONTROL

4.1 The corporate plan

4.1.1 The term corporate plan refers to the Trust's four year plan which sets out the strategic issues the Trust will deal with in that period. Consistent with the timetable for the NI Executive's Budget process reviews, BHSCT shall submit to the sponsor team a draft of its corporate plan normally covering the four years ahead. The Trust shall have agreed with the sponsor Department the issues to be addressed in the plan and the timetable for its preparation. A draft of the corporate plan should be provided to the sponsor team by 31st January in the year preceding the first year of the plan.

4.1.2 DoF reserves the right to see and agree BHSCT's corporate plan.

4.1.3 The plan shall reflect the Trust's statutory duties and, within those duties, the priorities set from time to time by the Minister. In particular, the plan shall demonstrate how the Trust contributes to the achievement of the Department's strategic aims, PfG objectives and targets and the CPD. The plan may also refer to the financial environment within which the Trust is operating.

4.1.4 The corporate plan shall set out:

- BHSCT's key objectives and associated key performance targets for the forward years, its strategy for achieving those objectives and an estimate of performance in the current year;

- alternative scenarios to take account of factors which may significantly affect the execution of the plan, but which cannot be accurately forecast;

- a forecast of expenditure and income, taking account of guidance on resource assumptions and policies provided by the sponsor Department at the beginning of the planning round. These forecasts should represent the Trust's best estimate of all its available income, not just any grant or GIA; and

- other matters as agreed between the sponsor Department and the Trust – for example - statement of purpose of organisation as per legislation, strategic aims, performance in preceding corporate plan period, governance and accountability arrangements, links with PfG, wider ministerial/departmental priorities and the CPD.

4.1.5 The main elements of the plan, including the key performance targets, shall be agreed between the sponsor Department and BHSCT in the light of the sponsor Department's decisions on policy and

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resources taken in the context of the Executive's wider policy and spending priorities and decisions.

4.1.6 In line with paragraph 4.1.1 the corporate plan should be submitted to the sponsor Department for approval.

4.2 The Trust Delivery Plan

4.2.1 The first year of the corporate plan, amplified as necessary, shall provide the basis of the Trust Delivery Plan (TDP) for the relevant forthcoming year. The Trust and the HSCB should agree on a timeframe for submission and agreement of the TDP, which shall include key targets and milestones for the year immediately ahead and shall be linked to budgeting information, so that resources allocated to achieve specific objectives can readily be identified by the sponsor Department.

4.2.2 The TDP should include reference to Specific, Measurable, Attainable, Realistic and Time-bound objectives that:

- support the delivery of PfG Commitments;
- support the delivery of Departmental policy and strategy;
- deliver on the functions etc. specified in BHSCT's founding legislation setting out the purposes for which the Trust was created and the functions/services it is to deliver;
- address known areas of underperformance, the findings of inquiries etc.; and
- respond to particular events, serious adverse incidents and near misses; and support the training and development of staff.

4.2.3 DoF reserves the right to ask to see and agree BHSCT's TDP.

4.2.4 The TDP is for formal approval by the HSCB.

4.3 Publication of plans

4.3.1 The corporate plan and the TDP shall be published by the Trust and made available on its website. A summary version shall be made available to staff.

4.4 Reporting performance to the sponsor Department

4.4.1 BHSCT shall operate management information and accounting systems which enable it to review in a timely and effective manner its financial and non-financial performance against the budgets and targets set out in its agreed corporate plan and TDP.

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4.4.2 The Trust shall take the initiative in informing the HSCB and the sponsor Department of changes in external conditions which make the achievement of objectives more or less difficult, or which may require a change to the budget or objectives as set out in the corporate plan or TDP.

4.4.3 The Trust's performance against the CPD's objectives and targets shall be reported to the Department on a monthly basis, through formal reporting arrangements with the HSCB and the PHA. Performance will be reviewed formally twice yearly through the formal accountability review process. by officials of the sponsor Department. The Minister may meet the Trust Board as appropriate to discuss the Trust's performance, its current and future activities, and any policy developments relevant to those activities.

4.4.4 The Sponsor Department may, at its discretion, request evidence of progress against key objectives at any time.

4.4.5 Senior Departmental officials will hold biannual Ground Clearing meetings with BHSCT. The purpose of these meetings is to discuss the Trust's overall performance, its current and future activities, any policy developments relevant to those activities, safety and quality, financial performance, corporate control/risk management performance, and other issues as determined by the Department. Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues will be escalated for discussion to the Accounting Officer Accountability meeting with the Chair and Chief Executive of the BHSCT.

4.4.6 The BHSCT's performance against key targets shall be reported in its annual report and accounts [see Section 5.1 below].

4.5 Budgeting procedures

4.5.1 BHSCT's budgeting procedures are set out in the *Financial Memorandum* at Appendix 2 to this Management Statement.

4.6 Internal audit

4.6.1 BHSCT shall establish and maintain arrangements for internal audit in accordance with the Public Sector Internal Audit Standards (PSIAS).

4.6.2 The sponsor Department shall:-

- have input to BHSCT planned internal audit coverage;

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- agree arrangements for the receipt of audit reports, assignment reports, the Head of Internal Audit's annual report and opinion etc;

- agree arrangements for the completion of Internal and External Assessments of the Trust's internal audit function against PSIAS including advising that the sponsor Department reserves a right of access to carry out its own independent reviews of internal audit in BHSCT; and

- have the right of access to all documents prepared by the Trust's internal auditor, including where the service is contracted out. Where the BHSCT's audit service is contracted out the Trust should stipulate this requirement when tendering for the services.

4.6.3 BHSCT shall consult the Business Services Organisation (BSO) to ensure that the latter is satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving the appointment are in accordance with Public Sector Internal Audit Standards (PSIAS) and relevant DoF guidance.

4.6.4 The sponsor Department will review the Trust's terms of reference for internal audit service provision. The Trust shall notify the sponsor Department of any subsequent changes to internal audit's terms of reference.

4.6.5 The sponsor team will have an annual meeting with BHSCT's internal audit to discuss the Trust's audit plan and strategy.

4.7 Audit Committee

4.7.1 BHSCT shall set up an independent Audit Committee as a committee of its Board, in accordance with current Cabinet Office Guidance and in line with the Audit and Risk Assurance Committee Handbook

4.7.2 The audit committee's meeting agendas and minutes shall be forwarded as soon as possible to the sponsorship team. Audit Committee papers should be provided to the sponsor team for the purposes of paragraph 4.7.5.

4.7.3 The Audit Committee should complete the National Audit Office Checklist on an annual basis. Assurance on completion of the checklist will be provided through the mid-year assurance statement. Any exception issues should be reported to the Department.

4.7.4 The sponsor team will review BHSCT's Audit Committee terms of reference. The Trust shall notify the sponsor Department of any subsequent changes to the Audit Committee's terms of reference.

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4.7.5 The sponsor team will attend at least one Trust Audit Committee meeting per year as an observer and will not participate in any Audit Committee discussion.

4.8 Fraud

4.8.1 BHSCT shall report immediately to the Counter Fraud and Probity Services (CFPS) within the BSO all frauds (proven or suspected), including attempted fraud. CFPS shall then report the frauds immediately to the Sponsor Department, DoF and the Comptroller & Auditor General. In addition the Trust shall forward to CFPS the annual fraud return, commissioned by DoF, on fraud and theft suffered by the Trust.

4.8.2 BHSCT must have an Anti Fraud Policy and Fraud Response Plan in place. These should be reviewed at least every 5 years and sent to CFPS for review. The Trust shall notify the sponsor Department of any subsequent changes to the policy or response plan.

4.9 Additional departmental access to BHSCT

4.9.1 In addition to the right of access referred to in paragraph 4.6.2 above, the sponsor Department shall have a right of access to all BHSCT's records and personnel for purposes such as sponsorship audits and operational investigations (See also paragraphs 3.4.4 and 4.7.2 access to Board and Audit Committee minutes).

5. EXTERNAL ACCOUNTABILITY

5.1 The annual report and accounts

5.1.1 After the end of each financial year BHSCT shall publish as a single document an annual report of its activities together with its audited annual accounts. The report shall also cover the activities of any corporate bodies under the control of the Trust. A draft of the report shall be submitted to the sponsor Department in line with the timescale set by the Department before the proposed publication date although it is expected that the Department and the Trust will have had extensive pre publication discussion on the content of the report prior to formal submission to the Department.

5.1.2 The report and accounts shall comply with the most recent version of the Government Financial Reporting Manual (FReM) issued by DoF. The accounts shall be prepared in accordance with any relevant statutes and the specific Accounts Direction issued by the sponsor Department.

5.1.3 The report and accounts shall outline BHSCT's main activities and performance during the previous financial year and set out in summary form its forward plans. Information on performance against key financial targets shall be included in the notes to the accounts, and shall therefore be within the scope of the audit.

5.1.4 The report and accounts shall be laid before-the Assembly and made available, in accordance with the guidance on the procedures for presenting and laying the combined annual report and accounts as prescribed in the relevant Finance Director (FD) letter issued by DoF.

5.1.5 Due to the potential accounting and budgetary implications, any changes to accounting policies or significant estimation techniques underpinning the preparation of annual accounts requires the prior written approval of Finance Directorate in the sponsor Department.

5.2 External audit

5.2.1 The C&AG audits BHSCT's annual accounts and passes the accounts to Finance Directorate in the sponsor Department who shall lay them before the Assembly. For the purpose of audit the C&AG has a statutory right of access to relevant documents as provided for in Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

5.2.2 The C&AG will liaise with BHSCT on the arrangements for completing the audit of its accounts. This will either be undertaken by staff of the NIAO or a private sector firm appointed by the C&AG to undertake the audit on his behalf. The final decision on how such audits will be undertaken rests with the C&AG, who retains overall responsibility for the audit.

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5.2.3 The C&AG has agreed to share with the sponsor Department relevant information identified during the audit process, including the report to those charged with governance, at the end of the audit. This shall apply, in particular, to issues which impact on the Department's responsibilities in relation to financial systems within BHSCT. The C&AG will also consider, where asked, providing Departments and other relevant bodies with reports which Departments may request at the commencement of the audit and which are compatible with the independent auditor's role.

5.3 VFM examinations

5.3.1 The C&AG may carry out examinations into the economy, efficiency and effectiveness with which BHSCT has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003. Where making payment of a grant, or drawing up a contract, BHSCT should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor providing access to the C&AG in relation to documents relevant to the transaction. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

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6. STAFF MANAGEMENT

6.1 General

6.1.1 The decision to create or fill a Director or Assistant Director position within BHSCT is subject to approval by the Permanent Secretary of the Department of Health. This position will be kept under review by the Department. Similarly, no change to the remuneration of Senior Executives can be made without prior approval by the Permanent Secretary of the Department. Any request for approval in connection with this paragraph should be addressed to the Departmental Director of Workforce Policy.

6.1.2 Within the arrangements approved by the Minister and DoF, BHSCT shall have responsibility for the recruitment, retention and motivation of its staff. To this end the Trust shall ensure that:

- its rules for the recruitment and management of staff create an inclusive culture in which diversity is fully valued; where appointment and advancement is based on merit; and where there is no discrimination on grounds of gender, marital status, domestic circumstances, sexual orientation, race, colour, ethnic or national origin, religion, disability, community background or age;

- the level and structure of its staffing, including grading and numbers of staff, are appropriate to its functions and the requirements of efficiency, effectiveness and economy;

- the performance of its staff at all levels is satisfactorily appraised and the Trust's performance measurement systems are reviewed from time to time;

- its staff are encouraged to acquire the appropriate professional, management and other expertise necessary to achieve the Trust's objectives;

- proper consultation with staff takes place on key issues affecting them;

- adequate grievance and disciplinary procedures are in place;

- whistle blowing procedures consistent with the Public Interest (Northern Ireland) Order 2003 are in place; and

- a code of conduct for staff is in place based on Annex 5A of Public Bodies: A Guide for NI Departments (available at www.afmdni.gov.uk).

7. REVIEWING THE ROLE OF BHSCT

7.1 The role of BHSCT may be reviewed at the discretion of the sponsor Department, particularly to align with the outcomes of the strategic transformation agenda. Chapter 9 of the Public Bodies: a Guide for Northern Ireland Departments refers.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

PERMANENT SECRETARY

DATE: 13/12/17

SIGNED ON BEHALF OF BHSCT

CHIEF EXECUTIVE

DATE: 19/9/17

Appendix 1

1. Documentary requirements

Documentation to be sent to the Sponsor Branch (except where elsewhere is specified, in which case cc to Sponsor Branch)

Monthly (or as the occasion arises)

- Board meeting agenda and draft minutes for each meeting as and when issued to Board members, and when requested, specific papers prepared for Board meetings
- Audit Committee agenda and papers (including draft minutes for each meeting as and when issued to Committee members
- Monthly financial monitoring returns, to Finance Directorate in the Department

Bi-annual

- Corporate Risk Register every six months
- DAC returns, to Finance Directorate in the Department

Annually

- Annual Governance Statement
- Mid-year Assurance Statement (by end-October)
- Annual report on Compliance with Controls Assurance Standards, to Governance Unit in the Department
- Annual Internal Audit work-plan
- Internal Audit Progress Report
- Annual Fraud return, to Finance Directorate in the Department

- The Head of Internal Audit's Annual Mid Year Assurance statements
- Register of Board members' interests
- Reports to Those Charged with Governance provided by NIAO to the Department's Permanent Secretary
- The annual report, with the draft submitted to the Department two weeks before the publication date (*separate timetable for the annual accounts, Governance Statement etc, set by Finance Directorate*)
- The Assurance Framework

Once and then when revised

- Code of Conduct for Board members, to Workforce Policy Directorate in the Department
- Audit Committee Terms of Reference
- Complaints procedure
- Anti-Fraud Policy
- Fraud Response Plan
- Whistle-blowing procedures
- Grievance and Disciplinary procedures
- Gifts & Hospitality Policy
- Equality scheme
- Publication scheme
- Consultation Scheme
- Business Continuity Plan

As specified

- Corporate Plan for approval

Once

- Adverse inspection reports by external bodies (e.g. RQIA, MHRA) to relevant policy leads in the Department.
- Internal Audit reports with less than satisfactory assurance.

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

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

Castle Buildings
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Mr Martin Dillon
Chief Executive
Belfast Health & Social Care Trust
A Floor, Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

Our Ref: SH5

Date: 20 October 2017

Dear Martin

We are writing to you in order to raise a number of significant issues around the recent allegations of abuse made against staff working in Muckamore Abbey Hospital, and the related suspension of staff.

You should take our decision to raise this directly with you as a measure of our growing concern as to the handling by your Trust of this very serious issue. This relates both to the way we became aware of this incident, and the partial and imprecise nature of information provided in response to a number of requests for information from Departmental officials.

As you will be aware, there is a clear procedure in place for the reporting of incidents such as this, as set out in Departmental Circular HSC (SQSD) 64/16: specifically criterion 7, which specifies incidents resulting in *'an immediate suspension of staff due to harm to patient/client'* and further stipulates that such incidents should be notified to the Department '*promptly (within 48 hours of the event in question)'.*

In light of this very clear guidance, it is wholly unacceptable that the Department was not made aware of these allegations through an Early Alert notification until 7th September. Indeed, this alert seems to have been raised only after the Department had been prompted to make enquiries following a phone call on 30th August to a senior official by an elected representative acting on behalf of the father of the patient in question.

It was further troubling to learn that there were also delays in the reporting of the incident within the Trust. Based on the information in the Early Alert received on 7th September, an adult safeguarding concern had been raised on 21st August regarding an alleged assault of a patient in the Psychiatric Intensive Care Unit in Muckamore Abbey hospital, which had actually occurred some nine days earlier on 12th August. This delay was separately explained to Departmental officials as due to a combination of a staff member who witnessed the incident going on leave, and some

subsequent confusion over who was responsible for reporting the incident in their absence. It was on the basis of this advice from the Trust that the attached response was issued to Gavin Robinson MP who had initially alerted the Department to the incident.

The Early Alert also advised that the named staff member involved was not on duty on 21st August, but in their absence was placed on precautionary suspension on 22nd August pending the outcome of the investigation. In line with established safeguarding procedures, the allegation was referred to the designated Adult Safeguarding Officer and the PSNI, who we were advised were taking the lead in the investigation.

Subsequently, however, an update to the original EA notification from the Trust was received by the Department on 26th September, advising that CCTV footage of the incident had been viewed which had given rise to 'grave concerns'. The nature of these concerns was not specified, prompting the Department to again contact the Trust to request further details.

Indeed, it was in response to this further request for information that we became aware that a second patient was involved in the incident, and a second member of staff had been placed on precautionary suspension, as well the nurse in charge of the ward on the day of the incident. Information regarding the redeployment of two other staff nurses to another ward pending the outcome of the investigation was also referred to in this update. These were clearly significant developments, and given the Department's clear interest in the incident, we cannot understand why this information was not relayed to us in the early alert.

In addition the Department is deeply concerned to learn following contact with the HSCB/PHA that the incident was not reported as an SAI until 22 September 2017. Given the seriousness of the circumstances and potential public interest the Trust should have reported this incident with 72 hours as an SAI as outlined in the HSCB Procedure for the Reporting and Follow up of SAI Section 4.2 and Section 6. As this did not happen it is clearly a breach of agreed procedures. We also now understand that the investigation initiated by the Trust into the alleged assault that took place on 12th August is now not PSNI led as originally reported, but is a Joint Agency investigation and that an SAI Level 3 Root Cause Analysis review has also been instigated by the Trust.

In view of the foregoing, it was with some considerable alarm that that we learned, through subsequent enquires made by the Department, that there had been a separate safeguarding concern raised relating to a patient in another ward in Muckamore and also involving a nurse now on precautionary suspension.

Again we are profoundly disturbed that this further incident was not formally reported to the Department through the Early Alert notification system (indeed no such report has been made at the time of writing).

To be clear: the lack of comprehensive, accurate and timely information to date, as outlined above, has made it difficult for the Department to be assured that the relevant adult safeguarding policy and procedures have been appropriately implemented in relation to these incidents. This is a situation which we find both unacceptable and unsustainable.

We ask now that, as a matter of urgency, you provide comprehensive written accounts both of the incidents in question, the actions of the Trust in managing them and provide an explanation for the apparent non-compliance with the relevant guidance as set out above.

Yours sincerely

Sean Holland
CHIEF SOCIAL WORK OFFICER

Charlotte McArdle
CHIEF NURSING OFFICER

Belfast Health and Social Care Trust
caring supporting improving together

3 November 2017

Mr Sean Holland/Mrs Charlotte McArdle
Chief Social Work Officer/Chief Nursing Officer
Castle Buildings
Stormont Estate
Belfast. BT4 3SQ

Dear Charlotte/Sean

Thank you for your letter of 20th October 2017 in which you set out your concerns regarding the delays in timely reporting of serious safeguarding incidents and breaches in the Serous Adverse Incident and Early Alert procedures.

The incidents reporting timeline has been subject to detailed scrutiny and challenge and it is evident that there were clear failures both internally and externally in respect of these requirements. Incident reporting in Learning Disability Services is a key quality indicator and the management and leadership behaviours in this area will be subject to further investigation and action. Please accept my unreserved apology for our shortcomings in this regard and for the concern this has raised about patient safety and the quality of service provided to these most vulnerable individuals in our care. I will ensue that the learning from our scrutiny of the timelines and around reporting both internal and external is applied in the future

I can confirm that the incidents which are subject to ongoing and further analysis fall into three broad areas of concern :

- 2 incidents of physical assault and several incidents which suggest the inappropriate use of physical restraint and seclusion.
- Neglectful practices specifically the lack of meal supervision with vulnerable patients and a apparent lack of meaningful engagement with patients
- A range of concerns regarding nursing practices, for example sleeping on duty and professionally qualified staff apparently observing some of these practices which were not subsequently reported.

To date the incidents have occurred out of hours and the actual incidents are confined to the members of staff already suspended. However the investigative processes are still at an early stage and this is an evolving picture.

I have provided a summary timeline of the incidents and actions below, I have also outlined the additional structures and actions the Directors are putting in place in order to provide the clear assurances you require about patient safety both now and in the future. In addition the footage collected during the test period has and may continue to highlight other incidents which will be reported to the Department of Health in a timely way.

Summary Timeline

- The incidents of the 12 August 2017 were not reported by ward staff until 21 August 2017; when reported it was immediately referred to Adult Safeguarding and the PSNI. The staff member involved was place on precautionary suspension. At this stage the PSNI informed the Trust that a single agency approach was being followed for this incident.

- At the time of the incident the CCTV monitoring system that had been installed to assist with Adult Safeguarding concerns was not due to become a live system until 11 September 2017.

- On the 29 August 2017 the Trust became aware that test footage may be available and sought legal advice to view the footage as part of the investigation into the allegations.

- On 6 September 2017 legal advice confirmed that the test footage could be viewed in line with the Trust policy and the information was shared with the PSNI. Contact was made with the CCTV installation company to arrange for Senior Staff to view the footage for 19 September 2017.

- The viewing centred on the incident of the 12 August 2017 and at this viewing a number of other safeguarding concerns were identified involving the staff member already on precautionary suspension and another Healthcare Support Worker. The incidents involved two patients in the Psychiatric Intensive Care Ward (PICU)

- The Trust immediately identified that the member of staff was not on duty and followed this up with a precautionary suspension. This was part of the protection plan.

- An urgent senior strategy meeting was convened by the Director of Adult and Social Primary Care on 22nd September 2017 when she was notified the incidents. After this meeting, an Early Alert update was issued and followed up with an SAI Level 3 notification, which was sent to HSCB and RQIA.

- The Staff Nurse in Charge of the ward on 12 August 2017 was also placed on precautionary suspension for failure to report and protect the patient on the ward. Two further staff nurses were transferred to another ward pending review of available information and delays in reporting safeguarding concerns.

- On 27 September 2017 a verbal update was given to the Department of Health Learning Disability Unit followed by a written submission on 28 September 2017 in response to the Department of Health queries about the incidents. A further update was completed on 20 October 2017.

- On 1 October 2017 a patient on Sixmile Ward reported that a Staff Nurse on night duty physically assaulted him. It was immediately escalated to managers who put in place and interim protection plan, and required the Staff Nurse not to report for night duty the following night. This was discussed and agreed with the Regional Emergency Social Work Service and followed up on 2 October 2017.

- On 2 October 2017 CCTV was viewed and whilst the complaint made by the patient could not be viewed on the CCTV as cameras are not installed in patients' bedrooms, images showed the Staff Nurse kicking the bedroom door of the patient at 5.20am before entering the room and this was considered highly significant as a safeguarding issue. The Staff Nurse was place on precautionary suspension on 4 October 2017.

- On 3 October 2017 the Trust held an Adult Safeguarding Strategy meeting with PSNI and RQIA. A decision was reached that the investigation should be a joint agency approach for all incidents.

- On 4 October 2017 the HSCB, PHA and DoH were verbally updated and a Serious Adverse Incident Form was submitted. The Early Alert should have been updated at this stage and I acknowledge and apologise for this error. Again, we will learn from this.

- Professional alerts have been submitted to the CNO for the two registrants on precautionary suspension.

Assurance

Directors have put in place additional structures and resources to provide clear direction, co-ordination and assurances across all the following investigative and management processes.

- Adult Safeguarding multi-agency strategic management group under Adult Safeguarding Procedures and the Memorandum of Understanding (2013)

- Level 3 Fully Independent Serious Adverse Incident Investigation

- Adult Safeguarding Investigation

- Police investigation under Regional Joint Protocol Procedures (Sept 2016)

- Disciplinary and Professional Procedures.

- Wider commissioning issues regarding discharge delays

- Liaison with RQIA

- Communication Strategy

- A full time Senior Safeguarding experienced officer external to Learning Disability who will be responsible for the effective co-ordination and reporting on all aspects of this investigation

- This individual will be supported by a dedicated team.

- A system of enhanced monitoring and escalation to ensure that the onsite teams are clear about expectations, responsibilities and accountabilities. This includes additional staff and real-time monitoring of CCTV.

- CCTV is being requested for wards who do not have them installed
- Ongoing random sampling of previous CCTV
- Ongoing announced and unannounced monitoring of wards by external senior Trust staff. This will be sensitive to the needs of patients.

I hope this above information provides sufficient information and assurance at this stage.

I recognise that further more comprehensive information will be required in the coming weeks and this will be provided.

Yours sincerely

Mr Martin Dillon
Chief Executive

Cc: Mrs Marie Heaney, Director of Adult Social and Primary Care Service
Miss Brenda Creaney, Director of Nursing and User Experience

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
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Our Ref: SH20

Date: 30 November 2017

Mr Martin Dillon
Chief Executive
Belfast Health & Social Care Trust
A Floor
Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

Dear Martin

MUCKAMORE ABBEY HOSPITAL

We are writing following the meeting with Marie Heaney and Brenda Creaney on 17 November. As you will know, this meeting was to discuss the detail of your letter of 2 November and the subsequent briefing report which was prepared for the Trust's Quality Assurance Committee.

This letter now seeks further written assurances on the range of issues which were raised during the 17 November meeting and on related matters which have emerged in parallel.

The Department acknowledges the Trust's apology and the subsequent steps the Trust has taken to address our concerns. In particular, we note you have indicated that 'management and leadership behaviours would be subject to further investigation and action'. We would welcome clarity on the Terms of References and modality for this investigation.

Trust Briefing Paper

Turning to the briefing paper which was prepared for the Trust's Assurance Committee, regarding Incidents in Muckamore Abbey Hospital, the Department has a number of observations and areas requiring further clarification.

Whilst the Department acknowledges the issues with regards to resettlement and delayed discharged, we are concerned that this could be interpreted as a contributory factor**.** I am sure you would agree under no circumstances should resettlement and/or delays in discharge be considered a causal factor for abuse and mistreatment of patients. Muckamore Hospital as a regulated facility is required regardless of patient status to deliver safe and person-centred care and to ensure all staff act with the highest degree of professional conduct.

We also note with particular concern that the paper presented to the Trust Assurance Committee made no reference to the Department's concerns as outlined in our letter to you on 20th October 2017. We would therefore seek assurance that your Board Senior Management Team and Assurance Committee have received a full chronology about the circumstance and concern regarding the initial management of events.

The Trust paper provides data on the number of 'Abuse by Staff to patient incidents on the Muckamore Abbey Hospital Site April 16 – Oct 17' which indicates 18 incidents in just 18 months. Unfortunately no explanation about the nature of the abuse or staff involved was provided. The data presented in the charts shows a worrying pattern, therefore the Department is seeking assurance that all these incidents have been thoroughly and comprehensively investigated by the Trust and that a full trend analysis has been completed to ensure that there are not recurring themes emerging.

We also believe the Trust now needs to review all allegations of abuse by staff over the last five years and the action taken by the Trust as part of its investigation**.** We therefore ask that this is now incorporated into the Terms of Reference for the 'Level 3' SAI investigation. As part of this, we also ask that the TORs include and examination of the failures to communicate the incident with the Department as well as the subsequent difficulties we faced in securing timely information from the Trust.

Proposed Turnaround Team

On 27th October the Department was contact by the Directors of Nursing and Adults Services to advise additional information had come to light following the review of CCTV footage which give rise to further and serious cause for concern. At this stage both Brenda and Marie indicated that the Trust was considering installing a 'Turnaround Team'. Following a meeting with the Trust on 30th October it would appear the Trust adjusted its position**.** It would be helpful if you could clarify the factors which contributed to the Trust's change of position, and how the Trust is assuring itself, in light of a number of failures to report by staff, that the practice of staff including managers is of the highest standards.

Safeguarding Investigation

In respect of the current adult safeguarding and police investigation, we are aware that a number of staff have been suspended pending investigation whilst others have been redeployed to other wards with enhanced supervision. In terms of ensuring patient safety, it would be helpful to understand how the Trust is ensuring safe and effective practice from those staff for whom there are significant concerns regarding their failure to report abuse yet they remain working within the hospital.

It is also our understanding that the Adult Safeguarding Investigation by the Trust has been completed and a report has been presented to the Director of Adult services**,** we are therefore requesting that the findings be made available to the Department.

Other Issues

We also note the Trust initially proposed to review 25% of CCTV footage, however in light of our responsibly to safeguard the public we do not believe this is adequate. We therefore are requesting that 100% of the footage is reviewed. Can you confirm the Trust's commitment to review all the CCTV footage?

In relation to the various investigations the Department expects the highest standards of independence and therefore anticipates the Trust will source an independent team from outside of Northern Ireland. Given our concern we request that you share a copy of the Terms of Reference with the Department.

We further understand that another team has been appointed to provide assurance about Nursing and Care Practice and again we are requesting a copy of the Terms of reference for this review.

You will also be aware of specific comments being made on social media, which indicates that some ex-patients may have experienced abusive treatment and that senior Trust officials knew and failed to act. Given the seriousness of these allegations can you outline Trust plans to reach out to those making these comments?

Future Reporting

As we trust is clear from the foregoing, we consider that the issues raised here are of the utmost seriousness. We are being guided in our approach by the standards of accuracy, detail and timeliness that we anticipate would be required were a Minister in place. With this in mind, and as this is an evolving Investigation, we are formally requesting a fortnightly update. We are happy to be copied into any updated information being provided to you and your senior team.

You will also appreciate that it may well prove necessary to write to you further as more details emerge.

Yours sincerely

SEAN HOLLAND
Chief Social Work Officer

CHARLOTTE McARDLE
Chief Nursing Officer

Belfast Health and Social Care Trust

caring supporting improving together

Chief Executive
Mr Martin Dillon

Chairman
Mr Peter McNaney, CBE

22 December 2017

Mr Sean Holland/Prof Charlotte McArdle
Chief Social Work Officer/Chief Nursing Officer
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Charlotte/Sean

I am writing in response to your letter of the 30 November 2017 to provide the further written assurance requested therein.

Like the Department, I expect and have requested the highest level of independence for the Level 3 SAI Panel and this review.

Trust Briefing Paper

With regard to the written update provided to the Trust's Assurance Committee, the Chairman had specifically requested that Board members be updated on the total number of patients currently residing in Muckamore, a profile of the various wards and an update on resettlement to include an update on the number of delayed discharge patients. Hence the inclusion of the context setting section.

The Trust did not seek to imply or infer – nor would it ever do such a thing – that the challenges of managing patients with complex needs and very challenging behaviours was or is in any way a contributory factor to or a mitigating factor for staff behaviours which were utterly unacceptable. Muckamore Hospital as a regulated facility is required to deliver safe and person-centred care with all staff acting with the highest degree of professionalism. This is what we expect and what we overwhelmingly find, the small number of recent serious incidents notwithstanding.

I can provide assurance that the DoH correspondence of 20 October was shared with the Chairman and Trust Board. The Assurance Committee were also fully informed of the initial chronology and management of events.

The data related to *'abuse by staff to patients'* on Muckamore Abbey Hospital between April 2016 and October 2017 is part of the collation of the regular key data used for trend analysis and monitoring.

Again, the purpose of the paper to the Trust's Assurance Committee where this data appears was not to provide detailed information on each of the incidents. I can provide assurance to the Department that all of these incidents have been investigated by Adult Safeguarding and any appropriate actions followed up.

Proposed Turnaround Teams

The Trust did initially consider the concept of an independent '*turnaround'* team however on reflection concluded that this was not feasible or likely to produce the outcome needed. They key reasons include the difficulties related to identifying and securing the appropriate expertise in a timely way. Furthermore the level of complexity involved in undertaking the necessary comprehensive investigation and analysis requires a multi-layered and sequenced approach.

Currently the Trust has put in place a number of additional supports which provide assurance that the current practice of staff and managers is of the highest standards.

These are detailed below.

a) Directors Oversight Group **-** A number of Directors *(Medical Director/Deputy Chief Executive, Director of Adult Social and Primary Care, Director of Nursing, Director of Social Work and Director of Human Resources)* have been meeting the Muckamore Abbey Hospital Multi-Disciplinary senior team on a weekly basis. This meeting is used to hold to account and monitor the implementation of the action plan which has been developed to provide the Trust with the assurance it requires in relation to patient safety. This Director' Group provides an open door invitation to all staff to directly engage in relation to any issues or concerns they wish to raise.

b) Enhanced Monitoring of Practice – This remains in place across all the wards at Muckamore Abbey Hospital.

c) Patient Protection Co-ordination Group - A group of senior managers with operational responsibilities meet on a weekly basis to monitor and review practice supervision arrangements for all wards. This group to date have had responsibility for viewing and reporting on the CCTV images. This group is responsible for implementing actions identified for the protection of patient's action plans and reporting progress to the Directors Oversight Group on a weekly basis.

d) Strategic Multi Agency Group - The second meeting of the multi-agency group is scheduled to meet on the 8 January 2018. This meeting ensures that all involved organisations are informed and actions co-ordinated.

This group includes:

- Northern HSC Trust
- RQIA
- HSCB
- PSNI
- DOH
- Belfast HSC Trust

e) External Support Team - The Trust has appointed an independent support team consisting of:

Yvonne McKnight – Senior Adult Safeguarding Specialist
Professor Owen Barr – University of Ulster
Frances Canon – NIPEC

This group has two key roles:

1. To review all actions taken to date by the Trust and provide feedback and advice

2. To support the Adult Safeguarding Investigations in respect of specialist nursing expertise

The Terms of Reference for this group are being developed and will be shared with DOH when agreed.

Adult Safeguarding Investigations

The Joint Agency Investigation remains ongoing in relation to the incidents of the 12 August and 1 October. The PSNI have indicated that they hope to complete their interviews with staff prior to Christmas.

The Trust's Adult Safeguarding is also ongoing and action plan is in place with HR and Adult Safeguarding processes closely aligned.

The two staff referred to in terms of their alleged failure to report have been returned to PICU ward on restricted practice and enhanced supervision. Their actions will be subject to a disciplinary investigation once PSNI have completed their interviews.

I can clarify that the Adult Safeguarding Investigation is not complete. Progress reports and action plans are developed and updated regularly. To date Adult Safeguarding investigation processes have focused on the individual incidents. The next step in this will be the screening interviews with staff, patients and relatives and this will require the additional support of the Trusts Adult Gateway Safeguarding Team. The Trust would wish to highlight that a further two staff have been suspended following a report of a historical allegation and the management of this matter. This is being investigated under Adult Safeguarding procedures.

Other Issues

I can confirm that in the interest of regaining public and other stakeholders' confidence the Trust intends to review all of the CCTV footage and is currently identifying additional independent support to complete this.

Independent Level 3 SAI

A fully independent panel is being appointed and is due to commence its work in late January 2018. The Terms of Reference are currently under consideration by the HSCB Designated Review Officer (DRO) and once agreed will be forwarded to you.

The panel members who have been appointed are as follows:

Name	Role	Expertise
Margaret Flynn	Chairperson	Significant experience in leading serious case reviews in Learning Disability including Winterbourne.
Professor Michael Brown	Policy Queens University	
Dr Ashok Roy	Consultant Psychiatrist, Coventry & Warwickshire Partnership Trust/Chair, Faculty of Intellectual Disability Psychiatry/Royal College of Psychiatrists	

The remaining members of the panel are being considered in consultation with the HSCB DRO to ensure full independence and will be confirmed in the coming weeks.

I can confirm that the Trust has included the need for a review of all allegations of abuse by staff over the last 5 years and the actions taken in response thereto in the Terms of Reference. I can also confirm that the Terms of Reference include an examination of the recent communication failures.

Social Media Comments

The Trust has examined the posts on social media, which mention a small number of previous patients (3). All of these patients have been cared for in Muckamore in the past, over 20 years ago. None have been recent In-patients. With regard to staff posts, there are no current staff posting, the individuals who posted are retired.

Further Reporting

I wish to assure Department colleagues that the Trust is actively aware of the seriousness of the concerns and are deeply committed to conducting this investigation to the highest standards of independence and competence.

The Trust will provide fortnightly updates from the date of this letter. In addition the Trust would like to suggest and extend an invitation to both of you to meet with the Directors Oversight Group at Muckamore Abbey Hospital to provide ongoing assurance.

Yours sincerely

Martin Dillon
Chief Executive

Copy Mr Peter McNaney, Chairman

Trust Oversight Group:
Dr Cathy Jack
Mrs Marie Heaney
Miss Brenda Creaney
Mr John Growcott
Mr Damian McAlister

Summary of 'A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go'

15th February 2019

In response to reports of inappropriate behaviour and the alleged abuse of patients by some staff in Muckamore Abbey Hospital, the Belfast Trust commissioned an independent team to undertake a Serious Adverse Incident (SAI) review to examine safeguarding practices at the Hospital between 2012 and 2017, chaired by Dr Margaret Flynn.

The final report was received in November 2018 and it has been shared with affected families, staff and key stakeholders during December 2018 and January 2019. SAI reports are learning documents containing patient- and family-sensitive information which are not appropriate to share in full and they are not published; however, the Trust committed to publishing a summary of the document at the earliest opportunity.

A comprehensive Summary of the Review, compiled by the Chair of the review team, is now publicly available at the link provided, detailing what the review team found; important considerations; lessons identified and recommendations by the team, patients' families, hospital staff, Trust senior managers and the RQIA. An easy-read summary is also provided.

The Trust reiterates its unreserved apology to those families who have been affected by staff behaviours which fell significantly below professional standards and our profound regret in letting patients and family carers down. The Trust gives its full assurance that it welcomes ongoing scrutiny and is committed to ensuring that patients are cared for safely in the hospital, a positive way forward is provided for patients and families and that the recommendations in the review are realised.

There is an ongoing PSNI investigation into the allegations at the hospital which has not yet concluded.

Click here for Summary of Muckamore Abbey Hospital Safeguarding Review.

Click here for Summary of Muckamore Abbey Hospital Safeguarding Review – Easy read.

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