HSC Public Health Agency

agenda

91st Meeting of the Public Health Agency Board

Thursday 16 February 2017 at 1:30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 15 December 2016		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive
7 1.50	Financial Performance Report	**PHA/01/02/17**	Mr Cummings

items for approval

8 2.00	Review of PHA Standing Orders and Standing Financial Instructions / Review of PHA Scheme of Delegated Authority	**PHA/02/02/17**	Mr McClean / Mr Cummings
9 2.15	Annual Quality Improvement Plan Report 2015/16	**PHA/03/02/17**	Mrs Hinds

items for noting

10 2.30	Governance and Audit Committee Update • Minutes of meeting of 6 October 2016 • Verbal briefing of meeting of 3 February 2017	**PHA/04/02/17**	Mr Coulter
11 2.45	Performance Management Report – Corporate Business Plan Targets for Period Ending 31 December 2016	**PHA/05/02/17**	Mr McClean

closing items

12 2.55	Any Other Business	Chair
13 3.00	Details of next meeting: *Tuesday 16 March 2017 at 1:30pm* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*	

HSC Public Health Agency

minutes

90th Meeting of the Public Health Agency Board

Thursday 15 December 2016 at 1:30pm

Conference Rooms 3+4, 12-22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Mrs Valerie Watts	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Councillor William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director

In Attendance

Mr Simon Christie	-	Assistant Director of Finance, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC
Mr Robert Graham	-	Secretariat

Apologies

Alderman Paul Porter	-	Non-Executive Director
Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB

126/16	**Item 1 – Welcome and Apologies**
126/16.1	The Chair welcomed everyone to the meeting. Apologies were noted from Alderman Paul Porter, Mr Paul Cummings and Mrs Fionnuala McAndrew.
127/16	**Item 2 - Declaration of Interests**
127/16.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
128/16	**Item 3 – Minutes of previous meeting held on 17 November 2016**
128/16.1	The minutes of the previous meeting, held on 17 November 2016, were **approved** as an accurate record of the meeting, subject to two amendments in paragraphs 117/16.2 and 119/16.8.

129/16 **Item 4 – Matters Arising**

Outcomes Based Accountability

129/16.1 The Chair said that he had not yet received a response from the Leadership Centre regarding Outcomes Based Accountability. He said that any training that is provided should be consistent with other providers. Mr McClean agreed to follow up on this.

Lifeline Contract

129/16.2 Mr Coulter asked about the Lifeline contract and whether the current contract was going to be extended. Dr Harper advised that in light of current circumstances, and based on procurement advice and the need to ensure a safe transition, PHA has extended the current contract to March 2018. The Chair asked for how long the contract has already been extended. Dr Harper said that the original contract had expired in March 2015. Mr Coulter expressed disappointment that the issue of the contract features on PHA's Corporate Risk Register, but there is limited mitigating action that PHA can take.

129/16.3 Mr Drew said that he agreed with Mr Coulter's views and asked how the extension to the contract had been approved. Mr Christie said that this would be the Agency Management Team under the Scheme of Delegated Authority.

129/16.4 Mr Drew said that if the new contract was due to start in March 2018, there was limited time to undertake a procurement process.

129/16.5 The Chair asked if Department officials are fully aware of the situation. The Interim Chief Executive indicated they did and agreed to raise this matter with the Permanent Secretary.

130/16 **Item 5 – Chair's Business**

130/16.1 The Chair informed members that Mrs Julie Erskine has been appointed as Chair of the Business Services Organisation and has subsequently tendered her resignation as a non-Executive Director of the PHA. He thanked Mrs Erskine for her contribution to the Agency over the past 8 years.

130/16.2 The Chair advised that he had attended a meeting of the Chairs' Forum to discuss the Delivering Together report.

130/16.3 The Chair said that he had attended a seminar in Derry/Londonderry which featured performances by people with disabilities. He said that he was impressed by the positive atmosphere. He added that he had also visited the Foyle Search and Rescue Service.

130/16.4 The Chair also visited Dove House, where a one-stop shop service is

provided for young people who are not in employment. He said that he was able to have informal discussions with service users who valued the service because of the qualities and integrity of the staff who treated them with respect.

131/16 Item 6 – Chief Executive's Business

131/16.1 The Interim Chief Executive told members that the Transformation Implementation Group overseeing the implementation of the Minister's new report, Delivery Together, has met. She said that the Group will consist of the Permanent Secretary, Chief Professional Officers, 2 Deputy Secretaries, Trust Chief Executives, the BSO Chief Executive and herself. She added that the discussion at the first meeting focused on the terms of reference and the need to set up other working groups. She said that there was also a discussion on elective care.

131/16.2 The Interim Chief Executive advised that there will also be a Transformation Advisory Board, the membership of which has yet to be finalised, but will consist of independent experts, representatives from trade unions, the community and voluntary sector and service users.

131/16.3 The Interim Chief Executive said that she and the Chair had attended the PHA Mid-Year Accountability Review meeting and that the meeting had focused on a small number of areas including the financial position, Making Life Better and the transformation programme. She said that it had been a very constructive meeting, with no major difficulties raised.

131/16.4 The Interim Chief Executive said that she had met with representatives from the Faculty of Public Health as she continued to learn more about the work of the Agency.

131/16.5 The Interim Chief Executive advised members that PHA had received correspondence from the Department of Health regarding financial planning scenarios for 2017/18, and that a response is due back to the Department by 9 January, with the final outcome communicated to PHA in due course.

131/16.6 The Chair asked about the savings which Trusts will be required to make. The Interim Chief Executive explained that Trusts are required to develop their own Savings Delivery Plans, while ALBs are requested separately to outline potential savings.

131/16.7 Ms Mann-Kler asked whether the PHA Board would have sight of the proposals. The Interim Chief Executive said that the Agency Management Team would be meeting to consider the proposals, and that any proposals would be shared with Board members in advance of the deadline.

132/16	**Item 7 – Finance Performance Report (PHA/01/12/16)**
132/16.1	Mr Christie said that the Finance Report is for the period up to 31 October 2016 and shows a year-to-date overspend of £572k, but that the year-end position should be a break-even one.
132/16.2	Mr Christie said that non-Trust expenditure for the month of October showed an overspend against the budget which was due to budget managers catching up against profiled expenditure, as there had previously been a surplus for the year to date. However, Mr Christie pointed out that 56% of the budget remains to be spent.
132/16.3	Mr Christie advised that the management and administration budget remains at break even, and that the prompt payment performance continues to be good.
132/16.4	Mr Drew asked whether PHA was confident of spending the remaining budget before the year end. The Interim Chief Executive said she had sought assurance in the same regard at the recent mid-year budget review meeting. Mr McClean added that there had been a follow up with budget holders by his staff and Finance staff, and that he remained confident from the assurances given that all programme expenditure will be incurred.
132/16.5	Mr Coulter asked about the EITP funding and expressed concern about the retraction as this work was having a positive impact. Mrs Hinds said that the money had not been "lost" as such, but there had been delays in getting the programme started. Dr Harper added that there had been issues in terms of recruitment of staff and staff sickness so the funding had been re-profiled. Mr Christie explained that this funding is ring-fenced and that the full budget will be carried forward.
132/16.6	Mr Coulter asked about the spending on Connected Health across each of the Trust areas, particularly the Belfast Trust. Mrs Hinds said that historically the Belfast Trust had been reticent about the implementation of Connected Health, and she added that with any new initiative it was necessary to have a "champion" in each Trust and this was a factor for the high take-up within the Northern Trust area.
132/16.7	The Chair asked if the Trusts should be challenged about this. Mrs Hinds said that Eddie Ritson would meet with each of the Trusts. Mr McClean indicated that Mr Ritson had given members a briefing recently on Connected Health, and may be in a position to further update on Connected Health spend.
132/16.8	Members noted the Finance Report.

133/16	**Item 8 – Personal and Public Involvement Update (PHA/02/11/16)**
133/16.1	The Chair welcomed Ms Michelle Tennyson, Mr Martin Quinn and Ms Sandra Aitcheson to the meeting. Ms Tennyson said that this presentation would give members an overview of recent key achievements within Personal and Public Involvement, an update on a piece of research and next steps, including a joint initiative with the Patient Client Council. She formally welcomed Ms Aitcheson who is the PPI champion within the nursing directorate.
133/16.2	Mr Quinn began the presentation by highlighting key achievements, including the introduction of PPI standards and monitoring, the establishment of an online training resource, a successful PPI conference, the commissioning of a piece of research into PPI and the creation of a HSC-wide branding for PPI.
133/16.3	With regard to the research, Mr Quinn said that it was a previous non-Executive Director, Dr Jeremy Harbison who had been keen to see PHA establish its own research and evidence base. The Chair asked why two universities had been involved. Mr Quinn explained that the research was led by Queen's University, but that Ulster University had pulled the team together. He added that there was also independent peer review.
133/16.4	Mr Quinn invited Ms Aitcheson to outline to members her role within the area of PPI.
133/16.5	Ms Aitcheson explained that her role as PPI champion involves not only following up monitoring, but learning from other parts of the organisation in terms of how PPI is being embedded. Within the nursing directorate, she said that PPI is core to what nurses do, and that it is common sense to develop a partnership approach. She cited the example of the Mental Health Recovery College and the 10,000 Voices initiative. She said that there is also work ongoing within older people's services.
133/16.6	Mr Quinn advised that the Department of Health has taken on board the recommendations made by PHA following PHA's monitoring visits to HSC Trusts and has asked the Trusts how it is implementing these recommendations.
133/16.7	Ms Mann-Kler said that she was pleased to hear that PPI will have a place within the new HSC reconfiguration. She added that she is keen to see the research once it is available.
133/16.8	Mr Coulter said it was a great pleasure to hear how PHA is taking a strong lead in this area and is continuing to push the boundaries of partnership working. He asked about small grants. Mr Quinn said that PPI can achieve good outcomes with small amounts of funding and gave the example of the "My Choking Story" video which won a national award. He added that he is continuing to push for PPI funding to get better

outcomes for service users and carers.

133/16.9 The Chair asked about PPI being part of staff appraisals. Mrs Hinds said that this had been picked up as part of the research and that she would be raising this with the Directors of Human Resources.

133/16.10 Mrs McKissick said that the update highlighted all of the good work that PHA is doing, and she was pleased to see the proactive approaches being taken.

133/16.11 Mr Drew said that the report was very encouraging, but he was concerned that expectations may be raised, but in future the funding may not be there. Mrs Hinds acknowledged that there is now a period of uncertainty coming up, but she was pleased to note that PHA had been asked by the Department of Health to work with PCC on a piece of work regarding public involvement, and that it was good news that Mr Brian O'Hagan has been nominated to sit on the Minister's advisory board.

133/16.12 The Chair thanked Mrs Tennyson, Mr Quinn and Ms Aitcheson for their overview and congratulated them on their great outcomes within PPI.

133/16.13 Members noted the PPI overview.

134/16 Item 9 – Overview of Allied Health Professions (PHA/03/11/16)

134/16.1 Mrs Hinds explained that at the request of a non-Executive Director from HSCB, PHA had compiled this overview of the work of Allied Health Professions (AHP) to give members an overview of this complex area of work. She invited Ms Tennyson to present the overview.

134/16.2 Ms Tennyson advised members that the AHP team within PHA is a small number consisting of 5 staff, who work in partnership across many sectors including health, education and housing. She said that there is a range of 12 different types of AHPs who carry out approximately 2.5million contacts annually. She added that the team is committed to PPI and partnership working.

134/16.3 Ms Tennyson highlighted work being undertaken in the area of older people and said that the figures show that people over the age of 65 spend on average 100 days a year alone. She said that specific work is being done across a range of support services in this area.

134/16.4 Mr Drew said that the report was very interesting and innovative and thanked Ms Tennyson for her overview. Mr Coulter echoed this, but he asked for more detail on the framework for children with special educational needs (SEN).

134/16.5 Ms Tennyson explained that work has been ongoing in this over the last 3 years, and that PHA has submitted a Report to the Department of Health and there was representation at a meeting of the Education Committee

last week.

134/16.6 Mr Coulter asked about dysphagia. Ms Tennyson acknowledged that this is one area where work has not progressed as PHA had hoped, but Mrs Hinds added that there is a new initiative being undertaken looking at choking and swallowing.

134/16.7 The Chair asked about the 100 days of loneliness experienced by older people, and queried if there was a role for volunteers. Ms Tennyson said that there is some good work being done across the system, with practical initiatives for those who are able to get out of their homes.

134/16.8 Members noted the AHP overview report.

135/16 Item 10 – The Northern Ireland AAA Screening Programme Annual Report 2014/15 (PHA/04/11/16)

135/16.1 Dr Harper presented the AAA Screening Programme Annual Report, and gave members an overview of some of the key findings. She said that overall, the uptake rate remained high (83%). She advised that 126 aneurysms were newly detected and 22 men were referred onward for treatment with large aneurysms and that 117 men are now being monitored under the surveillance programme. She welcomed Dr Stephen Bergin and Ms Jacqueline McDevitt to the meeting who would deal with any specific queries regarding the report.

135/16.2 The Chair noted the higher uptake rate and asked about take up rates within different socio-economic groups. Ms McDevitt said the team within the Belfast Trust have been linking with GPs, the Health Alliance and Healthy Living teams, and Men's Sheds initiatives to increase awareness. She said that there has been no publicity regarding the programme since it was launched. Dr Bergin said that the take-up within socio-economic groups ranged from 60% in the lower groups to 90% within the higher groups.

135/16.3 The Chair asked whether PHA carries out a survey of those who do not attend. Ms McDevitt said that there is a patient satisfaction survey and she said that a piece of work had previously been commissioned from the Health Intelligence team and perhaps this should be revisited.

135/16.4 Mr Coulter said that the Report showed that this was a very successful screening programme, but he queried why there was no screening location within the Lisburn area. Ms McDevitt said that at the outset, the screening team looks at areas of greatest density and engages with the local Trusts to arrange the clinics, but she agreed to check this specific query with the Programme Manager.

135/16.5 Mr Mahaffy asked why the programme was specifically aimed at men of the age of 65. Ms McDevitt said that men of any age can self-refer, but Dr Bergin explained that 65 is seen as the highest risk age category and

this is dictated by national guidance. Dr Harper added that there is a risk of younger men being screened and then being unnecessarily treated for something that may never do any harm,

135/16.6 Members noted the AAA Screening Report.

136/16 Item 11 – Corporate Risk Register (PHA/05/11/16)

136/16.1 Mr Coulter advised members that the recent meeting of the Governance and Audit Committee had had to be cancelled, and that as part of that meeting, the Committee would have considered this updated Corporate Risk Register. He invited Mr McClean to give members an overview.

136/16.2 Mr McClean said that following a review by each directorate, there were no additions or deletions to the Register. He added that this Register, which is for the period up to 30 September 2016, had been considered by the Agency Management Team.

136/16.3 Mr Coulter said that GAC would keep under review Risks 30 and 36 as key operational issues.

136/16.4 The Chair asked about Risk 26 and the possible market testing of PHA contracts. Mr McClean said that PHA has a Procurement Plan, which is progressing in keeping with an Internal Audit recommendation.

136/16.5 Members noted the updated Corporate Risk Register.

137/16 Item 12 – Any Other Business

137/16.1 There was no other business.

138/16 Item 13 – Date and Time of Next Meeting

Thursday 16 February 2017 at 1:30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Signed by Chair:

Date:

Public Health Agency

Finance Report

2016-17

Month 9 - December 2016

Public Health Agency
2016-17 Summary Position - December 2016

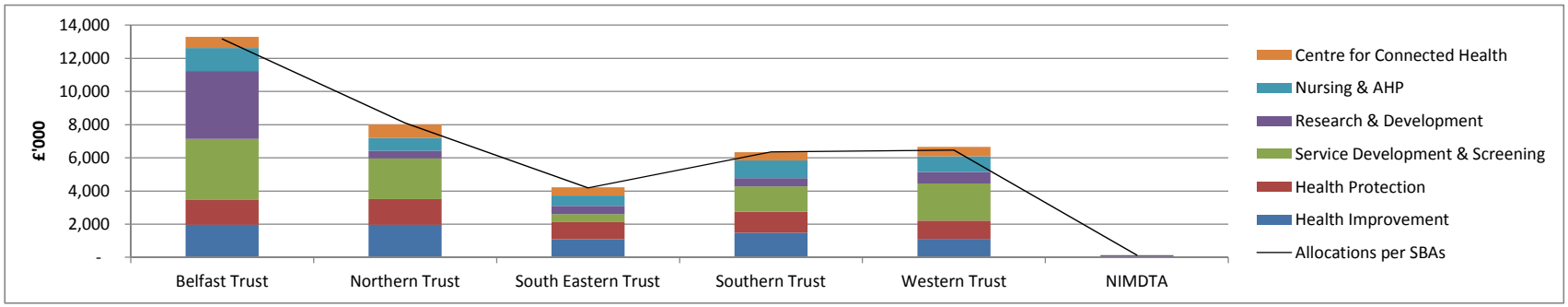
	Annual Budget				Year to Date			
	Programme		Mgt & Admin	Total	Programme		Mgt & Admin	Total
	Trust £'000	Non-Trust £'000	£'000	£'000	Trust £'000	Non-Trust £'000	£'000	£'000
Available Resources								
Departmental Revenue Allocation	32,279	45,315	18,352	**95,946**	24,311	27,714	13,591	**65,615**
Revenue Income from Other Sources	-	70	468	**538**	-	37	292	**329**
Capital Grant Allocation & Income	6,394	5,992	-	**12,386**	4,795	3,842	-	**8,636**
Total Available Resources	38,673	51,377	18,820	**108,870**	29,106	31,593	13,882	**74,581**
Expenditure								
Trusts	38,673	-	-	**38,673**	29,140	-	-	**29,140**
Non-Trust Programme *	-	51,177	-	**51,177**	-	31,128	-	**31,128**
PHA Administration	-	-	18,820	**18,820**	-	-	13,681	**13,681**
Total Proposed Budgets	38,673	51,177	18,820	**108,670**	29,140	31,128	13,681	**73,949**
Surplus/(Deficit) - Revenue	-	200	-	200	(34)	1,123	201	**1,291**
Surplus/(Deficit) - Capital	-	-	-	**-**	-	(658)	-	**(658)**

** Non-Trust Programme includes amounts which may transfer to Trusts later in the year*

Revised Departmental guidance means the vast majority of PHA's Research & Development (R&D) expenditure is now funded from a DoH capital budget (CRL), rather than a revenue budget (RRL) as was previously the case. Total CRL allocations received for R&D now total £11.4m, with additional receipts of £1.0m bringing the total to £12.4m. As a result of this change the majority of R&D programme will no longer form part of PHA's revenue breakeven requirement. However, total funds and expenditure are shown within these Finance Reports in a combined manner, but the individual CRL and RRL breakeven targets will be monitored and highlighted separately.

The year to date financial position for the PHA shows a net underspend against profiled budget of approximately £0.6m, mainly due to spend behind profile on Revenue Budgets (RRL) within Health Improvement and Service Development & Screening, offset by spend ahead of profile within Health Protection and R&D (see page 3). A surplus of £0.2m is currently projected for the full year as a result of lower than expected activity on screening programmes.

Programme Expenditure with Trusts

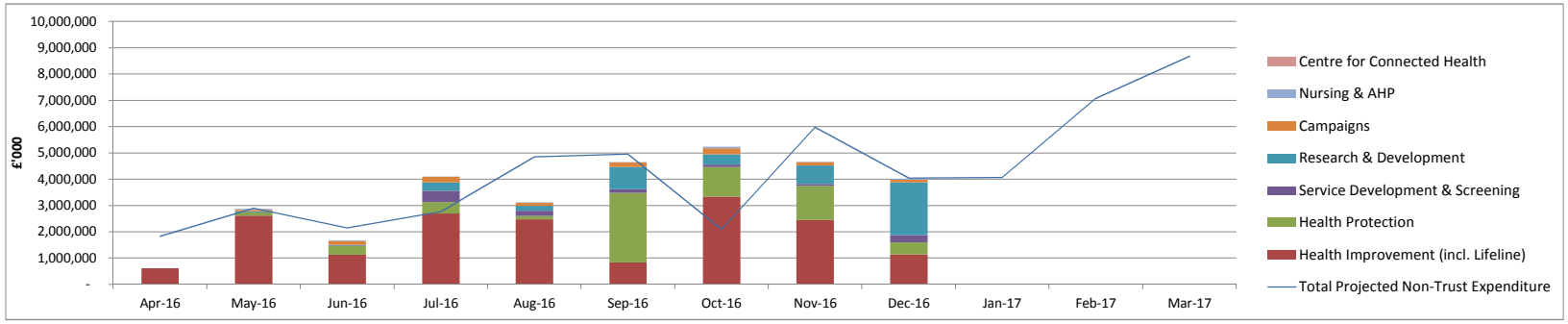


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIMDTA £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	1,970	1,972	1,089	1,477	1,107	-	**7,615**	5,681	5,711	(30)
Health Protection	1,495	1,534	1,044	1,269	1,101	-	**6,443**	4,828	4,832	(4)
Service Development & Screening	3,679	2,454	465	1,536	2,252	-	**10,386**	7,790	7,790	-
Research & Development	4,091	472	507	499	692	132	**6,393**	4,795	4,795	-
Nursing & AHP	1,391	755	611	1,058	933	-	**4,748**	3,561	3,561	-
Centre for Connected Health	670	832	510	498	577	-	**3,087**	2,451	2,451	-
Total current RRLs	**13,296**	**8,018**	**4,227**	**6,337**	**6,662**	**132**	**38,672**	**29,106**	**29,140**	**(34)**

The above table shows the current Trust allocations split by budget area. These amounts are primarily Revenue Resource Limits (RRL) but also include the Capital Resource Limit (CRL) for Research and Development.

The year to date position shows a small variance against profile, but this is a timing issue only and a breakeven position is expected for the full year. The net Programme position over both Trust and Non-Trust budgets (Page 3) is a £0.4m underspend at month 9, however this includes an overspend of £0.658m on the R&D capital budget.

Non-Trust Programme Expenditure



	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000	Sep-16 £'000	Oct-16 £'000	Nov-16 £'000	Dec-16 £'000	Jan-17 £'000	Feb-17 £'000	Mar-17 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Projected Expenditure																
Health Improvement	1,246	2,368	1,389	1,582	2,674	1,658	834	3,853	826	2,694	3,760	2,157	**25,041**	16,431	16,224	206
Lifeline	225	225	225	225	225	225	225	225	225	225	225	225	**2,700**	2,025	1,118	908
Health Protection	27	29	25	275	611	2,493	1,259	667	648	653	1,002	1,470	**9,158**	6,033	6,541	(508)
Service Development & Screening	217	148	392	157	102	375	(23)	68	375	127	86	425	**2,447**	1,809	1,545	264
Research & Development	8	8	8	372	1,002	21	(193)	957	1,660	8	1,576	3,706	**9,132**	3,842	4,500	(658)
Campaigns	115	115	115	115	187	165	1	242	237	242	298	292	**2,127**	1,295	1,173	122
Nursing & AHP	4	4	4	49	49	11	(64)	18	23	76	79	324	**577**	97	173	(76)
Safeguarding Board	-	-	-	-	-	12	-	-	-	-	-	12	**24**	12	-	12
Centre for Connected Health	-	-	-	-	-	-	-	-	-	-	-	22	**22**	-	-	-
Other	-	-	-	-	-	-	50	(50)	50	50	50	-	**150**	50	(146)	196
Total Projected Non-Trust Expenditure	**1,842**	**2,897**	**2,157**	**2,775**	**4,850**	**4,959**	**2,088**	**5,980**	**4,045**	**4,074**	**7,077**	**8,633**	**51,377**	**31,594**	**31,128**	**465**
Actual Expenditure	**620**	**2,914**	**1,663**	**4,127**	**3,040**	**4,795**	**5,229**	**4,571**	**4,169**	**-**	**-**	**-**	**31,128**			
Variance	**1,222**	**(18)**	**494**	**(1,351)**	**1,810**	**165**	**(3,140)**	**1,409**	**(124)**	**-**	**-**	**-**	**465**			

The Non-Trust Programme budgets show the opening budgets plus additional allocations received subsequently.

Expenditure is £0.5m behind profile for the year to date as a result of underspends in Health Improvement and Service Development & Screening, offset by spend in advance of profile in Health Protection and R&D. It should be noted that 39% of the budget remains to be spent by year end. While this is not unusual at this stage, budget managers should continue to review variances closely throughout the remainder of the year if the PHA is to achieve breakeven for the year.

PHA Administration
2016-17 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	2,801	3,354	9,215	452	316	507	**16,645**
Goods & Services	97	1,325	388	31	49	287	**2,177**
Total Budget	**2,898**	**4,678**	**9,603**	**483**	**365**	**794**	**18,821**
Budget profiled to date							
Salaries	2,053	2,514	6,892	325	237	319	**12,339**
Goods & Services	72	1,005	251	23	37	155	**1,543**
Total	**2,125**	**3,520**	**7,142**	**349**	**274**	**473**	**13,882**
Actual expenditure to date							
Salaries	2,120	2,459	6,927	174	243	319	**12,243**
Goods & Services	86	964	242	(22)	14	155	**1,438**
Total	**2,207**	**3,424**	**7,169**	**152**	**257**	**473**	**13,681**
Surplus/(Deficit) to date							
Salaries	(67)	55	(35)	151	(6)	(0)	**97**
Goods & Services	(14)	41	9	46	23	0	**105**
Surplus/(Deficit)	**(82)**	**96**	**(26)**	**197**	**16**	**0**	**201**

The total PHA funding allocation from the DoH in 2016-17 has been reduced by 10%, which equates to £1.6m. Although this reduction has initially been set against Commissioning funds by the DoH as an interim measure, the PHA Investment Plan requires the Administration budgets to deliver a contribution towards this reduction to enable PHA to achieve breakeven in-year.

The Administration savings target is based on anticipated savings as a result of restructuring following the VES 2015-16 process, the implementation of which is estimated to generate a net £0.4m after funded other pressures and priorities. Salaries budgets have been updated in line with these plans.

The year-to-date salaries budgets of both Nursing and Public Health remain under some pressure, mainly due to incremental drift and in-year costs of 2015-16 VES posts. The deficit in Public Health salaries has reduced in month as a result of a £45k credit being received from BHSCT for a medical post. The surplus in the PHA Board cost centre relates mainly to a £200k allocation for Making Life Better against which there has been minimal expenditure to date. A significant cost is anticipated in the last quarter of the year relating to the transfer of staff to new premises in Linum Chambers, and this is expected to fully utilise the year to date surplus. All Directorate surpluses and deficits are being closely reviewed to enable the overall PHA budget to breakeven in 2016-17.

PHA Prompt Payment

Prompt Payment Statistics

	December 2016 Value	December 2016 Volume	Cumulative position as at 31 December 2016 Value	Cumulative position as at 31 December 2016 Volume
Total bills paid (relating to Prompt Payment target)	£1,705,550	305	£37,282,005	3,983
Total bills paid on time (within 30 days or under other agreed terms)	£1,688,633	284	£35,872,143	3,740
Percentage of bills paid on time	**99.0%**	**93.1%**	**96.2%**	**93.9%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95%, although on volume performance is slightly below target at 94%. PHA has made good progress on ensuring invoices are processed promptly, and efforts to maintain this good performance will continue for the remainder of the year.

The 10 day prompt payment performance remained strong at 86.4% by value for the year to date, which significantly exceeds the 10 day DHSSPS target for 2016-17 of 60%.

Public Health Agency

Statement of Financial Position as at 31st December 2016

	31st December 2016 (Month 9) £000	31st March 2016 (Published Accounts) £000	
Non-current assets			
Property, plant and equipment	284	352	
Intangible assets	127	157	
Total non-current assets	411	509	
Current assets			
Trade and other receivables	274	579	
Other current assets	84	27	
Cash and cash equivalents	383	310	
Total current assets	741	916	
Current liabilities			
Trade and other payables	(6,688)	(7,773)	The movement in payables relates to payment of invoices for a range of liabilities which had been listed at the year end.
Provisions	(371)	(5)	The estimate figure for this legal case provided by DLS has increased.
Total current liabilities	(7,058)	(7,778)	
Non-current liabilities			
Provisions	-	-	
Total non-current liabilities	-	-	
Total assets employed	**(5,907)**	**(6,353)**	
Financed by taxpayers' equity			
Revaluation reserve	35	36	
SoCNE * reserve	(5,942)	(6,389)	The December Statement of Financial Position (Balance Sheet) is displayed against the audited position as at 31st March 2016.
Total taxpayers' equity	**(5,907)**	**(6,353)**	

* Statement of Comprehensive Net Expenditure

PHA Capital Expenditure Position

2016-17 - Month 9 (December 2016)

Capital Scheme	Annual Budget £000	Allocation/ Spend Year to Date £000	Annual Forecast Expenditure £000	Annual projected variance £000	Notes
ICT	183	-	183	-	This allocation is for ICT capital directly expended by the PHA. The amount covers a number of minor schemes and is expected to be fully utilised.
General Capital	242	-	242	-	This capital funding was an additional allocation in-year, and is forecast to be fully spent on building refurbishment works.
Capital Grants and 3rd party income					Permission has been received from DOH to receive just under £1m of 3rd party receipts for R&D
Research & Development - MRC - Cell Therapy	750	750	750	-	This R&D allocation relates to a development with the Medical Research Council and has been fully spent in 2016/17. It was approved separately from the main R&D budget below.
Research & Development	12,488	7,016	12,488	(0)	This allocation relates to PHA's R&D funding that is expended with 3rd parties (e.g. Queens University) and Trusts. This is a change from previous years when all R&D funding was disseminated through resource allocations as revenue, whereas R&D is now classified as capital following changes in European legislation. A breakeven position is expected for the year.
Total	**13,663**	**7,766**	**13,663**	**(0)**	

The PHA receives Capital Resource Limit (CRL) allocations for a range of capital initiatives, both those which create assets in the PHA's accounts and those which are provided to HSC Trusts, other providers, and academic bodies. This December review highlights the latest financial position and all CRL budgets are expected to breakeven by either direct expenditure by PHA, allocations made to other organisations, or withdrawal and reallocation of surplus CRL by DoH.

HSC Public Health Agency

board paper

Review of PHA Standing Orders and Standing Financial Instructions / Review of PHA Scheme of Delegated Authority

date	16 February 2017	**item**	8	**reference**	PHA/02/02/17
presented by	Mr Ed McClean, Director of Operations Mr Paul Cummings, Director of Finance				
action required	For approval				

Summary

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

A summary of the changes is outlined below:

Standing Orders

All references to the Department of Health have been reviewed, except in cases where the reference is to a document that has not been superseded.

The key main changes, where relevant, are that Department of Health, Social Services and Public Safety has been changed to Department of Health, and DHSSPS has been changed to DoH.

Other changes are:

On page 5, the date has been changed to 16 February 2017 and the name of the Chief Executive has been changed to that of the Interim Chief Executive.

On page 7, “Centrals Services Agency” has been changed to “Central Services Agency”.

On page 8, HSCB has been spelt out in full as this is the first reference to the Health and Social Care Board

On page 29, the text that was marked in bold and underline has been reverted to normal text

Page 30 was removed as this was a blank page. All subsequent page numbers have reduced by 1 and the content page updated accordingly

On page 112, “Chief Executive” has been capitalised and “his” replaced with “his/her”

Within both the terms of reference for the Governance and Audit Committee and the Remuneration Committee, a lot of extra spacing has been removed between paragraphs.

Standing Financial Instructions

As with Standing Orders, the main change to Standing Financial Instructions is that all references to DHSSPS have been updated to DoH.

On page 14, Circular 32/2013 has been superseded by Circular 47/2016. This change also sees the word “substantial” removed as it is no longer a descriptor.

Scheme of Delegated Authority

A review of the Scheme of Delegated Authority (SoDA) has also been undertaken as part of the Review.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **APPROVE** the revised Standing Orders and Standing Financial Instructions and the updated Scheme of Delegated Authority.

Public Health Agency

STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

February 2017

TABLE OF CONTENTS

STANDING ORDERS

Contents **Page**

APPENDICES

Foreword

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

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

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

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

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

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

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

The PHA's original Standing Orders and Standing Financial Instructions were approved by the Agency board at its meeting on 1 April 2009 and were subsequently forwarded to the Department.

These current Standing Orders and Standing Financial Instructions were approved by the Agency board on 16 March 2017.

_____	_____
Chairperson	**Interim Chief Executive**

Dated: ***16 March 2017***

1. Introduction - Contents

1. Introduction

1.1 Statutory Framework

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

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

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

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

1.2 Functions of the Agency

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

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

Board (HSCB) with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with the HSCB, the PHA has an important role to play in providing professional leadership to the HSC.

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

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

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

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

The Department produced the **Framework Document** (September 2011) meeting the requirement of The Health and Social Care (Reform) Act (NI) 2009, Section 5(1). The Framework Document sets out, in relation to each health and social care body:

- The main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;
- The matters for which the body is responsible;

- The manner in which the body is to discharge its functions and conduct its working relationship with the Department and with any other body specified in the document; and
- The arrangement for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC bodies.

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

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

The **Code of Conduct** draws attention to the requirement for public service values to be at the heart of Health and Social Care (HSC) in Northern Ireland. High standards of corporate and personal conduct are essential. Moreover, as the HSC is publically funded, it is accountable to the Northern Ireland Assembly for the services provided and for the effective and economical use of taxpayers' money. It also sets out measures to deal with possible conflicts of interest of board members.

The **Code of Practice on Openness in the HPSS** sets out the requirements for public access to information and for the conduct of

board meetings. The Agency is required to ensure appropriate compliance with the Freedom of Information Act (2000).

1.4 Financial and Performance Framework

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

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

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

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

Consistent with the timetable for Northern Ireland Executive Budgets, the PHA will submit annually to the DoH a draft of the Corporate Plan covering up to 3 years ahead; the first year of the Corporate Plan, amplified as necessary, shall foHHSSPS approval.

The Corporate/Business Plan shall be published by the PHA and made available on its website (www.publichealth.hscni.net)

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

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

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

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

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

1.5 Delegation of Powers

The Agency board is given powers as follows:

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

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

1.6 Interpretation

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

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

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

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

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

"BSO" means Regional Business Services Organisation.

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

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

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

“Chief Executive” means the chief officer of the Agency.

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

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

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

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

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

“Department” means the Department of Health (DoH). The term Department does appear as part of the title of other Government organisations and in these instances the title is given in full.

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

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

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

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

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

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

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

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

"Minister" means the Minister for Health in the Northern Ireland Assembly

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

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

"Officer" shall mean an employee of the Agency. In certain circumstances, an officer may include a person who is employed by

another HSC organisation or by a Third Party contracted to or by the Organisation who carries out functions on behalf of the Organisation.

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

"PCC" means the Patient and Client Council.

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

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

"SFIs" is an abbreviation for Standing Financial Instructions.

"SOs" is an abbreviation for Standing Orders.

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

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

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

2. Powers Reserved to the Agency Board - Contents

2.1 Introduction

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

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

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

2.2 Composition of the board

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

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

2.3 Key Functions of the Agency board

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

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

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

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

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

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

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

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

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

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

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

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

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

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

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

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

STANDING ORDERS
SCHEDULE OF POWERS RESERVED TO THE AGENCY BOARD

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

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

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

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

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

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

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

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

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

	ITEMS	RESPONSIBILITY/TASK	CONTROLS	LEAD PERSON
L L (i)	Code of Conduct and Code of Accountability: Implementation of measures to ensure authorised officers behave with propriety, i.e. withdrawal from discussion where there is a potential perception of a conflict of interest	 Approve measures to ensure that all Directors and staff are aware of the public service values which must underpin their conduct	 Code of conduct and code of accountability April 2011	 Chief Executive
L (ii)	Concerns of Staff & Others	Ensure arrangements are in place to guarantee that concerns expressed by staff & others are fully investigated & acted upon as appropriate and that all staff are treated with respect	The Public Interest Disclosure (NI) Order 1998 (whistle blowing) and aligned with DHSSPS Circular HSS(F) 07/2009 “Whistleblowing” – New circular issued HSC(F) 32-2015 with details of DFP good practice guide	Chief Executive
M	ALB Board Self-Assessment Tool	Review actions and agree Board self-assessment	DoH ALB Board Self-Assessment tool and guidance	Board Members

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

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

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

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

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

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

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

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

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

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

3. Powers Delegated by the Agency Board - Contents

3.5.3 Authorisation & Approval of Non Payroll Expenditure

3.5.4 Authority to Initiate and Approve Cash Advances

3.1 Arrangements for Delegation by the Agency Board

3.1.1 Introduction

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

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

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

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

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

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

3.1.2 Urgent Decisions

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

3.1.3 Delegation to Committees

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

The PHA has established two Committees:

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

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

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

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

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

3.1.4 Delegation to Officers

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

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

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

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

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

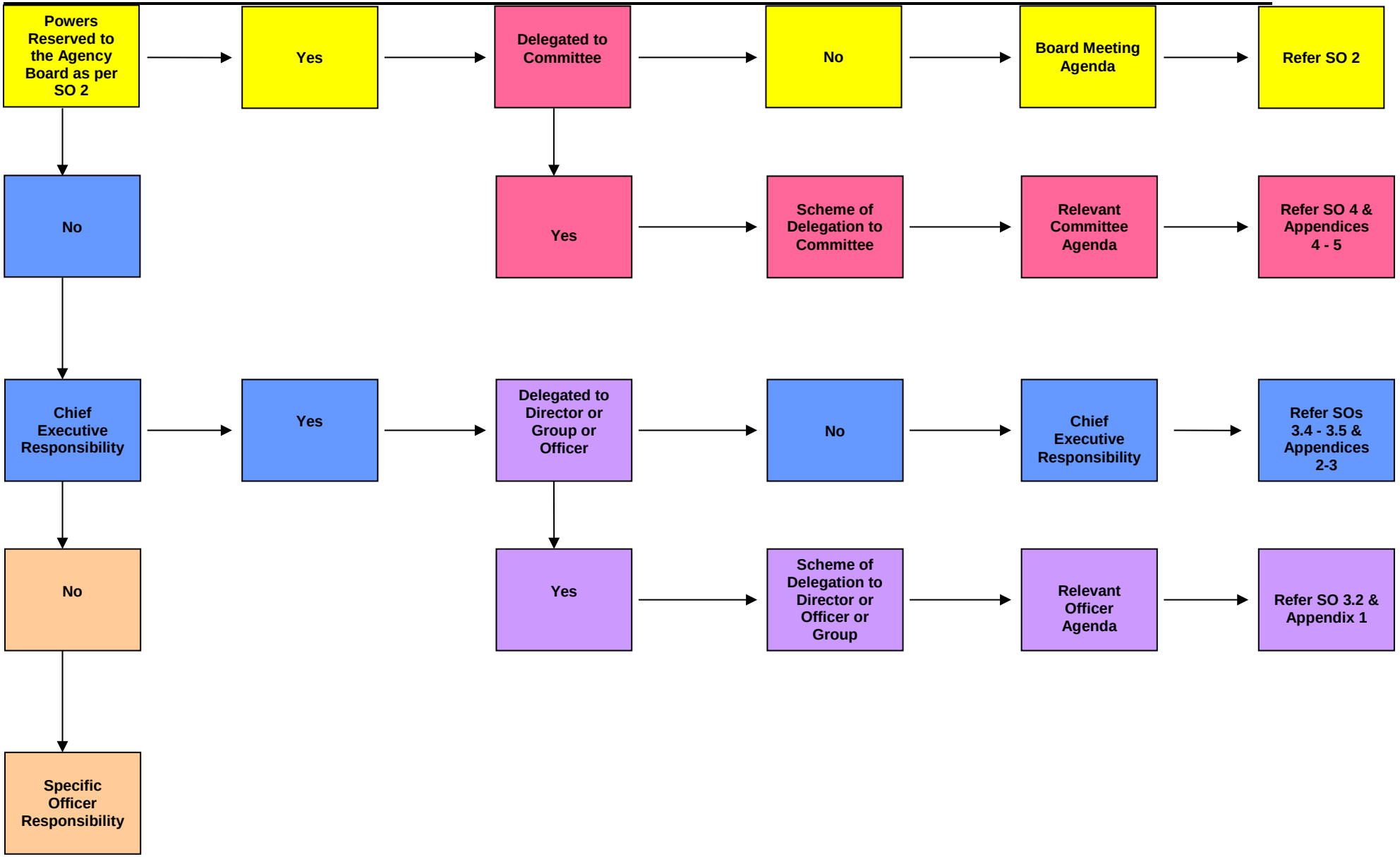
3.1.5 Decision Tree - Flowchart

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

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

Flowchart

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



3.2 Chief Executive's Scheme of Delegation

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

3.3 Statutory Schemes of Delegation

None applicable to the Agency at this time.

3.4 Administrative Schemes of Delegation

3.4.1 Custody of Seal

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

3.4.2 Sealing of Documents

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

3.4.3 Register of Sealing

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

3.4.4 Signature of Documents

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

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

3.4.5 Delegation of Budgets for Agency Administration

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

3.4.6 Procedure for Delegating Power to Authorise & Approve Expenditure

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

3.4.7 Procedure for Quotations and Tendering

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

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

3.4.8 Use of Management Consultants

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

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

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

3.5 Financial Schemes of Delegation

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

3.5.1 Procedure for Delegation of Budgets;

3.5.2 Authorisation & Approval of Payroll Expenditure;

3.5.3 Authorisation & Approval of Non Payroll Expenditure; and

3.5.4 Authority to Initiate and Approve Cash Advances.

4. Agency board Committees - Contents

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

4.1 Appointment of Committees

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

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

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

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

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

The board shall approve the appointments to each of the Committees, which it has formally constituted. Where the board determines, and regulations permit, that persons, who are neither members nor officers,

shall be appointed to a Committee the terms of such appointment shall be within the powers of the board as defined by the Minister. The board shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses.

Where the board is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Minister; and where such appointments are to operate independently of the board such appointment shall be made in accordance with the regulations laid down by the Minister.

See also SO 5.2.24 on Potential Conflicts of Interest.

4.2 Committees

Board Committees

Refer to:	**Appendix**
• Governance and Audit Committee	4
• Remuneration and Terms of Service Committee	5

Other board Committees may established as necessary

Sub Committees

* To be determined

Joint Committees

* To be determined

5. Conduct of Agency Board Business - Contents

5.1 Constitution and Remit of Agency

5.1.1 Constitution

All business shall be conducted in the name of the Agency.

All funds received in trust shall be held in the name of the Agency board as corporate trustee of the Agency.

5.1.2 Remit

The powers of the Agency established under statutory instruments shall be exercised by the Agency board meeting in public session except as otherwise provided for in SO 3.

The board shall define and regularly review the functions it exercises on behalf of the Minister.

The board has resolved that the board may only exercise certain powers and decisions in formal session. These powers and decisions are set out in 'Powers Reserved to the Agency board' SO 2.3.1-7 and have effect as if incorporated into the Standing Orders.

5.1.3 Composition of the Board

The Department of Health, Social Services and Public Safety determines the composition of the Agency board, which is currently as follows:

- A Chairperson appointed by the DoH;
- a prescribed number of persons appointed by the DoH;
- the chief officer of the PHA;
- such other officers of the PHA as may be prescribed;
- not more than a prescribed number of other officers of the PHA appointed by the Chairperson and the members specified the points above; and

- a prescribed number of members of district councils as appointed by the DoH.

Except in so far as regulations otherwise provide, no person who is an officer of the PHA may be appointed as the Chairperson or by the DoH. Regulations may provide that all or any of the persons appointed by the DoH must fulfil prescribed conditions or hold posts of a prescribed description.

Details of board members are as follows:

The Chairperson

The role of the Chairperson is outlined in Appendix 7.

Non Officer Members

- 5 Non-Executive Directors (Non-specified);
- 2 Non-Executive Directors (Local Government Representatives);

The Officer Members are

- Chief Executive;
- Director of Nursing and Allied Professions;
- Director of Operations;
- Director of Public Health/Medical Director; and
- Any other Officer who the Chief Executive determines should be a member of the Agency Management Team.

Others in Attendance at board meetings

The Director of Social Care & Children and the Director of Finance, both from HSCB or their deputies, will attend all Agency board meetings and have attendance and speaking rights.

A representative from the Patient and Client Council (PCC) will be in attendance.

5.1.4 The Agency Management Team comprises:

- Chief Executive;
- Director of Public Health/Medical Director;
- Director of Nursing/Allied Health Professionals;
- Director of Operations;
- Director of Social Care and Children, HSCB;
- Director of Finance, HSCB, and
- Any other Officer who the Chief Executive determines should be a member of the Agency Management Team.

Details of the role and remit of the AMT are outlined in Appendix 6.

5.2 Procedures for Meetings - Contents

5.2.1 Code of Practice on Openness
5.2.2 Open Board Meetings
5.2.3 Conduct of Meetings
5.2.4 Calling of Meetings
5.2.5 Setting Agenda
5.2.6 Petitions
5.2.7 Notice of Meetings
5.2.8 Notice of Motion
5.2.9 Deputations & Speaking Rights
5.2.10 Admission of the Public and media
5.2.11 Attendance of other HSC Organisation representatives
5.2.12 Chairperson of Meeting
5.2.13 Quorum
5.2.14 Record of attendance
5.2.15 Confidential Section of meetings
5.2.16 Motions
5.2.17 Voting
5.2.18 Joint Members
5.2.19 Suspension of Standing Orders
5.2.20 Minutes
5.2.21 Committee Minutes
5.2.22 Variation & Amendment of Standing Orders
5.2.23 Appointments
5.2.24 Potential Conflict of Interests

5.2.1 Code of Practice on Openness

The board shall pursue the aims of the **Code of Practice on Openness:**

'...to ensure that people may easily obtain an understanding of all services that are provided by the HSC and, particularly, changes to those services that may affect them or their families.'

The board shall accept the strong duty imposed on it by the Code to be positive in providing access to information; the presumption shall be in favour of openness and transparency in all its proceedings.

5.2.2 Open board Meetings

The Agency shall hold all its board meetings in public, although certain issues may be taken in a confidential section of the meeting.

A schedule of PHA public board meeting dates and venues will be posted on the Agency website (www.publichealth.hscni.net) for the financial year.

Public meetings shall be held in easily accessible venues across the region and at times when the public are able to attend. (**Code of Practice on Openness**; Annex A, Para 3.1)

5.2.3 Conduct of Meetings

The meetings and proceedings of the board shall be conducted in accordance with these Standing Orders.

Proceedings shall be in accordance with section 54 (1) and (2) of the Health and Social Services Act (Northern Ireland) 2001 which provides that sections 23 to 27 of the Local Government Act (Northern Ireland) 1972 (c9) shall also apply. This is specified in the Guidance on Implementation of the **Code of Practice on Openness**, Annex A, Para. 2.3.

The **Code of Practice on Openness** is not statutory, it does not set aside restrictions on disclosure, which are based in law and decisions shall rest on judgement and discretion. (See Guidance on the implementation of the **Code of Practice on Openness**, Para 6.3).

5.2.4 Calling of Meetings

Ordinary meetings of the board shall normally take place monthly and be held at such times and places as the board may determine although, as good practice, some meetings may be held outside normal working hours to facilitate wider attendance by the general public. The board shall pay particular attention to the commitments within its Equality Scheme when calling meetings.

The Chairperson may call a meeting of the board for a special purpose (including in the event of an emergency) at any time.

The notice, agenda and papers for such a meeting shall be conveyed to members as far in advance of the meeting as the circumstances shall allow. Notice of meetings and agenda shall be posted on the Agency web site.

If requested by at least one third of the whole number of members, the Chairperson shall call a meeting of the board for a special purpose. If the Chairperson refuses to call a meeting or fails to do so within seven days after such a request, such one third or more members may forthwith call a meeting. In the case of a meeting called by members in default of the Chairperson, the notice shall be signed by those members and no other business, other than that specified in the notice shall be transacted at the meeting. Failure to service such a notice on more than three members of the board shall invalidate the meeting. A notice shall be presumed to have been served one day after posting.

5.2.5 Setting the Agenda

The board may determine or may be directed to ensure that certain matters shall appear on every agenda for a meeting of the board and shall be addressed prior to any other business being conducted. If so determined these matters shall be listed as an appendix to the Standing Orders.

A member desiring a matter to be included on an agenda shall normally make his/her request in writing to the Chairperson at least 14 clear days before the meeting. The request may include appropriate supporting information and a proposed motion. It may also note any grounds which would necessitate the item of business being dealt with in a confidential section of the meeting. Requests made less than 14 days before a

meeting may be included on the agenda at the discretion of the Chairperson.

The agenda and supporting papers shall be despatched to members 5 working days in advance of the meeting and certainly no later than three working days beforehand, except in cases of emergency.

5.2.6 Petitions

Where the board has received a petition of at least 100 signatures the Chairperson shall include the petition as an item for the agenda of the next meeting, providing it is appropriate for consideration by the board. The Chairperson shall advise the meeting of any petitions that are not granted and the grounds for refusal. However if the petition is deemed to be urgent the Chairperson may call a special meeting.

5.2.7 Notice of Meetings

Before each meeting of the board, a notice of the meeting, specifying the business proposed to be transacted at it, and any motions relating to it, and signed by the Chairperson or by an officer of the board authorised by the Chairperson to sign on his/her behalf shall be delivered to each member and posted on the PHA website at least five clear days before the meeting.

Absence of service of the notice on any member shall not affect the validity of a meeting. Failure to serve such a notice on more than three members shall invalidate the meeting. A notice shall be presumed to have been served one day after posting.

In the case of a meeting called by members in default of the Chairperson, those members shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

5.2.8 Notices of Motion

With reference to matters included in the notice of meetings, a member of the board may amend or propose a motion in writing at least 10 clear days before the meeting to the Chairperson. All notices so received, shall be inserted in the agenda for the meeting subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda.

5.2.9 Deputations and Speaking Rights

Deputations from any meeting, association, public body or an individual, in relation to a matter on the Agency board agenda, may be permitted to address a public meeting of the board provided notice of the intended deputation and a summary of the subject matter is given to the board at least two clear days prior to the meeting and provided that the Chairperson of the board is in agreement. The specified notice may be waived at the discretion of the Chairperson. In normal circumstances this facility shall be confined to the making of a short statement or presentation by no more than three members of the deputation and making a copy of the presentation available in advance (at least one clear day) of the meeting. The Chairperson shall determine the actual allotted time and if the deputation has sufficiently covered the issue.

5.2.10 Admission of the Public and Media

The PHA board shall undertake the necessary arrangements in order to encourage and facilitate the public at open board meetings. Reasonable facilities shall be made available to enable representatives of the press and broadcasting media to report the meetings.

The Chairperson shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press and broadcasting media, such as to ensure that the board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public shall be required to withdraw upon the board resolving as follows:

'That in the interests of public order the meeting adjourns for (the period to be specified) to enable the board to complete business without the presence of the public.'

Nothing in these Standing Orders shall require the board to allow members of the public or representatives of the press and broadcasting media to record proceedings in any manner whatsoever, other than in writing, or to make an oral report of proceedings as they take place from within the meeting, without prior agreement of the Chairperson.

5.2.11 Attendance of other HSC Organisation representatives

Officers representing the HSCB, HSC Trusts, the PCC and the BSO may attend and participate in meetings of the Agency board, with the agreement of the Chair.

5.2.12 Chairperson of Meeting

At any meeting of the board, the Chairperson, if present, shall preside. In the absence of the Chairperson the Vice Chairperson, if previously appointed, shall preside, if not previously appointed then such member (who is not also an officer of the board) as the Chairperson may nominate shall preside or if no such nomination has been made, such non executive member as those members present shall choose, shall preside.

If the Chairperson is absent temporarily on the grounds of a declared conflict of interest such non-executive member as the members shall choose shall preside.

5.2.13 Quorum

No decisions may be taken at a meeting unless at least one-third of the whole number of the Chairperson and voting members appointed, (including at least one non-officer member and one officer member) are present. Members may receive items for information, which are included on the agenda, providing this is also recorded in the minutes.

An officer in attendance for an officer member but without formal acting up status may not count towards the quorum. If the Chairperson or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he/she shall no longer count towards the quorum. If a quorum is then not available for the passing of a resolution on any matter, that matter may be discussed further but not voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting.

5.2.14 Record of Attendance

A record of the names of the Chairperson, and members present at the meeting shall be noted in the minutes. If necessary, the point at which they join, leave or resume their place at the meeting shall also be noted. The name of those ‘in attendance’ shall also be included along with the items for which they attended.

5.2.15 Confidential Section of Meetings

The board may by resolution exclude the public or representatives of the press or broadcasting media from a meeting (whether during the whole or part of the proceedings at the meeting) on one or more of the following grounds:

- By reason of the confidential nature of the business to be transacted at the meeting;
- when publicity would be prejudicial to the public interest; or
- for such special reasons as may be specified in the resolution being reasons arising from the exceptional nature of the business to be transacted or of the proceedings at the meeting.

5.2.16 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a member to move:

- An amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business (+);
- the appointment of an ad hoc Committee to deal with a specific item of business;
- that the motion be now put (+); or
- a motion resolving to exclude the public (including the press).

In the case of sub-paragraphs denoted by (+) above: to ensure objectivity, only a member who has not previously taken part in the debate may put motions.

No amendment to the motion shall be admitted if, in the opinion of the Chairperson of the meeting, the amendment negates the substance of the motion.

When an adjourned item of business is re-commenced or a meeting is reconvened, any provisions for deputations or speaking rights, not

previously undertaken or other arrangements shall be treated as though no interruption had occurred.

(a) Withdrawal of Motion or Amendments

The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the second and the consent of the Chairperson.

(b) Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) that has been passed within the preceding 6 calendar months, shall bear the signature of the member who gives it and also the signature of 4 other board members.

When any such motion has been disposed of by the board, it shall not be appropriate for any member other than the Chairperson to propose a motion to the same effect within 6 months; however the Chairperson may do so if he/she considers it appropriate.

(c) Chairperson's Ruling

Statements of members made at meetings of the board shall be relevant to the matter under discussion at the material time and the decision of the Chairperson of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

5.2.17 Voting

Every item or question at a meeting shall be determined by the Chairperson seeking the general assent of voting members or the expression of a wish to proceed to a vote. A vote shall be determined by the majority of the votes of the Chairperson of the meeting and members present and voting on the question; in the case of the number of votes for and against a motion being equal, the Chairperson of the meeting shall have a second or casting vote.

All questions put to the vote shall, at the discretion of the Chairperson of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the members present so request.

If at least one third of the members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each member present voted or abstained.

If a member so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the board to act up for an officer member during a period of incapacity or temporarily to fill an officer member vacancy, shall be entitled to exercise the voting rights of the officer member. An officer attending the board to represent an officer member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the officer member. An officer's status when attending a meeting shall be recorded in the minutes.

5.2.18 Joint Members

Where more than one person shares the office of a member of the board jointly:

- Either or both of those persons may attend or take part in meetings of the board;
- if both are present at a meeting they shall cast one vote if they agree;
- in the case of disagreement no vote shall be cast; and
- the presence of one or both of those persons shall count as the presence of one person for the purposes of a quorum.

5.2.19 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by the Department, one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the board are present, including one officer and one non-officer member, and that a majority of those present vote in favour of suspension.

A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairperson and members of the board.

No formal business may be transacted while Standing Orders are suspended.

The Governance and Audit Committee shall review every decision to suspend Standing Orders.

5.2.20 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where the person presiding at it shall sign them.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairperson considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

Minutes shall be circulated in accordance with members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public upon request as required by **Code of Practice on Openness** in the HPSS and the **Freedom of Information Act 2000**.

5.2.21 Committee Minutes

The minutes of all board Committee meetings shall be presented to the public board meeting immediately following the committee where they have been approved except where confidentiality needs to be expressly protected.

At the board meeting following the meeting of the committee, the committee Chairperson will give a verbal update of the meeting in the absence of the full minutes being available.

Where Committees meet infrequently, the draft minutes may be presented to the subsequent confidential meeting of the board for information only.

5.2.22 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- A notice of motion under the appropriate Standing Order has been given;
- at least two-thirds of the board members are present;
- no fewer than half the total of the board's non-officer members present vote in favour of amendment; and
- the variation proposed does not contravene a statutory provision or direction made by the Department.

5.2.23 Appointments

(a) Appointment of the Chairperson and Members, and Terms of Office

The legislative provisions governing the appointment of the Chairperson and members, and their terms of office, are contained in, Schedule 2, paragraphs 3-6, of the Health and Social Care (Reform) Act (Northern Ireland) 2009. Non-Executive appointments are made in accordance with the **Code of Practice**, issued by the Commissioner for Public Appointments for Northern Ireland.

(b) Appointment of Vice-Chairperson

Subject to the following, the Chairperson and members of the board may appoint one of their number, who is not also an officer member of the board, to be Vice-Chairperson, for such period, not exceeding the remainder of his/her term as a member of the board, as they may specify on appointing him/her.

Any member so appointed may at any time resign from the office of Vice-Chairperson by giving notice in writing to the Chairperson. The Chairperson and members may thereupon appoint another member as Vice-Chairperson in accordance with the provisions above.

If no Vice-Chairperson is available and the Chairperson is unable to conduct a board meeting, members shall appoint one from among the Non Executive members present to act as Chairperson for that meeting.

If no meeting is scheduled or the Chairperson is not available and the Chief Executive needs to take advice on an urgent matter, the Chief

Executive may obtain the agreement of non-executive members to appoint one of their number as Chairperson for this purpose.

Where the Chairperson of the board has passed away or has ceased to hold office, or where he/she has been unable to perform his/her duties as Chairperson owing to illness, absence from Northern Ireland or any other cause, the Vice-Chairperson, if previously appointed, shall act as Chairperson until a new Chairperson is appointed or the existing Chairperson resumes his/her duties, as the case may be. If not previously appointed the board may appoint one of their number, who is not also an officer member of the board, to be Chairperson, for such period. References to the Chairperson in these Standing Orders shall, so long as there is no Chairperson able to perform his/her duties, be taken to include references to the Vice-Chairperson.

(c) Joint Members

Where more than one person is appointed jointly to a post in the board which qualifies the holder for officer membership or in relation to which an officer member is to be appointed, those persons shall become appointed as an officer member jointly, and shall count for the purpose of Standing Orders as one person.

5.2.24 Potential Conflict of Interests

Subject to the following provisions of this Standing Order, if the Chairperson or a board member has any potential conflict of interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the board at which the contract or other matter is the subject of consideration, he/she shall, at the meeting, and as soon as practicable after its commencement, disclose the fact. It shall be disclosed in a manner that cannot be perceived to influence subsequent discussion or decision, and the member shall withdraw from the meeting while the consideration or discussion of the contract or other matter and the vote is being taken.

In **exceptional circumstances** the individual who has declared a potential conflict of interest may be permitted to remain for the discussion where their expertise is specifically required to inform the other members in their discussions. This expert advice shall be restricted to the giving of factual and objective information before withdrawing while the decision and vote is taken.

The DoH may, subject to such conditions as it may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to be in the interests of the HSC that the disability shall be removed.

The board may exclude the Chairperson or a board member from a meeting of the board while any contract, proposed contract or other matter in which he / she has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chairperson or a board member shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chairperson or a board member shall be treated, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- He/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in any other matter under consideration; or

- he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in any other matter under consideration; and in the case of persons living together the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chairperson or a board member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

- of an interest of his as a person providing Family Health Services which cannot reasonably be regarded as an interest more substantial than that of others providing such of those services as he/she provides; or

- of an interest in any company, body or person with which he/she is connected as mentioned in Standing Orders above which is so

remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chairperson or a board member has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a Committee or Sub-Committee and to a Joint Committee as it applies to the board and applies to a member of any such Committee or Sub-Committee (whether or not he/she is also a member of the board) as it applies to a member of the board.

6. Code of Conduct and Code of Accountability – Contents

6.1 Introduction

The **Code of Conduct and Code of Accountability**, issued in July 2012, provides the basis on which the HSC bodies should seek to fulfil the duties and responsibilities conferred upon them by the DoH.

The Codes state that high standards of corporate and personal conduct must be at the heart of the Health and Social Care Organisations.

Since Health and Social Care Organisations are publicly funded, they must be accountable to the Minister for Health, Social Services and Public Safety and ultimately to the Northern Ireland Assembly and the Public Accounts Committee, for the services they provide and for the effective and economical use of taxpayers' money.

6.2 Public Service Values – General Principles

All board members must follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the 'Nolan Principles'):

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

The PHA is committed to these principles and all individuals are expected to adhere to them in the course of their work.

Those who work in the HSC have a duty to:

- Conduct business with probity;
- deal with patients, clients, carers, staff, residents and suppliers impartially and with respect;
- achieve value for money from public funds; and
- demonstrate high ethical standards of personal conduct.

The Chairperson, board members and all Agency employees/officers are required to accept the provisions of the **Code of Conduct and Code of Accountability** on appointment and to follow the principles set out herein.

The board must set a rigorous and visible example and shall be responsible for corporate standards of conduct and ensure acceptance and application of the Code. The Code shall inform and govern the decisions and personal conduct of the Chairperson, board members and all Agency employees/officers.

6.3 Openness and Public Responsibilities

The Code of Conduct advises that there should be a willingness to be open and to actively involve the public, patients, clients and staff as any need for change emerges. HSC business should also be conducted in a way that is socially responsible.

The duty of confidentiality of personal and individual patient/client information must be respected at all times.

6.4 Public Service Values in Management

It is a long established principle that public sector bodies, which include the PHA, must be impartial, honest and open in the conduct of their business, and that their employees shall remain beyond suspicion. It is also an offence under the Public Bodies Corrupt Practices Act 1889 and Prevention of Corruption Acts 1906 and 1916 for an employee to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour or disfavour, in the handling of contracts.

In the **Code of Conduct** issued by the Department in July 2012, it was emphasized that public service values must be at the heart of Health and Social Care.

HSC organisations, including the PHA, are accountable to the Minister of Health and ultimately to the Northern Ireland Assembly and the Public Accounts Committee for the services they provide and for the effective and economical use of taxpayer's money.

It is unacceptable for the board of any HSC organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. The Chairperson, board members and all staff have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible.

Proper stewardship of public monies requires value for money to be high on the agenda of the board at all times. Employment, procurement and accounting practices within the Agency must reflect the highest professional standards.

Individuals are expected to:

- ensure that the interests of patients and clients remain paramount at all times;
- be impartial and honest in the conduct of their official business; and
- use public funds entrusted to them to the best advantage of the service as a whole always ensuring value for money in the procurement of goods and services.

Public statements and reports issued by the Agency, or individuals within the Agency, shall be clear, comprehensive and balanced, and shall fully represent the facts. They shall also appropriately represent the corporate decisions of the Agency, or be explicit in being made in a personal capacity, where this is considered necessary.

Annual and all other key reports shall (on request) be made available to all individuals and groups in the community who have a legitimate interest in health and social care issues to allow full consideration by those wishing to attend public meetings on such issues.

6.5 Public Business and Private Gain

The **Code of Conduct** issued in July 2012 also outlined the principle that the Chairperson, board members and all staff shall act impartially and shall not be influenced by social or business relationships. No one shall use their public position to further their private interests.

It is the responsibility of all staff to ensure that they do not:

- Abuse their official position for personal gain or to benefit their family or friends or to benefit individual contractors; or
- seek to advantage or further private business or other interests in the course of their official duties.

Where there is a potential for private, voluntary or charitable interests to be material and relevant to board or HSC business, the relevant interest shall be declared and recorded in the board minutes and entered into a register, which is available to the public. This is set out in more detail in SO 6.11.

When a conflict of interest is established or perceived, the Chairperson, board member or member of staff shall withdraw and play no part in the relevant discussion or decision.

6.6 Counter Fraud Policy

The Agency is committed to maintaining an honest, open and well-intentioned atmosphere. It is therefore also committed to the elimination of any fraud within or against the Agency, and to the rigorous investigation of any such cases.

The Agency has in place a Fraud Policy and Response plan, to give officers specific direction in dealing with cases of suspected fraud, theft, bribery or corruption. Advice may also be obtained from the Director of Operations and the Fraud Liaison Officer (FLO) role provided by the Department of Finance. The PHA's Fraud Liaison Officer (FLO) will ensure that all reporting requirements detailed in Circular HSC(F) 44/2011 are complied with.

The Agency wishes to encourage anyone with reasonable suspicions of fraud to report them. The PHA Whistleblowing Policy enables staff to raise concerns about issues of public interest either internally or externally at an early stage.

6.7 Gifts, Hospitality and Sponsorship

6.7.1 Providing and Receiving Hospitality

The use of public funds for hospitality and entertainment shall be carefully considered within the guidelines issued by the Department in circular HSS(F) 49/2009, and within Standing Financial Instruction 18.

6.7.2 Gifts and Hospitality

Token gifts (generally at Christmas) of very low intrinsic value such as diaries or calendars may be accepted from persons outside the Agency with whom staff have regular contact. At present a limit of £50 is used as a guide to identifying gifts of low intrinsic value but the nature or number of gifts may mean that items whose value is less than this may be considered inappropriate. The number of gifts accepted shall be limited within any financial period.

Apart from trivial/inexpensive seasonal gifts, such as diaries, no gift or hospitality of any kind from any source should be accepted by anyone involved in the procurement or monitoring of a contract. This will ensure that no criticism can be made regarding bias to a particular company or supplier and that the principles of the Bribery Act are complied with.

More expensive or substantial items, valued at £50 or more and gifts of lottery tickets, cash, gift vouchers or gift cheques, cannot on any account be accepted.

All gifts offered, even if they are declined/returned must be recorded in the central register.

If in doubt, staff shall decline the gift or consult their Line Manager/ Director before accepting it. Full details are contained within the Agency's Gifts and Hospitality Policy.

6.7.3 Sponsorship

Commercial sponsorship is not generally acceptable, as acceptance may be perceived as compromising the organisation's integrity.

Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses might be acceptable providing the employee seeks permission in advance and the Agency can be absolutely satisfied that its decision making processes are not compromised.

Members of the board must be satisfied that their acceptance of any commercial sponsorship could not compromise or be perceived to compromise future decisions.

Acceptance of commercial sponsorship of conferences, courses or other events run by the Agency may only be accepted if it can be demonstrated that:

- Promotional material of the sponsor does not unduly dominate the event;
- no particular product is being promoted or receiving an implicit endorsement by association with the Agency; and
- other commercial bodies have been given an equal opportunity to sponsor and be associated with a particular event or other such events over a period of time.

Any decisions regarding sponsorship are to be referred to the Agency Management Team in the case of Agency organized events. Decisions, together with all relevant information, shall be recorded in the minutes for future scrutiny.

A suitable contract shall be drawn up with the prospective sponsor, which sets out the Agency's requirements in line with this Standing Order.

6.7.4 Register(s) of Hospitality, Gifts and Sponsorship

All instances when hospitality, gifts (of less than £50 in value) and sponsorship are accepted or rejected by any Officer and Non-Officer members of the board and by members of staff shall be notified to the Chief Executive's Office with a record thereof. The basis of the decision to accept or reject shall be maintained in the Register and monitored within performance management arrangements set out in the PHA Gifts and Hospitality Policy (compliant with circulars FD(DFP) 19/09 and DAO(DFP) 10/06 revised as at 3 Sept 2009) and shall be made available for public inspection on request.

6.8 Declaration of Interests

The **Code of Conduct and Code of Accountability** requires the Chairperson and board Members to declare interests, which are relevant and material to the Agency on their appointment. All existing managers or budget-holders within the Agency, having delegated responsibility to commit or influence commitment of Public Funds, shall declare such interests on appointment.

Interests that shall be regarded as 'relevant and material' are:

- Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
- ownership or part-ownership of private companies, businesses or consultancies likely, or possibly seeking, to do business with the HSC;
- majority or controlling share holdings in organisations likely, or possibly seeking to do business with the HSC;
- a position of trust in a charity or voluntary organisation involving the field of health and social care;
- any connection with a HSC organisation, voluntary organisation or other organisation contracting (or seeking to contract) for HSC services, or applying for or receiving financial assistance from any NHS body; and
- any other commercial interest in the decision before the meeting.

At the time board members' interests are declared, they shall be recorded in the board minutes. Any changes in interests shall be declared at the board meeting following the change occurring and recorded in the minutes. Such minutes will be drawn to the attention of the board's internal and external auditors.

Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the HSC shall be published in the board's Annual Report. The information shall be kept up to date for inclusion in succeeding Annual Reports.

During the course of a board meeting, if a conflict of interest is established, the Member concerned shall, as soon as practicable after its commencement, disclose the fact. It shall be disclosed in a manner that cannot be perceived to influence subsequent discussion or decision. The member shall withdraw from the meeting and play no part in the relevant discussion or decision (see SO 5.2.24).

There is no requirement under the code, for members to declare 'relevant and material' interests as defined above, held by their spouses or partner. However, it is a requirement of the Constitution Regulations that in the case of married persons, or persons (whether of different sexes or not) living together as if married, the pecuniary interest of one partner shall, if known to the other, be deemed to be also an interest of the other and shall be so disclosed.

The principles of the Bribery Act 2011 must be borne in mind by all Agency officers in conducting business.

6.8.1 Register of Interests

The Chief Executive shall ensure that a Register of Interests is established to record formally declarations of interests of members (including associated and co-opted) and officers. In particular the Register shall include details of all directorships and other relevant and material interests, which have been declared by executive and non-executive board members, managers and budget-holders as defined above.

These details shall be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months shall be incorporated.

The Register shall be available to the public and the Chief Executive shall take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing.

If board members or relevant officers have any doubt about the relevance of an interest, this shall be discussed with the Chairperson, Chief Executive or Executive Director as appropriate

The general principle to be adopted is that if there is uncertainty regarding the need to disclose a particular interest then, in the interests of openness, disclosure shall be made.

6.9 Employee Relations

The Public Health Agency must comply with legislation and guidance from the DoH, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to their staff and represent good value for taxpayers' money.

Appointments to Agency posts shall be made on the basis of merit and in line with all appropriate HR regulations.

The Agency Board shall ensure, through the Remuneration Committee, that executive board members' total remuneration can be justified as reasonable in the light of general practice in the public sector. All board members total remuneration from the organisation of which they are a member shall be published in the Annual Report.

6.10 Personal Liability of Board Members

The Code of Accountability sets out the personal liability of board members. Legal proceedings by a third party against individual board member are very exceptional. A board member may be personally liable if he or she makes a fraudulent or negligent statement which results in a loss to a third party; or may commit a breach of confidence under common law or a criminal offence under insider dealing legislation, if he or she misuses information gained through their position. However, the Department of Health has indicated that individual board members who have acted honestly, reasonably, in good faith and without negligence will not have to meet out of their own personal resources any personal civil liability which is incurred in execution or purported execution of their board functions.

6.11 Staff Policies and Procedures

The Agency has a number of policies and procedures on a range of issues affecting staff and how they work within the Agency. Staff can

access these from the policies and procedures sections of the PHA intranet site 'Connect' http://connect.publichealthagency.org/ , or directly from their Senior Officer.

The content of these policies has been consulted on with recognised staff side organisations and cover issues such as:

- Health and safety;
- equal opportunities;
- ICT security;
- HR policies (including attendance at courses/conferences, grievance, disciplinary, working well together, flexible working, special leave, drugs, alcohol and substance misuse) and
- Whistleblowing.

6.12 Staff Concerns

The Agency has in place a procedure for raising concerns about malpractice, patient safety, financial impropriety or any other serious risks that they consider to be in the public interest. The Agency Board promotes a culture of safety, built on openness and accountability. Staff are assured that it is safe and acceptable to speak up and that their concerns will be handled with sensitivity or respect for confidentiality. Full details can be found in the PHA Whistleblowing Policy.

7. POWERS AND DUTIES

The powers and duties of individuals within the Agency are generally set out in the relevant Job Descriptions and Contract of Employment. All individuals are expected to behave at all times in accordance with the Standing Orders.

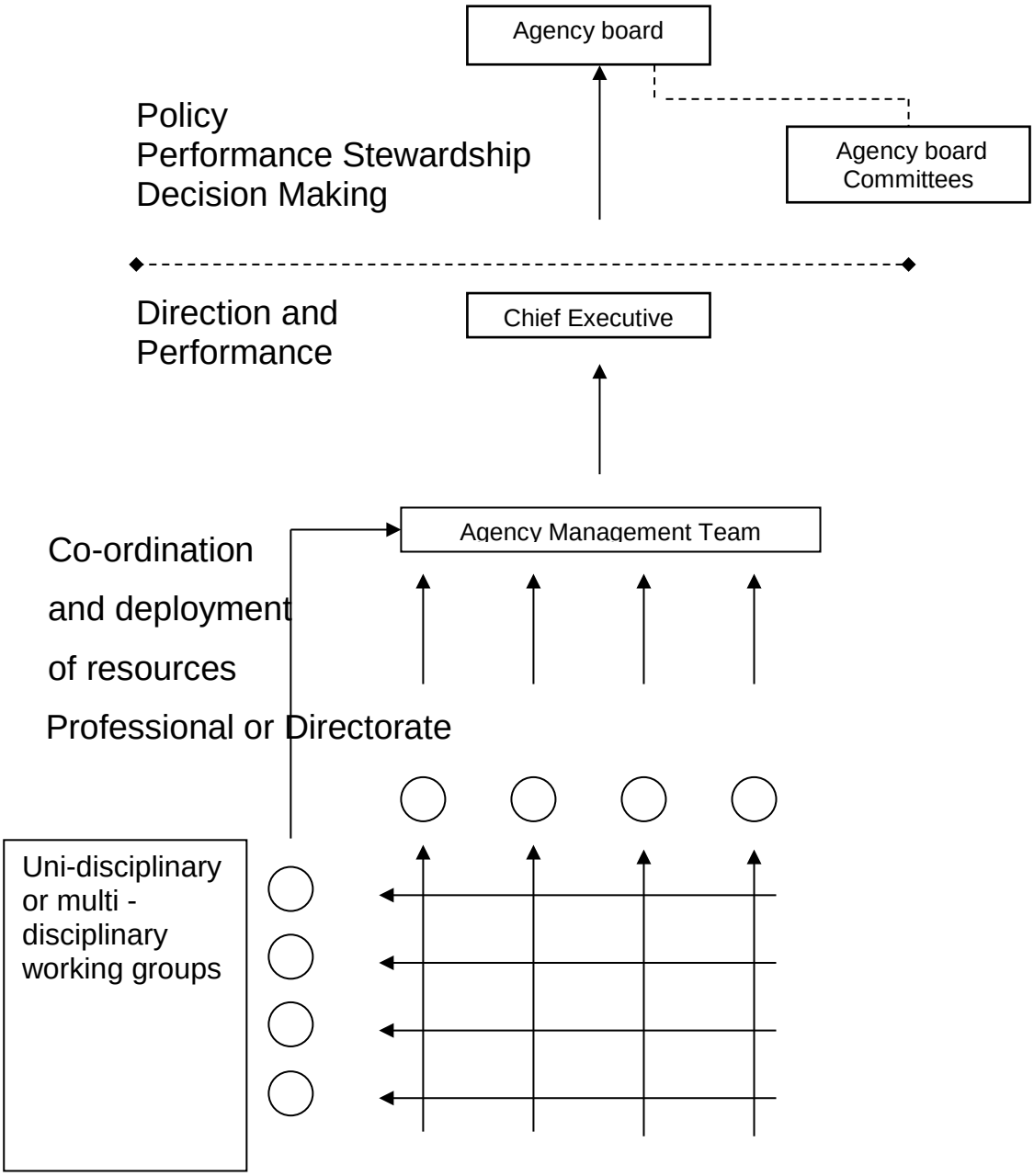
Those individuals who comprise the board, that is the Chairperson, Executive and Non-Executive board members, shall pay regard to SO 2, which sets out the main functions of the board and those matters that are reserved to the board.

When acting in the capacity of a member of a board Committee, those individuals shall have regard to the appropriate Scheme of Delegation which sets out those matters which have been delegated by the board.

The Chief Executive, Executive Directors, Senior Managers and other staff shall have regard to any appropriate Scheme of Delegation either by the board or by the Chief Executive. This may delegate responsibility to the individual in a personal capacity or as a member of a working group or committee.

Individuals are accountable through their professional or directorate management structure as well as through any participation on a working group, committee or functional role. This accountability is to the Chief Executive through the Agency Management Team as illustrated in the following diagram.

*** Accountability Structures**



APPENDICES

Appendix 1	Chief Executive's Scheme of Delegation
Appendix 2	Administrative Schemes of Delegation
Appendix 3	Financial Schemes of Delegation
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Chief Executive's Scheme of Delegation **Appendix 1**

This Appendix Relates to Section 3.2 of STANDING ORDERS
CHIEF EXECUTIVE'S SCHEME OF DELEGATION

	ITEMS	RESPONSIBILITY	CONTROLS	DELEGATED TO
3.2.1	Corporate Operational Matters	Matters which impact on the corporate operational performance of the board	Timely submission required from appropriate lead Director or joint submission	Agency Management Team
3.2.2	Corporate Plan	An accessible statement of the Agency's purpose, values and goals; and key actions to be undertaken by the Agency to deliver	To be prepared annually in line with Government proposals	Agency Management Team
3.2.3	Multidisciplinary Planning and Commissioning and Monitoring proposals	Proposed matters which involve the planning and commissioning and monitoring of services including in year management of resources.	Proposals to be submitted for Agency Management Team approval and monitoring	Appropriate Planning or Commissioning Team or Programme lead

	ITEMS	RESPONSIBILITY	CONTROLS	DELEGATED TO
3.2.4	Lead and Manage Individual Directorates	The operational management of individual directorates including leadership and development	Responsive to corporate needs	Individual Executive Directors
3.2.5	Financial Performance of Directorate Operations	Monitoring of individual Directorate performance to achieve overall corporate targets set by the DoH.	Monthly reporting by Director of Finance to achieve overall targets	Agency Management Team
3.2.6	Control Assurance Standards and Risk Management	Ensure Agency-wide implementation and compliance with the requirements of Controls Assurance Standards	To be reported through the Governance & Audit Committee to the board	Director of Operations
3.2.7	Policy Approval Process to comply with Control Assurance Standards (CAS)	New policy proposals requiring approval in accordance with the CAS	Policies relating to internal management arrangements to be submitted to Agency Management Team for approval. All other policies have approval reserved to the board	Agency Management Team

Administrative Schemes of Delegation **Appendix 2**

This appendix refers to Sections 3.4.5 – 3.4.8 of the Standing Orders

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.5 Delegation of Budgets for Agency Administration

ITEMS	RESPONSIBILITY	CONTROLS	DELEGATED TO
Authorisation and Approval of Non-Pay Expenditure for Agency Administration	The authorisation and approval of non-pay expenditure for Agency administration. Chief Executive further delegates these powers to Directors or nominated Officers within the budgets provided to them and the limits set out below. In turn, they may delegate them to named officers.	Within Limits set out below. The Director of Finance will bring forward annual budgets within which each Director must manage their annual expenditure.	Chief Executive/Directors or other nominated Budget Holders

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.6 Procedure for Delegating Power to Authorise and Approve Non-Pay Expenditure For Agency Administration

AUTHORITY TO INITIATE EXPENDITURE AND APPROVE PAYMENTS

Authority to initiate expenditure and to approve the payment of invoices is delegated to the Chief Executive who delegates it to Directors or nominated Officers. They in turn may delegate these powers to named officers in their directorates.

Each Director shall nominate appropriate officers and the Directorate of Operations will compile a comprehensive list. The list (including specimen signatures) will be copied to the BSO and HSCB (finance). A copy shall be retained in each directorate for reference. The list shall be amended as necessary and reviewed at least annually; a revised version will be distributed.

Expenditure in each specified category is only permitted within the budget provided for it.

The nominated officers shall observe the limits delegated to them on the list (see above), which shall not be exceeded without express approval of the Chief Executive. They must also note their responsibilities in authorising expenditure to be incurred by the Public Health Agency.

ROUTINE EXPENDITURE

Definition

This is expenditure on goods and services for which a budget is provided and which is usually initiated by requisition and repeated periodically. Examples would include office supplies and consumables together with the maintenance of equipment and other establishment costs.

Expenditure Limits

The delegated limits for accommodation leases was removed following Circular HSC(F) 43-2014.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.6 Procedure for Delegating Power to Authorise and Approve Non-Pay Expenditure For Agency Administration

NON-ROUTINE EXPENDITURE

Definition

This is expenditure which occurs on a once-only or occasional basis for which a budget may be provided. It may include books, periodicals, courses, travel, and equipment (costing less than £5,000).

Expenditure limits

As provided by the Scheme of Delegation within the budget or approved funding.

No Budget or Approved Funding:

If no budget or specifically approved funding exists for any such proposed expenditure, a Director or nominated Officer is to consult the Director of Finance to identify a possible source of funds. A submission may then be prepared for the Agency Management Team seeking the authorisation of the Chief Executive for the proposed expenditure and its funding.

Specific Items

Individual procedures applies to the:

- Use of External Management Consultants

(please refer to following sections for further information)

CAPITAL EXPENDITURE

Definition

Capital expenditure is defined in The HPSS Capital Accounting Manual.

The essential elements are that there is an asset capable of use for more than one year and that the expenditure exceeds £5,000.

Expenditure Limits

As provided by the Scheme of Delegation within the budget or approved funding.

Relates to Section 3.4 of STANDING ORDERS AND 8.7.2 WITHIN THE STANDING FINANCIAL INSTRUCTIONS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.7 Procedure for Quotations and Tendering of Non- Pay Expenditure For Agency Administration (unless order drawn from an existing tendered contract)

	Financial Limits	
	Order Value Up to and including £5,000	Requirement May be placed without seeking quotation
	£5,000 - £10,000	**Process to be undertaken by the Contractor:** 4 formal written quotations in sealed envelope to be opened in presence of 2 BSO officers normally including the Admin Services Manager.
	£10,000 - £30,000	**Process to be undertaken by the Contractor:** 5 formal written quotations in sealed envelope to be opened in presence of 2 BSO officers normally including the Admin Services Manager.
	£30,000 - £EU Public Procure-ment Threshold†	**Process to be undertaken by the Contractor:** Publicly advertised tender competition (newspaper/website). Advice will be provided by PaLS as to the most cost effective procurement process on a case by case basis. The approach taken will be dependent on the nature of the contract and the BSO assessment of the skills of the FM provider to undertake the process. The tender process must be conducted in line with Procurement Guidance Note 05/12 (Procurement of Goods, Works and Services over £30,000 and below EU Thresholds)

	>£EU Public Procurement Threshold†	Should be EU advertised and EU Directives apply. To be undertaken by PaLS.

† = EU threshold is currently £106,047. Further advice can be obtained from Finance

PLACING OF ORDERS

The advice of the Procurement and Logistics Service (PALs) of the Business Services Organisation should be sought in the case of any procurement queries in advance of contracting or ordering.

For orders falling within the financial limits above the Business Services Organisation (PALS) shall order under contracts already negotiated by tendering procedures OR shall advise on the tendering process on behalf of the requisitioning officer.

When selecting suppliers to be invited to submit a quotation or tender for procurements below £30,000, contracting authorities should provide opportunities for Small and Medium sized Enterprises (SMEs) to compete for business in line with Procurement Board's policy.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.7 Procedure for Quotations and Tendering of Non- Pay Expenditure For Agency Administration

For orders falling within the final two financial limits above Officers are advised to consult the Director of Finance. Reference shall also be made to current Procurement Guidance and Control notices and the Department's circular 'Contract Procedure Supplies'.

Requisitions should be placed by creating an "E-Procurement" requisition within the Finance, Procurement and Logistics System (FPL). Any Single Tender Award Contract i.e. those contracts awarded without competition must follow the agreed process set out in Standing Financial Instructions (Section 8) in advance of placing the "e-requisition". It should be noted that contracts of this type should only be approved by the Chief Executive.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

INTRODUCTION

DHSSPS Circular HSC(F) 25/2012, HSC(F) 48/2012 provides revised guidance on the use of professional services, covering the engagement of External Consultants by Health and Social Care organisations.

It applies to **all** contracts for External Management Consultancy projects and deals with the approval management and monitoring of such assignments.

Against this background the Agency has drawn up the following procedure to ensure compliance with this guidance and to enable the Agency's officers to carry out their delegated tasks with the assurance that they have achieved value for money, selected the best consultants for the job, followed the internal and external approval, Standing Orders and other procedures, managed the assignment in a professional manner and completed post review learning exercises.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

DELEGATION

The Agency requires that **all** proposed use of External Management Consultants **must** be submitted to the Chief Executive for authorisation, through the Director of Operations, **BEFORE** engaging or going out to tender. For payment of invoices after the initial approval process, and delivery of the project, the authorisation framework and thresholds shall be applied as set out for non-pay expenditure.

The nominated officer taking lead responsibility for the assignment shall complete relevant documentation (located on Connect and set out in HSC (F) 25/2012) and seek approval according to the summary below:
Annex A – Proposal Proforma
Annex B – Business Case
Annex C – Single Tender Action / Direct Award Contract
Annex D – Completion of Project
Annex E – Post Project Evaluation

These documents must be signed by the relevant Director and submitted to the Finance Department for review prior to authorisation by the Chief Executive. The approved forms must then be submitted to the DoH in all instances.

Appropriate AMT members shall be consulted before making a decision on whether the relevant skills and expertise are available internally.

Detailed guidance and all documentation is available on Connect.

TENDERING

The use of External Management Consultancy is subject to the normal contract procedures as referred to in Standing Orders, Administrative/Financial Schemes

	of Delegation for Non-Pay Expenditure, see above.		

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

LIAISON WITH DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

The circular requires that the Department's Policy and Accountability Unit is notified **in all instances** where there is a case for External Consultants being employed. The Agency has decided that in all cases the notification shall be directed via the Finance Department who shall provide advice on the completion of forms and the notification to the DoH.

The circular and associated supplements also require **the approval** of the Minister for Health, Social Services and Public Safety **before** going out to tender where the fees **are likely to exceed** £9,999 and DFP approval if greater than £75,000. As above, the Director of Finance shall advise on the referral process for approval and shall be the primary point of contact with the Department's Finance Policy and Accountability Unit (FPAU).

In addition, and in exceptional circumstances, if a single tender action (direct award contract without competition) is proposed for the External Consultancy project, the relevant Director must present the case to the Chief Executive who will decide whether the request may proceed to the Permanent Secretary (DoH) for approval of the Single Tender Action, which must be prior to the approval of the Management Consultancy Project.

This is the case at all levels of proposed expenditure on External Management Consultancy with a proposal for a single tender action.

The Business Services Organisation (PALS) should be consulted in cases where a tender is deemed necessary.

Relates to Section 3.4 of STANDING ORDERS

ADMINISTRATIVE SCHEMES OF DELEGATION
3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration

ENGAGEMENT OF CONSULTANTS

The Agency's standard letter of contract shall be used. Where it is deemed necessary to depart from this, advice shall be sought from the Director of Operations.

MONITORING

The sponsoring directorate or steering Committee must appoint an officer to manage the External Consultancy project.

FEES AND EXPENSES

All expenditure **must** be approved according to the Scheme of Delegated Authority after the initial approval to proceed with the scheme by the Chief Executive, Director of Finance, DoH, Minister or DoF as appropriate.

FINANCIAL MONITORING

The Director of Finance, with the support of the Director of Operations, is responsible for maintaining the records of expenditure on assignments completed and/or started during each year, which are required by the circular, and for submitting the quarterly and annual returns to the DoH.

The nominated officer identified as being responsible for managing the project is responsible for advising the Director of Finance on expenditure on the project.

REPORT

The appointed officer and/or the steering Committee/project team shall promptly complete the Post Project Evaluation report recording the assessment of the consultant, which the circular requires. It shall then be forwarded to the Finance Department for onward submission to the DoH. There is a requirement to disseminate lessons learnt from Post Project Evaluations as per Circular HSC(F) 51/2015.

Relates to Section 3.4 of STANDING ORDERS		
ADMINISTRATIVE SCHEMES OF DELEGATION **3.4.8 Procedure for Use of External Consultants for Non-Pay Expenditure for Agency Administration**		
	RECORDS The monitoring officer shall set up a contract file which includes: • terms of reference/consultants brief; • evidence of DoH notification and approval • evidence of notification to Trade Union, if applicable; • evaluation criteria; • copies of all the consultants proposals; • details of the short listing and final selection process; • the letter of contract and any variations; • records of payments; • implementation plans, and • project evaluation details. **CONSULTATION WITH STAFF** DHSSPS Circular HSC(F) 25/2012 requires that before commissioning any consultancy work on an efficiency assignment which may impact on the organisational structure and for staffing, the organisation should notify the relevant staff Association side. **EMPLOYMENT OF IT CONSULTANTS** In addition, the Information Management Group of the NHS HSS Executive has produced a guide on 'The Procurement and Management of Consultants within the NHS.' The Department has issued this as a model of good practice. Volume One focuses on the general issues of which senior management shall be aware and Volume Two on the practical details for a manager purchasing consultancy services.	

Any enquiries in connection with the above shall be addressed, in the first instance, to the Director of Operations.

Financial Schemes of Delegation Appendix 3

This appendix refers to Sections 3.5.1 – 3.5.4 of the Standing Orders

Relates to Section 3.5 of STANDING ORDERS **FINANCIAL SCHEMES OF DELEGATION** **3.5.1 Procedure for Delegation of Budgets**		
	The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and accompanied by a clear definition of: • The amount of the budget; • the purpose of each budget heading; • individual and group responsibilities; • Authority to exercise virement within total revenue or total capital; • achievement of planned levels of service; and • the provision of regular reports.	Standing Financial Instructions Section 5.3
	PRINCIPLES OF DELEGATION Control of a budget shall be set at a level at which budget management can be most effective. Whilst the Chief Executive retains overall responsibility for budgets, they may be delegated to Directors or nominated Officers who may, in turn, delegate the management of a budget to officers under their span of control. A list of the officers so authorised shall be forwarded to the Director of Operations and the Director of Finance.	

Relates to Section 3.5 of STANDING ORDERS

FINANCIAL SCHEMES OF DELEGATION
3.5.1 Procedure for Delegation of Budgets

GENERAL

All expenditure is to be included in the budgetary system and all items must be coded to a budget heading.

Where additional funding is required outside the budgetary framework for prospective expenditure the relevant Director or nominated Officer shall prepare a submission to the Agency Management Team.

TIMETABLE

The Director of Finance shall have discussions with designated holders in February and March of each year and submit proposed budgets to the Chief Executive for approval in March of each year. The delegation of budgets shall be arranged before 1 April each year.

VIREMENT

The rules governing virement are important. Virement powers cannot be unlimited as otherwise the initial budgetary decisions of the board could be nullified. Virement rules which are too restrictive, however, will not then allow the freedom to manage. The PHA board wishes to permit the optimum flexibility through virement, subject to its own priorities and plans. Virement is permissible except where expressly excluded as below:

- **No virement** between capital and revenue budgets is permitted except with the **written** permission of DoH;
- **no virement** from a non-recurrent to a recurrent purpose is permitted;
- **no virement** is permissible between a programme budget and the PHA's Management and Administration budget without prior written authorisation from the Director of Finance, Chief Executive and DoH;

- all non-recurrent virements must be agreed within a period of account and certainly no longer than one year;
- savings arising from PHA policy changes or from imposed cuts are not available to the budget holder;
- fortuitous savings are at the disposal of budget holders in the same way as planned savings (within the context of the above points), although the Chief Executive reserves the right to request all fortuitous savings to be made available for another planned purpose;
- where timing delays, such as the late delivery of capital equipment, mean that expenditure is not incurred in one period of account, then the 'savings' are not available for virement until the postponed expenditure in the following period of account has been committed; and
- If the proposed virement is between two budget holders, both must confirm their agreement to the Director of Finance in writing and the proposed virement must then be submitted to AMT to be approved by the Chief Executive.

OVERSPENDS AND UNDERSPENDS

The consent of the Chief Executive must be obtained before incurring any overspends which cannot be met by virement.

Any funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION **3.5.2 Authorisation & Approval Of Payroll Expenditure for Agency Administration**		
	AUTHORITY TO INITIATE AND APPROVE PAYROLL EXPENDITURE The power to authorise payroll expenditure is delegated to the Chief Executive as determined by the framework approved by the Remuneration and Terms of Service Committee on behalf of the board. The power to appoint a member of staff is delegated to members of the relevant interview panel provided that approval has been obtained from the Chief Executive to initiate the recruitment process. This applies to new posts or replacement staff for both permanent and temporary appointments. Additional payroll costs such as overtime payments are delegated to Directors and nominated Officers to authorise, providing they remain within the total funds for the individual budget concerned, and the approval levels delegated to these roles. The processing of supporting services will be outsourced to the Business Services Organisation managed through a Service Level Agreement mechanism.	
Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION (SO.4.5) **3.5.3 Authorisation and Approval of Non-Payroll Expenditure For Agency Administration**		
Financial Limits	The responsibility for the authorisation and approval of non-pay expenditure for Agency administration is delegated to the Chief Executive. The Chief Executive further delegates these powers to Directors and nominated Officers within the budgets provided to them and the limits set out below in line with the Scheme of Delegated Authority.	

	In turn, they may delegate them to named officers.	

Relates to Section 3.5 of STANDING ORDERS		
FINANCIAL SCHEMES OF DELEGATION (SO.4.5) **3.5.3 Authorisation and Approval of Non-Payroll Expenditure For Agency Administration**		
Not required	**1. <u>Routine Revenue Expenditure</u>** – Within budget limits	
Limits may be Varied	**2. <u>Non-Routine Revenue Expenditure</u>** **(excluding use of external management consultants (3.4.8)** **within budget or ear-marked funds:** Please refer to the current Scheme of Delegated Authority for full details of all authorised limits. **No budget or ear-marked funds**: – submission to Agency Management Team **Use of Management Consultants** <u>Authorisation of proposed use</u>:	
Up to £9,999	– Chief Executive and notify Policy & Accountability Unit in advance	
£10,000 - £74,999	– Chief Executive plus authorisation of the Minister (DoH) in advance.	
≥ £75,000	– Approvals as lower levels and DFP authorisation in advance	
Any amount	<u>Approval to pay</u>: As per the Scheme of Delegated Authority for Non-purchase order Administration costs. <u>Please note where a single tender action (direct award contract) is proposed for an External Consultancy project the Permanent secretary's advance approval must also be secured, this applies to ALL levels of expenditure.</u>	

Relates to Section 3.5 of STANDING ORDERS

FINANCIAL SCHEMES OF DELEGATION (SO.4.5)
3.5.3 Authorisation and Approval of Non-Payroll Expenditure For Agency Administration

	3. <u>Capital Expenditure</u> All capital expenditure is subject to appropriate business cases based on Green Book Guidance and the NI Guide to Expenditure Appraisal and Evaluation (DFP) (NIGEAE) Approval levels are as follows:	
<£50,000 >£50,000	– Chief Executive – PHA board	
	4. <u>Disposal of Agency Assets</u>	
<£50,000 >£50,000	– Chief Executive – PHA board	

Relates to Section 3.5 of STANDING ORDERS

FINANCIAL SCHEMES OF DELEGATION
3.5.4 Authority To Initiate And Approve Cash Advances To HSC Bodies

	FUNCTION **<u>CASH ADVANCES</u>** The responsibility for the authorisation and approval of Cash Advances to HSC Bodies is reserved to the Department of Health Social Services and Public Safety. The Department retains responsibility for the reconciliation of overall HSC cash draw and reported Income and Expenditure positions of individual HSC organisations in Northern Ireland. **<u>Limits of Authority</u>** There is no delegated authority, to the PHA from the Department for cash advances in any single financial year	

Appendix 4

GOVERNANCE AND AUDIT COMMITTEE - Contents

GOVERNANCE AND AUDIT COMMITTEE

1.0 REMIT AND CONSTITUTION

1.1 Introduction

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

1.1.1 The Code of Conduct and Code of Accountability originally issued in November 1994, updated and reissued in July 2012, specifies the requirement for HSC Bodies to establish an Audit Committee. It states that the audit committee supports the board and Accountable Officer with regard to their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. Circular HSS(PDD) 08/94 set out detailed guidance on the establishment of audit committees. In addition a Departmental letter issued on 10 July 2009 provides for a representative of the DoH to attend a Governance and Audit Committee once a year for the purposes of oversight of the Public Health Agency's systems. This follows on from the Public Accounts Committee's recommendations set out in their report in July 2008 entitled Good Governance – Effective Working Relationships between Departments and their Arm's Length Bodies.

1.1.2 Circular HSS(PPM) 06/2002 announced that the Department, in recognition of the importance of a sound system of risk management, had entered into a license agreement with Standards Australia for the use of their internationally recognised risk management standard AS/NZS 4360:1999 (now updated to 2004 model). The application of this internationally recognised approach to risk management would be seen as an important piece of evidence in support of a Statement of Internal Control.

1.1.3 The application of Controls Assurance standards within the HSC was announced in Circular HSS(PPM) 08/2002. This process would enable individual HSC organisations to provide evidence that they are doing their reasonable best to protect users, staff, the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can

discharge their responsibilities and provide assurances to the Department, the Assembly and the Public.

1.1.4 In January 2003 the Department issued guidance under Circular HSS(PPM)10/2002, specific to clinical and social care governance. The guidance was to enable HSC organisations to formally begin the process of developing and implementing clinical and social care governance arrangements within their respective organisations and set a framework for action which highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

1.1.5 The circular also stipulated the requirement that this new guidance should be read in the context of previous guidance already issued on the implementation of a common system of risk management and the development of controls assurance standards for financial and organisational aspects of governance.

1.1.6 The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HSC Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care have been issued by the Department. They will be used by the new Regulation, Quality Improvement Authority (RQIA) to assess the quality of care provided by the HSC.

1.1.7 The Audit and Risk Assurance Committee Handbook (NI), issued by the Department of Finance and Personnel (March 2014) sets out the five good practice principles (membership, independence, objectivity and understanding; skills; role of the audit and risk assurance committee; scope of work; communication and reporting) which Governance and Audit Committees should meet.

The board of the Agency have agreed the following process, which is reviewed in light of any subsequence guidance.

1.1.7 The Governance and Audit Committee will have an integrated governance approach encompassing financial governance, clinical and social care governance and organisational

governance, all of which are underpinned by sound systems of risk management.

1.1.8 The Governance and Audit Committee will support the PHA board and Accounting Officer by reviewing the completeness of assurances to satisfy their needs and by reviewing the reliability and integrity of the assurances.

1.1.9 A designated senior manager shall serve as secretary to the Committee

1.2. Role

1.2.1 The board is responsible for:

- management of its activities in accordance with laws and regulations; and
- the establishment and maintenance of a system of internal control designed to give reasonable assurance that:

    - assets are safeguarded;
    - waste and inefficiency are avoided;
    - reliable financial information is produced; and
    - value for money is continuously sought.

1.2.2 The Committee assists the board in these functions by providing an independent and objective review of:

- All control systems;
- the information provided to the board;
- compliance with law, guidance and **Code of Conduct and Code of Accountability**; and
- Governance processes within the board.

The Committee is authorised by the board to investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times to inspect any books, records or documents including any e-mail records of the board. It can seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The only

exception to this is patient identifiable data that is required to be kept confidential.

The Committee is authorised by the board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary subject to the board's procurement, budgetary and other requirements.

The Governance and Audit Committee may, by giving reasonable notice, require the attendance of any of the Officers or staff and auditors of the board at any meeting of the Committee.

1.2.3 The Committee shall give an assurance to the board of the Agency each year on the adequacy and effectiveness of the system of internal control in operation within the Agency.

1.2.4 The Chair of the Committee should report to the board on a regular basis on the work of the Committee.

1.3 Terms of Reference

The Terms of Reference will be reviewed at least annually by the PHA board and the Governance and Audit Committee to ensure that the work of the Committee is aligned with the business needs of the organisation.

1.3.1 The Committee shall undertake the following tasks:

- Review and recommend the board approve the Governance Framework, any associated implementation plan and the PHA Assurance Framework;
- review the monitoring reports of the Information Governance Steering Group;
- provide assurance to the board that governance is being appropriately managed in line with the Governance Framework;
- Advise the board on the strategic processes for risk, control and governance and the Governance Statement;
- review and approve the internal audit work plan prior to commencement of work;

- review verification reports and assurance reports from internal audit assignments and management's responses;
- monitor management’s progress in meeting internal audit recommendations;
- prior to the external audit, discuss the audit plan with the auditor including the reliance to be placed on internal audit;
- review the external auditor's report to those charged with Governance and management's response;
- review the Annual Report and the Financial Statements prior to signature by the Accounting Officer;
- periodically obtain the views of the external and internal auditors on the work and effectiveness of the Governance and Audit Committee;
- seek annual assurance of the independence and effectiveness of the Agency’s external and internal auditors;
- consider any report of the Public Accounts Committee or the Comptroller and Auditor General involving the Agency and review management's proposed response before presentation to the board;
- bring to the board's attention VFM studies that have been done elsewhere which might be relevant and review the work of the Agency in this area;
- review the Agency Officer responses and actions in respect of RQIA assessments and recommendations, where applicable;
- review Agency Officer responses and actions in respect of other regulatory and supervisory bodies;
- review and give particular attention to non-standardised issues of representation;
- give regular reports (both written and verbal) to the PHA board;
- provide an annual report to the PHA board timed to support preparation of the Governance Statement; and
- Carry out an annual review of the committee in accordance with the NIAO audit committee self assessment checklist.

1.3.2 The responsibility for internal control rests with management. The Governance and Audit Committee shall review its scope and effectiveness.

1.3.3 The Governance and Audit Committee shall also:

- Review proposed changes to standing orders and standing financial instructions;

- examine the circumstances associated with each instance when standing orders are waived;
- review all proposed losses for write-off and compensation payments and make recommendations to the board;
- approve accounting policies and subsequent changes to them;
- monitor the implementation of the **Code of Conduct and Code of Accountability** thus offering assurance to the board of probity in the conduct of business; and
- monitor and review the effectiveness of the Agency's Counter Fraud programme and the whistle-blowing processes.

1.4 Composition of the Governance and Audit Committee

1.4.1 The Committee shall comprise a minimum of four Non-Executive Directors with a quorum of three. In exceptional circumstances, and only with the approval of the Chair, the quorum shall be two. A number of Lay Advisors may be appointed and shall attend meetings of the Committee and shall participate fully in the discussions but shall not be able to vote.

1.4.2 None of these Non-Executive Directors shall be the Chairperson of the board although he/she may be invited to attend meetings that are discussing issues pertinent to the whole Agency. Additionally, none of the Governance and Audit Committee members should be the chair of members of the remuneration committee.

1.4.3 The Director of Operations of the Agency, the internal and external auditors and the Lead Officer for Governance (Assistant Director Planning and Operational Services) may attend the Committee by invitation and others may also be required to attend as necessary.

1.4.4 Where possible, at least one member of the Committee shall have financial expertise and if possible, the remaining members shall include representation from clinical and social care backgrounds.

1.4.5 The Non-Executive members shall select a Chairperson of the Committee from among their number.

1.4.6 The Chairperson of the Committee will ensure open lines of communication with members of the Committee, the board, Head of Internal Audit and Head of External Audit.

1.4.7 The Governance and Audit Committee will annually review the skills base to check they have the necessary skills required for an effective committee.

1.5 Establishment of a Governance and Audit Committee

1.5.1 The Governance and Audit Committee is to be constituted as a Committee of the board with the authority to act with independence. The terms of reference of the Committee are to be approved by the board and recorded in the board minutes.

The members of the Committee shall be appointed by the board and shall hold office for one year. At any time any member of the Committee may resign or be removed by the board and shall cease to be a member of the Committee upon ceasing to be a board member. Any vacancy shall be filled promptly by the board.

1.5.2 Governance and Audit Committee meetings shall be conducted formally and minutes submitted to the board at its next meeting in accordance with section 5.2.21.

1.5.3 The Committee shall expect to meet at least four times per year. Agendas and briefing papers shall be prepared and circulated in sufficient time for members to give them due consideration.

1.5.4 As part of one of the meetings, members shall consider the internal and external audit plans and at another meeting, shall review the annual report of the External Auditor. There shall be an opportunity for the Committee to meet the External Auditor once a year without the Chairperson of board, the Executives and officers being present.

1.5.5 If the Committee is of the view that there is evidence of an ultra vires transaction or the committing of improper acts, the Chairperson of the Governance and Audit Committee shall present the facts to a full meeting of the board. Exceptionally,

the matter may need to be referred to the DoH (to the Director of Financial Management in the first instance).

1.6 Relationship with Internal Audit

1.6.1 The Governance and Audit Committee must obtain the necessary information to assure the board that the systems of internal control are operating effectively and for this they shall rely on the work of Internal Audit together with the External Auditor and on the work of the Agency's Governance Officer Group.

1.6.2 The Governance and Audit Committee shall receive reports of findings on internal control. These reports shall form the basis of the Committee's conclusions and recommendations. The Director of Operations is responsible for the management of internal audit arrangements. The Committee shall participate in the selection process when an internal audit service provider is changed.

1.6.3 A nominated officer is responsible for securing an internal audit service. A direct reporting line, independent of the Chief Executive and other Executive Directors, shall be available to the Chair of the Governance and Audit Committee.

1.6.4 The Chair of the Governance and Audit Committee will meet annually with the head of Internal Audit.

1.7 Relationship with External Audit

1.7.1 The Governance and Audit Committee shall rely upon the certification of the accuracy, probity and legality of the Annual Accounts provided by the External Auditor, combined with the more detailed internal audit review of systems and procedures and other monitoring reports provided by officers, in discharging its responsibilities for ensuring sound internal control systems and accurate accounts and providing such assurances to the board.

1.7.2 The External Auditor shall provide an independent assessment of any major activity within his remit and a mechanism for reporting the outcome of value for money or regularity studies. Non-Executive Directors shall raise any significant matters which cause them concern.

1.7.3 The Northern Ireland Comptroller and Auditor General is the appointed External Auditor. He may appoint independent companies as external auditor. The Governance & Audit Committee has a duty to ensure that an effective External Audit service is provided. Officers shall offer advice to the Committee in their annual assessment of the performance of the External Audit Service. The Committee shall also monitor the extent and scope of co-operation and joint planning between external and internal audit. Any problems shall be raised with the External Auditor.

1.7.4 The Chair of the Governance and Audit Committee will meet annually with the External Auditor.

2.0 CONDUCT OF BUSINESS

2.1 Attendance

2.1.1 Only the members of the Committee, the Lay Advisors and the nominated senior manager (who acts as secretary to the Committee), shall attend meetings as a matter of course together with appropriate administrative support staff.

2.1.2 The board's Chairperson and other Executive or Non-Executive board members may be invited to attend as required. The Lead Officer for Governance, the Director of Operations and the Director of Finance shall have a standing invitation to attend all meetings except the annual meeting with the External Auditor when it is stipulated that no Officers shall attend (see 2.1.3 below).

2.1.3 The External Auditor shall be invited to attend any meeting of the Committee. The Committee shall meet the External Auditor, without the presence of officers, once a year.

2.1.4 A nominated senior manager is responsible for securing the internal audit service for the Agency. He/she shall ensure the management respond promptly to Internal Audit reports and shall monitor the performance of the Internal Audit Service on behalf of the Committee.

2.1.5 Any member of staff of the Agency may be required to attend a meeting of the Committee as necessary.

2.1.6 The Corporate Secretariat shall service the committee.

2.2 Agenda

2.2.1 Governance and Audit Committee meetings will include 'conflict of interest' as a standing item. In instances where there is a declaration of interest in any of the agenda items, members will be asked to leave the meeting while those items are being discussed. In instances where the conflict of interest is likely to be ongoing the member may be asked to stand down from the Governance and Audit Committee.

2.2.2 Items for 'Any Other Business' should formally be requested from the chair in advance of the meeting.

2.3 Frequency of Meetings

2.3.1 Routine meetings are to be held four times per year with a specific remit as the core of each meeting, although any appropriate matters may be considered at any meeting. Further meetings may be arranged at the discretion of the Chairperson as necessary. The Secretary to the Committee shall upon request of the Chair or any other member of the committee, or by the board's external auditors, call a meeting of the Committee, either by letter, e-mail, fax or telephone, giving at least three working days' notice.

2.4 Complaints Matters

2.4.1 Complaints will be reviewed by the Governance and Audit

Appendix 5

REMUNERATION AND TERMS OF SERVICE COMMITTEE

Contents

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1.0 REMIT CONSTITUTION AND CONDUCT OF BUSINESS

1.1 Introduction

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

The Code of Conduct and Code of Accountability, set out in Circular HPSS(PDD) 08/94, updated and reissued in July 2012, require that a Remuneration and Terms of Service Committee be established.

1.2 Background

All staff with the exception of Director's on Senior Executive Contracts are on the Nationally agreed terms and conditions of service. The work of the Committee must take place within this context.

1.3 Role

The primary responsibility of the Remuneration and Terms of Service Committee is to advise the board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives subject to the direction of the Department of Health, Social Services and Public Safety.

The Committee is authorised by the board to investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times to inspect any books, records or documents including any e-mail records of the board. It can seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The only exception to this is patient identifiable data that is required to be kept confidential.

The Committee is authorised by the board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary subject to the board's procurement, budgetary and other requirements.

1.4 Terms of Reference

The main functions of the Committee are:

- To make recommendations to the board of the Agency on the total remuneration and terms of service package for officer members of the PHA board to ensure that they are fairly rewarded for their individual contribution to the organisation. This would include having proper regard to the organisation's circumstances and performance and to the provision of any arrangements established by the Department of Health, Social Services and Public Safety for such staff, where appropriate. The Remuneration and Terms of Service Committee shall also ensure that board Members' total remuneration can be justified as reasonable in accordance with departmental limits;
- to oversee the proper functioning of performance and appraisal systems;
- to oversee appropriate contractual arrangements for all staff. This would include a proper calculation and scrutiny of termination payments, taking account of such national and departmental guidance as is appropriate;
- to agree and monitor a remuneration strategy that reflects national agreements and Departmental policy; and
- to monitor the application of the remuneration strategy to ensure adherence to all equality legislation;

1.5 Relationship with and Reporting to the board of the Agency

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

1.6 Composition of the Remuneration and Terms of Service Committee

The Committee shall comprise the Agency Chairperson and at least two Non-Executive Directors. A quorum shall be two members. None of these members should be members of the audit committee.

The Chief Executive and other Senior Executives shall not be present for discussions about their own remuneration and terms of service. However, they can be invited to attend meetings of the Committee to discuss other staff's terms as required.

The Chief Executive, Director of Operations and a nominated HR Officer from the BSO shall provide advice and support to the Committee.

1.7 Establishment of a Remuneration and Terms of Service Committee

The Committee shall be constituted as a Committee of the board with the power to make decisions on behalf of the board of the Agency and where appropriate make recommendations to the board of the Agency. The Terms of Reference are to be approved by the board and recorded in the board minutes.

Committee meetings shall be conducted formally and minutes submitted to the board at its next meeting in accordance with the Policy set out in 5.2.21.

The Committee shall expect to meet at least two times per year. Agenda and briefing papers shall be prepared and circulated in sufficient time for members to give them due consideration.

2.0 CONDUCT OF BUSINESS

2.1 Attendance

2.1.1 Only the members of the Committee, the Chief Executive, the Director of Operations and a nominated HR Officer (from the BSO) shall attend meetings as a matter of course. Appropriate administrative support staff shall be in attendance to record the business of the meetings.

2.1.2 Other Executive or Non-Executive board Members and Officers may be invited to attend as required. The Director of Operations shall have a standing invitation to attend all meetings.

2.1.3 A nominated HR officer (BSO) will be responsible for the implementation of remuneration and terms and conditions of

service in the Agency. He/she shall deal with all matters affecting terms and conditions of service. He/she shall be present at every meeting.

2.1.5 Any member of staff of the PHA may be required to attend a meeting of the Committee, as necessary.

2.1.5 The Committee Chair shall request fuller explanatory information in papers put before them, if there are any doubts or uncertainties and the issues discussed shall be summarised in the minutes.

2.2 Agenda

2.2.1 Remuneration Committee meetings will include 'conflict of interest' as a standing item. In instances where there is a declaration of interest in any of the agenda items, members will be asked to leave the meeting while those items are being discussed. In instances where the conflict of interest is likely to be ongoing the member may be asked to stand down from the Remuneration Committee.

2.3 Frequency of Meetings

2.3.1 Meetings should be held as least once every six months to review remuneration matters or deal with specific matters. Further meetings may be arranged at the discretion of the Chairperson, as necessary.

Appendix 6

AGENCY MANAGEMENT TEAM

Contents

1.0 Role

1.1 **The Agency Management Team (AMT) role can be summarized as:**

- Ensuring processes are in place to deliver key objectives and priorities;
- Ensuring coordination and oversight of budget plans and expenditure,
- Oversight of overall performance and outcomes in keeping with the strategic direction set by and decisions of the PHA board;
- Coordination of capacity and skills across Directorates, functions and with other bodies;
- Ensuring risks to the Agency, its work and assets are being managed and addressed satisfactorily; and considering and clearing papers for consideration by the board of the PHA.

1.2 In furtherance of this AMT will ensure proper consideration and approval of proposals such as those set out in development proposals, strategies, plans, business cases, evaluations, monitoring and investment/disinvestment proposals. This is particularly important where the PHA is the lead organization (albeit that the paper may also be of relevance to the HSCB/BSO or Trusts and may also subsequently be submitted to their senior management teams)

2.0 Attendance

2.1 The Agency Management Team comprises:

- Chief Executive;
- Director of Public Health/Medical Director;
- Director of Nursing/Allied Health Professionals;
- Director of Operations;
- Director of Social Care and Children, HSCB;
- Director of Finance, HSCB, and
- Any other Officer who the Chief Executive determines should be a member of the Agency Management Team.

The Chief Executive will chair AMT, with the Director of Operations deputising in his/her absence.

3.0 Frequency of Meetings

The AMT will normally meet on a weekly basis.

Appendix 7 – Role of Chairperson

The chair is responsible for leading the board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. The chair is accountable to the Minister through the Departmental Accounting Officer.

The chair has a particular leadership responsibility on the following matters:

- Formulating the board's strategy for discharging its duties;
- Ensuring that the board, in reaching decisions, takes proper account of guidance provided by the Department and other departmentally designated authorities;
- Ensuring that risk management is regularly and formally considered at board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;
- Encouraging high standards of propriety;
- Representing the views of the board to the general public;
- Ensuring that the board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual board members;
- Ensuring that all board members are fully briefed on the terms of their appointment, their duties, rights and responsibilities and assess, annually, the performance of individual board members.

A complementary relationship between the chair and the chief executive is important. The chief executive is accountable to the chair and non-executive members of the board for ensuring that board decisions are implemented, that the organization works effectively, in accordance with government policy and public service values, and for the maintenance of proper financial stewardship. The chief executive should be allowed full scope, within clearly defined delegated powers, for action fulfilling the decisions of the board.

PUBLIC HEALTH AGENCY

STANDING FINANCIAL INSTRUCTIONS

Reviewed and Revised Jan 2017~~6~~

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SO No.8 – STANDING FINANCIAL INSTRUCTIONS

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

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

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

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

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

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

1.1.6 Overriding Standing Financial Instructions

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

1.2 Responsibilities and Delegation

1.2.1 The Board of the PHA (board)

The board exercises financial supervision and control by:

(a) formulating the financial strategy;

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

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

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

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

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

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

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

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

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

1.2.6 The Director of Finance

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

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

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

The Director of Finance is responsible for:

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

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

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

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

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

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

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

1.2.7 Business Services Organisation

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

(a) Banking Services (ref section 6);

(b) Payroll Services (ref section 11);

(c) Payment Services (ref section12); and

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

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

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

1.2.8 PHA board Members, Members and Employees

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

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

(b) avoiding loss;

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

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

1.2.9 Contractors and their employees

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

1.2.10 Miscellaneous

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

2. AUDIT

2.1 Audit Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2.1 The Director of Finance is responsible for:

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

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

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

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

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

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

(f) explanations concerning any matter under investigation.

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

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

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

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

The report must cover:

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

2.3 **Role of Internal Audit**

2.3.1 Internal Audit will review, appraise and report upon:

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

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

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

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

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

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

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

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

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

The reporting system for Internal Audit shall be as follows:

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

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

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

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

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

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

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

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

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

(j) Revised descriptors have been issued as per circular guidance (HSC(F) ~~32~~47/201~~3~~6) ,which should be used to describe internal audit findings and when providing their overall opinion at ~~Y~~year~~-~~ end. The descriptors are ~~Substantial,~~ Satisfactory, Limited and Unacceptable.

2.4 External Audit

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

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

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

2.5 Fraud and Corruption

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

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

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

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

2.6 **Security Management**

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

3. RESOURCE LIMIT CONTROL

3.1 **Resource Limit Control**

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

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

3.1.3 Any sums received on behalf of the Minister for H~~ealth~~ealth~~SSPS~~ are treated as sums received by the PHA.

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

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

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

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

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

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

3.2 Promoting Financial Stability

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

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

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

4.1 Allocations

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

4.1.2 The Director of Finance will:

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

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

4.2 Preparation and Approval of Joint Commissioning Plans and Budgets

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

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

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

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

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

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

(c) accord with workload and manpower plans;

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

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

(f) identify potential risks.

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

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

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

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

4.3 Budgetary Delegating within the PHA

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

(a) the amount of the budget;

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

(c) individual and group responsibilities;

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

(e) achievement of planned levels of service;

(f) the provision of regular reports; and

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

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

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

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

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

4.4 **Budgetary Control and Reporting within the PHA**

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

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

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

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

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

(d) monitoring of management action to correct variances;

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

4.4.2 Each Budget Holder is responsible for ensuring that:

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

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

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

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

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

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

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

4.5 **Capital Expenditure**

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

4.6 **Monitoring Returns**

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

5. ANNUAL ACCOUNTS AND REPORTS

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

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

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

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

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

6. BANK ACCOUNTS

6.1 **General**

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

6.1.2 The board shall approve the banking arrangements.

6.2 **Banking Procedures**

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

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

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

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

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

6.3 **Bank Accounts**

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

(a) bank accounts;

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

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

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

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

6.4 **Tendering and Review**

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

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

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

7.1 **Income Systems**

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

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

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

7.2 Fees and Charges

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

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

7.3 Debt Recovery

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

7.3.2 Income not received should be advised to the Director of Finance (ref para 1.2.6) and be dealt with in accordance with losses procedures and guidance issued by D~~S~~oH~~SSPS~~ circular HSC(F) 50/2012.

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

7.4 Security of Cash, Cheques and other Negotiable Instruments

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

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

(b) ordering and securely controlling any such stationery;

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

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

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

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

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

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

8. TENDERING AND CONTRACTING PROCEDURE

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

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

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

Northern Ireland Public Procurement Policy, Directives by the Council of the European Union and Guidance on procurement matters promulgated by the D<u>o</u>H~~SSPS~~ prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

8.3 Reverse e-Auctions

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

8.4 **Capital Investment Manual and other ~~DHSSPS~~DoH Guidance**

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

8.5 **Formal Competitive Tendering**

8.5.1 General Applicability

The PHA shall ensure that competitive tenders are invited for:

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

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the D~~o~~H~~SSPS~~); and

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

8.5.2 Health Care Services

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

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

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

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

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

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

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

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

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

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

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

8.5.7 Officers should liaise with the Director of Operations prior to procurement to ensure latest DFP and ~~DHSSPS~~DoH procurement guidance is comp~~i~~lied with.

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

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

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

8.5.11 List of Approved Firms

The PHA shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Director of Operations it is desirable to seek tenders from firms not on

the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 8.6.8 List of Approved Firms).

8.5.12 Building and Engineering Construction Works

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

8.5.13 Items which subsequently breach thresholds after original approval

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

8.6 **Contracting/Tendering Procedure**

8.6.1 Invitation to Tender

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

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

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

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

  OR

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

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

(d) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with ~~DHSSPS~~DoH guidance and, in minor respects, to cover special features of individual projects.

8.6.2 Receipt and safe custody of tenders

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

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

OR

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

8.6.3 ~~—~~Opening tenders and Register of tenders

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

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

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

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

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

(e) The involvement of HSCB Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance (ref para 1.2.6) or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders;

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

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

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

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

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

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

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

(i) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other

tenders, should be dealt with in the same way as late tenders. (Standing Order No. 17.6.5).

8.6.4 Admissibility

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

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

8.6.5 Late Tenders

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.6.7 Tender reports to the board of the PHA

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

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

(a) Responsibility for maintaining list

BSO Procurement and Logistics service has been nominated by the Chief Executive to maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the PHA is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) Building and Engineering Construction Works

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

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

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

(c) Financial Standing and Technical Competence of Contractors

The Director of Finance (ref para 1.2.6), Director of Operations or the PHA's Centre of Procurement Expertise may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The lead care Director with responsibility for clinical and social care governance will make

such enquiries as is felt appropriate to be satisfied as to their technical/professional/medical competence.

8.6.9 Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Operations, or the Director with lead responsibility for clinical governance or the PHA's Centre of Procurement Expertise, it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

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

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

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

8.7.2 Competitive Quotations

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

(b) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone (only for order value up to and including **£2,000**). Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record;

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

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

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

8.7.3 Quotations to be within Financial Limits

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

8.8 Authorisation of Tenders and Competitive Quotations

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

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

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

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

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

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

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

(b) If the PHA does not use the PALs / COPE - where tenders or quotations are not required because expenditure is below **£2,000,** the PHA shall procure goods and services in accordance with procurement procedures approved by the Director of Operations.

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

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

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector (HSC(F) 47/2015;

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

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

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

8.11 **Compliance requirements for all contracts**

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

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

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

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

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

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

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

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

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

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

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

8.13 **Healthcare Services Agreements**

Service agreements with HSC providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the PHA. Service agreements are not contracts in law and are not enforceable by the courts. However, a contract with an NHS Foundation Trust, being a PBC, is a legal document and is enforceable in law.

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

8.14 **Disposals**

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

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

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

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

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

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

8.15 **In-house Services**

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

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

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

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

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

8.15.4 The evaluation team shall make recommendations to the board.

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

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

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

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

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

(a) promotion of Health and Wellbeing improvements;

(b) promotion of the reduction of inequalities;

(c) the standards of service quality expected;

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

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

(f) the Performance Assessment Framework;

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

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

9.2 **Involving Partners and Jointly Managed Risk**

A good SLA will result from a dialogue of clinicians, social workers, users, carers, public health professionals, AHPs and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the PHA works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA or Contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the PHA can jointly manage risk with all interested parties. Due consideration, in all provider/purchaser arrangements, must be observed as the HSC moves toward a ~~'"~~Patient/Client-led HSC~~"'~~.

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

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

9.4 **Reports to board on SLAs and Contracts**

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

10. JOINT COMMISSIONING

10.1 **Role of the PHA in Commissioning Health and Care Services**

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

10.2 **Role of the Chief Executive**

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

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

(a) Promote Health and Wellbeing improvements;

(b) Actively promote the reduction of inequalities;

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

(d) Meet the standards of service quality expected;

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

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

(g) Fit the Performance Assessment Framework;

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

(i) Are based on integrated care pathways.

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

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

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

10.3 **Role of Director of Finance (ref para 1.2.6)**

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

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

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

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

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

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

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

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

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

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

11.1.3 The Committee shall report in writing to the board the basis for its recommendations. The board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration

and terms of service of officer members in matters not already directed by the Department. Minutes of the board's meetings should record such decisions;

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

11.1.5 The PHA will pay allowances to the Chairman and non-executive members of the board in accordance with instructions issued by the Minister and in line with DoH~~SSPS~~ circular guidance HSC(F) 10/2014.

11.2 **Funded Establishment**

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

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

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

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

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

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

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

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

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

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

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

11.4 Processing Payroll

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

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

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

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

(a) verification and documentation of data;

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

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

(d) security and confidentiality of payroll information;

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

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

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

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

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

(j) pay advances and their recovery;

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

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

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

11.4.3 Appropriately nominated managers have delegated responsibility for:

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

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

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

11.4.4 Regardless of the arrangements for providing the payroll service, the Director of Operations, supported by the Director of Finance (ref para 1.2.6) of the HSCB, shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

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

11.5 **Contracts of Employment**

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

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

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

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

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

12. NON-PAY EXPENDITURE (Procurement and Programme)

12.1 Delegation of Authority

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

12.1.2 The Chief Executive will set out:

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

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

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

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

12.2.1 Requisitioning

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

12.2.2 System of Payment and Payment Verification

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

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

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

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

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

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

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

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

- Certification either manually or electronically that:

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

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

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

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

  - the account is arithmetically correct; and

  - the account is in order for payment.

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

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

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

12.2.4 Prepayments

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

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

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

(c) The Director of Operations will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

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

12.2.5 Official Orders

Official Orders either manual or electronic must:

(a) be consecutively numbered;

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

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

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

12.2.6 Duties of Managers and Officers

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

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

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

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with DoHSSPS "gGuidance on the Use of Professional Services relating to the Engagement of External Consultants" (HSC(F) 25/2012 and HSC(F) 47/2012 and the sharing of lessons learned from post project evaluation following the use of consultancy HSC(F) 51/2015.

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

- isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; or
- conventional hospitality, such as lunches in the course of working visits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) **Regularity** - funds should be used for the authorised purpose;
(b) **Propriety** - funds should be distributed fairly, and free from undue influence;

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

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

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

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

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

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

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

12.5 **HSC Organisations**

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

13. HSC FINANCIAL GUIDANCE

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

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

14.1 Capital Investment

14.1.1 The Chief Executive:

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

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

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

(d) is required to seek Department approval for:

- All capital projects with expenditure of £50k and above (in accordance with the Capital Investment Manual and DoH~~SSPS~~ Circular HSS(F) 13/2006 and DAO(DFP) 06/05); and

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

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

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

- an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

- the involvement of appropriate PHA personnel and external agencies;

- appropriate project management and control arrangements;

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

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

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

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

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

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

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

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

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

(a) specific authority to commit expenditure;

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

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

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

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

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

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

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

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

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

14.3 **HSC Organisations - Capital Proposals**

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

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

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

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

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

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

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

(a) the Strategic Context (SC);

(b) Outline Business Case (OBC); and

(c) Full Business Case (FBC).

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

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

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

14.4 Asset Registers

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

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

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

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

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

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

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

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

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

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

14.5 Security of Assets

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

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

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

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

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

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

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

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

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

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

15. STORES AND RECEIPT OF GOODS

15.1 General Position

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

(a) kept to a minimum;

(b) subjected to annual stock take; and

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

15.2 Control of Stores, Stocktaking, Condemnations and Disposal

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

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/officer. Wherever practicable, stocks should be marked as health service property.

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

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

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

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

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

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

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 **Disposals and Condemnations**

16.1.1 Procedures

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

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

16.1.3 All unserviceable articles shall be:

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

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

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

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

16.2 **Losses and Special Payments**

16.2.1 Procedures

The Director of Finance (ref para 1.2.6) must prepare procedural instructions on the recording of and accounting for condemnations, losses,

and special payments, in line with the requirements of circular HSC(F) 50/2012.

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

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

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

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

(a) the board;

(b) the Director of Finance; and

(c) the External Auditor.

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

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

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

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

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

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

17. INFORMATION TECHNOLOGY

17.1 Responsibilities and duties of the Director of Operations

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

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

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

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

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

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

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

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

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

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

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

(c) a supporting business case.

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

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

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

17.4 **Risk Assessment**

The Director responsible for ICT shall ensure that risks to the PHA arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

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

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

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

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

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

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

The Director of Operations shall ensure that all staff are made aware of the PHA policy on acceptance of gifts and other benefits in kind by staff available on CONNECT. This policy follows the guidance contained in DoH~~SSPS~~ circular guidance on gifts and hospitality, HSS(F) 49/2009 and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

19. PAYMENTS TO INDEPENDENT CONTRACTORS

19.1 Role of the PHA

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

19.2 Duties of the Chief Executive

The Chief Executive shall:

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

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

19.3 Duties of the Director of Operations

The Director of Operations shall:

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

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

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

- rules have been correctly and consistently applied;

- overpayments are detected (or preferably prevented) and recovery initiated in accordance with HSC(F) 50/2012 circular, Guidance on Losses and Special Payments, Appendix B “Recovery of Overpayments”;

- suspicions of possible fraud are identified and subsequently dealt with in line with DoH~~SSPS~~ Directions on the management of fraud and corruption.

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

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

20. RETENTION OF RECORDS

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

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

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

21. RISK MANAGEMENT AND INSURANCE

21.1 **Programme of Risk Management**

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

The programme of risk management shall include:

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

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

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control,

cost effective insurance cover, and decisions on the acceptable level of retained risk;

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

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

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

(g) arrangements to review the risk management programme.

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

21.2 **Insurance arrangements with commercial insurers**

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

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

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

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

PHA (Including SBNI) Scheme of Delegated Authority January 2017

	CASH PAYMENTS					SALARY		LEGAL	CONTRACTING /BUSINESS CASE APPROVAL				LOSSES	SINGLE TENDER ACTIONS
	STOCK/NON-STOCK WITH PURCHASE ORDER INC CAPITAL (E-procurement system)	NON-PURCHASE ORDER ADMIN COSTS. (FPM system manual payments including 3rd party orgs)	TRAVEL OR OTHER STAFF EXPENSES (HRPTS)	3RD PARTY/VOL.ORG PAYMENTS WITHIN SLA. (Non-invoice i.e. Upload or manual memo generated by PHA ONLY)	USE OF EXTERNAL/MGT CONSULTANT PROJECTS PAYMENTS	S &W AMENDMENTS	EARLY RETIREMENT PAYMENTS	LEGAL PAYMENTS	CAPITAL APPROVAL FOR CONTRACTS	SLAs / SBAs INTER HSC (including adjustments and release of RRL)	SLAs / SBAs 3RD PARTY ORG'S (incl. adjustments - contracts only (Voluntaries))	INITIAL APPROVAL OF USE OF EXTERNAL/MGT CONSULTANT PROJECTS	WRITE OFF/LOSSES	SINGLE TENDER ACTIONS EXC MANAGEMENT CONSULTANCY
CHAIR	17,500	✓	✓	17,500	0	✓	0	0	0	0	0	0	0	0
CHAIR SBNI	✓	✓	✓	50,000	✓	✓	20,000	✓	0	50,000	50,000	0	✓	0
CHIEF EXECUTIVE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	106,047
DIRECTORS (inc any new Directors)														
Director of Operations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	106,047
Director of Public Health	✓	✓	✓	l00,000	0	✓	20,000	✓	0	100,000	100,000	0	✓	0
Director of Nursing and Allied Health Professions	✓	✓	✓	l00,000	0	✓	20,000	✓	0	100,000	100,000	0	✓	0
Director of Operations SBNI	✓	✓	✓	50,000	✓	✓	20,000	✓	0	50,000	50,000	0	✓	0
ASSISTANT DIRECTORS (inc any new AD's)														
Assistant Directors Operations	30,000	30,000	30,000	50,000	0	✓	0	0	0	25,000	50,000	0	0	0
Assistant Directors Public Health	25,000	25,000	25,000	50,000	0	✓	0	0	0	25,000	50,000	0	0	0
Assistant Director R&D	25,000	25,000	25,000	60,000	0	✓	0	0	0	60,000	50,000	0	0	0
Assistant Directors Nursing & Allied Health Professions	25,000	25,000	25,000	50,000	0	✓	0	0	0	25,000	50,000	0	0	0
Director of ECCH	25,000	25,000	25,000	50,000	0	✓	0	0	0	0	0	0	0	0
Tier 4 Officers (inc any new Tier 4)														
Tier 4 Operations	10,000	10,000	10,000	20,000	0	✓	0	0	0	0	10,000	0	0	0
Tier 4 Public Health	10,000	10,000	10,000	20,000	0	✓	0	0	0	0	20,000	0	0	0
Tier 4 R&D	10,000	10,000	10,000	35,000	0	✓	0	0	0	0	10,000	0	0	0
Tier 4 Nursing & Allied Health Professions	10,000	10,000	10,000	20,000	0	✓	0	0	0	0	10,000	0	0	0
Professional Officer SBNI	10,000	10,000	10,000	20,000	0	✓	0	0	0	0	10,000	0	0	0
Specified Tier 5 (No lower than band 6)	1,000	1,000	1,000	0	0	0	0	0	0	0	0	0	0	0
OTHERS														
Director's PAs	500	500	0	0	0	0	0	0	0	0	0	0	0	0
Office Managers	500	500	500	0	0	0	0	0	0	0	0	0	0	0
Office Managers SBNI	500	500	500	0	0	0	0	0	0	0	0	0	0	0

NB: All open limits designed by a tick are to be in line with PHA and Accounting Officer Delegated limits, be within Agency approved policy and within allocated budget.

In relation to R&D expenditure now classified as capital expenditure, DoH have confirmed that the existing delegation of £250k for capital projects does not apply - the limit is £1.5m as per circular HSC(F) 52-2016.
Please refer to the Standing Orders and Standing Financial Instructions for further details.

SLAs with 3rd party organisations of £50k and above, or where they are novel or potentially contentious, MUST be brought to AMT for prior approval.

Delegated limits for SLAs/SBAs/3rd party organisations and approval of payments to 3rd party organisations are in respect of authorising payments and signing letters of offer, only after the necessary approvals to allocate have been obtained through AMT in line with PHA policies

It is the responsibility of all authorised signatories to ensure that the necessary approval to allocate/invest have been obtained, that any invoices are correct in line with contracts etc., and that they are within budget.

HSC Public Health Agency

board paper

Annual Quality Improvement Plan Report 2015/16

date	16 February 2017	**item**	9	**reference**	PHA/03/02/17

presented by Mrs Mary Hinds, Director of Nursing, Midwifery and AHPs

action required For approval

Summary

HSC Trusts are required to submit to PHA an annual Quality Improvement Plan which includes the indicators identified in the HSCB/PHA Commissioning Plan and locally identified quality improvement initiatives. Data of agreed measures relating to the commissioning plan indicators are required to be submitted via an electronic SharePoint within six weeks of each quarter end. An escalation protocol has been agreed in the event timely submissions are not received. This data is reviewed and analysed by the Quality, Safety and Experience Team, PHA and used to inform this report. The data relating to each indicator is accompanied by commentary to allow explanation of variation in compliance or outcome and any actions taken in response. Findings are used to prioritise the PHA Safety and Quality Work plan to support on-going quality improvement initiatives.

The key areas covered in this report are:

1. Prevention of Pressure Ulcers
2. Reduction of Harm from Falls
3. Reduction of harm to patients from Venothromboembolism
4. The Malnutrition Universal Screening Tool' (MUST)
5. National Early Warning Scores (NEWS)

The data relating to each indicator is accompanied by commentary to allow explanation of variation in compliance or outcome and any actions taken in response. Findings are used to prioritise the PHA Safety and Quality Work plan to support on-going quality improvement initiatives.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **APPROVE** the Annual Quality Improvement Plan Report.

Health and Social Care Board

Public Health Agency

Quality Improvement Plan Framework

2015-16

Indicator Report

Produced by HSCB Information, PMSID in conjunction with the QSE Team (PHA)

Contents

Introduction

Quality is at the heart of our services and the Public Health Agency (PHA) is committed to driving improvement in safety, outcomes, access, efficiency and patient satisfaction. Providing quality services is a collective endeavour, requiring shared effort and collaboration between Health and Social Care Board (HSCB) / PHA, Trusts and individuals at every level of the health and social care system.

Locally, the HSC framework requires HSCB/PHA to gain assurance on progress with regional safety and quality priorities via Quality Improvement Plans (QIPS). The Commissioning Plan is a response to the Commissioning Plan Direction[1], 2015/2016 and identifies the key strategic priorities and outline the safety and quality indicators which must be included in Quality Improvement Plans developed by Trusts.

The Quality 2020[2] Strategy aims to protect and improve the quality of health and social care in Northern Ireland. In line with this strategy, we are committed to measuring improvements; and in doing so, ensuring that lessons from the information are learned, areas of high performance are duplicated and areas of lower performance are supported to improve. A Q2020 task group has developed proposed core indicators for a Trust annual quality report. This report will inform Trust Boards, support HSCB/PHA with the commissioning cycle and be utilised by the DoH as part of year-end accountability arrangements.

The purpose of this document is to provide measurement on the regional priorities and the process through which this will be achieved. The information contained within this report has been supplied by HSC Trusts via a quarterly collection of data on the Public Health Agency (PHA) SharePoint site. Occupied beddays has been supplied by Department of Health (DOH).

Information supplied by Trusts is correct at time of print of this report, however it is subject to change as recording practices and audit findings are reviewed by Trusts through the Patient Safety Officers. The occupied bed-days information has been provided by the DOH.

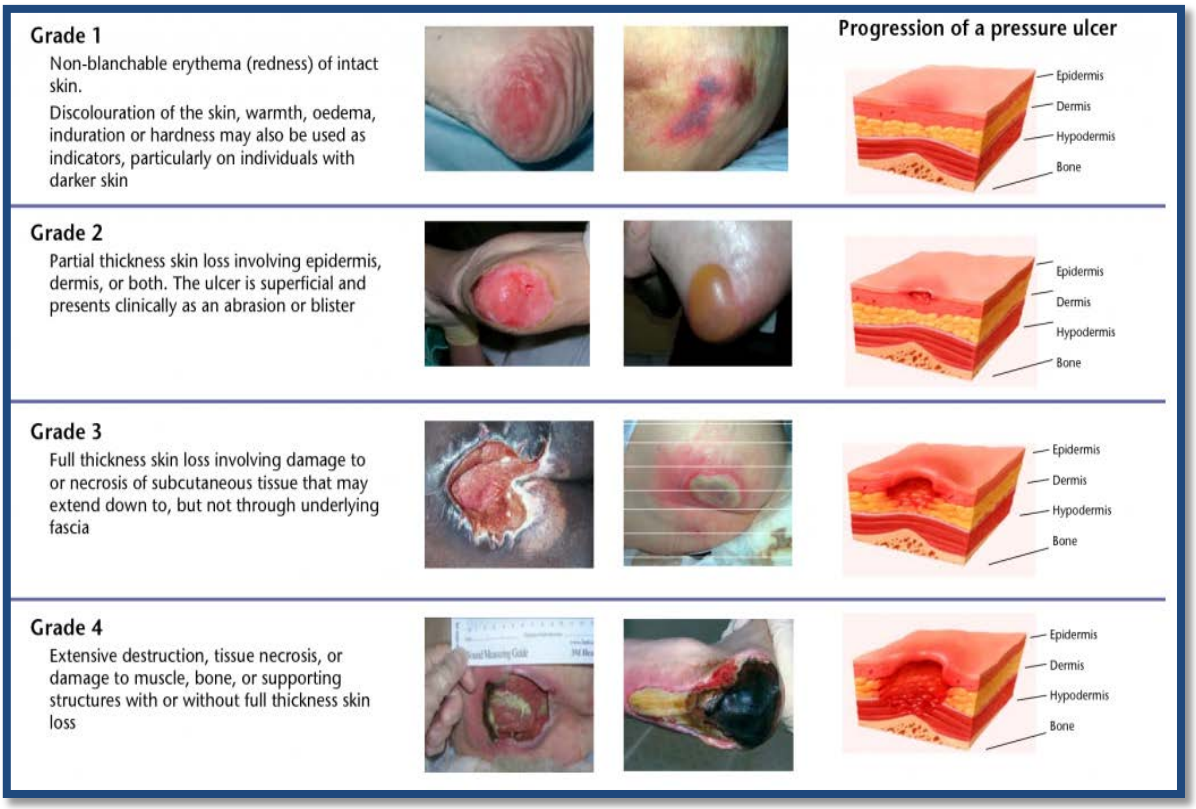
[1] The Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015
[2] Q2020 - A 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland, November 2011

1.0 Pressure Ulcer

1.1 What is a pressure ulcer?

A pressure ulcer is an area of localised damage to the skin and underlying tissue caused by pressure, shear, friction or a combination of these (EPUAP 2014)[3]. They are most likely to occur when a hard bony area covered by a thin layer of tissue is in contact with a hard surface, such as a bed, trolley, theatre table, wheelchair etc.

The body can withstand high interface pressures for a very short period of time. It is when the pressure is not regularly relieved that damage occurs and a pressure ulcer develops. Elderly patients, those with a long term medical illness / disease / condition are particularly vulnerable because their skin usually becomes thinner and more fragile with age. Pressure sores can develop in a matter of hours. There are four recognised grades of pressure ulcers in the EPUAP 2014 wound classification (see diagram below).



[3] Prevention and Treatment of Pressure Ulcers: Quick Reference Guide National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (2014)

Whilst some pressures ulcers are unavoidable, many are avoidable see definitions below.

Avoidable	Unavoidable
Avoidable means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: • evaluate the person's clinical condition and pressure ulcer risk factors • plan and implement interventions that are consistent with the persons' needs and goals, and recognised standards of practice • monitor and evaluate the impact of the interventions or revise the interventions as appropriate	**Unavoidable' means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors using the following:** • planned and implemented interventions that are consistent with the persons needs and goals and recognised standards of practice • monitored and evaluated the impact of the interventions and revised the approaches as appropriate • or the individual refused to adhere to prevention strategies in spite of education of the consequences of non-adherence

1.2 Commissioning Plan Target

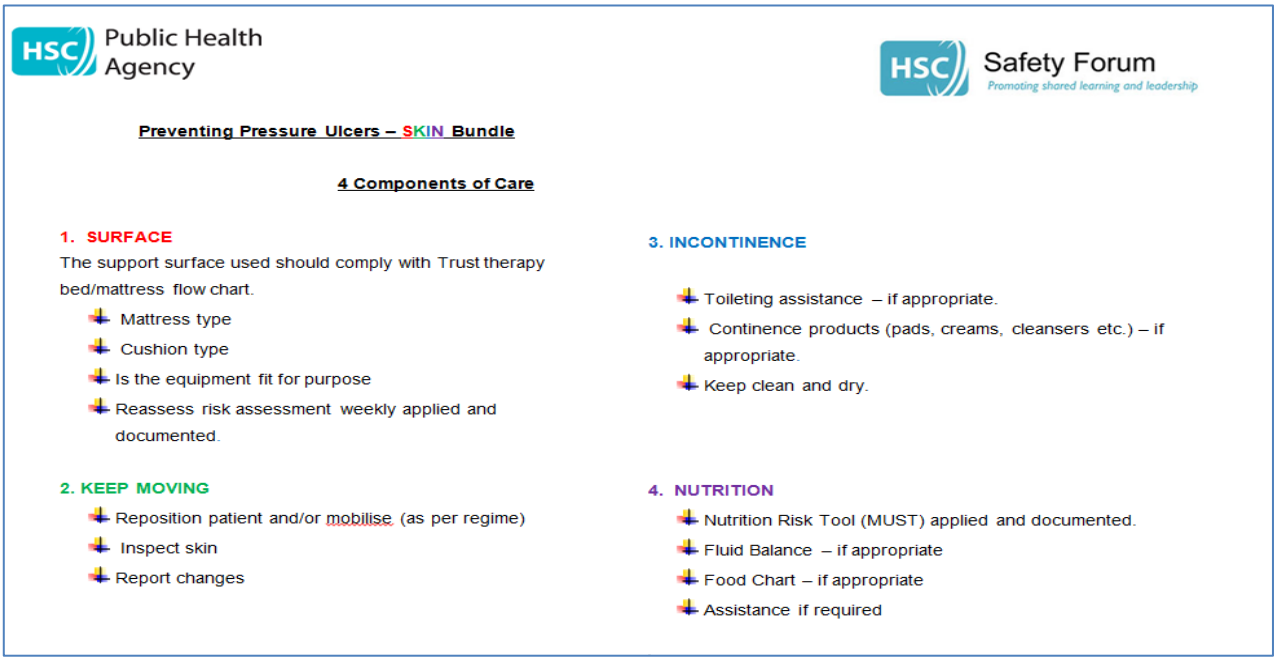
The 2015/16 Commissioning Plan[4] requirement states: "From April 2015, establish a baseline for the incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards and the number of those which were unavoidable. Trusts will monitor and provide reports on bundle compliance and the rate of pressure ulcers per 1,000 bed days."

Trusts are committed to ensuring pressure ulcer prevention is a priority. As part of their QIPs, pressure ulcer incidence is monitored and information submitted to HSCB and PHA on a quarterly basis.

The SKIN Bundle was developed in 2004 at St Vincent's Medical Centre[5], a 528-bed hospital in Florida, US. It was introduced in Wales in 2009 through Transforming Care[6], a ward-based programme for Wales that aimed to improve patient care by reducing pressure ulcers.

[4] HSCB/PHA Commissioning Plan 2015/16
[5] Joint Commission Journal on quality and Safety, (September 2006) Volume 32 Number 9
[6] http://www.1000livesplus.wales.nhs.uk/transforming-care

The SKIN Bundle (see diagram below) is an evidence based collection of interventions proven to prevent pressure ulcers. SKIN is an acronym that prompts nurses to remember four key elements of good skin care: **S**urface selection, **K**eep moving, **I**ncontinence management, and **N**utrition.



The PHA supports HSC Trusts through the Regional Pressure Ulcer Prevention Group to implement SKIN in all hospitals in Northern Ireland, using the Institute for Healthcare Improvement's (IHI) Model for Improvement[7] – plan, do, study, act – to test and implement the bundle through face to-face collaboration and through sharing and learning across the organisations. The IHI Model for Improvement is a simple and reusable model for introducing rapid change, resulting in sustained improvement. In addition within each Trust the pressure ulcer safety cross to measure incidents of pressure damage, has transformed attitudes – staff have went from accepting pressure damage as inevitable for some patients to scrutinising care to ensure everything was being done to prevent pressure ulcers from occurring.

The Regional Pressure Ulcer Prevention Group provides advice, support and shares regional learning across Northern Ireland. It focuses on sustainable strategies for pressure prevention and management across the Health and Social Care Trusts.

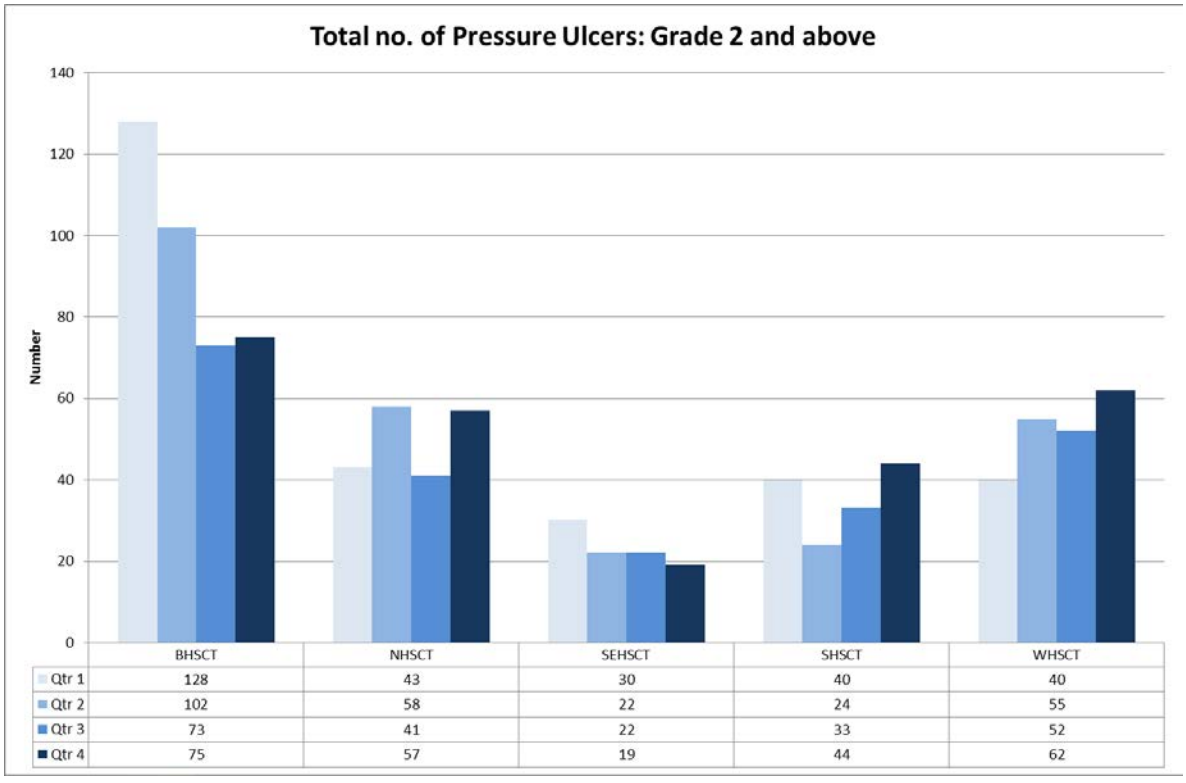
[7] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

The NICE guidelines[8] recommend that pressure ulcers of grade 2 and above are reported locally as incidents. This ensures that information is gathered about the circumstances of the pressure ulcer and helps prevent future incidents.

The higher the grade of pressure ulcer, the more severe the injury to the skin and underlying tissue. Grade 3 or 4 pressure ulcers can develop quickly, for example, in susceptible people, a full-thickness pressure ulcer can sometimes develop in just one or two hours. However, in some cases, the damage will only become apparent a few days after the injury has occurred.

1.3 Baseline numbers and rates of pressure ulcers

The following graphs show the15/16 **regional baseline numbers** and **rates** of pressure ulcers grade 2 and above.



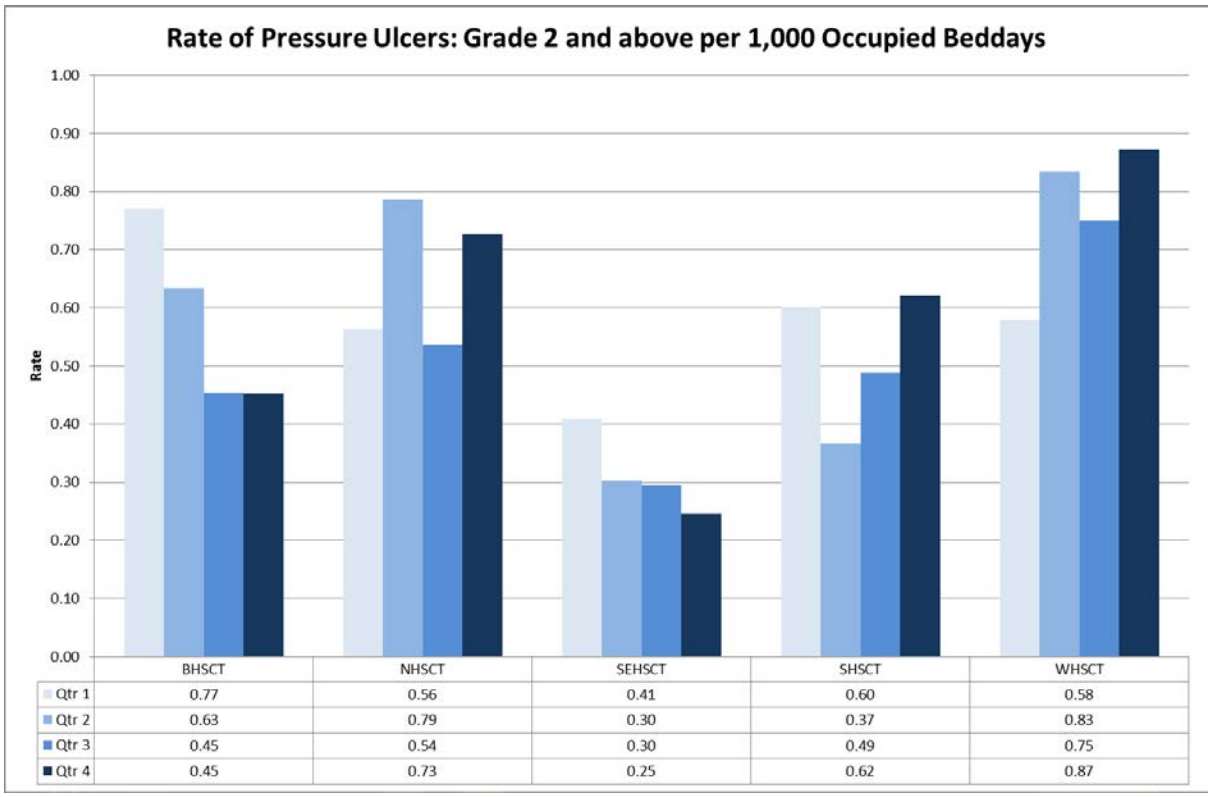
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	128	43	30	40	40
Qtr 2	102	58	22	24	55
Qtr 3	73	41	22	33	52
Qtr 4	75	57	19	44	62

[8] National Institute for Healthcare Excellence Guidelines - Pressure ulcers: prevention and management of pressure ulcers [CG179] 2014

It should be noted that there is a variance each Trust in relation to the number of wards included in the monitoring. The below table provides an overview of the number of wards each trust has implemented quality improvement for pressure ulcers, which equates to 100% total within the adult inpatients areas wards for each Trust.

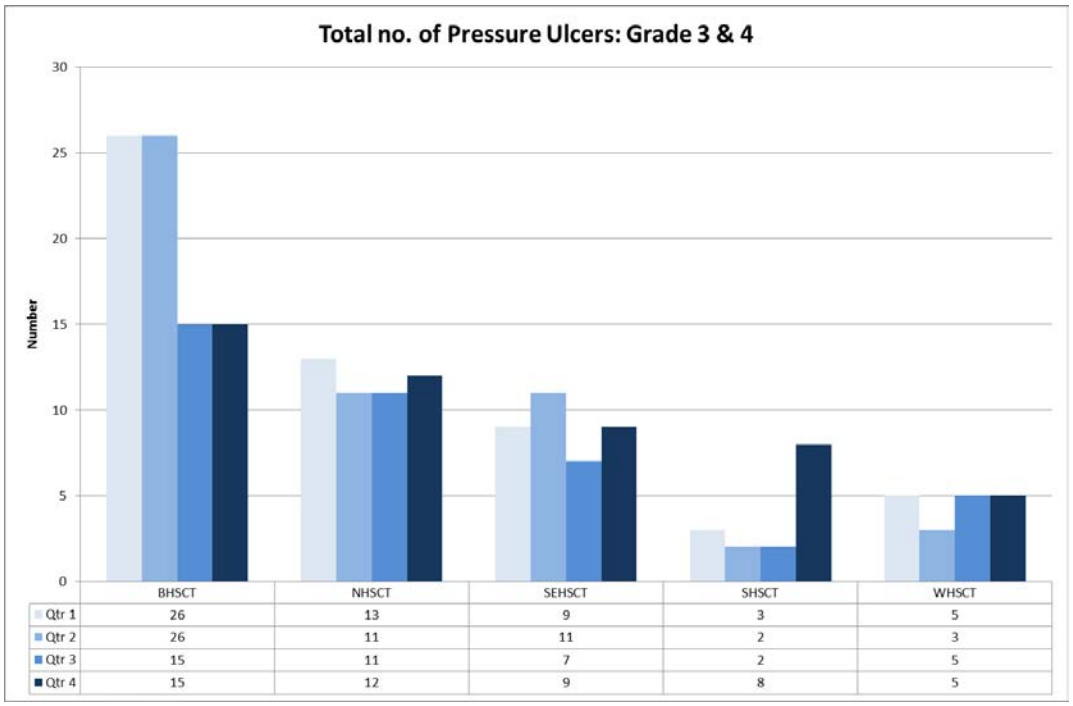
Total number of acute adult in-patient wards*					
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
Total	70	29	31	26	31

*when measuring the spread of quality improvement bundles the total number of adult inpatient wards may vary slightly within each Trust for a variety of reasons including; the appropriateness of the bundle within the particular area, the opening / closure of wards and/or re-categorisation of wards.

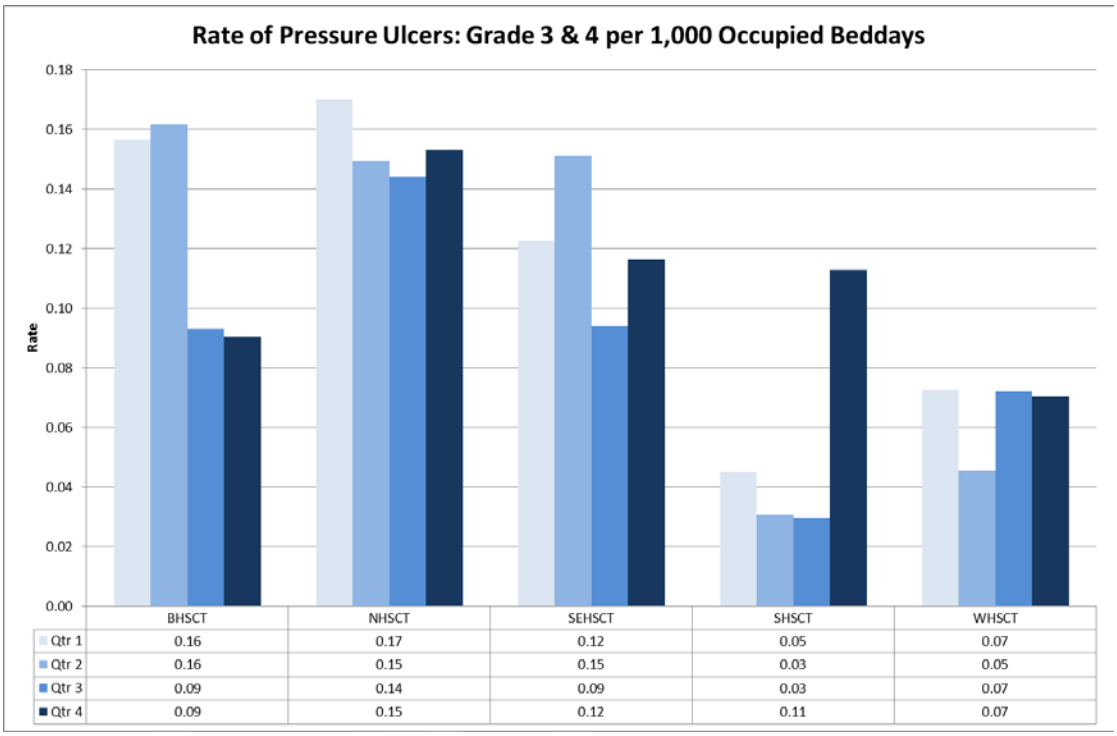


1.4 Baseline information for grade 3 & 4 pressure ulcers

The following charts below show the **total number & rate of grade 3&4 pressure ulcers** that were recorded each quarter by Trusts during 2015/16:



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	26	13	9	3	5
Qtr 2	26	11	11	2	3
Qtr 3	15	11	7	2	5
Qtr 4	15	12	9	8	5



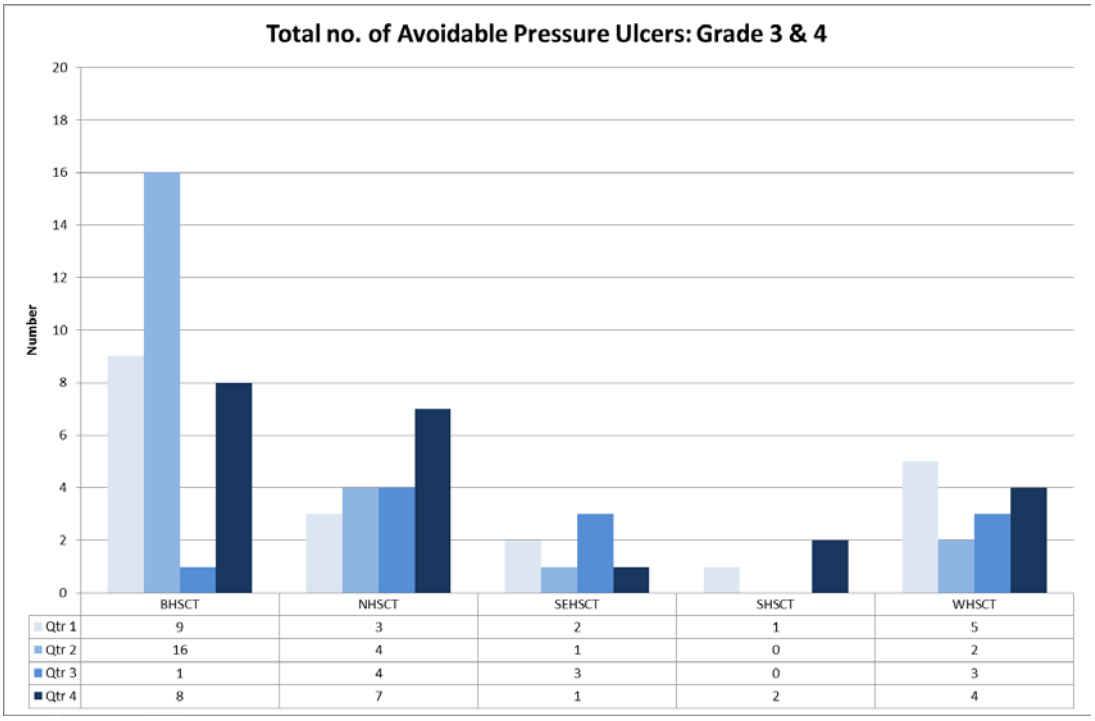
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	0.16	0.17	0.12	0.05	0.07
Qtr 2	0.16	0.15	0.15	0.03	0.05
Qtr 3	0.09	0.14	0.09	0.03	0.07
Qtr 4	0.09	0.15	0.12	0.11	0.07

During 2015/16 all Trusts except Belfast focussed on establishing baseline numbers for the incidents of grade 3 & 4 pressure ulcers occurring in all adult inpatient wards. BHSCT, as a pilot, had established their baseline data during 2014/15.

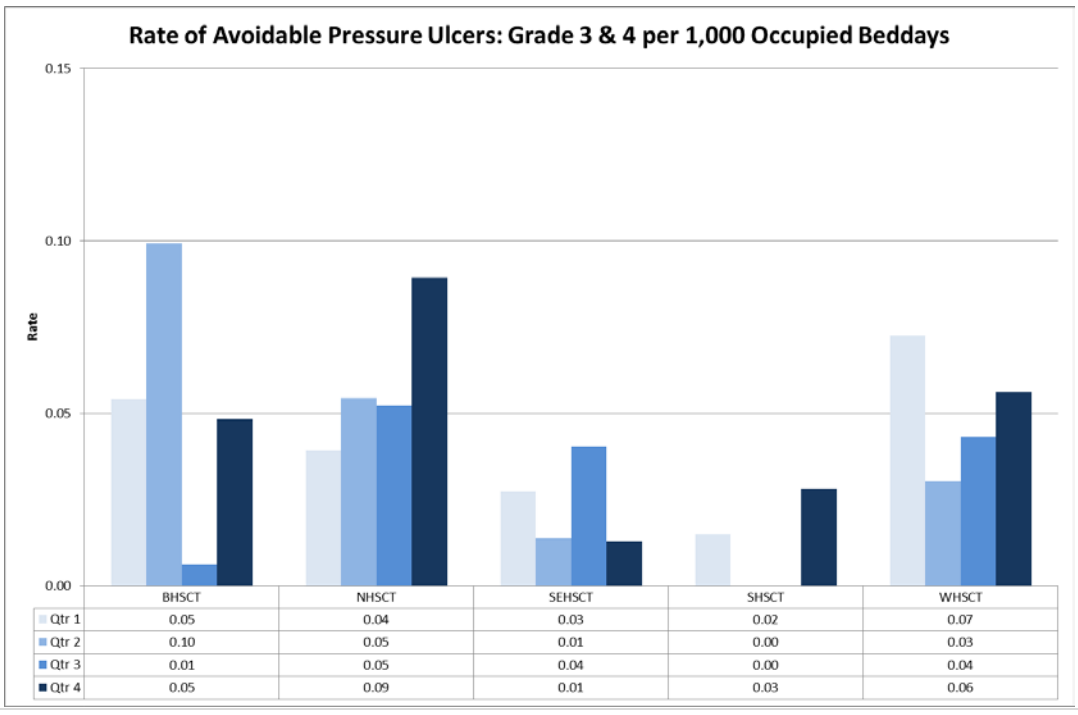
1.5 Prevention of avoidable grade 3 & 4 pressure ulcers

At the Regional Pressure Ulcer Prevention Group, Trusts had agreed to focus on prevention of avoidable grade 3 & 4 pressure ulcers, as these create deeper cavity wounds causing more pain and suffering to patients. This focuses on the more serious harm caused by pressure ulcers.

The following charts below shows the **number & rate** of **avoidable** grade 3 & 4 pressure ulcers that were recorded each quarter by Trusts during 2015/16:



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	9	3	2	1	5
Qtr 2	16	4	1	0	2
Qtr 3	1	4	3	0	3
Qtr 4	8	7	1	2	4

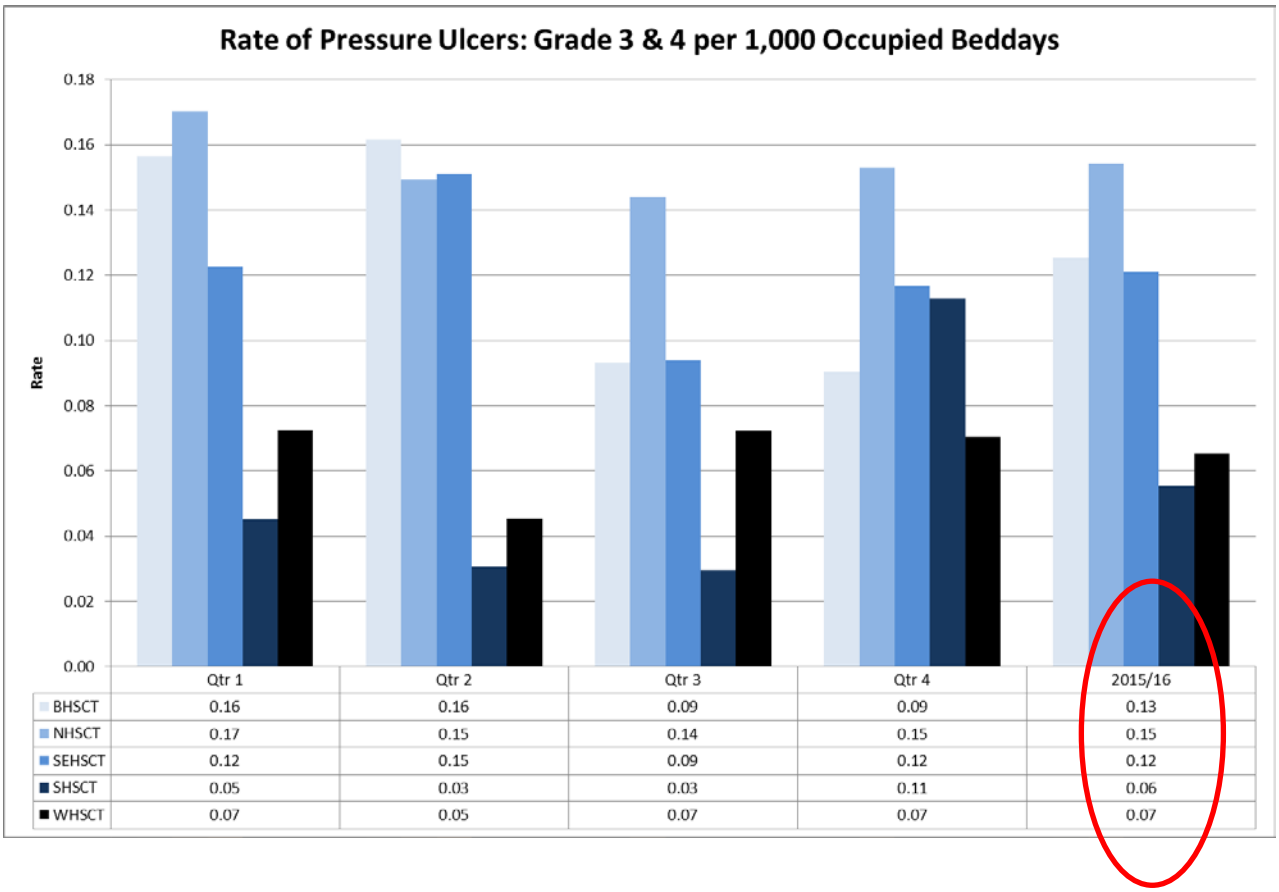


	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	0.05	0.04	0.03	0.02	0.07
Qtr 2	0.10	0.05	0.01	0.00	0.03
Qtr 3	0.01	0.05	0.04	0.00	0.04
Qtr 4	0.05	0.09	0.01	0.03	0.06

BHSCT had a significant rise in the numbers of grade 3 and 4 in Quarter 2 (1st July to 31st September 2015). However, it is important to note that the data should be analysed over a period of time and not on individual data points. In 2015/16 BHSCT had set a 10% reduction target in the number of grade 3 & 4 avoidable pressure ulcers in all adult inpatients; they exceeded their target and had 34 avoidable pressure ulcers across the Trust in 15/16 compared to 42 during 2014/15.

During 2016/17 Trusts are working towards a % reduction in the number of grade 3 & 4 avoidable pressure ulcers in all adult inpatients from their baseline figures.

1.6 Regional overview



	Qtr 1	Qtr 2	Qtr 3	Qtr 4	2015/16
BHSCT	0.16	0.16	0.09	0.09	0.13
NHSCT	0.17	0.15	0.14	0.15	0.15
SEHSCT	0.12	0.15	0.09	0.12	0.12
SHSCT	0.05	0.03	0.03	0.11	0.06
WHSCT	0.07	0.05	0.07	0.07	0.07

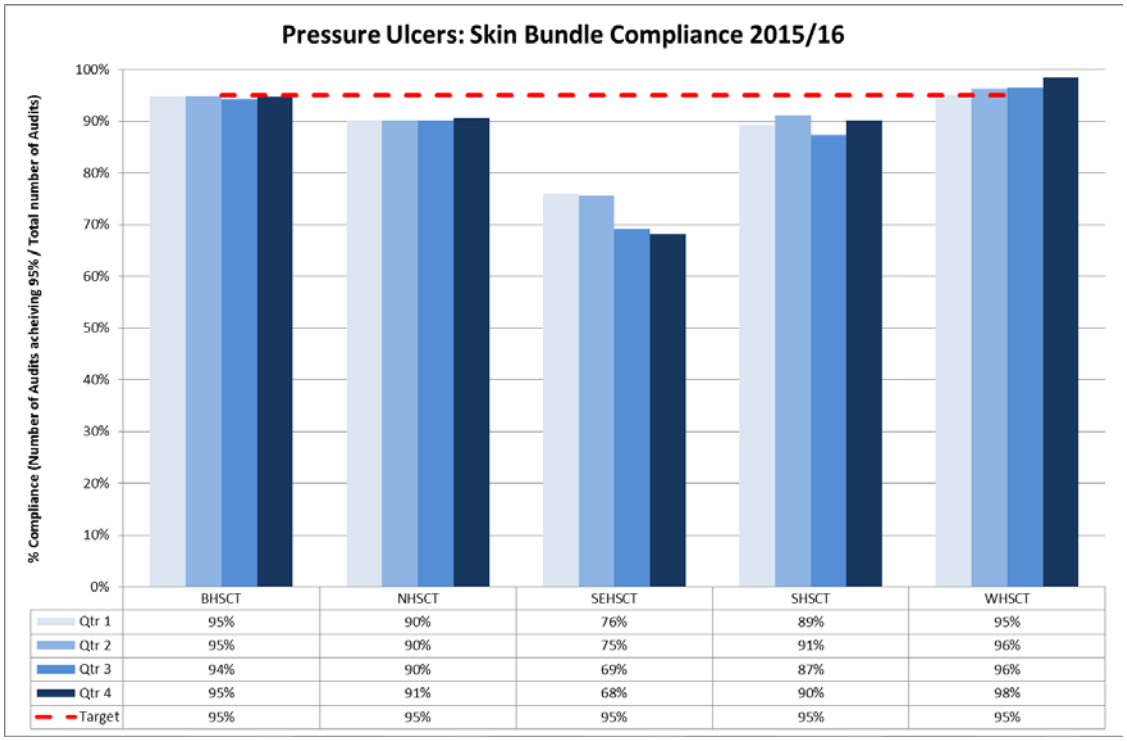
Regionally, the 2015/16 annual Trust range of pressure ulcer incidence rates grade 3 & 4 reported between 0.06% and 0.15% per 1,000 occupied bed days.

The total number of reported pressure ulcers (grade 2 and above) during 2015/16 was 1,020. Of these 198 (19%) were grade 3 & 4. Of the 198 grade 3 & 4 pressure ulcers, 122 (62%) were recorded as unavoidable and 76 (38%) as avoidable.

There are a number of individual hospital Trusts in England report pressure ulcer incidence rates per 1000 bed days as part of the NHS England Open and Honest Care Driving Improvement initiative. [9] At the end of March 2016 the reported pressure ulcer incidence rates for these Trusts range between 0 - 1.69% per 1000 bed days. It should be noted that this initiative uses incident rates to compare improvement over time, but not for the purpose of comparison between Trusts as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

1.7 Compliance with SKIN bundle

The following chart shows the percentage compliance with the Skin Bundle by Trust for each of the quarters in 2015/16:



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	95%	90%	76%	89%	95%
Qtr 2	95%	90%	75%	91%	96%
Qtr 3	94%	90%	69%	87%	96%
Qtr 4	95%	91%	68%	90%	98%
Target	95%	95%	95%	95%	95%

Throughout 2015/16 Belfast and Western Trusts have continually met, or almost met, the target of 95% compliance. As a result the WHSCT have reduced the number of audits performed in Q4 in areas where had sustained over 95% compliance over the past six quarters and also where they had achieved 1000 plus pressure ulcer free. The South Eastern Trust was measuring elements additional to

[9] NHS England Open and Honest Care Driving Improvement initiative

the regional documentation which resulted in lower compliance rates in comparison to other Trusts. The documentation has been changed to mirror the regional documentation from April 2016 therefore next year's reporting should comparative with other Trusts.

The following table shows more detail with the number of audits carried out in each Trust during each of the four quarters in 2015/16 with Regional compliance of the Skin Bundle:

	Skin Bundle % Compliance						Total Audits				
TRUST	Target	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
BHSCT	95%	95%	95%	94%	95%	**95%**	4593	4556	3600	4059	**16808**
NHSCT	95%	90%	90%	90%	91%	**90%**	833	789	643	599	**2864**
SEHSCT	95%	76%	75%	69%	68%	**72%**	441	608	674	503	**2226**
SHSCT	95%	89%	91%	87%	90%	**89%**	372	363	387	378	**1500**
WHSCT	95%	95%	96%	96%	98%	**96%**	895	847	735	240	**2717**
REGION	95%	93%	93%	98%	92%	**92%**	7134	7163	6039	5779	**26115**

The region as a whole has met the 95% target in quarter 3 of 2015/16, with an average % compliance of Skin Bundle over the 2015/16 year of 92% (24,056 of 26,115 audits being compliant). There are individual ward areas that are at 1000 plus pressure ulcer free days, in these areas there has been a reduction in audits.

1.8 Root cause analysis tool

Root cause analysis of pressure ulcer incidents can help to identify local priorities for action. All trusts from 1st April 2015 are undertaking Root Cause Analysis (RCA) on each individual reported incidence of grade 3 & 4 pressure ulcer to identify and spread learning to prevent future reoccurrences.

Trusts have reported the following key findings from RCAs to date and are working with the individual areas to implement improvements relating to each finding:

Key findings of causal factors resulting in pressure ulcers grade 3 & 4
• Pressure from a hard surface – such as a bed or wheelchair • Pressure that is placed on the skin through involuntary muscle movement – such as muscle spasms • Moisture – which can break down the outer layer of the skin (epidermis)

1.9 Sharing of Regional Learning

The Regional pressure Ulcer Group meet on a quarterly basis this group is led by the PHA and membership comprises a multidisciplinary team across the 5 HSC trusts. At each meeting progress is monitored, support and advice are given. In addition, regional learning is shared in relation to the prevention and management of pressure ulcers. The group have identified the following learning which has been shared and actioned across all Trusts.

- **Risk assessments** are performed for all inpatients on admission, if they are moved to another area and if their condition deteriorates. The group has contributed to the development of the regional nursing documentation relating to pressure ulcer prevention and management.

- **A skin inspection** should be done on every patient within 6 hours of admission, and re-inspection should occur every 8 to 24 hours, depending on the status of the patient. This practice is being promoted across all adult inpatient wards.

- **The pressure ulcer prevention plan** should include interventions that minimize or eliminate friction and shear, minimize pressure with off-loading, manage moisture, and maintain adequate nutrition and hydration. The SKIN bundle messages outlined below are key to achieving this and are shared with all staff and on induction and any training provided:
    - Surface – make sure people have the right support including support for patients with muscle spasm or involuntary muscle movement
    - Skin – early skin inspection means early detection
    - Keep moving – keep people mobile
    - Incontinence – keep patients dry and clean and free from moisture, this includes urine, faeces and sweat
    - Nutrition – make sure people have a MUST risk assessment on admission if they are moved to another area and if their condition deteriorates. A good diet with plenty of fluids, Is essential particularly for elderly patients or those who are at risk

- **Pressure ulcer treatment is evidence-based** and includes a patient assessment and wound evaluation, including the following elements: history and physical, wound description/staging, etiology of pressure, psychosocial

needs, nutritional status, and bacterial colonization/infection. Dr Jeannie Donnelly, Tissue Viability Nurse, BHSCT represents N.I on the European Pressure Ulcer Advisory Panel (EPUAP) and the European pressure ulcer conference will take place in the Waterfront Hall, Belfast, between 20 - 22 September 2017. The conference theme is: 'One Voice for Pressure Ulcer Prevention and Treatment. Challenges and Opportunities for Practice, Research and Education'.

- **Document** all risk assessments, skin inspection findings, pressure ulcer prevention interventions and treatments. A consistent documentation format is used across all HSC trusts.

- In addition to the regionally agreed RCA tool, the group has developed a regionally agreed data set to determine pressure ulcer incidents and ensure consistency in approach across N.I's HSC trusts.

- **Education** is provided to the patient, family, caregivers and health care team members regarding prevention and treatment of pressure ulcers. A regional pressure ulcer prevention leaflet, for patients and carers has been developed and is being used by all Trusts. The purpose of this leaflet is to provide patients and carer with information on pressure ulcers, how they develop and the steps they can take to prevent them. In addition a multidisciplinary eLearning tool has been developed and tested within BHSCT and has been shared with the regional group with agreement to use this as a regional tool.

- **Communication** of pressure ulcer development, risk assessment, skin inspection results, and treatments should be consistent. Any change in skin condition is communicated to direct and indirect care providers as soon as observed.

- Each of the 5 Trust has a number of wards that have reached 1000 plus pressure ulcer free days and many of these **celebrated their local success** on National stop Pressure Ulcer day.

2.0 Regional Falls Prevention

2.1 The significance of a fall

Falls are a common cause of injury. Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition. Falls are a common, but often overlooked, cause of injury. Around one in three adults over 65 who live at home will have at least one fall a year, and about half of these will have more frequent falls.

Frequently the cause of a fall is related to:

- footwear
- lighting
- activity
- medication
- eyesight

Most falls don't result in serious injury. The human cost of a fall includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year[10]. Therefore falling has an impact on quality of life, health and healthcare costs.

Fall prevention involves managing a patient‘s underlying fall risk factors (e.g., problems with walking and transfers, medication side effects, confusion, frequent toileting needs) and optimizing the hospital‘s physical design and environment. A number of practices have been shown to reduce the occurrence of falls.

Falls are among the top five (5) most frequent adverse incidents reported within Health and Social Care (HSC) Trusts. Falls can be categorised into a number of categories depending on harm caused. Regionally the PHA, HSCB, DoH and HSC Trusts have agreed definitions for moderate to severe harm.

[10] Falls in older people: assessing risk and prevention Clinical guideline [CG161] Published date: June 2013

Definitions of moderate and severe harm in the context of slips and falls[11]		
Moderate harm	**Severe harm**	**Death**
Harm requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected (e.g. fractured clavicle, laceration requiring suturing).	Harm causing permanent disability (e.g. brain injury, hip fractures *where the patient is unlikely to regain their former level of independence*).	Where death is directly attributable to the fall

2.2 Commissioning Plan Target

The 2015/16 Commissioning Plan requirement states:

- Trusts will continue to improve compliance with Part B of the 'Fallsafe' Bundle.
- Trusts will spread the regionally agreed elements of Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented.
- Trusts will monitor and provide reports on bundle compliance, the number of incidents of falls, those which cause moderate or more severe harm and the rate per 1,000 bed days."

Trusts are committed to ensuring falls prevention is a priority. As part of their QIPs, falls incidences are monitored and information submitted to HSCB and PHA on a quarterly basis.

During 2015/16 the PHA working closely with HSCB and HSC Trusts to implement and spread the Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls; in inpatient settings.

The Falls Bundle contains a number of regionally agreed elements, which are evidenced to reduce falls, outlined below, which Trusts measure compliance against and report to the PHA and HSCB on a quarterly basis.

[11] www.npsa.nhs.uk

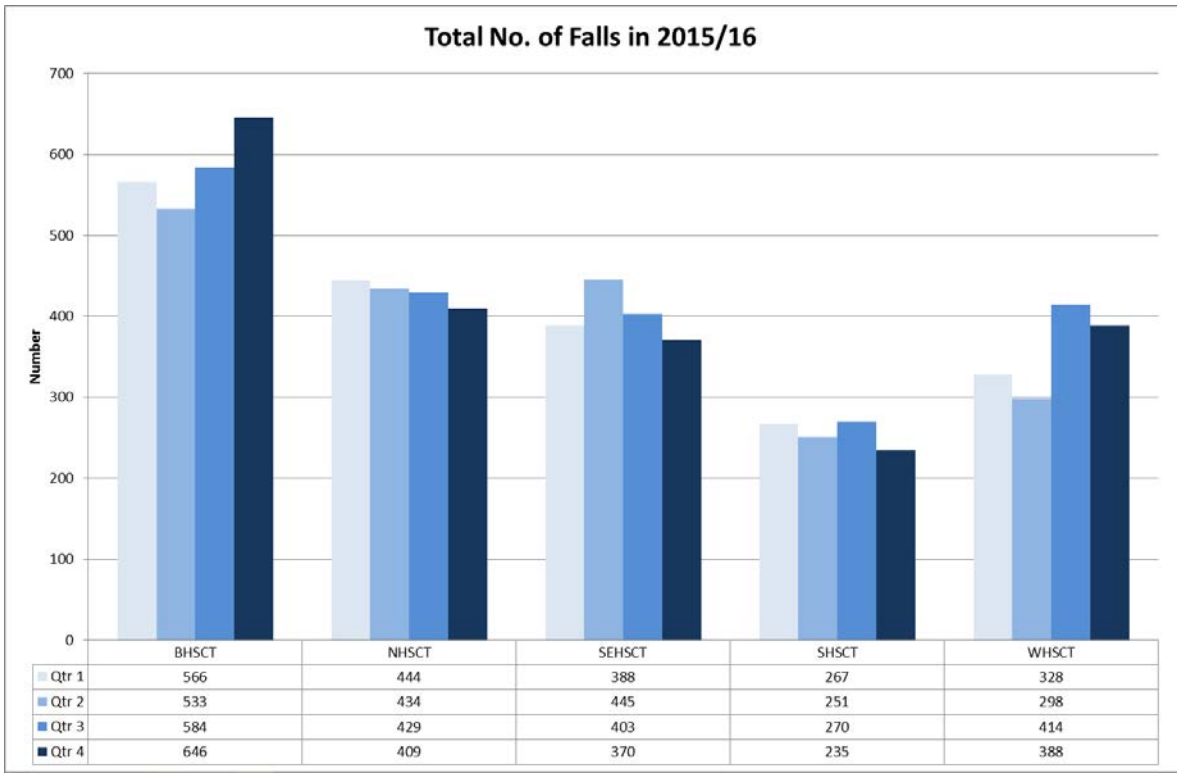
Part A Element	Part B Elements
• Asked about history of falls in past 12 months • Asked about fear of falls • Urinalysis performed • Avoidance of prescription of night sedation • Call bell in sight and reach • Safe footwear on feet • Clear communication regarding mobility status • Personal items within reach • No slips or Trips hazards	• Cognitive Screening • Lying & Standing Blood Pressure record • Full Medication review requested • Bedrails risk assessment

A core function of the Public Health Agency (PHA) is to provide leadership and support to health and social care providers in improving the quality of services delivered to service users. A Regional In-Patient Falls Group, led by the PHA, has been established to provide multidisciplinary advice and support across the HSC in preventing harm to patients who fall whilst in hospital and share regional learning across Northern Ireland. It focuses on sustainable strategies for falls prevention and management across Trusts.

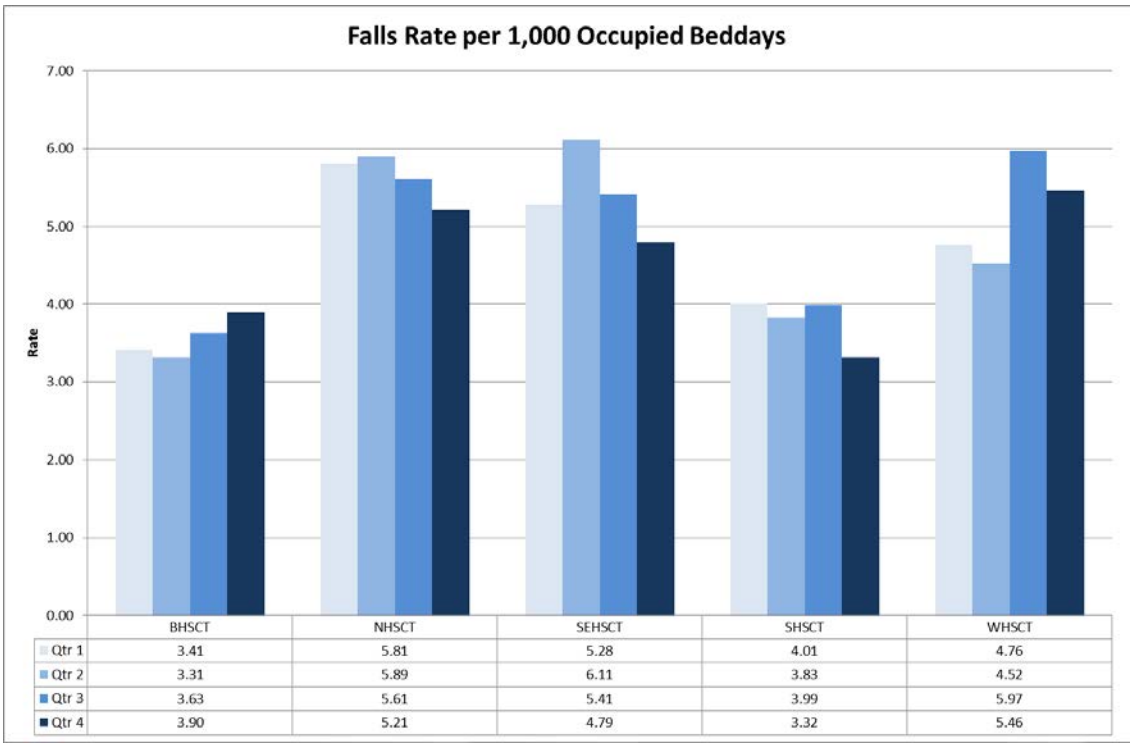
HSC Trusts routinely report to the PHA/HSCB and Department of Health (DoH), the number of falls incidents classified as causing moderate to severe harm.

2.3 Regional baseline rates for falls

The following graphs show the total number and rates of falls recorded per quarter across each HSC Trust.



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	566	444	388	267	328
Qtr 2	533	434	445	251	298
Qtr 3	584	429	403	270	414
Qtr 4	646	409	370	235	388



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	3.41	5.81	5.28	4.01	4.76
Qtr 2	3.31	5.89	6.11	3.83	4.52
Qtr 3	3.63	5.61	5.41	3.99	5.97
Qtr 4	3.90	5.21	4.79	3.32	5.46

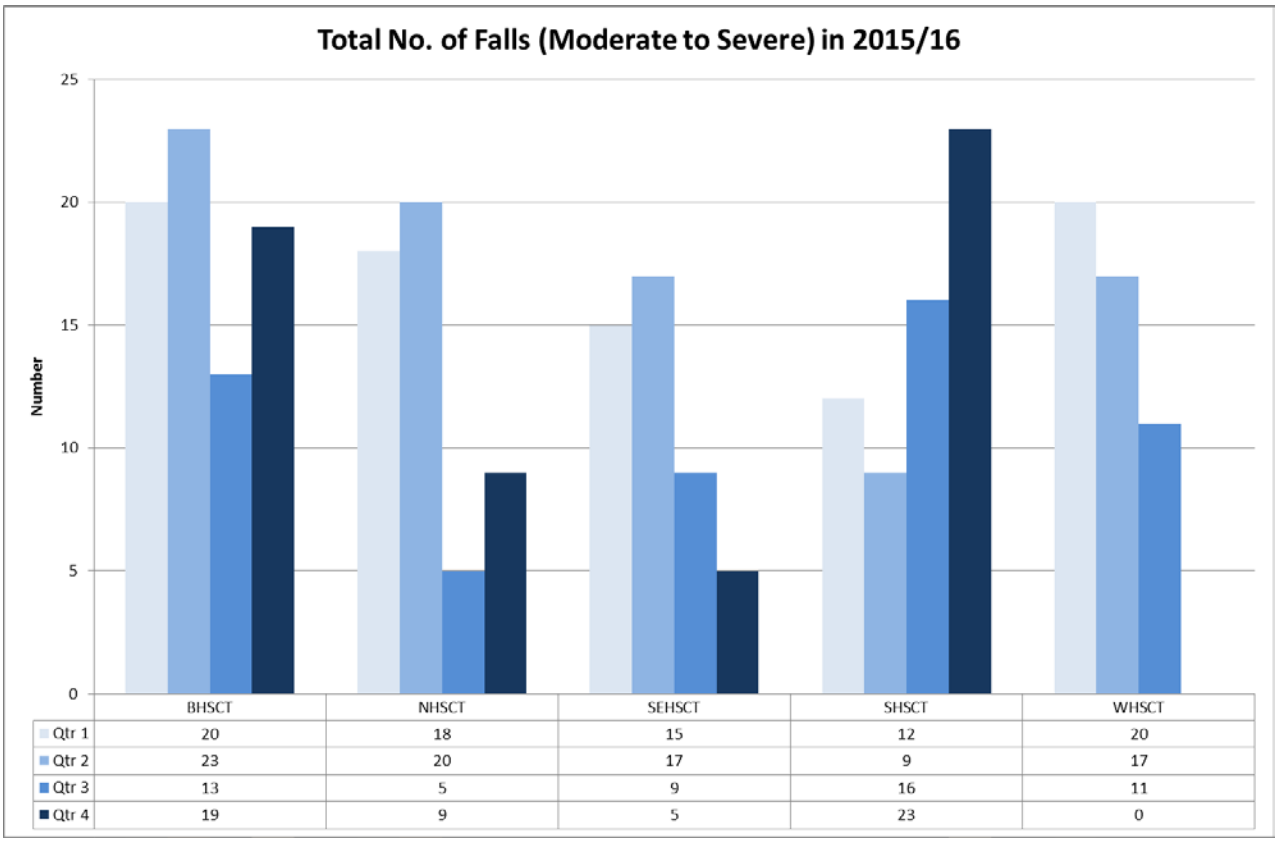
It should be noted that there is a variance each Trust in relation to the number of wards included in the monitoring. The below table provides an overview of the number of wards each trust has implemented quality improvement for falls, which equates to 100% total within the adult inpatients areas wards for each Trust.

Total number of acute wards spread*					
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
Total	70	29	31	26	31

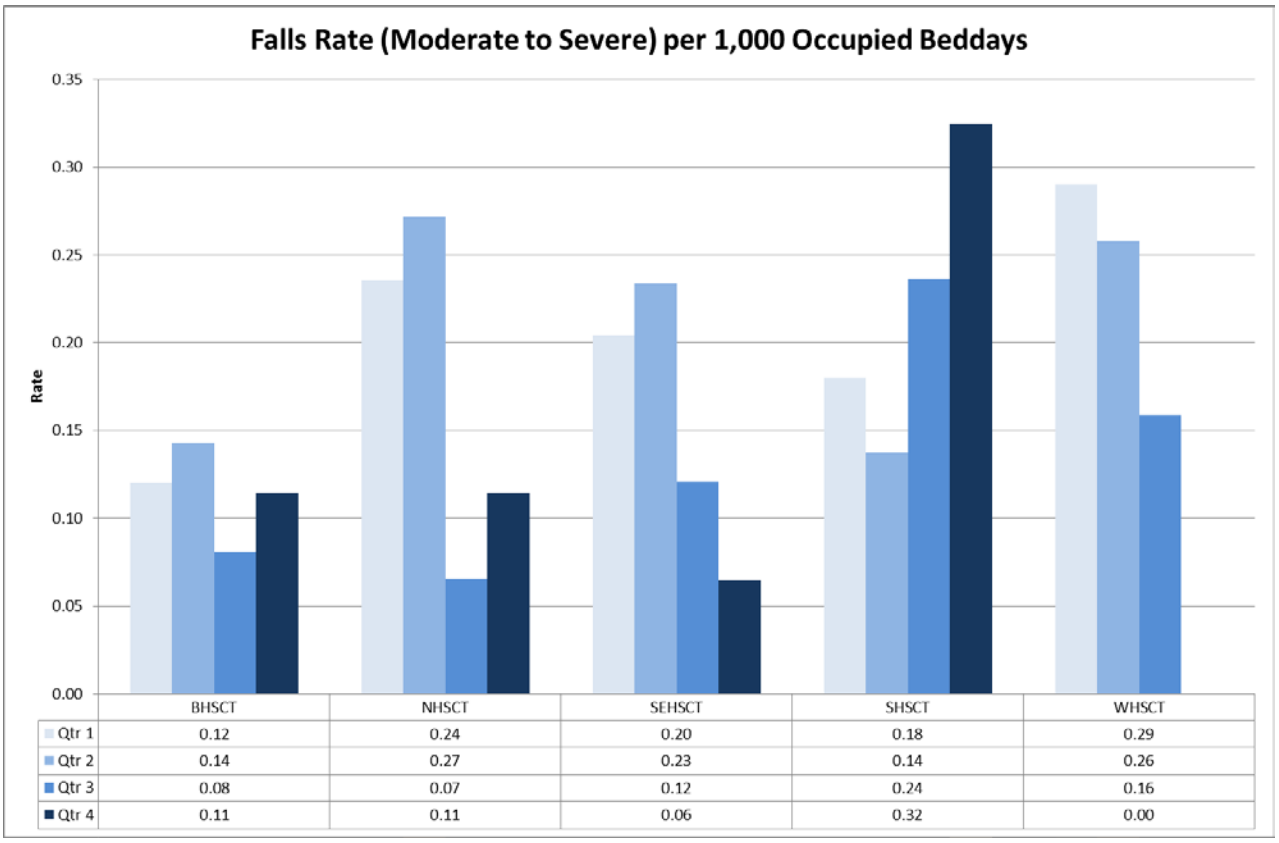
*when measuring the spread of quality improvement bundles the total number of adult inpatient wards may vary slightly within each Trust for a variety of reasons including; the appropriateness of the bundle within the particular area, the opening / closure of wards and/or re-categorisation of wards.

2.4 Total number and rates for falls resulting in moderate to severe harm

The following tables show the total number of falls and rate of falls per 1,000 occupied beddays which resulted in harm of a moderate/severe nature.

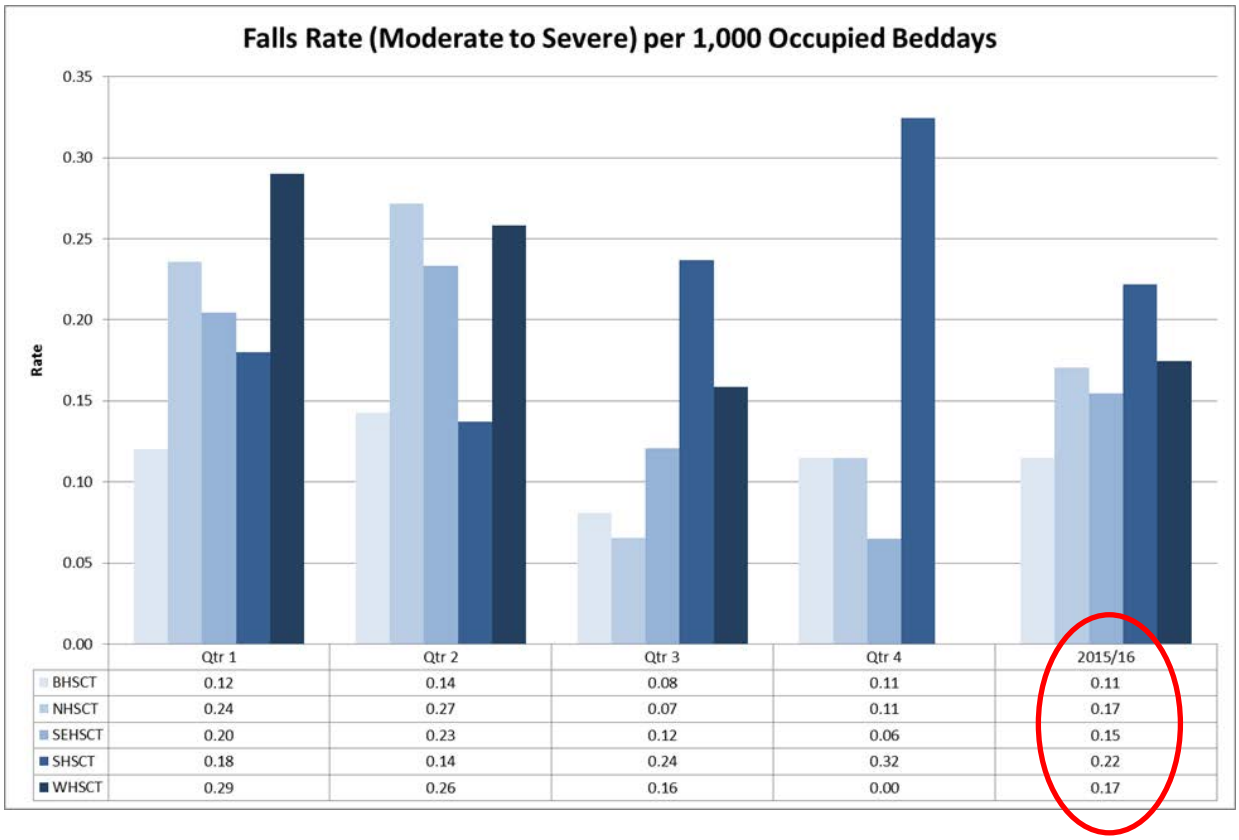


	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	20	18	15	12	20
Qtr 2	23	20	17	9	17
Qtr 3	13	5	9	16	11
Qtr 4	19	9	5	23	0



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	0.12	0.24	0.20	0.18	0.29
Qtr 2	0.14	0.27	0.23	0.14	0.26
Qtr 3	0.08	0.07	0.12	0.24	0.16
Qtr 4	0.11	0.11	0.06	0.32	0.00

2.5 Regional Overview



	Qtr 1	Qtr 2	Qtr 3	Qtr 4	2015/16
BHSCT	0.12	0.14	0.08	0.11	0.11
NHSCT	0.24	0.27	0.07	0.11	0.17
SEHSCT	0.20	0.23	0.12	0.06	0.15
SHSCT	0.18	0.14	0.24	0.32	0.22
WHSCT	0.29	0.26	0.16	0.00	0.17

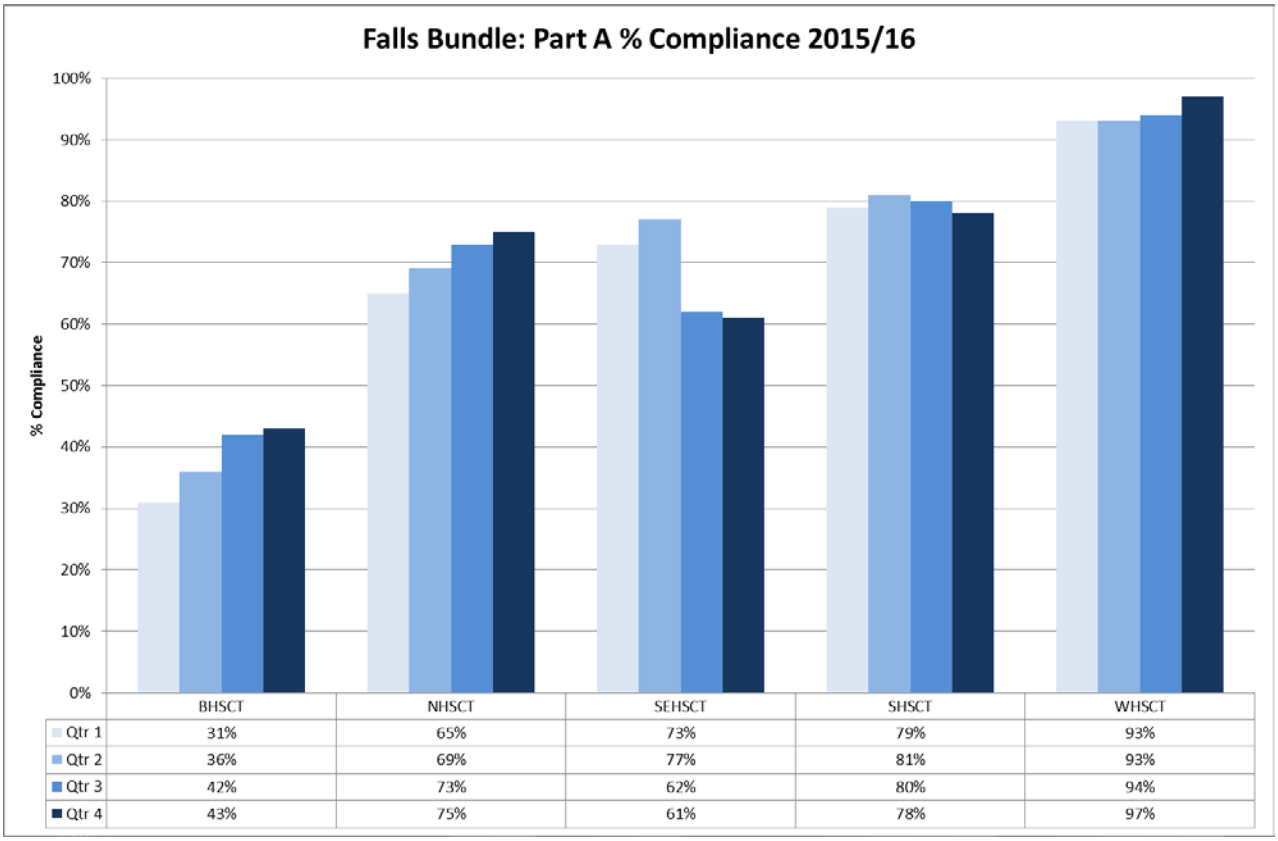
Regionally, the 2015/16 annual Trust range of falls resulting in moderate to severe harm reported between 0.11 to 0.22 per 1000 bed days.

There are a number of individual hospital Trusts in England report falls resulting in moderate to severe harm rates per 1000 bed days as part of the NHS England Open and Honest Care Driving Improvement initiative. In March 16 the reported moderate to severe harm for falls incidence rates for these Trusts range between 0.08 – 0.21% per 1000 bed days.

It should be noted that this initiative uses incident rates to compare improvement overtime, but not for the purpose of comparison between Trusts as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

2.6 Compliance with falls bundle

The following chart shows the percentage compliance with the Falls Bundle (Part A) by Trust for each of the quarters in 2015/16:



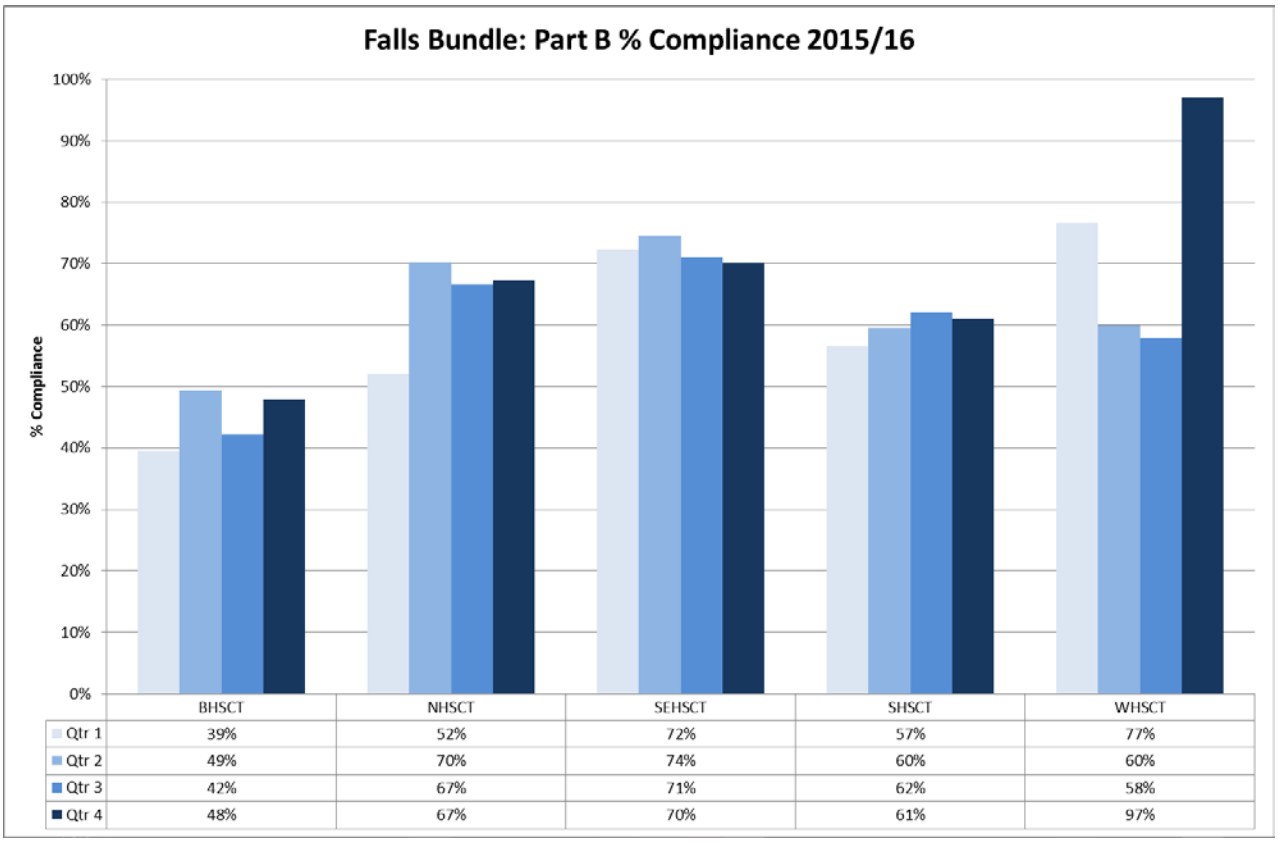
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Qtr 1	31%	65%	73%	79%	93%
Qtr 2	36%	69%	77%	81%	93%
Qtr 3	42%	73%	62%	80%	94%
Qtr 4	43%	75%	61%	78%	97%

Throughout 2015/16 the NHSCT and WHSCT have continually increased percentage compliance. It should be noted that BHSCT has spread both parts A & B of the Falls bundle from 28 inpatient wards in the first quarter to 70 inpatient wards in the final quarter, therefore this rapid spread would explain the reduction in compliance and it takes time for the elements to be embedded in all areas. The SEHSCT have experienced a marked percentage reduction due to difficulty in recording two elements of the bundle (communication of mobility status and urinalysis), this is being addressed by the Trust and they are currently working to improve compliance.

The following table shows more detail with the number of audits carried out in each Trust during each of the four quarters in 2015/16 with Regional compliance of the Falls Bundle Part A:

Trust	Part A % Compliance 2015/16					No. of Audits (Part A) carried out in 2015/16				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total
BHSCT	31%	36%	42%	43%	**37%**	210	170	492	708	**1,580**
NHSCT	65%	69%	73%	75%	**71%**	445	640	608	599	**2,292**
SEHSCT	73%	77%	62%	61%	**69%**	621	743	819	557	**2,740**
SHSCT	79%	81%	80%	78%	**80%**	586	562	589	593	**2,330**
WHSCT	93%	93%	94%	97%	**94%**	852	852	857	350	**2,911**
REGION	**76%**	**78%**	**71%**	**68%**	**73%**	**2,714**	**2,967**	**3,365**	**2,807**	**11,853**

In relation to Part B of the Falls Bundle, the following chart shows the percentage compliance with the Falls Bundle (Part B) by Trust for each of the quarters in 2015/16:

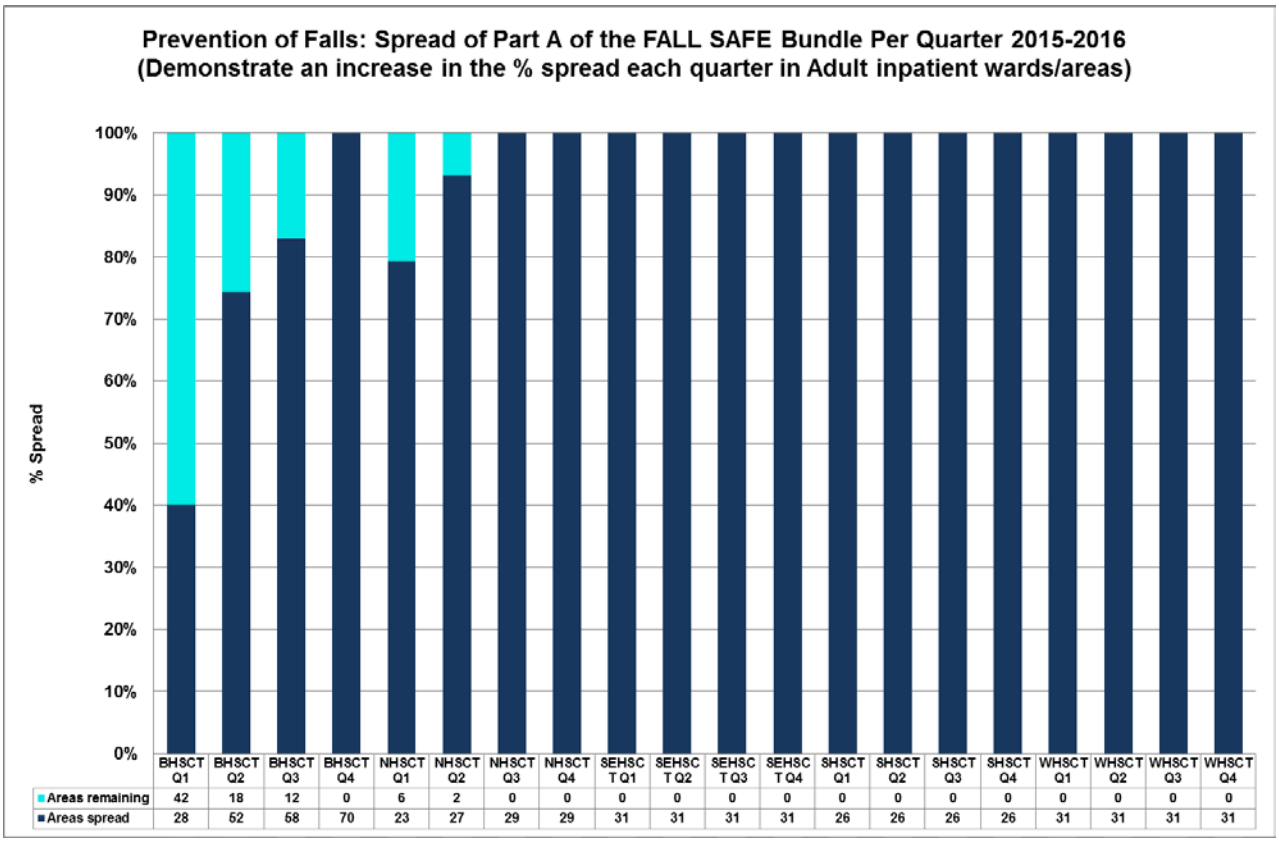


BHSCT, NHSCT and SHSCT have shown progress in percentage compliance with Part B of the Falls Bundle in 2015/16. The SEHSCT have remained steady with an average of 72% compliance. It should be noted that the WHSCT had a significant rise in progress with part B of the bundle for the final quarter of 2015/16. There has been an increased focus on training within the WHSCT in conjunction with Clinical Education Centre and they have increased their audit numbers for quarter 4.

The following table shows more detail with the number of audits carried out in each Trust during each of the four quarters in 2015/16 with Regional compliance of the Falls Bundle Part B:

Trust	Part B % Compliance 2015/16					No. of Audits (Part B) carried out in 2015/16				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total
BHSCT	39%	49%	42%	48%	**45%**	190	170	440	686	**1,486**
NHSCT	52%	70%	67%	67%	**65%**	445	640	608	599	**2,292**
SEHSCT	72%	74%	71%	70%	**72%**	621	743	819	557	**2,740**
SHSCT	57%	60%	62%	61%	**60%**	394	420	446	447	**1,707**
WHSCT	77%	60%	58%	97%	**86%**	60	60	50	300	**470**
REGION	**60%**	**68%**	**63%**	**65%**	**64%**	**1,710**	**2,033**	**2,363**	**2,589**	**8,695**

The following chart shows the spread* of the Falls Bundle (Part A) during 2015/16:



* when measuring the spread of quality improvement bundles the total number of adult inpatient wards may vary slightly within each Trust for a variety of reasons including; the appropriateness of the bundle within the particular area, the opening / closure of wards and/or re-categorisation of wards.

All Trusts have achieved 100% spread by quarter 4 in 2015/16.

2.7 Sharing of Regional Learning

The Regional Falls Group meet on a quarterly basis this group is led by the PHA and membership comprises a multidisciplinary team across the 5 HSC trusts. At each meeting progress is monitored, support and advice is given and regional learning is shared in relation to the prevention and management of falls.

The group have identified the following learning and this has been shared and actioned across all Trusts:

- Risk assessments are performed for all inpatients on admission, if they are moved to another area and if their condition deteriorates. The group has

contributed to the development of the regional nursing documentation relating to falls prevention and management.

- The falls prevention management plan should include the regionally agreed elements of the falls bundle interventions that minimize or eliminate the risk of falling for all patients assess of being at high risk of falling.
- Document all risk assessments, falls prevention interventions and treatments. A consistent documentation format is used across all HSC trusts.
- Communication of falls management, risk assessment and treatments should be consistent. Any change in the patient's condition is communicated to direct and indirect care providers as soon as observed.

2.71 Thematic Review of falls reported as serious adverse incidents (SAIs)

A thematic review of all falls reported as serious adverse incidents (SAIs) over a six month period was carried out in 2015/16; this provided a detailed analysis, identifying themes and causative factors. As a result a different approach relating to the post falls review of these incidents was adopted.

Trusts will manage falls resulting in moderate to severe injury as adverse incidents and undertake a post falls review internally; ensuring front line multidisciplinary staff are involved in this review, unless there are particular issues or identified learning that need to be investigated through the SAI process.

All falls resulting in moderate to severe harm are reviewed locally by Trusts as near to the incident happening as possible; and on a quarterly basis are reported to the Regional In-Patient Falls Group to identify learning, themes and trends. The Regional In-Patient Falls Group are working towards adopting a regional approach to the management of patient falls across Trusts in N.I. It will work towards the standardisation of a regional post falls review documentation and post falls assessment tool for use in all settings in line with best practice. This approach will be evaluated in April 2017 to assess its effectiveness.

The identified themes will be highlighted to inform the quality improvement work in falls prevention through the Regional Falls Group. Elements within the 'Fallsafe' bundle link directly with the themes arising from the thematic review and confirm the opportunity to use this to address the factors contributing to harm.

3.0 Venous thromboembolism (VTE)

3.1 What is Venous Thromboembolism?

Venous thromboembolism (VTE) is a blood clot in the vein. It's related to two life-threatening conditions:

- Deep vein thrombosis (DVT) is a clot in a deep vein, usually in the leg.
- Pulmonary embolism (PE) is a DVT clot that breaks free from a vein wall, travels to the lungs and blocks some or all of the blood supply. Blood clots in the thigh are more likely to break off and travel to the lungs than blood clots in the lower leg or other parts of the body.

VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance[12] has been endorsed by DHSSPS and implemented in Northern Ireland. Assessing the risks of VTE and bleeding is a key priority for implementation of the guidelines.

3.2 Commissioning Plan Target

The 2015/16 Commissioning Plan requirement states: “Trusts will sustain 95% compliance with VTE risk assessment across all adult inpatient hospital wards by March 2016”.

3.3 VTE Risk Assessment

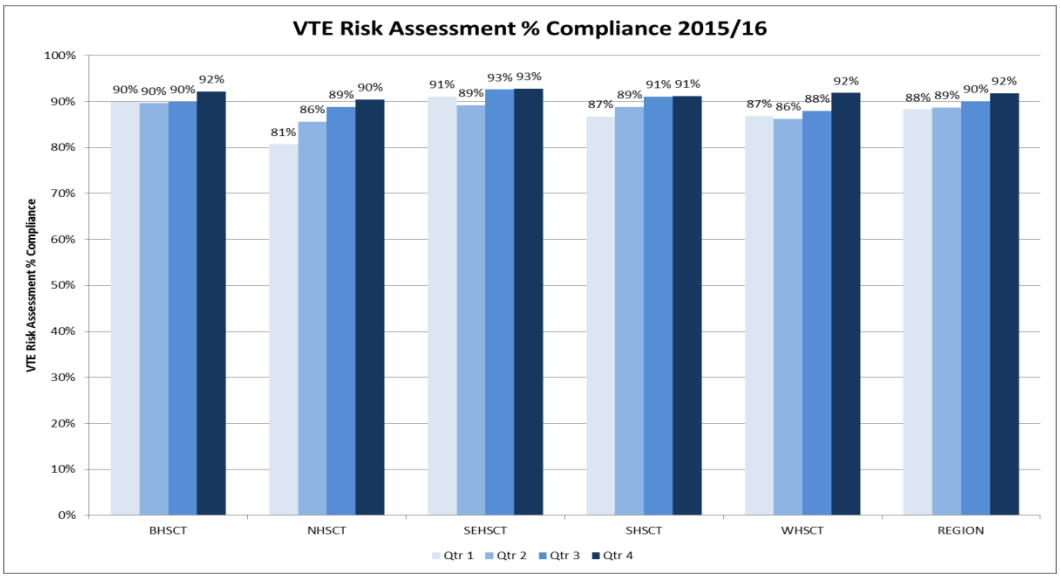
VTE prevention is, above all, about saving lives and reducing long term ill-health. This is a common and often avoidable circumstance. There is extensive evidence including the NICE guidelines [13]to assert that the patient must be assessed for their risk of a VTE and where appropriate should receive a form of prophylaxis suitable to their personal risk and existing conditions.

The measure being used by the Trusts is compliance with the completed VTE risk assessment in all clinical areas as identified below.

[12] NICE (Venous thromboembolism: reducing the risk for patients in hospital CG92: Published date: January 2010 Last updated: June 2015. https://www.nice.org.uk/guidance/cg92?unlid=4466718652016121651549

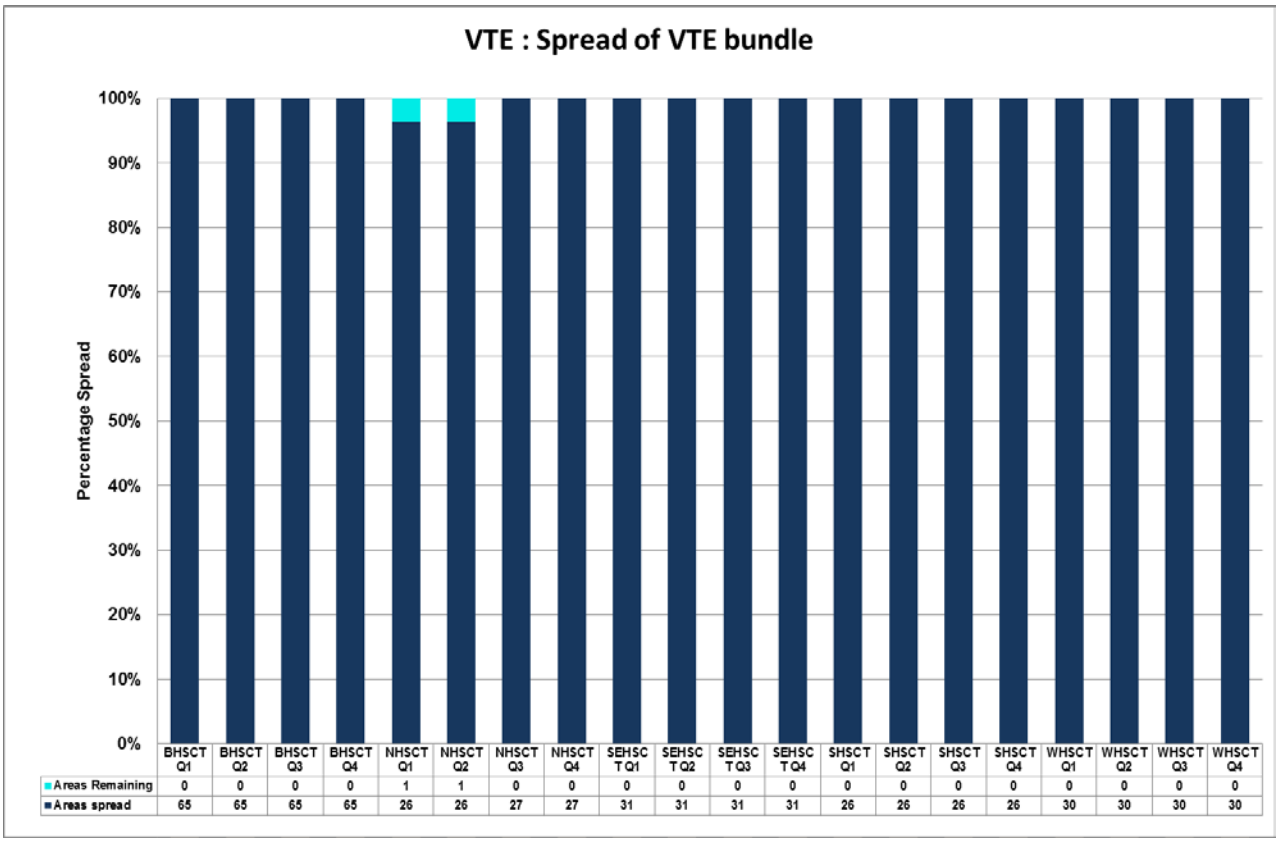
- All adult in patient areas – Adults (18years and older) admitted to hospital as an inpatient or formally admitted to a hospital bed for day case procedures.
- Excludes – people younger than 18 years (even if they are in adult ward), outpatients, ED patients who are not for admission, patients admitted with confirmed or suspected deep venous thrombosis or pulmonary embolus, obstetric patients.

The following chart shows the percentage compliance with the VTE Risk Assessment by Trust for each of the quarters in 2015/16:



While all Trusts have reported progress towards the 95% target for compliance of the VTE Risk Assessment across all adult inpatient hospital wards, no Trust has met this during any quarter of 2015/16. Regionally during 2015/16 there were 27,067 audits undertaken with 24,285 compliant – this equates to percentage compliance throughout the year of 90% for the region. Trusts reported they found it a significant challenge in achieving compliance with the risk assessment for VTE but all are committed towards achieving improvement.

The chart below shows the spread of the VTE Risk Assessment bundle during each quarter of 2015/16 for all Trusts:



During the final two quarters of 2015/16 all Trusts reported 100% spread of the VTE Risk Assessment Bundle, across all adult inpatient hospital wards.

4.0 The 'Malnutrition Universal Screening Tool' (MUST) tool

4.1 What is MUST?

The Promoting Good Nutrition Strategy (PGN) (DHSSPS, 2010)[14] identified the Malnutrition Universal Screening Tool (MUST) (BAPEN, 2003)[15] as the screening tool of choice to identify those adults who are at risk of malnourishment or who are malnourished. Nutritional screening is the first step in the identification of malnutrition. The screening process enables detection of significant risk of malnutrition and supports the implementation of a clear plan of action, such as simple dietary measures or referral for expert advice.

The nutritional status of hospitalised patients can be compromised by a number of factors, including the failure to detect poor nutrition, poor recording of information about patients' nutritional status (such as weight loss), poor referral systems, fragmented working practices, inadequate educational or training programmes, inadequate ward staffing and confusion over who has the primary responsibility for patients' nutrition. As well as preventing malnutrition it is important to anticipate those people who may be at risk of malnutrition. This is achieved through nutritional screening. In 2006, NICE[16] estimated that only 30% of patients were screened for malnutrition on admission to hospital. Nutritional screening should be undertaken using a validated screening tool. MUST has been validated for all health and care settings in Northern Ireland and for use by a range of professionals.

Since the initiation of the PGN Strategy in 2011 there has been a significant amount of work progressed across sectors to improve good nutrition, good hydration and enhance the patient/client experience of mealtime.

The Regional Promoting Good Nutrition Steering Group carried out an evaluation of the strategy in April 2016. it was noted that progress has been made in acute hospital settings on implementing and improving including key characteristic 9, 'MUST is embedded in acute areas of health and social care' .

[14] DHSSPS (2010) Promoting Good Nutrition Strategy http://www.dhsspsni.gov.uk/index/index-good-nutrition.htm accessed at 10 June 2013

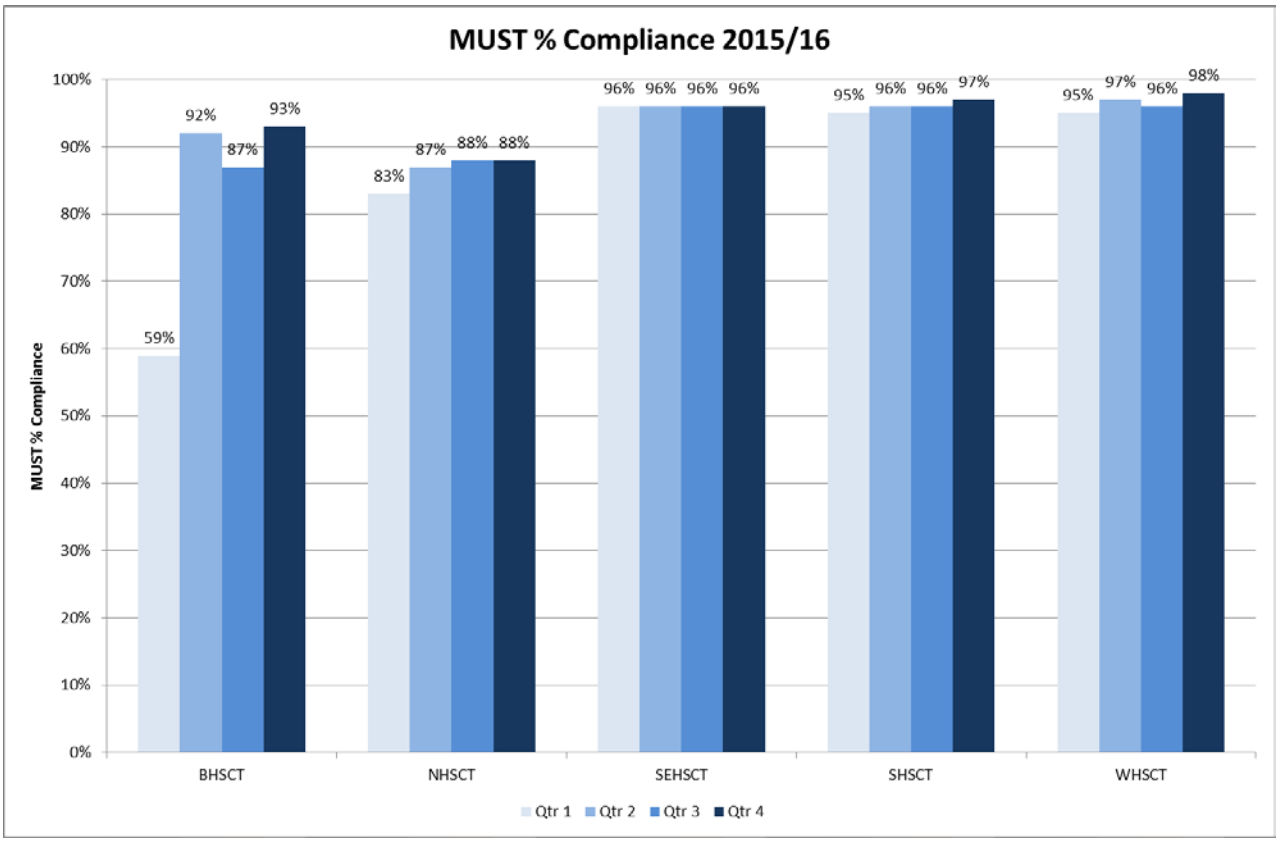
[15] For further information on 'MUST' visit http://www.bapen.org.uk

[16] Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition Clinical guideline [CG32] Published date: February 2006

4.2 Commissioning Plan Target

The 2015/16 Commissioning Plan requirement states: "% compliance of the completed MUST tool within 24 hours admission to hospital in all Adult Inpatient Wards by March 2016."

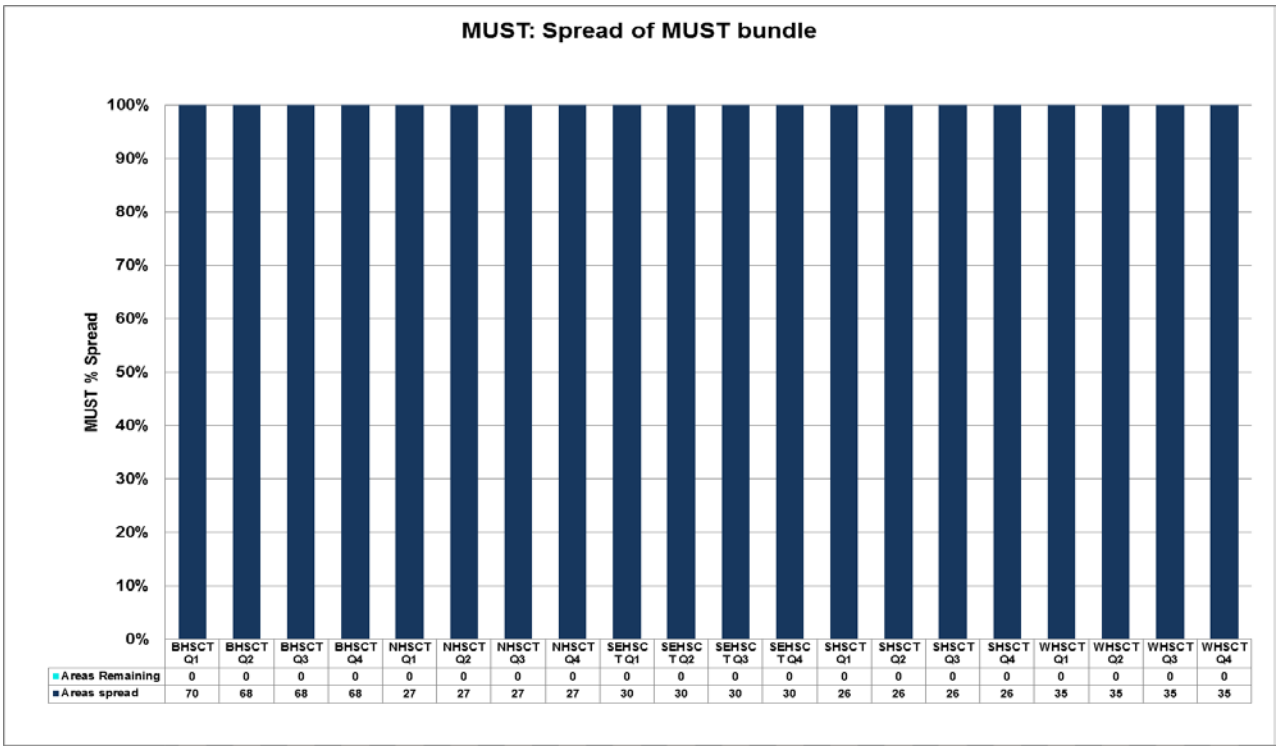
The following chart shows the percentage compliance with the MUST tool by Trust for each of the quarters in 2015/16:



By quarter 4 in 2015/16 the percentage compliance ranged from 88% (NHSCT) to 98% (WHSCT), with a regional percentage compliance of 94%.

Spread* of the MUST tool has been consistent at 100% for each Trust during each quarter in 2015/16. The chart below reflects this:

*when measuring the spread of quality improvement bundles the total number of adult inpatient wards may vary slightly within each Trust for a variety of reasons including; the appropriateness of the bundle within the particular area, the opening / closure of wards and/or re-categorisation of wards.



5.0 NEWS (National Early Warning Scores)

As part of its leadership role, the HSC Safety Forum has led the regional implementation of the National early warning score (NEWS), including appropriate escalation arrangements to improve care of the deteriorating patient, in all HSCTs. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating HSCTs to clearly define their expectations regarding intervention when NEWS is abnormal.

5.1 Commissioning Plan Target

The 2015/16 Commissioning Plan requirement states: "% compliance with accurately completed NEWS charts".

The following table shows the total number of audits completed with percentage compliance of NEWS by Trust for each of the quarters in 2015/16:

Trust	News % Compliance during 2015/16					No. Audits Carried Out during 2015/16				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	2015/16	Qtr 1	Qtr 2	Qtr 3	Qtr 4	2015/16
BHSCT	96%	97%	97%	98%	**97%**	5,348	6,500	5,246	7,249	**24,343**
NHSCT	94%	94%	94%	94%	**94%**	840	790	650	600	**2,880**
SEHSCT	80%	78%	88%	82%	**82%**	487	840	855	599	**2,781**
SHSCT	88%	90%	91%	92%	**90%**	554	539	548	535	**2,176**
WHSCT	97%	95%	85%	85%	**93%**	450	445	140	240	**1,275**
REGION	**94%**	**95%**	**95%**	**96%**	**95%**	**7,229**	**8,669**	**7,299**	**8,983**	**32,180**

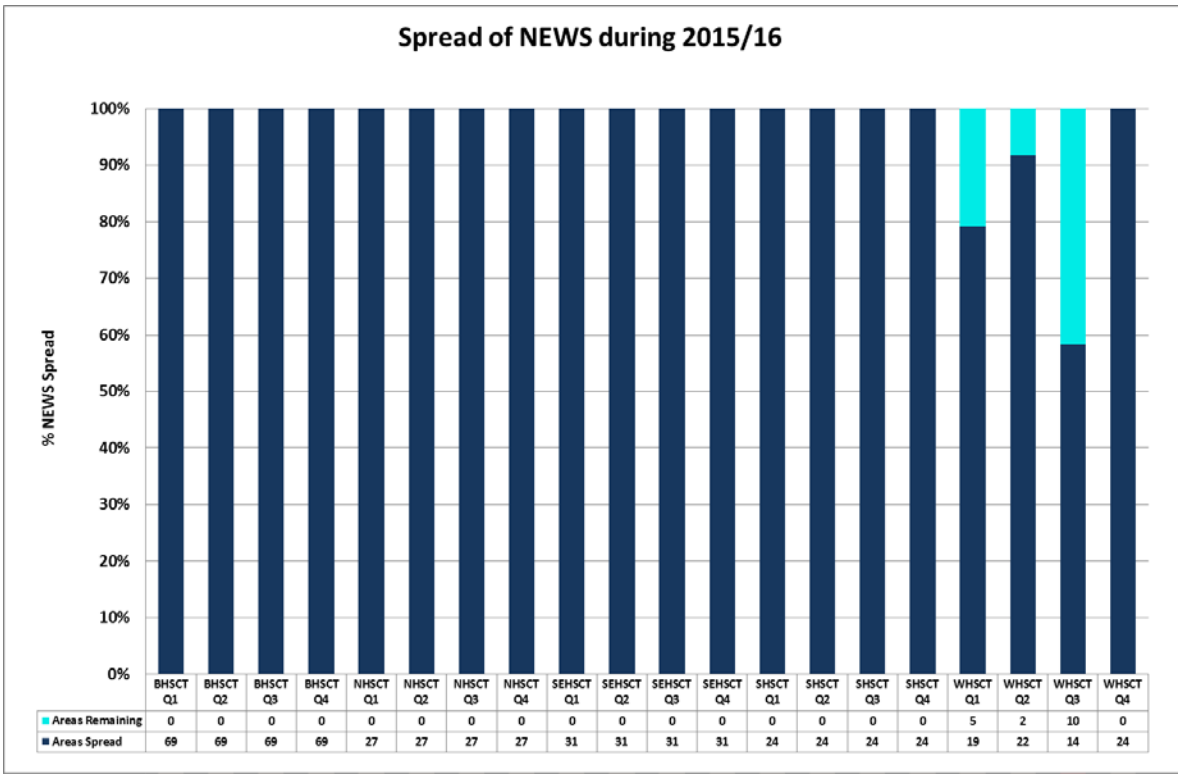
Only the WHSCT have recorded a lower % compliance in the final two quarters compared to the first two quarters in 2015/16, however as they were in the process of spreading it to new units, there can be an expected dip in compliance until the practices embed into the new areas.

Regionally the % compliance has increased each quarter over the same period.

It should be noted that using the Regional Audit Tool and guidance notes developed by the Regional EWS Working Group, an audit has been undertaken annually by each Trust since 2014 (in the period Jan-March) with the aim of measuring the use of NEWS and associated care escalation protocols. The 2016 figures from the N.I. Safety Forum relating to the overall compliance with NEWS charts shows a regional average compliance rate of 82% with a range of 64-98% across Trusts, this relates to a point prevalence survey being undertaken over the period January 2016 to March 2016.

The following chart shows the spread* of NEWS by Trust each quarter during 2015/16:

*when measuring the spread of quality improvement bundles the total number of adult inpatient wards may vary slightly within each Trust for a variety of reasons including; the appropriateness of the bundle within the particular area, the opening / closure of wards and/or re-categorisation of wards.



The WHSCT had difficulty in their spread of the regional audit tool and have worked with their clinical staff to improve this, in the final quarter 4 of 2015/16 they achieved 100% spread.

6.0 Conclusion

The HSCB/PHA have worked with the Trusts to produce a QIP Framework for 2016/17, which clearly outlines the processes for reporting, the escalation plan and gives further details on the regional priorities and the processes through which this will be achieved.

The PHA/HSCB will continue to seek assurances from HSC Trusts on the implementation of regional safety and quality priorities through the QIPs. HSC Trusts are required to provide quarterly information on the implementation of identified priorities to improve the quality in services and better outcomes for patients and clients.

The HSCB/PHA will monitor the implementation of the priorities identified in the QIPs recognising that it takes time to embed sustained improvements which demonstrate better outcomes for patients/clients. The PHA/HSCB will continue to work with HSC Trusts to review and address any identified issues and support the implementation of these priorities.

HSC Public Health Agency

MINUTES

Minutes of the Governance and Audit Committee
Thursday 6th October 2016 at 10:00am,
Fifth Floor Meeting Room, 12/22 Linenhall Street,
Belfast, BT2 8HS

PRESENT:

Mr Brian Coulter	-	Chair
Mr Leslie Drew	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director

IN ATTENDANCE:

Mr Ed McClean	-	Director of Operations
Miss Rosemary Taylor	-	Asst. Director, Planning and Operational Services
Mrs Michelle Tennyson	-	Asst. Director, Nursing, Midwifery and PPI
Mr Simon Christie	-	Asst. Director, Finance, HSCB
Ms Tracey McCaig	-	Head Accountant, HSCB
Mr David Charles	-	Internal Audit, BSO
Ms Christine Hagan	-	ASM
Mr Brian O'Neill	-	NI Audit Office
Mr Robert Graham	-	Secretariat

APOLOGIES:

Mr Thomas Mahaffy	-	Non-Executive Director
Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Catherine McKeown	-	Internal Audit, BSO

		Action
57/16	**Item 1 – Welcome and Apologies**	
57/16.1	The Chair welcomed everyone to the meeting and noted apologies from Mr Thomas Mahaffy, Mr Paul Cummings and Mrs Catherine McKeown.	
58/16	**Item 2 - Declaration of Interests**	
58/16.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

59/16	**Item 3 – Minutes of previous meeting held on 3 June 2016**
59/16.1	The minutes of the previous meeting, held on 3 June 2016, were approved as an accurate record of the meeting.
60/16	**Item 4 – Chair's Business**
60/16.1	The Chair advised that he had attended a meeting of the Information Governance Steering Group on 19 September at which he was saddened to hear that Joan Farley was leaving the post of Information Governance Manager. He went on to say that within the area of Information Governance, all aspects were working well but there remained some issues with regard to compliance with training, but he hoped that managers and Directors would continue to push this forward.
60/16.2	The Chair said that the Committee had received a report about an internal FOI and queried the appropriateness of HSC organisations submitting FOIs within the HSC family.
61/16	**Item 5 – Matters Arising**
	37/16 Assurance Framework
61/16.1	The Chair asked Mr McClean about the Assurance Framework and the diagrammatic summary. Mr McClean said that an amendment to a similar framework used by another HSC is currently being considered.
	42/16 Shared Services
61/16.2	The Chair said that the Committee would leave open the possibility of arranging to meet with the Chair of the Governance Committee of BSO as the Chief Executive of BSO is attending today's meeting.
	Meeting with Mr Liam McIvor, Chief Executive, BSO
61/16.3	The Chair welcomed Mr Liam McIvor, Chief Executive, BSO, and Ms Maxine Paterson, Acting Head of Shared Services, BSO, to the meeting. He said that the Committee were concerned with the impact on PHA of the findings within the Shared Services Internal Audit reports and had held a similar meeting in the past

	with the previous Chief Executive.
61/16.4	Mr McIvor began by saying that these reports had also been brought to the Audit Committee and Senior Management Team of BSO. He said that there was a recognised need for BSO to work with the Trusts to get solutions to the recruitment and payroll issues. He advised that a Task and Finish Group has been established and that this Group meets regularly to review progress against established KPIs.
61/16.5	Ms Paterson said that the Task and Finish Group will continue to meet until December. She explained that it is seeking to enhance the eRec system and what it can deliver by looking at the operational information it produces to see where the blockages are and to address these by, for example, providing training for managers. She advised that the database of requisitions is being analysed in order to see if any processes can be improved. Finally, she said that there are a number of different forums being set up for customers.
61/16.6	Ms Paterson said that of the recommendations within the latest Internal Audit report, the majority of the Priority One recommendations had been implemented and that the remaining ones should be completed within the next 3 months. The Committee was informed that the Western and South Eastern Trusts, as well as the Ambulance Service, will be brought on board soon.
61/16.7	Ms Mann-Kler thanked Mr McIvor and Ms Paterson for attending and providing this update. She noted that many of the recommendations had existed for 2/3 years. She also asked about any lessons learnt, and expressed concern that the introduction of new customers may bring new issues. However, she was assured by the fact that 82% of recommendations have been fully implemented.
61/16.8	Ms Paterson said that, with regard to recruitment, a key lesson learned related to need for standardisation and having training in place where everyone is aware of their contribution and role. She acknowledged that the recruitment system wasn't fit for purpose as a year ago, there was no reporting. She said that another lesson learnt was that there needed to be a collaborative approach from the outset with customers working alongside the

	supplier to develop the system. Ms Paterson noted that the work of the Group is very focused with very positive collaboration.
61/16.9	Mr McIvor noted that when the Southern Trust had come on board, their processes were different than those of other organisations and this highlighted the need for standardisation. He said that there is now better data to assess performance with metrics being shared with the Task and Finish Group representatives. He added that the next piece of work was to review the way the recruitment team work and whether to align staff to professional groupings or geographical areas. He emphasised the need for training and ensuring that in future where any problems are identified that issues are fixed immediately to prevent further damage further along the process.
61/16.10	Ms Mann-Kler asked about the issues in relation to payroll. Mr McIvor said that he had only been in post for 5 months and that in that period changes have been made based on the most recent audits, but there will be a consolidation done of all other outstanding audits. Ms Mann-Kler said that this is an area the Committee will continue to keep an eye on, given the potential for reputational damage. Mr McIvor said that from this point on, there will be an unrelenting focus on resolving the outstanding issues.
61/16.11	Mr Drew said that he was encouraged to see the Service Improvement Plan in place, and asked about the end date. Ms Paterson said that the remaining priority one areas should be addressed within the next 4/5 months and advised that in relation to overpayments, a workshop has been arranged. Mr Drew suggested that the original timelines in the project plan were unrealistic. He said it appeared that there was a lot of work required to reconfigure the system and train managers. He also asked if systems are in place to identify and share learning from this process.
61/16.12	Mr McIvor noted that the original BSTP project was led by the Department of Health and that there is a piece of work to, “close down” ongoing. He said that from his perspective, BSO is responsible for delivering the service and that he will ensure that any lessons learnt are taken forward. Mr Drew asked if any consideration had been given to involving the organisation who had been responsible for developing the system. Ms Paterson

advised that the system is an “off the shelf” package, and the focus is more on the users rather than on the supplier.

61/16.13 The Chair thanked Mr McIvor and Ms Paterson for attending and for their frankness and honesty in presenting the key issues. He said that the main issues for PHA had been about the efficiency and effectiveness of the systems and he acknowledged the level of detail provided in the responses. He added that it was reassuring that Internal Audit has noted improvements in its most recent audit.

62/16 Item 6 – Internal Audit

BSO Internal Audit Annual Report 2015/16 [GAC/36/10/16]

62/16.1 Mr Charles presented the first Internal Audit annual report which gives an overview of all Internal Audit activity across the HSC. He said that Internal Audit had appointed an IT Audit Manager, and therefore there is capacity to interrogate large amounts of data and look at trends. He noted some of the themes in relation to which areas received limited assurance and noted that 77% of recommendations had been fully implemented across the HSC. He highlighted PHA’s performance within the report in terms of assurance levels and follow-up performance.

62/16.2 Mr Drew said that it was very encouraging to see that there are robust processes in place and asked how many staff are employed. Mr Charles said that there are 34 staff within Internal Audit across 4 locations. Mr Drew expressed surprise at there being audit recommendations not implemented from 2010/11, but Mr Charles said that it may be the case that organisations have implemented them as far as they can, but are relying on others to complete the implementation.

62/16.3 Ms Mann-Kler commented on PHA having 4% of recommendations not implemented at the end of 2015/16 and how this is represented in the graph. Mr Charles accepted that the graph may appear skewed as PHA had a much lower number of recommendations than other organisations.

62/16.4 Mr Coulter asked about the performance in terms of finalising reports and receiving management comments. Mr Charles noted that the response times for draft reports can depend on the

	timing of Governance and Audit Committee meetings.
62/16.5	Mr Coulter asked if Internal Audit had ever conducted an investigation at short notice. Mr Charles said that this has sometimes happened, but would depend on the piece of work.
62/16.6	Members noted the BSO Internal Audit Annual Report.
	Internal Audit – New Definitions Cover Note [GAC/37/10/16] HSC(F) 47-2016 – Internal Audit Opinions and Prioritisation of Recommendations [GAC/38/10/16]
62/16.7	Mr Charles advised that a new circular changing classifications has been issued and these changes will take effect from 2017/18. He said that the definition of the priorities has changed and that Internal Audit will now be undertaking some work in their own team studying these new definitions and how they will be applied.
62/16.8	Ms Mann-Kler asked if the definitions were being used across the UK. Mr Charles said that in Northern Ireland, this was already the system in place across other Civil Service departments.
62/16.9	Ms McCaig asked if previous recommendations will be required to be reclassified, but Mr Charles said that Internal Audit had not yet had the opportunity to consider that.
62/16.10	Members noted the new definition cover note and the circular.
	Progress Report [GAC/39/10/16]
62/16.11	Mr Charles said that the Internal Audit Progress Report gives a snapshot of the Internal Audit activity for 2016/17 to date.
62/16.12	Mr Charles went through the audit conducted on contracts with the community and voluntary sector. He noted that in these contracts, there is reliance on organisations outside PHA's control. He said that 6 organisations had been visited, 2 of which had been visited in a previous audit. He said that overall there was a satisfactory level of assurance for PHA in terms of its management, and a satisfactory level of assurance for 5 of the 6 organisation, but limited assurance with regard to 1.

62/16.13	In terms of the priority one weaknesses in respect of the PHA management of contracts, Mr Charles highlighted the auditing of accounts and procurement. He noted that the issue which emanated from the auditing of accounts did not relate to PHA funding, and with regard to procurement he accepted that PHA is on a journey and significant progress has been made.
62/16.14	Mr Drew asked if PHA has the skills and capacity to carry out audits of accounts. Mr Christie explained that there is a finite resource and that initially accounts would be reviewed by the budget manager, and any areas of concern flagged up with the HSCB finance team.
62/16.15	Ms Mann-Kler asked about the organisation where this issue had emanated from and implications. Mr Charles reiterated that there is no risk to PHA as PHA normally provides funding on a quarterly basis on receipt of confirmation that specific objectives have been completed. Ms Mann-Kler asked about governance oversight. Mr Charles said that there are normally SLAs, and within these there should be expectations outlined regarding governance and financial management. Mr McClean agreed that there would be an expectation that organisations are functioning on a proper basis. Mr Coulter made reference to the role of the Charity Commission. Mr O'Neill added that irregularities in expenditure could lead to accounts being qualified.
62/16.16	Ms McCaig said that this is an area of concern, but PHA cannot assume a duty of care for every organisation that it deals with. She said having Internal Audit carry out these audits is one form of assurance. Mr McClean said that there are probity checks and governance checks for all organisations who apply for tenders.
62/16.17	Mr Charles moved onto the audit concerning the Centre for Connected Health. He said that the main contract is Telemonitoring and there are a small number of other European projects. He said that a satisfactory level of assurance had been provided in terms of the project management, but a limited level in terms of governance and oversight.
62/16.18	Mr Charles advised that there were some Priority One weaknesses identified, including how performance management information is fed up to senior level, the need to formalise the relationship between PHA and HSCB and a formal process for

	reviewing projects once they have been completed. He added that there was a need to share learning with other HSC organisations and develop SMART objectives.
62/16.19	Ms Mann-Kler asked about the outcomes based approach in the absence of SMART objectives. Mr McClean said that PHA is on a journey in relation to outcomes, and that there is a challenge in developing these outcomes, but also delivering them in a short period of time.
62/16.20	Mr Coulter said that he was concerned about the application of technologies within HSC settings and noted that this is an area of interest to the PHA Board.
62/16.21	Mr Charles moved on to the BSO Shared Services update report. He said that the area that requires greatest work is overpayments, but added that in some other areas there has been substantial progress and that it would be the intention of Internal Audit to carry out a further review in February/March 2017.
62/16.22	Members noted the progress report.
	Follow Up Report [GAC/40/10/16]
62/16.23	Mr Charles advised that the follow up report which tracks the progress of implementation of previous recommendations shows that 49 of the 60 recommendations have been fully implemented, and that there has been good progress with the remaining 11 being partially implemented.
62/16.24	Members noted the follow up report.
	Mid-Year Assurance Statement [GAC/41/10/16]
62/16.25	Mr Charles presented the Internal Audit Mid-Year Assurance Statement which is compiled from the information in all of the other audit reports. He explained that, although the Shared Services Audit is the responsibility of BSO, it appears within this report because of its impact on PHA.
62/16.26	Members noted the Mid-Year Assurance Statement.

63/16	**Item 7 – Finance**
	Fraud Liaison Officer Update Report [GAC/42/10/16]
63/16.1	Ms McCaig advised that the two cases previously reported to the Committee remained ongoing. She advised that the National Fraud Initiative for 2016 had commenced and that International Fraud Awareness Week would take place from 13-19 November 2016.
63/16.2	The Chair asked whether the amount involved in the first fraud case was substantial. Ms McCaig replied that it was a number of thousand pounds.
63/16.3	Members noted the report.
	Fraud and Bribery Policy and Response Plan Review [GAC/43/10/16]
63/16.4	Ms McCaig said that the Fraud and Bribery Policy and Response Plan had been approved several years ago and required to be updated. She highlighted the key changes. Mr O'Neill asked if there was reference within the Policy to the Comptroller and Auditor General. Ms McCaig advised that all cases would be reported to the Department of Health who have a responsibility to advise the Comptroller and Auditor General.
63/16.5	Members **approved** the policy and it was agreed that it should be brought to the PHA Board for approval.
	R&D – Changes to Funding Streams and Implications [GAC/44/10/16]
63/16.6	Ms McCaig advised that this paper was being brought to the Committee to formally record that PHA and HSCB are working through this change process. Mr Coulter said that the PHA Board was aware of this and thanked Ms McCaig for the paper.
63/16.7	Members noted the changes to R&D funding streams and implications.

	HSC(F) 47-2016 Internal Audit Opinions and Prioritisation of Recommendations [GAC/45/10/16]
63/16.8	This was covered under Internal Audit update.
	HSC(F) 52-2016 Revision of Delegated Limits [GAC/46/10/16]
63/16.9	Ms McCaig presented the updated Circular and highlighted the key changes. She said that the delegated limits for capital are now significantly different. She added that there is a change in terms of the limits for gifts and this will require a minor revision in the PHA Gifts and Hospitality Policy.
63/16.10	Members noted the circular.
64/16	**Item 8 – Corporate Governance**
	Corporate Risk Register (as at 30 June 2016) [GAC/47/10/16]
64/16.1	Miss Taylor advised that the Committee was today considering the Corporate Risk Register as at 30 June 2016, but that a further review, as at 30 September 2016, is under way. She said that at the end of June there had been no changes to the Register, with no new risks identified, and none of the risk ratings changed.
64/16.2	Mr McClean informed members that with regard to the procurement plan, there is reduced capacity with the impact of VES and that arrangements are being put in place, but there may be an impact of approximately 6 months in some aspects of the Plan.
64/16.3	Members noted the Corporate Risk Register.
	Assurance Framework 2015/17 (at 30 September 2016) [GAC/48/10/16]
64/16.4	Miss Taylor said that the Assurance Framework has been amended and drew members' attention to the key changes.
64/16.5	Members **approved** the updated Assurance Framework.

	Controls Assurance Standards Assessment Process for 2016/17 [GAC/49/10/16]
64/16.6	Miss Taylor explained to members that of the 22 Controls Assurance Standards, 15 are applicable to PHA and each year some are selected for external verification. In addition to the three core standards which are verified each year, Miss Taylor said that Emergency Planning and Human Resources will also be reviewed. She advised that processes are in place for the completion of the self-assessments with this work lead by the Senior Operations Manager.
64/16.7	Members noted the Controls Assurance Standards Assessment Process for 2016/17.
	Freedom of Information Internal Review Procedures [GAC/50/10/16]
64/16.8	Miss Taylor said that the Information Governance Steering Group had reviewed these procedures and that there were no substantial changes. She explained that the internal process review is instigated if an individual making an FOI request is not content with how their query was resolved and wishes this to be reviewed. If the complainant remains dissatisfied, Miss Taylor said that they can contact the Information Commissioner's Office.
64/16.9	Ms Mann-Kler asked if PHA had ever received any complaints relating to FOI. Miss Taylor said that there had been a small number and that PHA's procedures had been amended in light of learning from these.
64/16.10	Members **approved** the Freedom of Information review procedures which will be brought to the next meeting of the PHA Board.
	Information Governance Action Plan [GAC/51/10/16]
64/16.11	Miss Taylor advised that the Information Governance Action Plan had been updated, and that one of the key pieces of work completed was the development of guidance relating to small cell size publication.
64/16.12	Miss Taylor said that many of the other work areas have standing

	actions which are undertaken routinely. She highlighted the review of Information Asset Registers and explained that this work would normally be conducted later in the year but IGSG members had agreed that there would be more capacity in the third quarter to complete this. She added that there are some issues with regard to training which also need to be resolved.
64/16.13	Members noted the updated Information Governance Action Plan.
65/16	**Item 9 – SBNI Declaration of Assurance**
65/16.1	Miss Taylor explained that PHA is the corporate host for SBNI and that SBNI must comply with PHA policies and procedures and as part of that, develop its own Declaration of Assurance. She said that the SBNI have not raised any new issues, but advise that previous issues are being addressed.
65/16.2	Ms Mann-Kler asked whether there had been an external review of SBNI. Miss Taylor said that the Jay Review had been published. Mr Christie also said that the report contained some strong recommendations.
65/16.3	Referring to the Declaration of Assurance, Ms McCaig expressed concern about the reference to finance and explained that HSCB finance staff had been working with key staff in SBNI who are no longer there. Miss Taylor said that it was her understanding that the Director of Human Resources in BSO was working with the Department of Health regarding the staffing issue.
65/16.4	Mr Coulter said that he would be interested in getting further information around the transfer of the Child Death Overview Panel function to PHA.
65/16.5	Members approved the Declaration of Assurance.
66/16	**Item 10 – PHA Mid-Year Assurance Statement**
66/16.1	Miss Taylor said that PHA is required to submit its Mid-Year Assurance Statement to the Department of Health. She advised that key assurances are in place. She drew members' attention to the Internal Control Divergences which had come from the previous Governance Statement and have been updated to

	reflect the position as at 30 September 2016. Members asked for a small amendment to reflect Governance and Audit Committee continuing to watch BSTP progress.
66/16.2	Members approved the Mid-Year Assurance Statement and recommended that it go to the PHA Board for approval.
67/16	**Item 11 – Any Other Business**
67/16.1	The Chair asked the non-executive members to remain behind to discuss a confidential issue.
68/16	**Item 12 – Date and Time of Next Meeting** Date: Wednesday 7 December 2016 Time: 9:30am Venue: Fifth Floor Meeting Room Belfast BT2 8BS Signed by Chair: **Brian Coulter** Date: **3 February 2017**

HSC Public Health Agency

board paper

Performance Management Report – Corporate Business Plan Targets for period ending 31 December 2016

date 16 February 2017 **item** 11 **reference** PHA/05/02/17

presented by Mr Ed McClean, Director of Operations

action required For noting

Summary

This report highlights PHA performance against the 90 targets in the Annual Business Plan This is the update for the third quarter of 2016/17 – the period ending 31st December 2016.

Of the 90 targets – **77** are coded as green for achievability, **13** as amber and **0** as red.

One other target moved from Green to Amber (Target 6.9 on page 49) and four moved from Amber to Green (Targets 1.2, 2.4, 3.2 and 3.11)

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the Performance Management Report.

DRAFT

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Annual Business Plan 2016 – 2017

December 2016

Overview

This report provides an initial update on achievement of the targets identified in the PHA Annual Business Plan 2016-17.

The updates provided are for the period ending 30th December 2016. These updates on progress toward achievement of the targets were provided by the Lead Officers responsible for each target.

There are a total of **90 targets** in the Annual Business Plan.

Of these 90 targets – **77** are coded as green for achievability, **13** as amber and **0** as red.

One target moved from Green to Amber (Target 6.9 on page 49) and four moved from Amber to Green (Targets 1.2, 2.4, 3.2 and 3.11)

1. PROTECTING HEALTH						
Target from Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
1.1) The Agency will continue to work with Trusts to secure a further reduction of 25% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and in-patient episodes of MRSA bloodstream infection. *(Commissioning Plan Direction Target – By March 2017, secure a reduction of 25% in MRSA and Clostridium Difficile infections compared to 2015/16)*	This HCAI reduction target is a composite target comprising individual Trust reductions in MRSA and CDI cases to be delivered during 2016-17. *Note –CDI and MRSA position at 30 June 2016 is provisional pending C Ex sign-off of enhanced surveillance data.* As of 30 June 2016 13 cases of MRSA have been reported. As of 30 June 2016 76 cases of CDI have been reported	G	A	A		At this stage the targets are still potentially achievable. A range of measures are being undertaken to assist the Trust achieve their targets: Healthcare associated infection improvement workshop being planned to identify more effective approaches to reducing infections. Regular feedback of infection surveillance data to HSC Trusts (IPC teams and senior management) to enable targeting of their control measures. Monitoring and provision of assistance for any HCAI outbreaks that occur.

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
1.2) In line with DoH priorities, continue to work on the development/introduction of a surveillance system for anti-microbial resistance (AMR) in Northern Ireland and bring NI in line with the rest of the UK.	Recruitment of 2 fixed term posts agreed by Scrutiny Committee is now commencing.	A	A	G		Recruitment currently underway for the Band 8a and Band 7 EPI scientists (interview scheduled for Feb 2017).
1.3) During 2016/17 achieve uptake targets for seasonal influenza vaccinations set by DoH.	Work is progressing as planned to meet DoH vaccination targets. Seasonal flu vaccine programme for 2016-17 only commenced in late Sept 2016 so too early to have uptake figures.	G	G	G		
1.4) Continue to work with HSCNI organisations to vaccinate against Men B and Men ACWY and encourage uptake rates through information/educational campaigns.	Work is progressing as planned.	G	G	G		

2. IMPROVING HEALTH AND WELLBEING & TACKLING HEALTH INEQUALITIES

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.1) Develop and deliver a range of integrated public information campaign solutions to target audiences in line with key PHA priorities.	Mental Health campaign concluded. New request from DoH for Organ donation campaign in Feb / Mar. Campaigns part delivered for obesity, smoking, dementia and sexual health. Media planning agreed for programme remainder. Breastfeeding development underway (advertising tender). Development and part production required – on course Bowel cancer campaign development and production completed however implementation on hold due to service issues.	G	G	G		
Giving Every Child the Best Start - Theme 1 Making Life Better						
2.2) Ensure that implementation of Early Intervention Transformation Programme Work Stream One is in keeping with business goals and implementation plan.	Progress is being made in relation to the three key elements of EITP WS1: I. Alignment of HV to preschool settings – implementation commenced April 2016 II. 3+ health review in pre-school education settings – extension of pilot involving a target of 20% of children availing of DE funded preschool places commenced Sept 2016. III. Antenatal group based care and education – Group base care and education programmes commenced in all five HSCTs. Implementation Review – report received from Helga Sneddon and recommendations being taken forward by Steering Group.	A	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.3) Implement Early Intervention service linking with family support hubs. (Early Intervention Transformation programme Work Stream Two).	Early Intervention Support Services are operational across NI and complementary Parenting Programmes and Family Group Conferencing contracts in place. Programme implementation proceeding. QUB research instigated to enable a Control Group research programme.	G	G	G		
2.4) Implement the regional Infant Mental Health plan and commission training to HSC and early years workforce.	Multi-agency Infant Mental Health Implementation Group established and workgroups being formed to support specified actions within 2016/17. Regional Infant Mental Health Plan produced and issued. Infant Mental Health service development on the agenda of HSCB and plans produced by CAMHS Commissioners. Western Trust Pioneer Community Plan presented to IMH Implementation Group and CDPB agreed support. Meeting with Public Health Directors in Scotland and Wales and NI with WAVE Trust on the ACE agenda undertaken November 2016.	G	A	G		Infant Mental Health 2016/17 training programme identified and resources required to deliver to be secured. Solihull Approach Training Plan has been developed.
2.5) Implement the Action Plan of the Breastfeeding Strategy for Northern Ireland.	Breastfeeding Strategy Implementation Steering Group (BSISG) meeting took place on 3 October 2016, with the next meeting scheduled to take place on 8 February 2017. Action plan updated and RAG ratings for each of the 10 Work strands recorded.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.6) Ensure regional implementation of Family Nurse Partnership in keeping with Family Nurse Partnership specification and licence requirement	Work is continuing as planned.	G	G	G		
2.7) Promote the health, wellbeing and safeguarding of children through implementation of Healthy Child Healthy Future and Healthy Futures policy.	Summary report on Delivering Care Phase 4 (health visiting) submitted to DoH; Additional investment made by HSCB for one additional health visitor to all HSCTs and seven Child Health Assistants (CHA) between three of the five HSCTs based on existing CHA workforce; GAIN audit Every Child Counts – recommendations being taken forward by Healthy Futures Programme Board; Three monthly reporting on CHPP compliance (DH IoP) indicates increased regional compliance rate from 84.8% to 87% against seven of nine contacts (Quarter ending September 2016) – data being quality assured through regional audit; Other areas of work include school health profiling including Special Schools, Speech and Language Therapy Implementation plan and development of a Vision Screening Protocol.	G	A	A		Pilot of eCAT system for health visitor caseloads continues and consideration being given to applicability of eCAT for school nursing; 46 student health visitors commenced training Sept 2016;

Target from Business Plan	Progress	Achievability Jun Sep Dec Mar	Mitigating actions where performance is Amber / Red
Equipped Throughout Life – Theme 2 Making Life Better			
2.8) Procure a range of suicide prevention and mental health promotion services, including a focus on more vulnerable groups. Commission and/or procure the 24/7 Lifeline crisis intervention service. *(Commissioning Plan Direction Target – By March 2020, to reduce the differential in the suicide rates across NI and the differential in suicide rates between the 20% most deprived areas and the NI average. Areas of focus for 2016/17 should include early intervention and prevention activities, for example through improvement of self-harm care pathways and appropriate follow up services in line with NICE guidance.)*	Engagement element of procurement plan has commenced. The regional team has carried out engagement workshops in the areas of Mental Health and Suicide Prevention, community capacity and bereavement support. Current scoping exercise is underway with health intelligence regarding current services who are commissioned to deliver counselling services. Further engagement with young people is scheduled ad full consultation on all planned procured services will take place winter 2016. It is envisaged at this stage that the new Protect Life Strategy will be published. Currently awaiting decision of Health Minister on the next step in relation to the procurement of the Lifeline service.	G A A	Engagement sessions with young people have commenced. Full consultation has been delayed until the publication of the new Protect Life Strategy which is currently out for consultation. At this stage, it is unlikely to be available within the financial year. Awaiting decision from the Health Minister on next steps relating to the procurement of the Lifeline service. The Protect Life Strategy II will not now be published until after the Assembly Election and this will have an impact on the procurement process. This will also impact on the Lifeline service procurement.

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.9) Provide strategic leadership and co-ordinate the Regional Learning Disability Health Care & Improvement Steering Group on behalf of PHA & HSCB to ensure that good practice is promoted, health inequalities are identified and addressed and that services are responsive and make adequate adaptation to meet the health care needs of people with a learning disability.	The Regional Learning Disability Healthcare & Improvement Steering Group is continuing to progress improvement in the healthcare and health & social wellbeing of people with learning disabilities and to reduce inequalities in health for this client group. There are three Forums for specific areas of improvement. Workplans for each forum have been agreed and 2016/17 objectives are being progressed as follows: **Health Care Facilitators (HCF) Forum** **1. Electronic Health Check Form & Data Capture Excel Sheet** Electronic version of health assessment form has been developed. Completion of summary sheet by GP post health check and send this HCFs. HCFs are inputting data post health check from 1 April 2016, it is anticipated there will be available data to analyse by March 2017. **2. Excel tailored training (Leadership Centre):** Training for HCFs was delivered on 15 September 2016. The training was well attended by HSC Trusts. Evaluation of training disseminated to Trust AD's for information. **Health and Wellbeing Action Plans:** The Health and wellbeing action plan, guidance notes to support and pathway to illustrate process have been approved by Bamford review group. The Trusts have been asked to complete 20 Health and wellbeing action plans for this financial year.	G	G	G		

	The Regional Health & Social Wellbeing Improvement Forum This forum are taking forward a number of objectives in 2016/17, to include focus on: • Promotion of healthy eating within Day Centres for adults with a learning disability; • Measures to promote healthy personal and sexual relationships for adults with a learning disability; • Promotion of physical activity for people with a learning disability and their families/ carers. **The Regional General Hospital Care Forum: Learning Disability** **Development of Regional Hospital Passport** • Draft Passport developed and piloted across all Trusts, with support from the HSC Safety Forum. • Feedback excellent, full endorsement across clients, carers and staff • Official launch is expected April 2017 The forum continue to monitor any potential risk of Trusts failing to progress with implementation of recommendations from the RQIA Report & GAIN Guidelines. A progress report (to December 2016) from all 3 Forum is available. A further progress report will be collated post March 2017.					

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
Empowering Healthy Living – Theme 3 Making Life Better						
2.10) Implement the Tobacco Control implementation plan including Brief Intervention Training, smoking cessation services, enforcement control and Public Information. *(Commissioning Plan Direction Target – In line with the Department's ten year Tobacco Control Strategy, by March 2020 reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%*	The Tobacco Strategy Implementation Plan is being rolled out with KPI monitoring presented to Tobacco Strategy Implementation Steering Group (TSISG). Smoking cessation services information for Q2 not yet available. Q1 services information will be shared with TSISG on 12 October 2016. Brief intervention training is being offered in HSCTs and with other groups, such as optometrists. 'Smoke Free' was launched in health and social care sites in March 2016. Enforcement work is progressing well across the region. Preliminary work is underway on a public information campaign. TSISG continues to meet thrice per year with specific actions updated with 'RAG' ratings. Currently, the proportion of: • 11-16 year old children who smoke is 5% • Adults who smoke is 22% • Pregnant women who smoke is 14.7%	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.11) Support and lead multi-agency partnerships to oversee regional and local delivery of Protect Life and Mental and Emotional Wellbeing strategies including the regional Bamford structures and local Protecting Life Implementation Groups' Action Plans.	Thematic plan 2016-17 complete, with local implementation plans in place and continues to be monitored closely. Regional Bamford group continues to be chaired by PHA and meets thrice per year. Regional programmes are presented at these meetings. PHA awaits clarification on the future role of Bamford in the new Protect Life Strategy. Five local areas have Protect Life Implementation multi-agency partnerships who share information locally and contribute to the regional Bamford group. Local implementation plans are in place and continue to be closely monitored.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.12) Implement the obesity prevention action plan including: weight management programmes for children, adults and pregnant women, development of a common regional Physical Activity Referral programme, implementation of Active Travel programme in schools, implementation of Active Travel Plan Belfast and public information and awareness. *(Commissioning Plan Direction Target – In line with Departmental strategy A Fitter Future For All, by March 2022 reduce the level of obesity by 4% points and overweight and obesity by 3% points for adults and by 3% points and 2% points for children)*	Year 3 of the Childhood Obesity campaign launched in NI on 12 May 2016 with focus on treats and sugary treats at this stage. The campaign will be re-launched again during the year focusing also on portion sizes. *'Weigh to a Healthy Pregnancy'* pilot and evaluation completed. Intervention now being mainstreamed for 2016/17. Specification drafted and IT system being developed for Physical Activity Referral Programme, new scheme and system to be fully operational in 16/17. Active Schools Programme commissioned with Department of Infrastructure for 2016/17 – 2019/20.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.13) Take forward recommendations of the RQIA 'Review of Specialist Sexual Health services in Northern Ireland' in partnership with DoH, HSCB and HSC Trusts.	Preparations for a workshop in October 2016 progressed well during Q2 of 2016/17 and are on target, to deliver a revised RQIA review implementation and strategic action plan addressing all recommendations by the end of Q3.	G	G	G		
2.14) Ensure Trusts continue to deliver Telehealth and Telecare services including through the Telemonitoring NI contract, to targets set by the PHA.	Detailed plans for achievement of Trust targets are currently being developed by Trusts for consideration by CCHSC. The use of Telemonitoring is being expanded in new areas including renal patient monitoring, obesity management during pregnancy, malnutrition monitoring and head and neck cancer.	G	G	G		

Target from Business Plan	Progress	Achievability Apr	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
Creating the Conditions – Theme 4 Making Life Better						
2.15) Develop and implement a consistent approach to workplace health and wellbeing programmes working with local government and other partners.	A new workplace health and wellbeing service has been commissioned. Contracts have been awarded to: • Health Matters – Belfast, Southern and south east. • NICHS – northern area • Derry Healthy Cities – western area Monitoring arrangements agreed with local offices. First Regional meeting with provider has been scheduled to promote and share good practice. Workplace health conference proposed for 2nd March 2017 in Riddell hall. Theme for next year requested by BITC Challenges of an Ageing Workforce.	G	G	G		
2.16) Lead AHPs in the development of Public Health Strategies for Children & Older People	The AHP older peoples working group meets regularly. The development of AHP public health strategies/ messages for older people is in progress. These messages are being developed in partnership with Age NI and older people with the aim of promoting independence and reducing loneliness. Key health promotion for children and young people have been agreed and amended following wide consultation with service users. The posters associated with communicating these messages are at the final stages of development.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
Empowering Communities – Theme 5 Making Life Better						
2.17) Further develop the Travellers Health and Wellbeing Forum and delivery of the regional Action Plan.	Revised 2016/17 Thematic Plan issued, new commissioning resources and programmes for Traveller Posts and Mental Health and Emotional Wellbeing both completed and Regional Forum meetings planned and being undertaken**.**	G	G	G		
2.18) Work with local communities and community based organisations to develop integrated approaches to improving health.	Work continues with local communities and community based organisations to develop integrated approaches to improving health and wellbeing. This includes agreeing shared aims and objectives for Healthy Living Centres on a number of key thematic areas, as well as contributing to the Community Planning Partnerships across each council area to develop joint goals and shared outcomes for communities.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.19) Encourage, facilitate and support the active involvement and participation of service users, carers and the public in the planning, delivery and evaluation of health to enable people to take more ownership of and self-responsibility for their own health and social well-being	The PHA continue to encourage, facilitate and support the active involvement and participation of service users, carers and the public through a number of work streams, including: • Facilitation and support of service users and carers on the Regional HSC PPI Forum to participate at a high level in the planning delivery and evaluation of HSC services. • Establishment of agreed processes to embed PPI monitoring recommendations into Trust Action Plans. • Encourage HSC Trusts to implement agreed PPI Standards and use best practice in PPI. • Share best practice and develop understanding of PPI through promotion, e.g. Articles and photographs and social media. • Supporting a range of regional priority areas to use best practice approaches to involving service users and carers, these include E-Health Strategy, EHCR, EITP, Stroke services, procurement of social care services, medicines management, modernisation of pharmacy services, PHA corporate strategy.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.20) Continue to work with local government on the alignment and development of community planning and PHA planning and to initiate a range of demonstration projects in each council area embedding the key drivers of 'Making Life Better'	Work continues with local government on the alignment and development of community planning and PHA planning. PHA continues to work with councils, individually and collectively, as well as contributing to each of the community planning partnerships to develop joint goals and shared outcomes for communities. Work is also underway with councils to ensure alignment where possible of indicators and data to monitor and measure impact and implementation of community planning, MLB and the corporate plan. PHA identified, proposed and agreed the following four areas of joint working with all HSC organisations at the Making Life Better Autumn Forum as the key areas for HSC in community planning: • Healthy lives – physical activity and healthy weight; • early years and early interventions; • mental health and wellbeing; • active ageing and age friendly This shared programme, based on local need and regional direction, is currently being developed to consolidate Making Life Better and community planning goals and demonstrate collaboration and impact. These four areas have also been agreed as important aspects of delivery of the Healthier Lives Programme outlined in the draft Programme for Government (2016-2020) for outcomes 2, 3, 4 and 7.	G	G	G		

Target from Business Plan	Progress	Achievability Jun Sep Dec Mar	Mitigating actions where performance is Amber / Red
Developing Collaboration – Theme 6 Making Life Better			
2.21) Continue to work with key stakeholders to lead and coordinate implementation of Making Life Better through the Regional Project Board, local partnerships and Health and Social Care Northern Ireland	Work continues with key stakeholders to lead and coordinate implementation of Making Life better. Work is underway with ADOG to consider the impact of their review and recent renewed membership on the Regional Project Board and how to ensure it is delivery focussed as we progress. The second annual MLB HSC Autumn Forum took place on 30 September 2016. HSC organisations came together to discuss priorities and implementation of Making Life Better within HSC and agreed four key areas for HSC joint working with and input into community planning: • Healthy lives – physical activity and healthy weight; • early years and early interventions; • mental health and wellbeing; • active ageing and age friendly. These areas have also been embedded within the draft Programme for Government Delivery Plan (2016-2020) for indicators 2, 3, 4 and 7. Engagement with local government is also underway through existing partnerships and community planning processes to identify key areas of joint working in line with community planning and Making Life Better.	G G G	

Target from Business Plan	Progress	Achievability Jun Sep Dec Mar	Mitigating actions where performance is Amber / Red
2.22) As professional Lead in development and implementation of Regional e-Health and Care Strategy, engage with nursing and AHP workforce as part of strategy implementation; agree action plan and monitoring process	Work continues to engage nursing and AHP workforce in • raising awareness of the use of eHealth in care delivery • the need to standardise care pathways in preparation for digital transformation An outline business case is currently being developed for a single digital electronic health and care record for NI. A nursing Informatics network to shape the design and development of initiatives in the future was established in January 2017 A professional communications and engagement plan will be developed by April 2017	G G G	

3. IMPROVING THE QUALITY OF HSC SERVICES						
Target from Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
3.1) Work with the HSCB to take forward the review of the Cancer Services Framework and implementation of the revised Framework during 2016/17 (staff and financial resource dependant.)	PHA & HSCB colleagues are working in conjunction with DoH officials to finalise a draft Cancer Services Indicator Framework (CSIF).	G	A	A		The draft CSIF is expected to be agreed by 31 March 2017.
3.2) Work with the HSCB to take forward the Cardiovascular Services Framework Implementation Plan.	Work proceeding more slowly than planned. CVSFW Lead has returned to work. The Cardiology Lead has been off on unexpected leave. The mid-year report is under development.	A	A	G		
3.3) Take forward the Implementation Plan for the Respiratory Service Framework, following consultation.	The Respiratory Framework implementation plan was formally approved by the DoH in February 2016. We are now in the first year of implementation cycle and currently working with Trusts to collect data on the first year KPIs. First year report was submitted to DoH in September 2016 after AMT/SMT approval. We are currently working to prepare mid-year report for year 2.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.4) Continue to Lead the Long Term Conditions Regional Implementation Group to deliver on its action plan, and commission patient and self –management programmes as outlined in PfG, (subject to funding).	Additional investment is planned for diabetes and cardiac rehabilitation.	A	A	A		No funding identified for generic self-management programs that could support multiple LTCs.
3.5) In collaboration with the DoH, DoJ, HSCB and HSC Trusts provide Public Health leadership and professional nursing advice to the Joint Health Care & Criminal Justice Strategy. Work alongside YJA, PSNI and HSCB colleagues to identify health care model for the provision of health care in Police custody and Woodlands Juvenile Justice Centre.	Engagement in the Joint Health Care & Criminal Justice Strategy which is Departmental led. Determination that Healthcare in Custody will not transfer to healthcare at this time. PHA working with PSNI to develop a new model for healthcare in custody including skill mix of nurses and Forensic Medical Officers. Project lead appointed to drive workplan forward The C/EX YJA escalated nurse staffing shortage to the Board and PHA due to the significant risks. PHA nursing advice, support and recommendations provided to newly appointed Director at Woodlands in relation to nursing workforce and practice standards. Responsibility for health care at Woodlands remains with Juvenile Justice (JJ). Arrangements are in place so that JJ can avail of professional nursing support when this is required.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.6) Produce final report for issue to Department on the mental health nursing framework, 'Developing Excellence, Supporting Recovery' including impact of implementing a Recovery model for service improvement.	The final report on the DESR Action Plan was agreed and sent to the CNO for approval in June 2016. The DESR Implementation Group awaits guidance on the future of the strategy. The DESR Group continue to meet on a quarterly basis to assist in taking forward several identified key pieces of work for Mental Health Nursing in the near future, which includes: **1.** Co-Production in Mental Health – A final draft is currently being presented to Trust professionals and service users for consultation. **2.** Mental Health 'Nursing Delivering Care' Review – Literature review and final draft for consultation to be completed by mid Feb 2016. **Mental Health Nursing KPI's** Therapeutic and Psychological Therapy Interventions – has been developed and will be tested in WHSCT – March 2017. Absconding – Currently in the 4th quarter of monitoring – Data for quarters 1 – 3 has been submitted by Trusts via Sharepoint. Regional group meet regularly to review the data and discuss the monitoring process.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.7) Along with HSCB lead the implementation of the NI Dementia Strategy and lead the OFMDFM/AP funded Dementia Signature Project (due to complete June 2017).	• Information, support and advice including media campaign PHA launched Phase 2 of 'Still Me' dementia public awareness campaign in December 10/10 Dementia Navigators have been recruited. • Training Work is continuing on a Delirium Collaborative in acute wards as well as ED. Targets have been agreed to implement a delirium bundle over the next two years. 1000 staff have been trained and 'train the trainer' approach is now being implemented as a legacy of the project. The first cohort of Dementia Champions are due to graduate in Feb 2017. Aim is to have up to 300 staff trained by Nov 2017. The first cohort will complete training by Jan 17. Carers training commenced in June following contracts being awarded to Alzheimer's Society and 352 Skills. • Innovative short breaks and respite Contracts have been awarded for four pilots: home support, extended domiciliary care, emergency support and enhanced day opportunities. • Regional Review of memory OP services This work completed in October 2016 and implementation discussions are ongoing with senior DOH staff.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.8) Take forward recommendations on the DoH District Nursing Framework.	Contribution made to drafting and progress made on Delivering Care element.	A	A	A		Awaiting the final publication of the Framework.
3.9) Continue to lead on the implementation of PPI policy in HSC, with a focus on promotion of the new PPI Standards, extension of the PPI Monitoring function and roll out of the PHA led PPI Training Programme for staff.	The PHA continues to lead on the implementation of PPI policy across the HSC system. In recent times this has included: • Leading on the development of a guide on co-production and involvement to inform the work of Transformation workstreams. • Embedding of PPI Standards as the framework for PPI monitoring and as a structure for action plans. • Review and update work on future PPI monitoring arrangements with HSC Trusts.	G	G	G		
3.10) Progress existing programs of quality improvement, continue to build capacity and knowledge on patient safety, improvement science and human factors, and explore future options for collaboration in QI and safety with CAWT partners.	Work is continuing as planned.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.11) The HSC Safety Forum will work with HSC Trusts to support the further spread of the Sepsis 6 bundle beyond the pilot areas identified in the 2014/15 period.	Some trusts have had difficulty with engagement but all trusts now collecting at least baseline data	A	A	G		
3.12) The HSC Safety Forum will work with the Regional Learning Disability Healthcare and Improvement Group to identify potential future opportunities to work collaboratively in quality and safety improvement.	Meeting held in Spring with several potential areas for work. Unable to progress currently due to lack of capacity	A	A	A		Some potential for improvement work identified but little internal capability/capacity for QI within L&D and no capacity within Safety Forum for additional areas of work except to provide general advice.
3.13) Continue the review of school nursing using a needs led, child focused and evidence based approach to service developments.	A pilot has been completed to test a school health profile across a small number of primary and post primary schools in each HSCT in partnership with education to identify health needs. A report on the data and views of the users will with be available in the autumn 2016. Work on a system to consider workforce make-up and a method of determining staffing requirements has commenced. Development of regionally consistent practices across four levels of need is progressing.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.14) Continue to develop the methodology and models for phases 2–4 of the Delivering Safe and Effective Care Project (ED, DN and HV), and progress monitoring arrangement with HSCB for implementation of Phase 1.	Progress report shared at Regional Delivering Care Steering Group. Phase 2, 3 and 4 summary papers finalised with endorsement from Chief Nursing Officer. Working assumptions for Phase 3 still underway. Data collection for ED & HV baselines finalised. Phase 5 Mental Health commenced. Phase 6 Neonatal Nursing underway.	A	A	A		Awaiting the final publication of the District Nursing Framework to inform Phase 3 implementation plans.
3.15) Ensure adherence to statutory midwifery supervision and provide professional leadership in relation to the development of high quality, safe and effective midwifery services in keeping with the Maternity Strategy.	In accordance with the NMC Midwives rules and standards (2012). Plans in preparation for change in legislation that will result in HSCTs taking responsibility for midwifery supervision, and removing responsibility from the Local Supervisory Authority (PHA).	G	G	G		
3.16) Q2020 – Lead the development of the Annual Quality Report in conjunction with the HSCB.	Work is continuing as planned. The 2015/16 PHA/HSCB Annual Quality report was developed and published on world quality day in November 2016.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.17) Lead on the professional issues relating to the transition of HSCB/PHA Medicines Management Model from HSCB to PHA.	The business plan entry refers to an action that will be taken forward by Nursing and Allied Health Professions within the agency regarding learning and transition from the non-current model to a recurrent model. Currently work is ongoing between the HSCB, PHA and NHSCT to progress the commissioning of this recurrent model. The commissioning and service specifications have now been finalised and agreed between HSCB, the Public Health Agency and Northern HSC Trust, and the aim is to transfer the service from 1st January 2017. NHSCT will be the host Trust for the Regional Management Medicine Dietetic service of 5 Dieticians with support from Prescribing support assistants. The team will work in Primary Care to identify, assess and provide recommendations to patients and relevant Health Care professionals, including GPs on the appropriate use of oral nutritional supplements, promoting a food first approach.	A	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.18) Work with Trusts to integrate the Patient Client Experience work programme and 10,000 Voices Initiative to develop systems to listen to, learn from and act upon patient and client experience.	Work is continuing as planned. The regional patient and client experience programme of work is continuing to be implemented – this includes: - Monitoring the implementation of the 4 key regional priorities - Continuation of the 10,000 Voices work plan in range of areas - Planning key priority areas for 2017/18 - PHA Provided responses to the DoH healthcare experience framework and await the outcome of the post consultation.	G	G	G		
3.19) Ensure professional readiness of Therapeutic Workforce in WHSCT Radiotherapy Unit.	The workforce is in place, correct skill mix, appropriately trained Links established within and external to trust to ensure professional governance Links and professional support being offered by the PHA and accepted by professional staff RAG status green – the unit has opened	G	G	G		
3.20) Lead a programme of work to drive reform of Allied Health Professionals Services including • Improving data quality; • Development of Care Pathways	The PHA is continuing to work alongside the HSCB to complete the final capacity and demand project with BHSCT. All other Trusts have received correspondence from Director of Commissioning outlining gaps and HSCB expectations on filling the gaps. Work has also been completed on the development of elective pathways in key areas constituting highest levels of demand.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.21) Lead development and implementation of year 4 Allied Health Professionals Strategy Action Plan	A final report was compiled and presented to DOH outlining key achievements in line with the 4 themes of the Strategy. The report included a number of areas which would require further development and to achieve this proposed to the DOH the need for an extension to the current strategy for their consideration.	A	G	G		
3.22) Lead the development of Palliative Care services	The Regional Palliative Care structures consist of a Programme Board, Clinical Engagement Group and a Service User and Carers Engagement Group. The Programme Board consists of members from across the five localities coterminous with HSC Trust boundaries in NI. Membership also include representatives from DoH, HSCB/PHA, Northern Ireland Ambulance Service, Hospice and independent palliative care providers, community and voluntary sector, Integrated Care, ICPs, Primary Care and service users and carers. The Programme Board is co-chaired by Mary Hinds, Executive Director of Nursing and AHPs, PHA and Dean Sullivan, Director of Commissioning, HSCB. The key work areas for 16/17 ; <u>Identification</u> To improve the identification of people with palliative care needs, <u>Keyworker</u> To ensure everyone identified as being in their possible last year of life has an allocated keyworker	G	G	G		

	<u>Advance Care Planning</u> To ensure everyone identified as being in their possible last year of life has the opportunity to discuss <u>Planning for Specialist Palliative Care Services</u> Working with the Clinical Engagement Group, a report on workforce planning relating to Specialist Palliative Care across the region for: Medicine Consultants, AHPs, Nurses and Social Workers. Other Workstreams in 2016 The work areas commenced under the 'Transforming Your Palliative and End of Life Care' initiative, and some outstanding work from LMDM will continue to be progressed in 2016/17 namely: • Palliative Care Tools • Pharmacy • Hospital Discharge • Carers Support • Training for Nursing Homes • Ambulance Service • Monitoring and Measures • Raising Awareness And in addition, the eight recommendations of the RQIA Review of the Implementation of the Palliative and End of Life Care Strategy (LMDM). Communication					

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.23) In support of safe and effective person centred care, Commissioners through the Director of Nursing PHA should require of organisations and bodies from which services are commissioned, that appropriate systems are in place to ensure that nurses and midwives are appropriately supported to fulfil regulatory requirements of the NMC, in particular the introduction of revalidation for Nurses and midwives.	In accordance with the NMC Midwives rules and standards (2012) Revalidation Lead provides ongoing support, resources and Face to face awareness sessions to all nurses (HSCB/PHA) and their line managers. Established an Xl database of Nurses in HSCB/PHA shared with HR On-going support is available from PHA to GP practice nurses including face to face meetings. Professional Forum offers regular opportunity for updates to be provided. All communication from NMC/NIPEC cascaded to HSCB/PHA Midwives are required to have an annual review completed which ensures that their date for revalidation is noted at the time of entry onto the LSA database.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.24) Develop framework for primary care nursing.	Primary Care Framework completed in partnership with RCGP, BMA and RCN. Report shared at regional event in October 2016 by senior nurses including CNO. Regional Implementation & Steering Group in place. Agreement to fund additional Advanced Nurse Practitioner places for primary care nurses agreed. Funding from DOH / GP led review to be determined for additional posts. Numbers to be confirmed with PHA. To date progress has been positive. ANP course to be delivered by University of Ulster with cohort from Down Federation. Funding for GP-led review proposed. Training for Primary Care Nurses to be progressed with Regional Steering Group.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.25) Develop and take forward regional service improvement within older peoples environment focusing on initiative regarding workforce recruitment/and education.	A Vision statement and paper focusing on the role of nurses in the care and support of Older People developed in partnership with Age NI. Action plan being considered. Each Trust is in process of developing a work plan and progress will be monitored via the Band 7 older peoples nurse which PHA funded non-recurrently. Significant work will be progressed through the Burdett Trust grant project which PHA has secured for 18 month for nurse recruitment, retention and co-design. Discussions are underway with each Trust to develop older persons/dementia networks which will eventually develop into a regional nursing network. These networks will discuss service improvements within elderly wards and any staff education needs will be identified.	G	G	G		
3.26) To complete the review of AHP support for children with statements of special educational needs, agreeing a proposed framework and implementation plan for consideration by the Minister of Health, Social Services and Public Safety.	The review is now complete. The proposed framework, implementation plan, findings report and equality screening have been signed off by the Project Board and submitted to DoH.	G	G	G		

4. IMPROVING THE EARLY DETECTION OF ILLNESS						
Target from Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
4.1) Rolling programme of analysis by health intelligence of screening data and evidence reviews of actions elsewhere to better inform targeting of screening in lower uptake populations.	Work has been completed on breast screening re:inequalities. Some ad hoc work was done on diabetic eye screening to feed the review and this will be returned to when the new DESP information system has bedded down.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
4.2) Implement actions to address the recommendations in the RQIA review of Diabetic Eye Screening Programme.	Of the 40 recommendations from RQIA there are 28 completed and 12 outstanding. The 12 outstanding recommendations have not been completed within the timeframes set by RQIA which is why performance has been marked as amber. However there are processes in place to address them.	A	A	A		Of the outstanding items there is work on-going with significant progress which is dependent on a range of factors. For example - Priorities and progress of on-going modernisation programme Developing Eye-care Partnerships Programme Embedding of failsafe protocols and training of failsafe officers Embedding of software solutions in other parts of Ophthalmology in HSC Trusts, and establishing reliable ICT links between services. Identification of routine, reliable data sources for audit, which includes the merging (and cleansing) of databases in Q3 (2016/17) On-going work with Public Health England with respect to conducting external Quality Assurance of the programme. This work is being overseen by the DESP Modernisation Project.

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
4.3) Maintain all existing screening programmes and the quality assurance function.	Workforce issues have had a significant impact on population screening work in the PHA. All existing programmes are being maintained. Some quality improvement work has been scaled back and some quality assurance work has been postponed e.g. the triennial QA visit to the breast screening unit in the SHSCT. However, following scrutiny decision to support the appointment of permanent staff to fill the vacant posts we are now in a much better position to maintain the QA function. A number of new staff commenced work in January 2017. Two key posts remain to be filled but these have been advertised.	A	A	A		Focussing on essential QA functions. Considerable progress has been made since September '16. As new staff become familiar with their roles and vacant posts are filled,the QA function will become fully operational over the next few months.
4.4) Develop a TVU service for the early detection of Ovarian Cancer.	Training complete and on going Primary /integrated care involved Referral pathway agreed Regional reporting guidelines agreed Patient information booklet – text complete awaiting photography On the agenda for the next NICaN gyna group to ratify regional referral and scanning protocols as October meeting was not quorate Has been included in Cancer commissioning priorities	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
4.5) Develop a system to prioritise the X-ray reports of Older people from Nursing Homes.	Scoping work on going to define acceptability and operational feasibility work ongoing in radiology and ED may address this independently – RAG status amber but on track for green by the end of the year Rag status green - the Modernising Radiology Clinical Networks work plan has superseded this as it is looking at a regional prioritisation of plain film reporting in all ED's	G	G	G		

5. USING EVIDENCE, FOSTERING INNOVATION AND REFORM						
Target from Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
5.1) Lead on the implementation of the new HSC R&D Strategy: *Research for Better Health & Social Care (2015-2025).*	A plan for the review of the infrastructure is currently being finalised and will commence with an electronic consultation with key stakeholders in the New Year. The findings from this consultation will inform the second stage of the Review. A project manager will be recruited to lead this work pending budget confirmation.	G	G	G		
5.2) Support researchers to secure research funding from external sources including NIHR evaluation, trials and studies co-ordinating centre (NETSCC), Horizon 2020 & other EU sources.	NETSCC: Since the investment began 22 NI-led applications with a total value of the awards is £20.36 million have been successfully reviewed**.** H2020: TO-REACH (Transfer of Organisational innovations for Resilient, Effective, equitable, Accessible, sustainable and Comprehensive Health Services and Systems): successful application led by Istituto Superiore di Sanita, Italy in response to call SC1-HCO-06-2016 Towards an ERA-NET for building sustainable and resilient health system models (total value approximately €2 million, NI value €41,000, 29 partners, including HSC R&D Division). Project Kick-off meeting taking place on 31 January – 1 February 2017. INTERREG VA: CHITIN (Cross-Border Healthcare Intervention Trials in Ireland Network) Letter of Offer currently under review; Project Mobilisation Meeting between PHA and SEUPB planned for 26 January 2017	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.3) Support the Northern Ireland Public Health Research Network (NIPHRN) to identify opportunities for research in PHA priority areas.	Continuing to work with the NIPHRN and its stakeholders to identify potential research opportunities in areas of interest to the PHA. Changes in staffing relating to the NIPHRN Co-ordinator post may lead to reduced activity in the remaining period of 17/18 until full input is resumed.	G	A	A		An appointment of a new Network Co-ordinator has been made and the candidate took up post on 1/10/16. The appointee will contribute 0.5WTE activity until May 2017 (due to the completion of a CRUK Fellowship award) and 1FTE thereafter when full activity of the NIPHRN will be resumed.
5.4) Continue to work with the Social Work community to support and encourage research within Social Work/Care.	Commissioned local research e.g. Early Intervention Transformation Programme Call has actively encouraged applications from multidisciplinary teams and priority setting exercises have commenced led by Social Work Strategic Advisory Group with input from HSC R&D Division. Opportunities to showcase local research are planned for the 4th Research Conference to be held on 1 March 2017	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.5) Working with CCHSC to facilitate service development and service improvement within Telemonitoring NI: • Contribute to the redesign of patient pathways sharing examples of local good practice regionally • Provide professional nursing advice to the specification and implementation process for TMNI replacement	CCHSC continue to work with Trusts to implement new and innovative uses of telehealth and to plan for the specification and implementation of services to replace the existing Telemonitoring service.	G	G	G		
5.6) Establish new and support existing expert nursing groups, for example Cancer, Neurology and District Nursing, Stroke and Palliative and End of Life Care.	A number of nursing groups are underway and some newly established groups are: Stroke Nurse Specialists and OOHs nursing.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.7) Host a HSC wide Conference on PPI, highlighting best involvement practice, reflecting on the new involvement Standards, sharing findings from the PPI research initiative and examining how to address the report recommendations for the benefit of service users and carers.	The PHA, in partnership with QUB and HSC partners, held a PPI conference, 'Involving you, improving care' on the 22nd of June 2016. Key findings from the PHA and PCC commissioned PPI Research were referenced at the conference, with the aim of launching the final report on the 27th February 2017.	G	G	G		
5.8) Ensure that the learning from PHA/SBNI/QUB research on infant death is embedded into SCPHN and midwifery practice	Evidence based resources developed for use by public and multi-agency practitioners – to be issued with final research paper being completed by John Devaney (QUB).	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.9) CCHSC will have specified and commenced the implementation of service(s) to replace Telemonitoring NI.	CCHSC have commenced an engagement exercise with relevant stakeholders to develop a shared understanding of the strength and weakness of current service and to elicit views on arrangements which should replace the current Telemonitoring NI service. The outputs from the engagement process are being consolidated taking into account the findings of the QUB evaluation of Telemonitoring to develop a model for technology enabling healthcare (TEHC) in relation to: • Supporting Healthy People • Enable people to look after their condition • Supporting people to reduce use of health service • Support people to stay safe and independent	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.10) CCHSC will seek opportunities to develop and utilise innovative technologies to improve health and wellbeing including leading the NI input to EIP AHA; EU and other sources of funding and working collaboratively with HSCNI and other key stakeholders	CCHSC continue to contribute to the work of the European Innovation Partnership on Active and Healthy Ageing (EIP AHA) through involvement in a number of action groups to improve the health of older people in Northern Ireland and across Europe; CCHSC coordinates the EU-funded project called Beyond Silos which aims to improve the integration of service delivery by building on the Northern Ireland Electronic Care Record and implementing an interactive Shared Care Summary. CCHSC is a partner in an EU-funded project entitled ACT@Scale which aims to enhance mainstream the roll out of Telemonitoring. CCHSC is a partner in an EU-funded project entitled SUNFRAIL which aims to improve the identification, prevention and management of frailty and care of multimorbidity. Further opportunities to participate in EU projects are under continual review and development.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.11) To lead work on the implementation of the eHealth and Care Strategy objectives: • Supporting People; • Using Information and Analytics; • Fostering Innovation. Which will contribute to the development of a regional EHCR.	CCHSC anticipate that the new services specified as part of the future telemonitoring service will progress the Supporting People objective set out in the draft *eHealth & Care Strategy* and will feed into the "HSC Connected Caring Communities" established under the auspice of *Making Life Better*. Work is ongoing with regard to the development of an Information and Analytics Plan in partnership with HSCB and DoH The continuing involvement and partnership gained form contributing to EU work acts as a foundation for developing local innovation.	G	G	G		
5.12) Commence process to benchmark AHP input against National Findings for Unscheduled Care	• Subscription to NHS Benchmarking data giving access to UK database. • Consideration of UK data for transferability to NI Unscheduled Care. • Align with work emerging from NI Unscheduled Care Network structures. • Currently working on a draft USC workforce paper to define the process	G	G	G		

6. DEVELOPING OUR STAFF AND ENSURING EFFECTIVE PROCESSES							
Target from Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
6.1) Manage the process of organisational change in line with further clarification from the DHSSPS, ensuring appropriate and timely internal and external communication.	PHA senior staff have participated in a series of workshops focused on future HSC structures The PHA will continue to work with DoH, and will communicate with and support staff during this period of change.	G	G	G		
6.2) Maintain capacity to deliver core duties and deliverables identified for the PHA in 2016/17.	Recent key retirements, together with 37 staff leaving by June 2016 on VES in order to meet management and administration cost reduction targets, have reduced PHA capacity and capability. This continues to be managed through management focus on core deliverables, prioritising staff time, active consideration of the need for and form of vacant posts by Scrutiny Committee and close liaison with DoH through sponsorship review and other meetings.	G	G	G		
6.3) Achieve substantive compliance for all 15 controls assurance standards applicable to the Public Health Agency.	On target to achieve substantive compliance for all 15 controls assurance standards applicable to PHA	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.4) Test and review the PHA business continuity management plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	The annual test will be conducted during Exercise Cygnus 18-20 October. The Business Continuity Plan will be reviewed and updated accordingly at the conclusion of this exercise.	G	G	G		
6.5) Explore an electronic records management solution in line with Controls Assurance Standards.	Initial alternative options to a full EDRMS have been explored by PHA.	A	A	A		HSCB E-Health has advised that this will be taken forward on a regional HSC basis. While PHA will work with other HSC colleagues, this is likely to mean that timescales for introduction of an EDRMS will be delayed.
6.6) Continue to take forward implementation of the PHA Procurement Plan.	The PHA continues to progress the procurement plan within the resources available. The overall timelines for progressing individual procurements is currently being reviewed in light of significant changes in key staff and wider strategic considerations such as the finalisation of a new Strategic Plan for Protect Life. An undated Plan will be agreed by March 2017.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.7) Finalise the new PHA Corporate Strategy and the PHA Annual Business Plan for 2017/18 in line with DoH requirements and timescales. (when notified)	Work continues to develop the PHA Corporate Strategy, building on the engagement exercise carried out in 2014/15. Following guidance from DoH, the corporate strategy is being developed in line with Making Life Better and the new draft Programme for Government. A draft plan has been developed and was agreed by the PHA board for consultation. The consultation period will run from 28 Nov 16 to 17 Feb 17 and will include focussed engagement workshops and the use of social media to raise awareness and to encourage responses.	G	G	G		
6.8) Develop and agree a new Internal communications strategy and action plan to ensure PHA business is supported by efficient and effective internal communication systems.	Internal Communications Action Plan - Several actions completed and under way including introduction of new weekly update for PHA staff, erection of digital signage on 4th Floor, Linenhall St, Belfast, redevelopment of Connect, introduction of generic email addresses for improved internal email communication, email branding, standard corporate auto signature.	G	G	G		
6.9) Review and Revise PHA digital assets including PHA Corporate and Intranet sites.	Paper developed on road map for PHA web presence. AMT approval of migration of health topic information to NI Direct. Process to redevelop PHA Intranet site Connect to progress through the TPA.	G	G	A		All elements on course except for revision of Corporate site. AMT request that this is deferred pending reform programme

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.10) Continue to enhance social media activity, extending the agency's reach through its online channels and broadening the types of content used.	Development of social media activities continues, with follower numbers increasing and integration of rich media content ongoing to deliver strong engagement. To make dissemination of messaging more effective, a range of content is created to reflect target audiences and approaches. The new digital signage on 4th Floor Linenhall Street, Belfast has a live Twitter feed.	G	G	G		
6.11) Extend the range of communications tools used by the agency e.g. infographics and audio recordings, to support its work to convey key messages to target audiences.	A range of new approaches to delivering agency messaging are being deployed, including recording and sending audio clips to journalists along with news releases, developing video and stop motion content for social media, and creating animated GIFs. This is kept under constant review to keep abreast of trends and to 'meet' target audiences where they go to access information.	G	G	G		
6.12) Build on the suicide awareness media and engagement work which has been developed by the agency.	The monitoring of coverage of suicide continues, with articles in breach of Samaritans guidelines being actioned. The method of monitoring is kept under review to help ensure it is as effective as possible. Engagement with journalists and journalism students also continues, to increase awareness of the Samaritans guidelines and encourage responsible reporting.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.13) Ensure that by 30th June 2016 90% of staff will have had an annual appraisal of their performance during 2015/16.	Over 90% of staff have received their annual appraisal as at 30th June 2016.	G	G	G		
6.14) Ensure that by 31 March 2017 we meet the 95% target that doctors working in PHA have been subject to an annual appraisal.	All doctors who were due medical appraisal have successfully completed the process.	G	G	G		
6.15) Continue to provide professional leadership, advice and guidance on PPI.	The PPI team continue to provide strategic and operational professional leadership, advice and guidance in relation to PPI. This includes continued input into areas of strategic importance to PHA and HSC e.g. EITP, Unscheduled Care, Older People's Nursing, E-Health, Medicines Management, EHCR, etc. Continue to develop 'Engage' as a web repository of information for PPI, available to HSC organisations, staff and the public. The PHA continues to seek funding to maximise the Engage outreach learning and development resource for PPI. It is anticipated that the first draft will be complete by end of March 2017.	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.16) Utilize Safety Forum QI expertise to aid the delivery of training to HSC staff as envisioned by the Attributes Framework and facilitate entry to Scottish Quality and Safety Fellowship programme.	Work is continuing as planned.	G	G	G		
6.17) Ensure that PHA duties and responsibilities in relation to Local Supervising Authority Midwifery Officer are evidenced in annual report presented to AMT & PHA Board.	The Annual report has been completed and submitted to AMT. Annual report will also be submitted to PHA Board.	G	G	G		
6.18) Revalidation champions will provide on-going support to registrants and managers across the PHA and HSCB, as well as engaging with GP employed nurses.	Revalidation Lead provides ongoing support, resources and Face to face awareness sessions to all nurses (HSCB/PHA) and their line managers. Established an Xl database of Nurses in HSCB/PHA shared with HR On-going support is available from PHA to GP practice nurses including face to face meetings. Professional Forum offers regular opportunity for updates to be provided. All communication from NMC/NIPEC cascaded to HSCB/PHA	G	G	G		

Target from Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.19) Provide professional support to Nurses/midwives through the quarterly Professional Forum.	Professional Nursing and Midwifery Forum held 1/4ly Network of nurses across HSCB.PHA, attend and invitation extended to MOD, PSNI, NIBTS. Topic specific 'Learning sets' arranged for professional updates.	G	G	G		
6.20) Develop and implement the Nurses and Midwives verification of NMC policy through HRPTS system.	Policy for the Verification of NMC registration developed HRPTS to implement changes before verification policy can be implemented. Interim solution: reminder system developed – 6 and 3mths prior to renewal (by directorate of Nursing staff). System established to remind staff of revalidation renewal System established to update internal records.	G	G	G		
6.21) Meet DHSSPS financial, budget and reporting requirements.	All deadlines in relation to Monthly monitoring to the DoH have been met and the year-end annual accounts completed.	G	G	G		