Northern Ireland Ambulance Service
Health and Social Care Trust

A Meeting of Trust Board to be held at 2.00pm on Thursday, 29 May 2014 at NIAS Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast

A G E N D A

		Paper Enclosed
Welcome, Introduction and Format of Meeting		
1.0	**Apologies**	
2.0	**Procedure:**	
	Declaration of potential Conflict of Interest/Pecuniary Interest Quorum:	
3.0	**Minutes of the previous meeting of the Trust Board held 27 March 2014** (for approval and signature)	TB/1/29/05/14
	3.1 Action Log	TB/2/29/05/14
4.0	**Matters Arising**	
5.0	**Chairman's Business**	
	5.1 Chairman's Update	
6.0	**Chief Executive's Business**	
	6.1 Chief Executive's Update 6.2 Transforming Your Care Update	
7.0	**Performance Reports**	
	7.1 Performance Report 2013/14 as at Year End - 30 March 2014	TB/3/29/05/14 (*under separate cover*)
	7.2 Assurance Report 2014/15 as at 30 April 2014	TB/4/29/05/14 (*under separate cover*)
	Highlight Reports by each Director: Chief Executive Director of Operations Director of Finance & ICT Director of HR & Corporate Services Medical Director	
8.0	**Items for Approval**	
	8.1 Board Governance Self-Assessment Submission 2013/14	TB/5/29/05/14

	8.2	Terms of Reference – Assurance Committee	TB/6/29/05/14
9.0	**Items for Noting**		
	9.1	Patient Client Council – HSC Online User Feedback System	TB/7/29/05/14
	9.2	NIAS Management Statement and Financial Memorandum	TB/8/29/05/14
	9.3	Minutes of Assurance Committee held 24 March 2014	TB/9/29/05/14
	9.4	Minutes of Audit Committee held 24 March 2014	TB/10/29/05/14
	9.5	GP Out of Hours – Ministerial Announcement	TB/11/29/05/14
10.0	**Application of Trust Seal**		
11.0	**Forum for Questions**		
12.0	**Any Other Business**		
13.0	**Forward Agenda**		

Next meeting of Trust Board will be held on Thursday, 31 July 2014 at in the Northern Division. Venue to be confirmed.

Standing Orders

This section is designed to provide information extracted from Standing Orders pertinent to the smooth running of the public Board meeting. The full Standing Orders are

available for consideration at any time through the Chief Executive's Office or from the website. The excerpts below represent key items relevant to assist with the management of the Public Meeting.

Admission of Public and the Press

3.17 ***Admission and Exclusion on Grounds of Confidentiality of business to be transacted***

The public and representatives of the press may attend meetings of the Board, but shall be required to withdraw upon a resolution of the Trust Board as follows:

'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 23(2) of the Local Government Act (NI) 1972'

3.18 ***Observers at Board meetings***

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these Terms and Conditions as it deems fit.

PROCEDURE RELATING TO SUBMISSION OF QUESTIONS FROM THE PUBLIC AT NIAS TRUST BOARD MEETINGS

Questions may be put to the Board which relate to items on the Agenda.

Every effort will be made to address the question and provide a response during the meeting at the appropriate point on the Agenda.

If it is not possible to provide a response during the meeting a written response will be provided within seven days.

Questions must be put to the Board in written form and must be passed to the Executive Administrator before the item on the Agenda entitled "Forum for Questions".

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

Meeting to be held on Thursday, 29 May 2014 at NIAS HQ, Knockbracken Healthcare Park, Saintfield Road, Belfast. BT8 8SG

TB/1/29/05/14

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Trust Board Meeting held on Thursday, 27 March, 2.00pm at Best Western Plus White Horse Hotel, 68 Clooney Road, Londonderry, BT47 3PA

Present:

Mr P Archer	Chairman
Mr L McIvor	Chief Executive
Ms A Paisley	Non-Executive Director
Prof M Hanratty	Non-Executive Director
Mr R Mullan	Non-Executive Director
Mr N McKinley	Non-Executive Director
Dr J Livingstone	Non-Executive Director
Mrs S McCue	Director of Finance & ICT
Mr B McNeill	Director of Operations
Dr D McManus	Medical Director
Ms R O'Hara	Director of Human Resources and Corporate Services

In Attendance:

Ms P Burn	Executive Administrator (T)
Miss K Baxter	Senior Secretary

Welcome and Format of the Meeting

The Chairman opened the meeting by welcoming members of the public and Trust Board.

1.0 Apologies

No apologies were received.

2.0 Procedure: Declaration of potential Conflict of Interest / Pecuniary Interests Quorum.

No potential conflicts of interest / pecuniary interests were declared and the Board was confirmed as quorate.

3.0 Minutes of the Previous Meeting of the Trust Board held on 30 January 2014

Members accepted the minutes of the meeting which took place on 30 January 2014 as a true reflection of discussions held on the proposal of Ms Paisley, seconded by the Chief Executive.

4.0 Matters Arising

There were no matters arising from the previous meeting.

5.0 Chairman's Business

5.1 Chairman's Update

The Chairman gave a brief outline of his diary commitments since the last Board meeting.

5.2 Visit to Non Emergency Ambulance Control Room

The Chairman commented that the visit to Non Emergency Control Room based at Altnagelvin Hospital site was a very interesting visit and that they had the opportunity to speak to staff.

The Chair commented that the work that the Control Room carries out tends to be behind the scene but nevertheless is an important and vital part of the service arranging more than 200,000 patient journeys a year. NEAC also arranges journeys carried out by the Voluntary Car Service with drivers providing regular transport for patients attending outpatient and inpatient appointments.

Professor Hanratty commented that it would be a good idea to write a letter of thanks to the Non Emergency Control Room to thank them for providing a valued visit.

Miss Paisley commented on the hard work of the staff and complemented their enthusiasm and attitude towards their work.

Director of Operations mentioned that the revised proposal of the booking system had just been approved by the Minister last week. Director of Operations also confirmed that a new ambulance was being trialled in South Division which would carry five wheelchairs compared to the vehicles which can only carry one at present.

Professor Hanratty confirmed that the visit was timely in connection with the progression of Transforming Your Care in the future.

Chief Executive stated that discussions have been had with Commissioners regarding service growth and acute service changes being considered in TYC to support treating patients in their own homes or under the care of their GP's.

Action: The Chairman to write to NEAC on behalf of the Board.

6.0 Chief Executive's Business

6.1 Chief Executive's Update

The Chief Executive gave a brief outline of some of his activities since the last Board meeting:

- Met with David Reeson from KPMG on 18 February 2014 regarding the implementation of reform plans as part of the TYC Programme
- Attended a two day NICON Conference on 5/6 March 2014.
- Meeting of the Strategic Investment Group on 7 March 2014.
- Met with Andrew Hine. Head of KPMG UK Health Care on 10 March 2014.
- Two Day Conference - Delivering Safer Care on 12/13 March 2014

6.2 Transforming Your Care Update

An update was provided by the Chief Executive who confirmed that he was due to attend TYC Transformation Programme Board meeting on Friday, 28 March 2014 and reported that the programme is still at amber as per previous update given.

Chief Executive reported that Integrated Care Partnerships are working well with action plans for projects being integrated and completed for April and May 2014.

Local partnership engagement at local level is working well. NIAS engagement at beginning of work has an influence on decisions being made.

Consultation on closure of NHS residential care homes in Northern Ireland closed on 7 March 2014.

6.3 NIAS Shift Cover

The Chief Executive presented a paper on NIAS Shift Cover. The purpose was to explain to the Board how the Trust manages shift cover and highlighted that not all shifts are covered due to resource limitations and the consequences of this.

The Chief Executive reported that some of the dropped shifts are down to short term sickness absence in advance or during the shift.

Chief Executive informed the Board that the Resource Management Centre based at Knockbracken Healthcare Park arranged cover for vacant shifts based on staff availability for shifts, recording annual leave and sickness absence.

Chief Executive stated that 4.6% shifts were dropped between April and December 2013 and advised that this was an improvement over last year. Additional recurrent funding could support further improvement on this The paper showed that NIAS recognised the risks that were associated with dropped shifts. Greater risks presented at weekends and nights above less

pressurised shifts which generally occurred during the day and efforts to manage cover reflected this.

Miss Paisley welcomed this paper being in the public domain especially with media attention around risks to patients with delays in A&E Departments.

7.0 Performance Report as at 28 February 2013

The Chief Executive presented the Performance Report as at 28 February 2014.

Operations

The Director of Operations updated members on his report He referred to page 106 which sets out the monthly performance cumulative position for 2013/2014 to February 2014.

The following issues were highlighted by the Director of Operations:

- The Trust will not achieve 72.5% of Category A calls being responded to within 8 minutes for the year
- However it was confirmed that there had been 3.6% increase in 999 calls so far
- It was reported that Belfast region performance had declined from 78.8% in January to 75.1% in February 2014
- Calls in South East and North areas have increased
- A&E On-line Dash Boards have been installed in A&E Departments which highlight 4-6 hour breaches both to Emergency Ambulance Control Room and A&E Departments.

Dr Livingstone highlighted that page 108 showed the increase in calls over all areas from April 2013 until February 2014.

Chief Executive highlighted that this may be an important time to look at how the information was reported.

Finance & ICT

The Director of Finance & ICT presented her report and it was anticipated that at the end of February 2014 the Trust is on target to achieve financial breakeven by year end, subject to a series of assumptions being made.

The following issues were raised:

- On page 43 it was confirmed that the target of 95% of invoices being paid within 30 days during 2013/14 will not be met. This was largely due to new FPL systems being introduced under BSTP. On page 59 it was reported a red RAG rating was recorded against the Proposal for savings within PCS as anticipated in the 2013/2014 Trust Delivery Plan, however savings target are expected to be achieved overall through a combination of bridging finances and non recurrent contingency measures
- On page 123 it was reported that there was a small cumulative surplus of £9k at the end of February 2014.

It was noted that the Enniskillen Business case had been approved on 10 February 2014.

There was discussion around the large amount of expenditure on Fleet. Director of Finance confirmed that this would not result in an under spend.

Human Resources & Corporate Services

The Director of Human Resources and Corporate Services updated members on her report. The following issues / comments were raised :

- Three Directorates are currently green on absence target with the exception being Operations who were under performing with an absence figure of 7.66%
- It was highlighted that musculoskeletal injuries were still resulting in a high percentage of sickness at 35% with Stress being the second factor at 25%.

It was confirmed that the Director of Human Resources and Corporate Services and Director of Operations carried out quarterly meetings with Area Managers whose Areas were under achieving the absence target.

Director of Operations stated that the Trust were aware that patients were not getting any lighter and that every effort was being carried out to support staff in these circumstances. He confirmed that in some cases crews had asked for a second crew to assist.

It was advised that 96% of KSF PDCR's had been completed as at 30/09/2013. Chief Executive commended the work that had been completed.

Medical

The Medical Director presented his report.

On page 67 it was highlighted that a major incident took place on 6 February 2014 when forty patients outside a social venue and seventy inside needed on scene treatment. Medical Director reported that the incident was dealt with professionally and confirmed that NIAS had subsequently taken part in a regional de-brief which had been called by the Health Minister. Professor Hanratty commended Mr McPoland, Communication/Information Officer's excellent work updating the public and social media sites with detailed information on what was happening.

- Mr Mullan asked what provisions were put in place for other emergency calls during this major incident.

- Medical Director confirmed that the Emergency Control Room prioritised calls in the normal way with resources been pulled in from other areas when needed. Medical Director confirmed that the hospitals were using their Major Incident Plans, meaning that the whole system was working together.

Medical Director referred members to the Clinical Audit from page 100 onwards which presented data on Stroke/TIA and Cardiac Arrest for the period 2009-2012. On page 103 the report illustrated the time it took for the ambulance from arrival on scene to arrival at hospital for Stroke and TIA.

8.0 Items for Approval

8.1 Harmonisation Strategy

Director of HR & Corporate Services presented the Harmonisation Strategy paper for approval by Trust Board. Director of HR & Corporate Services confirmed that the paper had been previously presented to SEMT.

Director of HR & Corporate Services stated that the purpose of this paper was to harmonise terms and conditions for staff consistent with Agenda for Change. Director of HR & Corporate Services advised that appendices were restricted documents which had not been included in the papers due to their confidentiality.

Chief Executive informed the Committee that there were a number of issues which fell under AfC, one example being travel costs.

Director of HR & Corporate Services confirmed that savings could be made through not paying staff who were travelling to work to carry out overtime

Trust Board approval was given on the Strategy by Professor Hanratty and seconded by Mr McKinley.

8.2 Media Strategy

Director of HR & Corporate Services presented the Media Strategy paper for approval by Trust Board. Director of HR & Corporate Services confirmed that the paper had been previously presented to SEMT.

Mr McKinley stated that he thought it was a well prepared strategy which briefly described in terms of what the Trust hoped that they could achieve.

Trust Board approval was given on the Strategy by Dr Livingstone and seconded by Mr McKinley.

8.3 NIAS Trust Transformation and Modernisation Plans

Director of HR & Corporate Services presented the NIAS Trust Transformation and Modernisation Plans for approval by Trust Board. Director of HR & Corporate Services confirmed that the paper had been previously presented to SEMT.

Director of HR & Corporate Services reported that the paper was approaching how NIAS can address Transformation and Modernisation Plans under one umbrella through Project Management methodology. She confirmed that TYC Assistant Director was due to take up employment with the Trust on 01 April 2014.

Chief Executive confirmed that the1st Tuesday of every month would be dedicated to TYC Change Programme meeting with the new TYC Assistant Director facilitating the meeting.

Trust Board was advised that NIAS had placed a bid of £495k for TYC transition funding over a two year period which would enable NIAS to take forward its transformation. It was confirmed that the Trust had received HSC support for this bid.

Trust Board approval was given on the Plans by Mr McKinley and seconded by Professor Hanratty.

8.4 Report on Administration and Clerical Staff (including Management) Costs

Director of Finance presented the Report on Administration and Clerical Staff (including Management) Costs for approval by Trust Board.

Director of Finance confirmed that the paper had two sections:

1. Administration and Clerical staff costs
2. Management Costs

Director of Finance reported that this paper had been discussed at Audit Committee on 6 March 2014.

The paper had been benchmarked with other Trusts and showed the Administration and Clerical costs for NIAS had a 3% increase compared to Western Health and Social Care Trust which had an increase of 9%.

Director of Finance confirmed that NIAS Management costs fell from 2009/10 from 6.34% to 6.19% at the end of March 2013.

Trust Board approval was given on the report by Dr Livingstone and seconded by Miss Paisley.

9.0 <u>Items for Noting</u>

9.1 Update on Mid Staffordshire Report Action Plan

The Chief Executive presented this paper to Trust Board for information and noting.

9.2 Data Protection Manual

Director of Finance presented the Data Protection Manual for noting. Director of Finance stated that it is a detailed report adapted from the Department's Manual.

Miss Paisley commented that the acronym DPLO is mentioned in the first couple pages and she suggested that this should not be abbreviated as not everyone would know the meaning.

- Mr McKinley asked if the manual had been shared with Managers.
  - Director of Finance confirmed that a summary of this manual would be placed on the intranet for staff information.

Chairman asked if the summary could also be forwarded to Non Executive Directors.

Action: Director of Finance to provide summary to Non Executive Directors.

9.3 Timeline for 2013/14 Financial Accounts

Director of Finance presented the Timeline for 2013/14 Financial Accounts and confirmed that this paper had been discussed at Audit Committee on Monday, 6 March 2014.

The paper was prepared by the Department and its purpose was to confirm the timescales for the preparation, audit, approval and certification of annual account for 2013-14. The annexes gave a timetable of actions that needed to be carried out by HSCB, PHA, BSO and Trusts.

Professor Hanratty confirmed that there had been an extra meeting of the Audit Committee called for Tuesday, 20 May 2014. The purpose of this meeting was to complete work on Governance Statement and look at the Audit reports.

9.4 Trust Board Self Assessment – Rolling Action Plan

The Chairman presented the Trust Board Self Assessment – Rolling Action Plan for noting and confirmed that this paper was discussed in detail at the 'In Committee' meeting.

9.5 BSTP Update paper

Director of Finance presented a BSTP Update to Trust Board for noting.

Director of Finance confirmed that Finance and Human Resources Departments across all Trusts had been engaged with BSTP since 2010. NIAS have a small team of staff working on different projects including a new Finance, HR, Payroll system.

Director of Finance reported that NIAS had not received as high a level of support as other trusts as we are the last Trust to go live.

9.6 Minutes of Audit Committee meeting held on 27 January 2014

Director of Finance presented minutes from Audit Committee meeting which took place on 27 January 2014 to Trust Board for noting.

10.0 <u>Application of Trust Seal</u>

It was confirmed that Trust Seal was used for Enniskillen Business case and a number of documents had been considered by Health Estates and PALS. Director of Finance confirmed that a number of consultants had been instructed to undertake the work of the Business Case on behalf of Trust.

11.0 Forum for Questions

No questions were received.

12.0 Any Other Business

None.

Date, Time and Venue of Next Meeting

The next meeting of the Trust Board will be held on Thursday 29 May 2014 in Headquarters.

The Chairman thanked those present for attending and called proceedings to a close.

Signed: _____

Date: _____
Chairman

TB/2/29/05/14

Northern Ireland Ambulance Service
Health and Social Care Trust

Trust Board Meeting - Action Log

At each Board Meeting, action points are recorded throughout the meeting to note items which need further development, additional work or raise other issues which need to be considered or discussed. This document has been created to keep a record of these action points.

Date of Meeting	Minute Reference	Agenda Item (topic)	Allocated To	Action
27/03/14	5.2	Visit to NEAC	Chairman	Chairman to write to NEAC on behalf of the Board
	9.2	Data Protection Manual	Director of Finance & ICT	Director of Finance to place on the internet and provide a summary to Non-Executive Directors

TB/5/29/05/14

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

29 May 2014

Title:	Board Governance Self-Assessment Submission 2013/14
Purpose:	DHSSPS requirement for Yearly Governance Self-Assessment
Content:	Board Governance Self-Assessment & Rolling Action Plan
Recommendation:	For approval
Previous Forum:	The Governance Self-Assessment for 2012/13 was submitted to DHSSPS 22 January 2014
Prepared by:	Dr Jim Livingstone, Non Executive Director
Presented by:	Mr Paul Archer, Chairman

Board Governance Self- Assessment Submission

2013/14

Name of ALB…….**Northern Ireland Ambulance Service**

Date of Board Meeting at which Submission was discussed…….....

Approved by ……..... (Chair)

1. Board composition and commitment ALB Name: NIAS Date.....

1.1 Board positions and size

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled.	**Green**	Standing Orders Establishment Order Board and Committee Papers and Minutes			
GP2	The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities.	**Green**	Board and Committee Papers and Minutes			
GP3	It is clear who on the Board is entitled to	**Green**	Standing Orders Board and Committee Papers and Minutes			

	vote.					
GP4	The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders.	**Green**	Standing Orders Establishment Order Board and Committee Papers and Minutes			
GP5	Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.	**Green**	Letters of Appointment			DHSSPS manage the appointment process and need to ensure due account is taken of this requirement

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair and/or CE are currently interim or the position(s) vacant.	Green		
RF2	There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago).	Green		
RF3	The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	Green		

1. Board composition and commitment ALB Name: NIAS Date.....

1.2 Balance and calibre of Board members

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan.	**Green**	Letter to department – gap in financial skills was identified specifically and addressed. Minutes of accountability meetings with permanent secretary.			As a board we will engage with the department going forward to maintain clinical, financial and other expertise as vacancies arise.
GP2	The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.	**Green**	Board Member Biographies on Website			DHSSPS manage the appointment process and need to ensure due account is taken of this requirement

GP3	The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*.	**Green**	NIAS Section 75 Return			
GP4	There is at least one NED with a background specific to the business of the ALB.	**Green**	Board Member Biographies on Website			DHSSPS manage the appointment process and need to ensure due account is taken of this requirement
GP5	Where appropriate, the Board includes people with relevant technical and professional expertise.	**Green**	Board Member Biographies on Website			DHSSPS manage the appointment process and need to ensure due account is taken of this requirement
GP6	There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on	**Green**			Limited Turnover of Executive Directors.	Appropriate balance is not defined. Measures to achieve balance are constrained.

	the Board for longer.					
GP7	The majority of the Board are experienced Board members.	**Green**	Board Member Biographies on Website			
GP8	The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.	**Green**				DHSSPS manage the appointment process and need to ensure due account is taken of this requirement. Further definition is required of terms used.
GP9	The Chair of the Board has previous non-executive experience.	**Green**	Board Member Biographies on Website			
GP10	At least one member of the Audit Committee has recent and relevant financial experience.	**Green**	Board Member Biographies on Website			

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There are no NEDs with a recent and relevant financial background.	**Green**		
RF2	There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector.	**Green**		(As of Dec 2012)
RF3	The majority of Board members are in their first Board position.	**Green**		
RF4	The majority of Board members are new to the organisation (i.e. within their first 18 months).	**Green**		
RF5	The balance in numbers of Executives and Non Executives is incorrect.	**Green**		(As of Dec 2012, the Board is at full complement).
RF6	There are insufficient numbers	**Green**		

	of Non Executives to be able to operate committees.			

1. Board composition and commitment ALB Name: NIAS Date.....

1.3 Role of the Board

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	The role and responsibilities of the Board have been clearly defined and communicated to all members.	**Green**	Standing Orders Code of Conduct Induction programme			
GP2	Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit.	**Green**	NIAS Corporate Plan NIAS Annual Plan and Trust Delivery Plan Appointment Letters			
GP3	There is a clear understanding of the roles of Executive officers and Non-Executive Board members.	Amber/Green	Code of conduct Letters of appointment Standing Orders Job descriptions Management Statement	This is being addressed by Working Group 6 in the Trust's Governance Action Plan.	There has been an emphasis on the role and development of Non-Executive Directors in recent guidance which has not been mirrored	The Board would welcome further consideration by DHSSPS of the role of Executive Director as a member of the Board.

					with Executive Directors.	
GP4	The Board takes collective responsibility for the performance of the ALB.	**Green**	Standing Orders Board & Committee Papers & Minutes DHSSPS Accountability Review Ministerial Public-Facing Accountability			
GP5	NEDs are independent of management.	**Green**	Standing Orders Minutes			
GP6	The Chair has a positive relationship with the Minister and sponsor Department	**Green**	Reappointment of Chair Ministerial & DHSSPS Engagement			
GP7	The Board holds management to account for its performance through purposeful, challenge and scrutiny.	**Green**	Board & Committee Papers & Minutes			
GP8	The Board operates as an effective team.	Amber/Green	Board & Committee Papers & Minutes Minutes of accountability meetings.	This is being addressed by Working Group 6 in the Trust's Governance Action Plan.	The Board has identified potential to explore improvement in problem identification and solving.	
GP9	The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence.	**Green**	Board & Committee Papers & Minutes Standing Orders			

GP10	Board members respect confidentiality and sensitive information.	**Green**	Board & Committee Papers & Minutes			
GP11	The Board governs, Executives manage.	**Green**	Board & Committee Papers & Minutes Scheme of Delegation			
GP12	Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function.	**Green**	Board & Committee Papers & Minutes			
GP13	The Chair is a useful source of advice and guidance for Board members on any aspect of the Board.	**Green**	Board & Committee Papers & Minutes			
GP14	The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken.	Amber/Green		This is being addressed by Working Group 7 in the Trust's Governance Action Plan.		
GP15	The Board considers the concerns and needs of all	**Green**	PPI strategies Board & Committee Papers & Minutes Section 75 Return		The Board does actively consider the concerns of stakeholders	

	stakeholders and actively manages it's relationships with them.				however there is an opportunity to improve further, contingent upon resource constraints being addressed.	
GP16	The Board is aware of and annually approves a scheme of delegation to its committees.	Amber/Green	Scheme of delegation Committee Terms of Reference Standing Orders	This is being addressed by Working Group 8 in the Trust's Governance Action Plan.		
GP17	The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.	Amber/Green		This is being addressed by Working Group 8 in the Trust's Governance Action Plan.		

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair looks constantly to the Chief Executive to speak or give a lead on issues.	**Green**		
RF2	The Board tends to focus on details and not on strategy and performance.	**Green**	This has been addressed by Working Group 2 in the Trust's Governance Action Plan. This risk will be mitigated by Trust Board work to refresh the Assurance Framework & NIAS Corporate Plan.	
RF3	The Board become involved in operational areas.	Amber/Green	This is being addressed by Working Group 2 in the Trust's Governance Action Plan.	There are occasions when members need to focus on an operational area e.g. when there is reputational risk or significant performance variance.
RF4	The Board is unable to take a decision without the Chief Executive's recommendation.	**Green**		
RF5	The Board allows the Chief Executive to dictate the Agenda.	**Green**		
RF6	Regularly, one individual Board	Green		

	member dominates the debates or has an excessive influence on Board decision making.			

1. Board composition and commitment ALB Name: NIAS Date.....

1.4 Committees of the Board

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board.	**Green**	Board & Committee Papers & Minutes Standing Orders			
GP2	Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees.	**Green**	Board & Committee Papers & Minutes Standing Orders			
GP3	Schemes of delegation from the Board to the Committees are in place.	**Green**	Standing Orders Standing Financial Instructions			
GP4	There are clear lines of	**Green**	Board & Committee Papers & Minutes			

	reporting and accountability in respect of each Committee back to the Board.		Standing Orders			
GP5	The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle.	**Green**	Governance Framework and Statement Board & Committee Papers & Minutes Standing Orders			
GP6	The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made.	**Green**	Board & Committee Papers & Minutes			
GP7	The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.	Amber/Green	Chairman holds a regular debrief with the chairs of the audit and assurance committee. The Chief executive holds a similar debriefing meeting	This is being addressed by Working Group 7 in the Trust's Governance Action Plan.	For the remuneration and assurance committees this has not been a formal process to date.	
GP8	It is clearly documented who is responsible for reporting back to the Board.	**Green**	Board & Committee Papers & Minutes			

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board notes the minutes of Committee meetings and reports, instead of discussing same.	Green		The Trust Chair provides the opportunity for respective Chairs of Committees to identify any matters arising which require the attention of the Trust Board
RF2	Committee members do not receive performance management appraisals in relation to their Committee role.	Amber/Green	This is being addressed by Working Group 3 in the Trust's Governance Action Plan. Trust Board are seeking advice from the Department on a mechanism for undertaking this.	
RF3	There are no terms of reference for the Committee.	Green		
RF4	Non Executives are unaware of their differing roles between the Board and Committee.	Green		
RF5	The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team	Green		

1. Board composition and commitment ALB Name: NIAS Date.....

1.5 Board member commitment

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Board members have a good attendance record at all formal Board and Committee meetings and at Board events.	**Green**	Board & Committee Papers & Minutes Annual Report			
GP2	The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time.	**Green**	NED Appraisal			
GP3	Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or	Amber/Green	Board & Committee Papers & Minutes Standing Orders NED Appraisals Executive Director Appraisal (by Chief Executive)	This is being addressed by Working Group 9 in the Trust's Governance Action Plan.		

	the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair.					
GP4	Board meetings and Committee meetings are scheduled at least 6 months in advance.	**Green**	Board & Committee Papers & Minutes			

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There is a record of Board and Committee meetings not being quorate.	Green		
RF2	There is regular non-attendance by one or more Board members at Board or Committee meetings.	Green		
RF3	Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings).	Green		
RF4	There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.	Green		Board members are working through some recent difficulties and are committed to finding a resolution to those difficulties as well as further exploration of expected behaviours in difficult situations.
RF5	The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	Green		

2. Board evaluation, development and learning ALB Name: NIAS Date.....

2.1 Effective Board level evaluation

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	A formal Board Governance Self-Assessment has been conducted within the previous 12 months.			Self-Assessment will be repeated annually.	Self-Assessment undertaken in 2013-14	
GP2	The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal evaluations that have been undertaken.	Amber/Green		Changes/improvements have been identified through this self-assessment process. This is being addressed by Working Group 7 in the Trust's Governance Action Plan.		
GP3	The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 2 years by a 3rd	Amber/Green		The Board will consider commissioning an independent 3rd party to undertake the evaluation. This is being addressed		The Board will seek advice from the Department on what constitutes independent 3rd party evaluation.

	party that has a good track record in undertaking Board effectiveness evaluations.			by Working Group 7 in the Trust's Governance Action Plan.		
GP4	In undertaking its formal evaluation, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.	Amber/Green		The Board will engage with DHSSPS to identify measures to enhance the board assessment process. This is being addressed by Working Group 10 in the Trust's Governance Action Plan.		
GP5	The focus of the evaluation included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and	Amber/Green		This is being addressed by Working Group 10 in the Trust's Governance Action Plan.		

	skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various sub-committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to							

	the organisation and external considerations; and business conducted at public board meetings and that done in confidential session						

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	No formal Board Governance Self-Assessment has been undertaken within the last 12 months.	Green		This is the first formal self-assessment. The Board will now be undertaking the annual self-assessment in line with other HSC Trusts.
RF2	The Board Governance	Amber/Green	This is being addressed by Working Group 1 in the Trust's Governance Action Plan.	

	Self-Assessment has not been independently evaluated within the last 3 years.			
RF3	Where the Board has undertaken an evaluation, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc).	Amber/Green	This is being addressed by Working Group 1 in the Trust's Governance Action Plan.	This will be in line with Departmental guidance
RF4	Where the Board has undertaken an evaluation, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	Amber/Green	This is being addressed by Working Group 1 in the Trust's Governance Action Plan.	This will be in line with Departmental guidance.

2. Board evaluation, development and learning ALB Name: NIAS Date.....

2.2 Whole Board development programme

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual evaluation (see previous section) and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements.	Amber/Green		This is being addressed by Working Group 11 in the Trust's Governance Action Plan.		
GP2	Understanding the relationship between the Minister, Department and the ALB - Board members have an	Green	Management Statement NED Appraisal Executive Director			

	appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities.		Appraisal Job Descriptions			
GP3	Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.	Green	Board & Committee Papers & Minutes Annual Report Governance Framework and Statement Internal Audit Reports			
GP4	Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: The focus and balance of Board time; The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; How the Board responded to any service, financial or governance failures; Whether the Board's subcommittees are operating	Amber/Green	Board & Committee Papers & Minutes Annual Report Governance Framework and Statement Internal Audit Reports	This is being addressed by Working Group 11 in the Trust's Governance Action Plan.		

	effectively and providing sufficient assurances to the Board; The robustness of the ALB's risk management processes; The reliability, validity and comprehensiveness of information received by the Board.					
GP5	Time is 'protected' for undertaking this programme and it is well attended.	Amber/Green		This is being addressed by Working Group 11 in the Trust's Governance Action Plan.		
GP6	The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.	Amber/Green		This is being addressed by Working Group 11 in the Trust's Governance Action Plan.		

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members.	Amber/Red	This is being addressed by Working Group 5 in the Trust's Governance Action Plan.	
RF2	The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	Amber/Red	This is being addressed by Working Group 5 in the Trust's Governance Action Plan.	

2. Board evaluation, development and learning ALB Name: NIAS Date.....

2.3 Board induction, succession and contingency planning

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB.	Green	Induction Programmes Job Descriptions			Refer to previous comments on development of executive director role as a member of the board.
GP2	Induction for Board members is conducted	Green	Induction Programmes			

	on a timely basis.					
GP3	Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders.	Green	Induction Programmes			
GP4	Deputising arrangements for the Chair and CE have been formally documented.	Green	Standing Orders Chief Executive Notification of deputising arrangements			
GP5	The Board has considered the skills it requires to govern the organisation effectively in the future and to the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.	Amber/Red		This is being addressed by Working Group 11 in the Trust's Governance Action Plan.		

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Board members have not attended the CIPFA “On Board” training course within 3 months of appointment.	Green		
RF2	There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable.	Green		
RF3	There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable.	Green		
RF4	NED appointment	Green		

	terms are not sufficiently staggered.			

2. Board evaluation, development and learning ALB Name: NIAS Date.....

2.4 Board member appraisal and personal development

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair	Green	NED Appraisal			
GP2	The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.	Amber/Green		This is being addressed by Working Group 9 in the Trust's Governance Action Plan.		
GP3	There is a comprehensive	Green	Chair Appraisal			

	appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary).					
GP4	Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis.	Amber/Green	Remuneration Committee Minutes (for executive director)	This is being addressed by Working Group 9 in the Trust's Governance Action Plan.		No requirement for setting specific objectives for NEDs – outside of committee chairs. DHSSPS guidance would be welcomed.
GP5	Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role.	Amber/Green		This is being addressed by Working Group 9 in the Trust's Governance Action Plan.		
GP6	As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.	Amber/Green	Board & Committee Papers & Minutes NED Appraisal	This is being addressed by Working Group 9 in the Trust's Governance Action Plan.		
GP7	Where appropriate, Board members comply with the requirements of their respective	Green	Appraisal			

	professional bodies in relation to continuing professional development and/or certification.					

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received.	Amber/Red	This is being addressed by Working Group 4 in the Trust's Governance Action Plan.	There is no current 360 appraisal of Non-Executive Directors, although NEDs are subject to formal appraisal with the Trust Board Chair. However this process does not extend to Executive Directors. Executive Directors are subject to performance appraisal, and this is undertaken by the Chief Executive in line with the conditions of Senior Executive pay. That appraisal does not include performance in the Board role, as that would necessitate an appraisal by the Chair. Executive Directors do not participate in any personal 360 review
RF2	Individual Board members have not received any formal training or professional development relating to their Board role.	Green		
RF3	Appraisals are perceived to be a 'tick box' exercise.	Green		(Note: Appraisals are not considered to be a tick box exercise by either NEDs or Executive Directors. However, appraisal is subject to the comments above (RF1).
RF4	The Chair does not consider the differing roles	Green		(Note: Executive Directors are not members of any Board committee,

	of Board members and Committee members.			only attendees).

3. Board insight and foresight ALB Name: NIAS Date.....

3.1 Board performance reporting

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.	Green	NIAS TDP Board & Committee Papers & Minutes Annual Report			
GP2	The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a	Green	Board & Committee Papers & Minutes Annual Report			

	range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of					

	performance to comparable organisations is included where possible.					
GP3	The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made	Green	Board & Committee Papers & Minutes			
GP4	The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.	Green	Board & Committee Papers & Minutes Governance Framework and Statement			
GP5	An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.	Amber/Green	Board & Committee Papers & Minutes	This is being addressed by Working Group 7 in the Trust's Governance Action Plan.	Further development of the action log and reporting mechanisms is required.	

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Significant unplanned variances in performance have occurred.	Amber/Red	This is being addressed by Working Group 2 in the Trust's Governance Action Plan.	There have been occasional but significant unplanned variances in performance. These have been discussed and decisions made as appropriate at Board level.
RF2	Performance failures were brought to the Board's attention by an external party and/or not in a timely manner.	Green		
RF3	Finance and Quality reports are considered in isolation from one another.	Green		
RF4	The Board does not have an action log.	Green		
RF5	Key risks are not reported/escalated up to the Board.	Green		

3. Board insight and foresight ALB Name: NIAS Date.....

3.2 Efficiency and Productivity

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans.	Green	Board & Committee Papers & Minutes Annual Report Governance Framework and Statement NIAS TDP			
GP2	The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service.	Green	Board & Committee Papers & Minutes			
GP3	The Board receives information on all efficiency and	Green	Board & Committee Papers & Minutes			

	productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated.					
GP4	There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.	Green	Board & Committee Papers & Minutes			

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not receive performance information relating to progress against efficiency and productivity plans.	Green		This is further supported by on-going work on the Board Assurance Framework
RF2	There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans.	Green		
RF3	Efficiency plans are based on a percentage reduction across all	Green		

	services rather than a properly targeted assessment of need.			
RF4	The Board does not a Board Assurance Framework (BAF).	Green		

3. Board insight and foresight ALB Name: NIAS Date.....

3.3 Environmental and strategic focus

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).	Green	Board & Committee Papers & Minutes			
GP2	The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from	Green	Board & Committee Papers & Minutes			

	independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.					
GP3	The Board has conducted or updated an analysis within the last year to inform the development of the Business Plan.	Green	Board Workshop Notes NIAS TDP TYC Submissions			
GP4	The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis**.**	Green	Board & Committee Papers & Minutes			
GP5	The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the	Green	Board & Committee Papers & Minutes Board Workshops			

	Board Assurance Framework (BAF).					

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not have a clear understanding of Executive/Departmental	Green		

	priorities and its statutory responsibilities, business plan etc.			
RF2	The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB.	Green		
RF3	The Board does not formally review progress towards delivering its strategies.	Green		

3. Board insight and foresight ALB Name: NIAS Date.....

3.4 Quality of Board papers and timeliness of information

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time.	Green	Board & Committee Papers & Minutes			
GP2	A timetable for sending out papers to members is in place	Green	Standing Orders Board & Committee Papers & Minutes			

	and adhered to.					
GP3	Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion).	Green	Board & Committee Papers & Minutes			
GP4	Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal monthly meetings.	Green	Board & Committee Papers & Minutes Standing Orders			Board Meetings do not take place monthly
GP5	Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred	Green	Board & Committee Papers & Minutes			

	option, including the degree of scrutiny that the paper has been through.					
GP6	The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place.	Green	Board & Committee Papers & Minutes Internal & External Audit Reports			
GP7	The Board can provide examples of where it has explored the underlying data quality of performance measures that have been RAG rated green.	Amber/Green	Board & Committee Papers & Minutes Internal & External Audit Reports	This is being addressed by Working Group 7 in the Trust's Governance Action Plan.	While positive performance is acknowledged and commended, a focus is maintained on issues of under-performance to deliver improvement.	
GP8	The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should	Amber/Green	Board & Committee Papers & Minutes Assurance Framework NIAS TDP	This is being addressed by Working Group 2 in the Trust's Governance Action Plan.	The recently revised Assurance Framework provides the means by which Assurance Committee and Trust Board review sources of	

	be collected and quality assured.				information leading to assurance and identify gaps/weaknesss.	
GP9	Board members can demonstrate that they understand the information presented to them, including how that information was collected and quality assured, and any limitations that this may impose.	Green	Board & Committee Papers & Minutes			
GP10	Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.	Green	Board & Committee Papers & Minutes			

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the	Green		This area is subject to on-going review.

	Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing.			
RF2	Board discussions are focused on understanding the Board papers as opposed to making decisions.	Green		Further assurance in this area will be provided by the current review of the Assurance framework including a review of the formal record of decisions.
RF3	The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting.	Green		
RF4	Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision.	Green		Further assurance in this area will be provided by the current review of the Assurance Framework.

RF5	The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	Green		

3. Board insight and foresight ALB Name: NIAS Date.....

3.5 Assurance and risk management

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required

GP1	The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board.	Green	Board & Committee Papers & Minutes Risk Strategy Internal & External Audit Reports			
GP2	The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured.	Green	Board & Committee Papers & Minutes NIAS TDP Internal & External Audit Reports			
GP3	The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc	Green	Board & Committee Papers & Minutes Internal & External Audit Reports			

GP4	The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services.	Green	Self Assessment process for Trust Board and Committees	Self assessment in development for Assurance Committee		
GP5	The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate.	Green	Risk Strategy Internal & External Audit Reports			
GP6	An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.	Green	Job Descriptions			

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not receive assurance on the management of risks facing the ALB.	Green		
RF2	The Board has not identified its assurance requirements, or receives assurance from a limited number of sources.	Green		

RF3	Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic.	Green		
RF4	The Board has not reviewed the ALB's governance arrangements within the last two years.	Green		

4. Board engagement and involvement ALB Name: NIAS Date.....

4.1 External stakeholders

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Board has an approved PPI consultation scheme which formally outlines and embeds their	Green	Board & Committee Papers & Minutes			

	commitment to the involvement of service users and their carers in the planning and delivery of services.					
GP2	A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.	Green	Board & Committee Papers & Minutes PPI Strategy			
GP3	The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the	Green	NIAS TDP CSR Proposal Consultation Document CSR Implementation Report PPI Strategy			

	ALB and provide examples of where their views have been included and not included in the Business Plan.					
GP4	The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.	Green	PPI Strategy Board & Committee Papers & Minutes Public Facing Accountability			
GP5	The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide	Green	Board & Committee Papers & Minutes			
GP6	The ALB has constructive and effective relationships with its key stakeholders.	Green	Board & Committee Papers & Minutes Annual Report DHSSPS Accountability Reviews Public-Facing Accountability			

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The development of the Business Plan has only involved the Board and a limited number of ALB staff.	Green		The development of the Business Plan has included other staff and the HSCB and DHSSPS. However, the Board recognise that the process could have benefited from greater involvement and will look to doing this going forward.
RF2	The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc.	Green		
RF3	Feedback from clients is negative e.g. complaints, surveys and findings from	Green		

	regulatory and review reports.			
RF4	The ALB has received adverse negative publicity in relation to the services it provides in the last 12 months.	Amber/Green	This is being addressed by Working Group 2 in the Trust's Governance Action Plan.	There has been adverse negative publicity in the last 12 months. However, this is an exception to the norm, and the Board seek to learn and act accordingly
RF5	The Board has not overseen a system for receiving, acting on and reporting outcomes of complaints.	Green		

4. Board engagement and involvement ALB Name: NIAS Date.....

4.2 Internal stakeholders

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.	Green	Station Visits Staff Meetings Board & Committee Papers & Minutes Communication Strategy			
GP2	The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have	Amber/Green	CSR Consultation Proposals NIAS TDP	This is being addressed by Working Group 8 in the Trust's Governance Action Plan.		

	been included and not included.					
GP3	The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities.	Amber/Green	KSF Personal Development Review NIAS TDP NIAS Corporate Plan Annual Report Board & Committee Papers & Minutes	This is being addressed by Working Group 8 in the Trust's Governance Action Plan.	Personal Development Review partially implemented at this stage.	
GP4	The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB.	Green	Long Service Medal Ceremony Queens Ambulance Medal Compliments Letters for Chief Executive			
GP5	The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours.	Green	NIAS TDP NIAS Annual Plan Annual Report KSF Personal Development Review Disciplinary Procedures Grievance Procedures Board & Committee Papers & Minutes			

GP6	There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.	Green	Board & Committee Papers & Minutes Clinical/Non-Clinical Memos & Updates Emergency Planning Engagement (eg G8: Local Unrest) Untoward Incident Reports Serious Adverse Incident Reports			

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The ALBs latest staff survey results are poor.	Amber/Red	This is being addressed by Working Group 2 in the Trust's Governance Action Plan.	This assessment is based on 2010 staff survey. Findings from the latest staff survey were not available to the Board at the time

				of assessment.
RF2	There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.).	Amber/Red	This is being addressed by Working Group 6 in the Trust's Governance Action Plan.	The Board and its members have not been subject to a 'vote of no confidence'. However, there are unresolved issues at Board level in respect of Agenda for Change Job Evaluation. Members are committed to resolving this issue. The Trust works in partnership with Trade Unions, in line with regional guidance maintaining regular contact with DHSSPS, and there has been no industrial action. works in partnership with Trade Unions and there has been no industrial action
RF3	There are significant unresolved quality issues.	Green		
RF4	There is a high turnover of staff.	Green		
RF5	Best practise is not shared within the ALB.	Green		

4. Board engagement and involvement ALB Name: NIAS Date.....

4.3 Board profile and visibility

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made.	Amber/Green	Long Service Medal Ceremony Board Station Visits	This is being addressed by Working Group 7 in the Trust's Governance Action Plan.		
GP2	There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders.	Amber/Green	Chair Diary CX Diary Corporate Diary	This is being addressed by Working Group 7 in the Trust's Governance Action Plan.	No structured programme in place	
GP3	Board members attend and/or present at high profile events.	Green	Chair Diary CX Diary Corporate Diary			

GP4	NEDs routinely meet stakeholders and service users.	Amber/Green		This is being addressed by Working Group 7 in the Trust's Governance Action Plan.	Limited opportunity given pre-hospital setting	
GP5	The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.	Green	Board & Committee Papers & Minutes			
GP6	As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.	Green	Board & Committee Papers & Minutes NED Appraisal			Repeat of GP7 in section 2.4

Red Flags	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	With the exception of	Green		

	Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board.			
RF2	Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	Green		

Summary Results **ALB Name: Northern Ireland Ambulance Service Trust** **Date.....**

1.Board composition and commitment			
Area	Self Assessment Rating		Additional Notes
1.1 Board positions and size	G		score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some Red flag / 0 / 1 with action plan / 2 with action plan / Lack action plans
1.2 Balance and calibre of Board members	G		score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some Red flag / 0 / 1 with action plan / 2 with action plan / Lack action plans
1.3 Role of the Board	A	G	score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some Red flag / 0 / 1 with action plan / 2 with action plan / Lack action plans
1.4 Committees of the Board	A	G	score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some Red flag / 0 / 1 with action plan / 2 with action plan / Lack action plans
1.5 Board member commitment	A	G	score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some Red flag / 0 / 1 with action plan / 2 with action plan / Lack action plans

	2.Board evaluation, development and learning

Area	Self Assessment Rating		Additional Notes
2.1 Effective Board level evaluation	A	G	score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some / Red flag / 0 / 3 with action plan / 2 with action plan / Lack action plans
2.2 Whole Board development programme	A	R	score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some / Red flag / 0 / 1 with action plan / 2 with action plan / Lack action plans
2.3 Board induction, succession and contingency planning	A	G	score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / 1 with action plan / Red flag / 0 / 1 with action plan / 2 with action plan / Lack action plans
2.4 Board member appraisal and personal development	A	G	score / green / Amber/green / Amber/red / Red Good practice / All OK / All Explained/Action Plans / Some / Red flag / 0 / 1 with action plan / 1 with action plan / Lack action plans

	3.Board insight and foresight		
Area	Self Assessment Rating		Additional Notes
3.1 Board performance reporting	A	G	score / green / Amber/green / Amber/red / Red

			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	1 with action plan	Lack action plans	
3.2 Efficiency and Productivity	G		score	green	Amber/green	Amber/red	Red	
			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	2 with action plan	Lack action plans	
3.3 Environmental and strategic focus	G		score	green	Amber/green	Amber/red	Red	
			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	2 with action plan	Lack action plans	
3.4 Quality of Board papers and timeliness of information	A	G	score	green	Amber/green	Amber/red	Red	
			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	2 with action plan	Lack action plans	
3.5 Assurance and risk management	G		score	green	Amber/green	Amber/red	Red	
			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	2 with action plan	Lack action plans	

4. Board engagement and involvement								
Area	Self Assessment Rating		Additional Notes					
4.1 External stakeholders	A	G	score	green	Amber/green	Amber/red	Red	
			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	2 with action plan	Lack action plans	

4.2 Internal stakeholders	A	R	score	green	Amber/green	Amber/red	Red	
			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	2 with action plan	Lack action plans	
4.3 Board profile and visibility	A	G	score	green	Amber/green	Amber/red	Red	
			Good practice	All OK	All Explained/Action Plans	Some		
			Red flag	0	1 with action plan	2 with action plan	Lack action plans	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes
5.1	Green	Ambulance Turnaround Issue
5.2		
5.3		

Areas where additional training/guidance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes

score	green	Amber/green	Amber/red	Red
Good practice	All OK	All Explained/Action Plans	Some	
Red flag	0	1 with action plan	2 with action plan	Lack action plans

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers recent case studies in the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the Trust. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB

Name.....NIAS.....Date.....

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	Title: Improving Hospital Turnaround Times
Brief description of issue	The Northern Ireland Ambulance Service (NIAS) has been experiencing increasing delays at hospitals in particular within Emergency Departments (EDs) throughout Northern Ireland for a number of years. Ambulance turnaround times are recognised as a key component of the Ambulance response timeline and lengthy ambulance turnarounds at hospital are not only adversely impacting on patient care but also the ability of ambulance crews to respond to further emergency calls in the community. Since 2012, NIAS and Health & Social Care Trusts have been working together to address this issue with a number of noticeable positive outcomes. Nevertheless there is still room for improvement. The purpose of the paper presented to Trust Board was to share the benefits and impact of the actions taken to date put forward proposals for continued improvements including the introduction of monitoring mechanisms. In addition, this document will clearly describe the processes involved in patient handover, the challenges inherent in the patient flow system and the reasons for delays. Trust Board Support sought for the Improvement Plan.
Outline Board's understanding of the issue and how it arrived at this	Hospital Turnaround data presented in regular Board papers. Issue identified through staff and stakeholder engagement. Issue discussed regularly at Trust Board to enhance understanding and consider improvement opportunities.
Outline the challenge/scrutiny process involved	In addition to above, Trust Board reviewed paper presented and examined and questioned information, before approving proposals.

Outline how the issue was resolved	Board support for proposals secured, with ongoing monitoring of impact via Trust Board papers and testing at station visits with ambulance personnel.
Summarise the key learning points	Ambulance turnaround recognised as system issue requiring whole system engagement and ownership for resolution. Paper outlined NIAS contribution and engagement to resolve, and identified improvements made.
Summarise the key improvements made to the governance arrangements directly as a result of above	Revised presentation of information on ambulance turnaround times providing greater clarity to Trust Board. Wider debate and consideration of associated issues. Valuable topic for discussion with ambulance personnel on Trust Board station visits/staff engagement opportunities, directly linking board to patient experience.

6. Board impact case studies ALB

Name.....Date.....

6.2 Case Study 2

Organisational Culture Change	Title:
Brief description of area of focus	
Outline reasons/ rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	

6. Board impact case studies ALB Name.....Date.....

6.3 Case Study 3

Organisational strategy	Title:
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	

NIAS GOVERNANCE ASSESSMENT ROLLING ACTION PLAN

ACTION	RED FLAG/ GOOD PRACTISE ISSUES	ASSESSMENT COMMENT	BY WHOM	BY WHEN	NOTE
1. Establish process to Update Governance self-assessment for 2013-14 and subsequent years and implement Rolling Action Plan	No formal Board Governance Self-Assessment has been undertaken within the last 12 months. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years. Where Board has undertaken an evaluation, only the perspectives of Board members were considered, not those outside the Board (e.g.staff, etc) Where the Board has undertaken an evaluation, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	This is the first formal self-assessment. The Board will now undertake the annual self-assessment with other HSC Trusts. The Board will seek advice from the Department on what constitutes independent evaluation, This will be in line with Departmental guidance, as above This will be in line with Departmental guidance, as above	Chair **(Convenor)** CEO NED (JL)	Feb 2014	Process Paper submitted to Board for approval
2. Conduct Board Workshop to Review & Refresh Assurance Framework.	The Board tends to focus on details and not on strategy and performance. The Board become involved in operational areas.	There are occasions when members need to focus on an operational area e.g. when there is reputational risk or significant	All Board Members	Feb 2014	Refreshed Assurance Framework agreed

		performance variance.			
	Significant unplanned variances in performance have occurred.	There have been some significant unplanned variances in performance. These have been discussed and decisions made as appropriate at Board level.			
	The Board does not receive 12 month rolling cash flow forecast information.	Financial systems are neither structured nor sophisticated enough to provide 12 month rolling cash flow forecast information.			
	The ALB has received adverse negative publicity in relation to the services it provides in the last 12 months.	There has been adverse negative publicity in the last 12 months. However, this is an exception to the norm, and the Board seek to learn and act accordingly			
	The ALBs latest staff survey results are poor.	This assessment is based on 2010 staff survey. Findings from the latest staff survey were not available to the Board at the time of assessment.			
3. Obtain DHSSPS guidance on Appraisal of Committee members in terms of roles	Committee members do not receive performance management appraisals in relation to their Committee role.		Chair	May 2014	Inputs to Actions 4 and 9
4. Board Working Group to review available guidance,	There is not a robust performance appraisal process in place at Board level that includes consideration of	There is no current 360 appraisal of NEDs, although they are subject to formal appraisal with the Trust Board Chair. However this	HR Dir. (R O'H) **(Convenor)**	Sept 2014	Proposals paper to Board and

and report to Board, early options for change in respect of appraisal processes	the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received.	process does not extend to Executive Directors. Executive Directors are subject to performance appraisal, and this is undertaken by the Chief Executive in line with the conditions of Senior Executive pay. That appraisal does not include performance in the Board role, as that would necessitate an appraisal by the Chair. Executive Directors do not participate in personal 360 review	NED (N McK) Asst. Dir. (tbc)		inputs to Action 9
5. Board Working Group to develop early options for Board Development Programme	The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.		Chair **(Convenor)** CEO Asst. Dir. (HR- ELD)	Sept 2014	Proposals paper to Board and inputs to Action 11
6. Board Working Group to develop Programme of Structured Team-Building Activity for Trust Board	There is a clear understanding of the roles of Executive officers and Non-Executive Board members. The Board operates as an effective team.	There has been an emphasis on the role and development of Non-Executive Directors in recent guidance which has not been mirrored with Executive Directors. The Board would welcome further consideration by DHSSPS of the role of Executive Director as a member of the Board. The Board has identified potential to explore improvement in problem identification and solving.	Fin. Dir. (S McC) **(Convenor)** NED (RM) Asst. Dir. (HR-ELD)	Sept 2014	Proposals paper to Board

	The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.	The Board and its members have not been subject to a 'vote of no confidence'. However, there are unresolved issues at Board level in respect of Agenda for Change Job Evaluation. Members are committed to resolving this issue. The Trust works in partnership with Trade Unions, in line with regional guidance maintaining regular contact with DHSSPS, and there has been no industrial action. Board members are working through some recent difficulties and are committed to finding a resolution to those difficulties as well as further exploration of expected behaviours in difficult situations.			
7. Board Working Group to Review Structure & Format of Board Business	The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken.	Work is on-going to improve the structure of Board meetings and their agenda.	Ops. Dir. (B McN) **(Convenor)** NED (MH)	Jun 2015	Proposals paper to Board

	The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.	The Board will establish processes to undertake formal evaluation of its three main committees. Chairman holds a regular debrief with the chairs of the audit and assurance committee. The Chief executive holds a similar debriefing meeting For the remuneration and assurance committees this has not been a formal process to date.	Asst. Dir. (Finance) Board Exec Asst.		
	The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal evaluations that have been undertaken.	Changes/improvements have been identified through this self-assessment process.			
	The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.	The Board will consider commissioning an independent 3rd party to undertake the evaluation. The Board will seek advice from the Department on what constitutes independent 3rd party evaluation			
	An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.	Further development of the action log and reporting mechanisms is required.			

	The Board can provide examples of where it has explored the underlying data quality of performance measures that have been RAG rated green. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. NEDs routinely meet stakeholders and service users.	While positive performance is acknowledged and commended, a focus is maintained on issues of under-performance to deliver improvement. The recently revised Assurance Framework provides the means by which Assurance Committee and Trust Board review sources of information leading to assurance and identify gaps/weaknesses. No structured programme in place Limited opportunity given pre-hospital setting			
8. Board Working Group to Review Trust Board Agenda – form, items, standing items, etc.	The Board is aware of and annually approves a scheme of delegation to its committees. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes. A formal Board Governance Self-Assessment has been conducted	The Board will bring forward its scheme of delegation and committee terms of reference on an annual basis. A process will be established to bring forward to the Board post-evaluation reviews on all major projects and programmes. Self-Assessment will be repeated annually.	Med Dir. (D McM) **(Convenor)** NED (AP) Asst. Dir. (Ops)	June 2015	Proposals paper to Board

	within the previous 12 months. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities.	 NIAS will continue to explore methods to more fully engage with staff and elicit their views. Personal Development Review partially implemented at this stage.			
9. Board Working Group to Review longer term Appraisal for Trust Board Members (taking account of Action 4 above)	Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair and included as part of each Board member's annual appraisal. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.	DHHSPS should review wording of this question as Chair does not directly undertake appraisal of Executive Directors to enable appraisal as described. Consideration will be given to incorporation in the appraisal process for executive directors.	HR Dir. (R O'H) **(Convenor)** NED (N McK) Asst. Dir. (tbc)	Sept 2015	Inputs from Action 4 Proposals paper to Board

	Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. There are processes in place to ensure the development of Executive Directors as Corporate Directors As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.	The Board will consider developing objective-setting processes to incorporate objectives specific to the Director's Board role. No requirement for setting specific objectives for NEDs – outside of committee chairs. DHSSPS guidance would be welcomed. The Board will consider further developing current appraisal processes to formalise Personal Development Plans specific to their Board role. There are processes in place to ensure the development of effective directors as corporate directors however there needs to be further clarification on the executive directors' role. The Board will consider further developing processes to ensure the development of Executive Directors as Corporate Directors.			
10. Review Governance Self-Assessment Process	In undertaking its formal evaluation, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a	The Board will engage with DHSSPS to identify measures to enhance the board assessment process.	Chair **(Convenor)** CEO	Jan 2015	Report to Board

	representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. The focus of the evaluation included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various sub-committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and	The Board will engage with DHSSPS to identify measures to enhance the board assessment process.			

	business conducted at public board meetings and that done in confidential session				
11. Develop longer term Board Development Programme (taking account of Action 5 above)	The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual evaluation and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: The focus and balance of Board time; The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; How the Board responded to any	Consideration will be given to the production of a Board development plan building on the outcomes and priorities arising from this assessment. Consideration will be given to the production of a Board development plan building on the outcomes and priorities arising from this assessment.	Chair **(Convenor)** CEO Asst. Dir. (HR- ELD)	June 2015	Inputs from Action 5 Proposals paper to Board

	service, financial or governance failures; Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; The robustness of the ALB's risk management processes; The reliability, validity and comprehensiveness of information received by the Board.				
	Time is 'protected' for undertaking this programme and it is well attended.	Consideration will be given to the production of a Board development plan building on the outcomes and priorities arising from this assessment.			
	The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.	Consideration will be given to the production of a Board development plan building on the outcomes and priorities arising from this assessment.			
	The Board has considered the skills it requires to govern the organisation effectively in the future and to the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.	Consideration will be given to the production of a Board development plan building on the outcomes and priorities arising from this assessment. The Board will give consideration to the development of a process to formalise succession planning.			
12. Board Working	Rolling Action Plan will need to be		Chair	Mar	DHSSPS

Group to draft 2013/14 Self-Assessment return and update Rolling Action Plan for Self-Assessment	updated consequent upon completion of 2013/14 Assessment for submission to DHSSPS by 31 March 2014 and for subsequent years		**(Convenor)** CEO NED (JL)	2014 June 2014	return for Board approval Revised Action Plan For Board approval

TB/6/29/05/14

Northern Ireland Ambulance Service
Health and Social Care Trust

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

29 May 2014

Title:	Terms of Reference – Assurance Committee
Purpose:	Review of framework for the operation of the Assurance Committee.
Content:	1. Constitution 2. Membership 3. Attendance at Meetings 4. Frequency of Meetings 5. Authority 6. Duties 7. Reporting 8. Other Matters
Recommendation:	For Approval
Previous Forum:	Assurance Committee Meeting 24 March 2014
Prepared by:	Medical Director
Presented by:	Chief Executive

TERMS OF REFERENCE

ASSURANCE COMMITTEE

1.0 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Assurance Committee (The Committee).

1.2 The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.3 All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

2.0 MEMBERSHIP OF THE COMMITTEE

2.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members.

2.2 A Non-Executive Member of the Committee will be appointed Chair of the Committee by the Board.

2.3 The Chairman of the Trust Board shall not be a member of the Committee.

2.4 In the absence of the Chair another Non-Executive Member may be appointed to that role by agreement of the Non-Executive Directors.

2.5 One member of the Committee shall be the Chair of the Audit Committee.

2.6 One member of the Committee should have a clinical background.

2.7 A quorum shall be two members in addition to the Chair.

3.0 ATTENDANCE AT MEETINGS

3.1 The Medical Director, Director of Operations, Director of Finance & ICT and Director of Human Resources & Corporate Services shall normally attend meetings.

3.2 The Chairman, Chief Executive and other Officers of the Trust may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Officer.

3.3 The Medical Director shall attend to the minutes of the meeting and provide appropriate support to the Chairman and Committee members.

4.0 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year.

5.0 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of Governance (clinical and non clinical) and risk management and that such matters are properly considered and communicated to the Board.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6.0 DUTIES

6.1 The duties of the Committee can be categorised as follows:

6.2 Governance, Risk Management and Internal Control

The Committee shall contribute to the establishment, review 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.

6.3 In particular the Committee will:

6.3.1 Provide assurance that adequate systems and processes are in place to support the achievement of the organisation's objectives and strategically manage clinical and non-clinical risks.

6.3.2 Provide assurance that adequate systems and processes are in place for the delivery of high quality patient care that is safe, effective and patient focused through the review and monitoring of:

- clinical activities;
- professional self-regulation;
- development and implementation of national standards of care and practice;
- clinical audit activity;
- professional and clinical performance standards;
- continuing professional development for all staff;
- adverse incidents and complaints with a clinical component;
- infection prevention and control arrangements;
- clinical research and development activity;
- Personal and Public Involvement (PPI) arrangements and activities;
- corporate social responsibility.
- emergency planning and business continuity;
- information governance;
- compliance with the relevant DHSSPS Controls Assurance Standards and associated action plans.

6.3.3 Review the Trust's Assurance Framework and the Trust's Risk Register and to make recommendations to Trust Board for action as required to ensure high quality patient care.[1]

6.3.4 Report and review the outcome of Serious Adverse Incidents (SAI) including Serious Clinical Adverse Incidents in line with DHSSPS guidance and to ensure that appropriate remedial action has been taken including measures to prevent recurrence.[2]

6.3.5 Receive reports from other Committees and Working Groups in relation to areas of risk and governance.

6.3.6 Provide Trust Board with regular reports on the management of risk and quality of patient care and an annual report on clinical governance.

6.4 In carrying out its work, the Committee will utilise the work of Internal Audit, External Audit, and other assurance functions where appropriate, but will not be limited to these functions. It will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

[1] Safety First – A framework for sustainable Improvement in the HPSS (March 2006)
[2] Procedure for reporting and follow up of SAI (April 2010)

6.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

6.6 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

6.7 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DHSSPS commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

6.8 Governance Statement

The Committee shall review the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

7.0 REPORTING

7.1 The Minutes of Committee meetings shall be formally recorded and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Quality Standards and Controls Assurance Standards.

8.0 OTHER MATTERS

8.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

DATE OF ISSUE: **March 2014**

DATE OF REVIEW: **March 2015**

TB/7/29/05/14

Patient and Client Council
Your voice in health and social care

Patient and Client Council
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18 Ormeau Avenue
BELFAST BT2 8HS

Freephone: 0800 917 0222
Tel : 028 90321 230

Web:http://www.patientclientcouncil.hscni.net/

Our Ref: 29-14-HM

Mr Paul Archer
Chair
Northern Ireland Ambulance Service
HSC Trust
Site 30, Knockbracken Healthcare Park
Saintfield Road
BELFAST BT8 8SG

14 April 2014

Dear Mr Archer

Re: HSC Online User-Feedback System

In liaison with the Department, the Patient and Client Council (PCC) has been looking at how an HSC Online User-Feedback System could be implemented into Northern Ireland in order to empower and support service users to contribute to shaping HSC services.

In January 2013 a presentation was made to the HSC Chief Executives Group and there was agreement that the PCC should scope out this project with view to moving it forward. A steering group was established, made up of service users and representatives of HSC Trusts, the Health and Social Care Board (HCSB) and the Public Health Agency (PHA). Focus groups were held and based on information gathered, a Business Plan was drawn up and submitted to the Department for consideration.

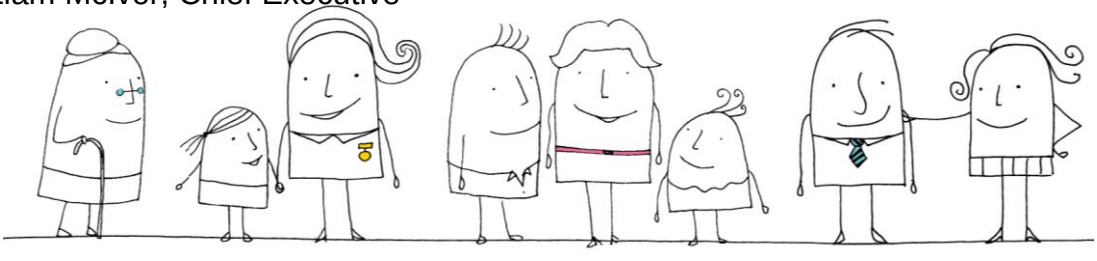
At a subsequent presentation (September 2013) to the HSC Chief Executives' group, a request was made by the group that the PCC produce a brief paper outlining the context and aims of this project which could be circulated to the respective Boards.

The PCC has now produced this paper and I would be grateful if you could table this paper at your next Board Meeting, asking your Board Members to note the proposals being put forward for development of this initiative.

Yours sincerely,

Maeve Hully
Chief Executive

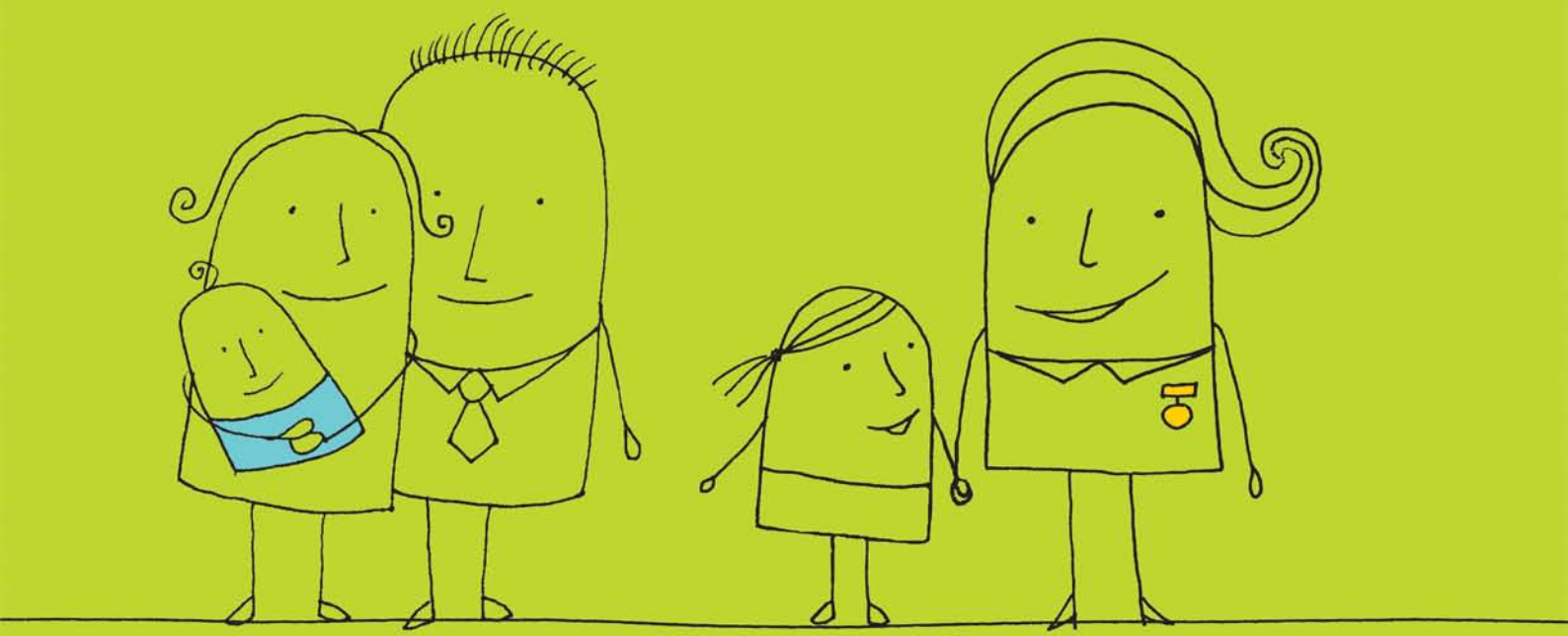
cc. Mr Liam McIvor, Chief Executive



Patient and Client Council

HSC Online User-Feedback System

Project Report for all HSC Boards, April 2014



Project Context

Building on strong evidence, health and social care services all across the world are seeking to move to a more person-centred approach. This new approach seeks to empower citizens to take care of their own health and to support people to contribute to shaping services in the future. A critical element of this approach is to use insights gathered from service users to drive improvements.

The Aim of the project is to procure and implement an online user feedback system for all HSCNI services. This Feedback system will be about honest and meaningful conversations between service users and health and social care services. At the heart of this project is the firm belief that service user feedback –*good or bad* – is essential in improving HSC services. These are people's personal experiences about the care they have received in HSC organisations. Their stories are incredibly powerful and have the potential to improve services as they highlight 'the user's perspective' in as near-real time as possible. A need for a system such as this was highlighted in the recent Francis Report:

> *"In a society that increasingly relies on internet and social media based applications for its information, the days when it might have been justifiable to rely on a periodic conventional survey have now passed. Such a method suffers from a number of disadvantages, not least of which is that its results tend to arrive too late to be currently relevant."*
>
> ***vol 3 p 1664, Robert Francis QC, Feb 2013***

Stakeholder Engagement

A high level presentation on this topic was made to the Health and Social Care Chief Executives' group in January 2013 and there was agreement that this was, in principle, a good idea. The group had agreed that the PCC should further scope out this project to take this initiative forward. A steering group made up of service users and representatives of HSC Trusts, HSCB and the PHA was set up to help steer the project. The Project team carried out a scoping exercise with 13 focus groups in the summer of 2013 to understand if there was an appetite for such a feedback system. Service users were unanimous that a system such as this would add great value to the HSC service as this would give them an additional channel to speak to HSC organisations (service users stated that currently complaints are the only means they feel they can get heard in HSC). At a NICON event in June 2013, the project was afforded the opportunity to present to about 80 stakeholders and again there was unanimous support that this would add great value both to service users and HSC organisations.

The Project team have concluded the scoping exercise and have subsequently made a presentation to the Chief Executives' group in October 2013. In November 2013, the Department asked the PCC to proceed to business case with an aim of submitting the same in February 2014. The business case was submitted and PCC is awaiting response from the department.

High Level Summary of the proposal -

The 4 foundational elements of this system will be:

1. **Regional system covering all HSC services in Northern Ireland** - The proposal is for a single web based feedback system covering all HSC services in Northern Ireland (i.e. both health stories and social care stories will need to be captured)

2. **Independent of all HSC provider organisations –** The system will need to be independent of HSC service providers to assure service users that they are giving feedback to an independent body, so that they are able to be as critical as needs be, without the fear that they can be identified and/or that their future care may be affected. This was a particular concern that service users highlighted at the focus groups.

3. **Open & Transparent**: The uniqueness of this website is that all feedback given through this it will be open and transparent (similar to reviews on Tripadvisor, Amazon.co.uk or Argos website). Fundamentally, the system should not be a 'closed system', i.e. service users should be able to see what other service users have said about a particular HSC services and also how the service provider has responded and/or changed services.

4. **Responsive:** The system should enable service users stories to be shared as quickly as possible (both in the public domain and also with the relevant staff) and for HSC staff to be able to respond quickly through the system (please see examples of these on www.patientopinion.org.uk website). Further, the Independent organisation hosting this system will need to work closely with all HSC partner organisations so that feedback and response can flow smoothly and quickly both ways (to and from service users).

Summary of the proposal - ***How will it work?***

1. HSCNI *feedback* system created and in partnership with all HSC partner organisations, agree protocols and governance issues.
2. The Feedback System administrator will create a comprehensive 'nominated person(s)' database for each HSC organisation. (e.g. Dermatology manager for SET, dermatology ward sister, Rheumatology co-director for BHSCT, A&E Manager for SHSCT, etc.) so that the story is sent to the right staff in as quick a time as possible.
3. Service users share their story of using a health and social care service through the web based feedback system.
4. Feedback system administrators will moderate the story (this is to ensure that names are removed to maintain privacy of service users and staff).
5. Feedback staff will upload the moderated story and simultaneously the system will email the story to the right staff in the relevant HSC organisation so that they can learn from it. (e.g. if a story is generated about NIAS, then the system will send an automated email to a named person(s) in NIAS.
6. The HSC organisation's nominated staff may respond to the story and this will be uploaded on to the site. The system then sends an automated email to service user that a response has been generated to their story.
7. Story may help staff to change services, which will be captured and highlighted on the site so that the public recognise the change that has taken place.

There are a number of such web based services currently in use in England, Scotland and Wales (E.g. https://www.patientopinion.org.uk/, https://www.iwantgreatcare.org/ https://www.nhs.uk/careconnect/choices). These web based systems are not for complaints purposes, it's for those who frequently say, "I don't want to complain but I just want to let you know…." For example:

Patient Opinion has over 70,000 Stories

Roughly 1/2 are positive stories

1/3 are mixed stories

1/6 are purely negative stories

Benefits

A system such as this will make it easy to gather people's personal views of their care and will instil confidence in service users and wider public that HSC organisations are genuinely listening to and acting on their feedback.

A system such as this will not only be able to provide what service users are saying about services, but will also be capable of data analysis and will enable staff and key stakeholders to get bespoke (near-real time) reports. This will be of enormous benefits to operational managers, assistant directors and directors in trusts, non-executive directors in HSC organisations, HSC commissioners, RQIA, Department of Health, etc.
Other key Benefits:

1. Gives service users an additional channel to dialogue with HSC organisations
2. Helps HSC organisations become more open & transparent
3. Boosts staff morale
4. Drives service change & promotes good practice

For Further Information please contact HSC Userfeedback Project Lead:

Deepak Samson
Advice and Information Services Manager
Patient and Client Council
07887420513
deepak.samson@hscni.net

TB/8/29/05/14

From:

Wendy Patterson

Performance Management Unit

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk
AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Liam McIvor
Chief Executive
Northern Ireland Ambulance Service
HSC Trust
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Room D1.1
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Stormont
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Tel: 028 9052 3112
Fax: 028 9052 2622
Email:
wendy.patterson@dhsspsni.gov.uk

Our Ref: DH1/11/153498
Date: 15th August 2011

Dear Liam

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

MANAGEMENT STATEMENT/FINANCIAL MEMORANDUM

1. It is a standard requirement of *Managing Public Money Northern Ireland* that a department must agree a DFP-approved Management Statement/Financial Memorandum (MS/FM) with each of its arm's length bodies (ALBs).

2. An MS/FM defines the relationship between the Minister/Department and the ALB concerned, sets out the control framework within which that relationship is to be managed, and lays down the main duties to be performed by each party. It is liable to revision in the light of experience, changing circumstances etc. Such changes will always require

Departmental agreement; if significant, they will also require approval by DFP.

3. Following on from John Allen's letter of 24th March I am pleased to note that you and Andrew McCormick have both signed off the MS/FM that is to subsist between the Northern Ireland Ambulance Service HSC Trust and the Department.

Action required

4. The purpose of this letter is to issue you with the final signed MS/FM for your records.

5. If you or Trust colleagues have any queries on the MS/FM either Fergal Bradley (fergal.bradley@dhsspsni.gov.uk) or I will be happy to answer them.

Yours sincerely

Wendy Patterson

Wendy Patterson
PERFORMANCE MANAGEMENT UNIT

Northern Ireland Ambulance Service
Health and Social Care Trust

Northern Ireland Ambulance Service

HSC Trust Management Statement

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1. INTRODUCTION
1.1 This document

1.1.1 Subject to the legislation noted below, this *Management Statement* establishes the framework, agreed with the Department of Health, Social Services and Public Safety (the sponsor Department), within which the Northern Ireland Ambulance Service HSC Trust (hereafter referred to as the Trust) will operate. The term 'Department' throughout this document is used to include the authority of both the Department and its Minister. Only in those cases where reference is intended to his/her personal authority (see, principally, Section 3.1) is the Minister specified.

1.1.2 The associated *Financial Memorandum* sets out in greater detail certain aspects of the financial provisions which the Trust shall observe. However, the *Management Statement* and the associated *Financial Memorandum* do not convey any legal powers or responsibilities, nor do they comprise the totality of the guidance, directives etc which have applied and (as determined by the Sponsor Department) continue to apply to the Trust.

1.1.3 The document shall be reviewed by the sponsor Department at least every five years. The first review is planned to take place at the end of the 2014-15 financial year

1.1.4 In addition, the Trust or the Department may propose amendments to this document at any time. Any such proposals by the Trust shall be considered in the light of evolving Departmental policy aims, operational factors and the record of the Trust itself. The guiding principle shall be that the extent of flexibility and freedom given shall reflect both the quality of the Trust internal controls to achieve performance and its operational needs. The Department shall determine what changes, if any, are to be incorporated in the document. Legislative provisions shall take precedence over any part of the document. Significant variations to the document shall be cleared with DFP after consultation with the Trust, as appropriate. The determination of those issues

that are ‘significant’ will be made by the Department and DFP on a case by case basis.

1.1.5 This MS/FM has been approved by DFP Supply, and signed and dated by the Department after consultation with the Trust.

1.1.6 Any question regarding the interpretation of the document shall be resolved by the Department after consultation with the Trust and, as necessary, with DFP (and OFMDFM if appropriate).

1.1.7 Copies of this document and any subsequent substantive amendments shall be placed in the Library of the Assembly. Copies shall also be made available to members of the public on the Trust website.

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

1.2 Trust Founding legislation, functions, duties etc

1.2.1 The Trust is established by means of an Establishment Order made under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991.The Order is the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995. The Trust does not carry out its functions on behalf of the Crown.

1.2.2 The Trust is established for the purposes specified in Article 10 (1) of the 1991 Order. These include any functions of the Department with respect to the administration of health and social care that the Department may direct. The Trust’s general powers etc are listed in Schedule 3 of the Order.

1.3 Classification

1.3.1 For policy/administrative purposes the Trust is classified as a Health and Social Care body (akin to an executive non-departmental public body) and for national accounts purposes the Trust is classified to the central government sector.

2. AIMS, OBJECTIVES AND TARGETS

2.1 Overall aims

2.1.1 The approved overall aims for the Trust are as follows:

To improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, by providing effective, high quality, equitable and efficient health and social care.

2.2 Objectives and key targets

2.2.1 The Department determines the Trust's performance framework in light of its wider strategic aims and of current Public Service Agreement (PSA) objectives and targets. The key targets, standards and actions to be delivered by the Trust are defined by the Department within Priorities for Action (PfA) and are approved by the Minister.

3. RESPONSIBILITIES AND ACCOUNTABILITY

3.1 The Minister

3.1.1 The Minister is accountable to the Assembly for the activities and performance of the Trust. His/her responsibilities include:

- keeping the Assembly informed about the Trust's performance, as part of the HSC system;
- carrying out responsibilities specified in the founding legislation including appointments to the Board (including its Chairman) and laying of the annual report and accounts before the Assembly; and
- approving the remuneration scheme for Non-Executive Board members and setting the annual pay increase each year under these arrangements.

3.2 The Accounting Officer of DHSSPS

3.2.1 The Sponsor Department's Accounting Officer (the 'Departmental Accounting Officer') has designated the Chief Executive of the Trust as the Trust's Accounting Officer, and may withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role. The respective responsibilities of the Departmental Accounting Officer and the Accounting Officers of arm's length bodies are set out in Chapter 3 of *Managing Public Money Northern Ireland* (*MPMNI*).

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

- the Trust's plans support the Department's wider strategic aims and will contribute, as appropriate, to the achievement of PSA and PfA targets, standards and actions;
- the financial and other management controls applied by the Department to the Trust are appropriate and sufficient to safeguard public funds, and that the Trust's compliance with those controls is effectively monitored ("public funds" include not only any funds granted to the Trust by the Assembly but also any other funds falling within the stewardship of the Trust); and
- the internal controls applied by the Trust conform to the requirements of regularity, propriety and good financial management.

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

- continuously monitor the Trust's activities to measure progress against approved targets, standards and actions, and to assess compliance with safety and quality, governance, risk management and other relevant requirements placed on the organisation;
- address significant problems in the Trust, making such interventions as he/she judges necessary to address such problems;
- periodically carry out an assessment of the risks both to the Department's and the Trust's objectives and activities;
- inform the Trust of relevant Government policy in a timely manner; and
- bring concerns about the activities of the Trust to the full Trust Board, requiring explanations and assurances that appropriate action has been taken.

3.2.4 The Planning & Performance Management Directorate within the Department is the sponsoring team for the Trust, forming its primary point of contact with the Department on non-financial management and performance. Regarding such

matters, the team is the primary source of advice to the Minister on the discharge of his/her responsibilities in respect of the Trust. It also supports the Departmental Accounting Officer on his/her responsibilities towards the Trust.

3.2.5 The relationship between the Trust and its Departmental sponsoring team, based on the principles of good public administration, is articulated through direction and guidance, and on good practice as notified to the Trust. The salient requirements are described at **Appendix 1**.

3.2.6 On financial matters, the primary point of Departmental contact for the Trust is Finance Directorate. That Directorate also supports the Departmental Accounting Officer on his/her responsibilities towards the Trust as regards accounting arrangements, budgetary control and other financial matters. In doing so, Finance Directorate liaises as appropriate with the Planning & Performance Management Directorate.

3.3 The Chief Executive's role as Accounting Officer

3.3.1 The Chief Executive, as the Trust's Accounting Officer, is personally responsible for safeguarding the public funds of which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day-to-day operations and management of the Trust. In addition he/she should ensure that the Trust as a whole is run on the basis of the standards (in terms of governance, decision making and financial management) set out in Box 3.1 of *MPMNI*.

3.3.2 In addition, the Chief Executive must, within three months of appointment, attend the training course ' An introduction to Public Accountability for Accounting Officers'.

Responsibilities for accounting to the Assembly

3.3.3 These responsibilities include:

- signing the accounts and be responsible for ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with any directions issued by the Department or DFP;
- signing a Statement of Accounting Officer's responsibilities, for inclusion in the annual report and accounts;
- signing a Statement on Internal Control regarding the Trust's system of internal control, for inclusion in the annual report and accounts;
- signing a mid-year assurance statement on the condition of the Trust's system of internal control;
- acting in accordance with the terms of this document and with the instructions and relevant guidance in *MPMNI* and other instructions and guidance issued from time to time by the Department; and
- giving evidence, normally with the Accounting Officer of the Department, if summoned before the Public Accounts Committee on the use and stewardship of public funds by the Trust.

Responsibilities to the Department

3.3.4 Particular responsibilities to the Department include:

- establishing, with the approval of the Department, the Trust's Corporate/ Business Plan in support of the Department's wider strategic aims and objectives and targets in the PfA and PSAs;

- informing the HSCB of the Trust's progress in helping to achieve the Department's wider strategic aims and objectives, and relevant targets in the PfA and PSAs, demonstrating how resources are being used to achieve those objectives and targets;
- ensuring that timely forecasts and monitoring information on performance and finance are provided to the HSCB including prompt notification of overspends or underspends, and that corrective action is taken;
- ensuring that any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, are notified to the HSCB or to the Department as appropriate and in timely fashion;
- ensuring that a system of risk management, based on Departmental guidance, is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets;
- ensuring that an effective system of programme and project management and contract management is maintained; and
- ensuring compliance with the Northern Ireland Public Procurement Policy;
- reporting on compliance with controls assurance and quality standards to the Department;
- ensuring that an Assurance Framework is developed and maintained;
- ensuring that a business continuity plan is developed and maintained;
- ensuring that effective procedures for handling complaints about the Trust are established and made widely known within the Trust;
- ensuring that effective procedures for handling adverse incidents are established and made widely known within the Trust;

- ensuring that an Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and OFMDFM;
- ensuring that Lifetime Opportunities is taken into account;
- ensuring that the requirements of the Data Protection Act 1998 are complied with;
- ensuring that the requirements of the Freedom of Information Act 2000 are complied with and that a publication scheme is in place which is reviewed as required and placed on the website; and
- ensuring that the requirements of relevant statutes, court rulings, and departmental directions are fully complied with.

Responsibilities to the Board of the Trust

3.3.5 The Chief Executive is responsible for:

- advising the Board on the discharge of its responsibilities as set out in this document, in the founding legislation and in any other relevant instructions and guidance that may be, or have been, issued from time to time;
- advising the Board on the Trust's performance compared with its aims and objectives;
- ensuring that financial considerations are taken fully into account by the Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed; and
- taking action in line with Section 3.8 of *MPMNI* if the Board, or its Chairman, is contemplating a course of action involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity, or does not represent prudent or economical administration, efficiency or effectiveness.

3.4 The Chief Executive's rôle as Consolidation Officer

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

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

3.4.3 As Consolidation Officer, the Chief Executive shall comply with the requirements of the Trust Consolidation Officer Memorandum as issued by DFP and shall, in particular**:**

- ensure that the Trust has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and
- prepare the consolidation information (including the relevant accounting and disclosure requirements and all relevant consolidation adjustments) in accordance with the consolidation instructions and directions ["Dear Consolidation Officer" (DCO) and "Dear Consolidation Manager" (DCM) letters] issued by DFP on the form, manner and timetable for the delivery of such information.

3.5 Delegation of duties

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

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

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

3.7 The Trust's Board

3.7.1 The Board must ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. The Board must set up an Audit Committee, which complies with the requirements of DAO 07/07 and any subsequent relevant guidance, is chaired by an independent non-executive member, and comprises solely independent members, to provide independent advice on the effectiveness of the internal control and risk management systems.

3.7.2 The Board has corporate responsibility for ensuring that the Trust fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient, economic and effective use of staff and other resources by the Trust. To this end, and in pursuit of its wider corporate responsibilities, the Board shall:

- establish the overall strategic direction of the Trust within the policy and resources framework determined by the Department/Minister;
- ensure that the Trust's performance fully meets its aims and objectives as efficiently and effectively as possible;
- ensure that the Department, if appropriate through the HSCB or PHA, is kept informed of any changes which are likely to impact on the strategic

direction of the Trust or on the attainability of its targets, and determine the steps needed to deal with such changes;

- ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Board operates within the limits of its statutory authority and any delegated authority set by the Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Board takes into account all relevant guidance issued by DFP and the Department or other relevant authority;
- ensure that it receives and reviews regular financial information concerning the management of the Trust; is informed in a timely manner about any concerns about the activities of the Trust; and provides positive assurance to the Department that appropriate action has been taken on such concerns;
- ensure that an executive member of the Board has been allocated lead responsibility for risk management;
- constructively challenge the Trust's executive team in their planning, target setting and delivery of performance;
- demonstrate high standards of corporate governance at all times, including using the independent audit committee (see paragraph 3.7.1) to help the Board to address the key financial and other risks facing the Trust; and
- appoint a Chief Executive to the Trust and, in consultation with the Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive which give due weight to the proper management and use of public monies.

3.8 The Chairman's personal responsibilities

3.8.1 The Chairman is accountable to the Minister through the Departmental Accounting Officer. Communications between the Trust Board and the Minister should normally be through the Chairman (who will ensure that the other Board members are kept informed of such communications). He/she is responsible for ensuring that the Trust's policies and actions support the Department's wider strategic policies; and that the Trust's affairs are conducted with probity. Where appropriate, these policies and actions should be clearly communicated and disseminated throughout the Trust.

3.8.2 The Chairman 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, the HSCB or the PHA;
- 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; and
- 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. Meetings must be open to the public, the public should be advised of meetings through the press and the minutes must be placed on the Trust website after formal approval.

3.8.3 The Chairman shall also:

- ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and, within three months of appointment, receive appropriate induction training, including on the financial management, risk management and reporting requirements of public sector bodies and on any material differences which may exist between private and public sector practice within three months of appointment;
- advise the Department of the needs of the Trust when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;
- assess, annually, the performance of individual Board members. Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed by the Chair of the Board at the end of each year. Members will be made aware that they are being appraised, the standards against which they will be appraised and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the Departmental Accounting Officer or an official acting on their behalf; and
- ensure that a Code of Practice for Board Members is in place, based on the NHS *Code of Conduct and Code of Accountability*.

3.9 Individual Board members' responsibilities

3.9.1 Individual Board members shall act in accordance with their wider responsibilities as members of the Board – namely to:

- comply at all times with the Code of Practice (see paragraph 3.8.3) that is adopted by the Trust and with the rules relating to the use of public funds and to conflicts of interest;
- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organizations; and to declare publicly and to the Board any private interests that may be thought to conflict with their public duties;
- comply with the Board's rules on the acceptance of gifts and hospitality, and of business appointments as set out in the Financial Memorandum; and
- act in good faith and in the best interests of the Trust.

3.10 Consulting Service users and other interest groups

3.10.1 The Trust will work in partnership with its patients, clients, other service users and carers, and with stakeholders, to deliver the services/programmes, for which it has responsibility, to agreed standards. It will consult regularly to develop a clear understanding of citizens' needs and expectations of its services, and to seek feedback from patients, clients, other service users and carers, and from stakeholders, and will work to deliver a high quality, safe and accessible service. It will disseminate public information about the services for which it is responsible.

3.10.2 The Trust will in carrying out its equality duties consult in a timely, open and inclusive way and in accordance with the Equality Commission's guiding principles. It will monitor its policies to ensure that as each policy is revised it promotes greater equality of opportunity.

3.10.3 The Trust must prepare its own consultation scheme to be submitted to the Department for approval and to be reviewed regularly.

4. PLANNING, BUDGETING AND CONTROL

4.1 Corporate/Business Plan

4.1.1 Consistent with the timetable for Northern Ireland Executive Budgets, the Trust shall submit annually to the sponsor Department a draft of the Trust's Corporate Plan covering up to three years ahead. The Trust shall have agreed with the sponsor Department the issues to be addressed in the Plan and the timetable for its preparation. The Plan will be subject to Departmental approval.

4.1.2 The Plan shall reflect the Trust's statutory duties and, within those duties, the priorities set from time to time by the Minister. The Plan shall, to the extent required by the Department, demonstrate how the Trust contributes to the achievement of the Department's strategic aims and Programme for Government objectives. Its contents will also reflect the sponsor Department's decisions on policy and resources taken in the context of the Executive's wider policy and spending priorities and decisions.

4.1.3 The first year of the Corporate Plan, amplified as necessary, shall form the Business Plan. The Business Plan shall include key targets and milestones for the year immediately ahead and shall be linked to budgeting information so that resources allocated to achieve specific objectives can readily be identified by the sponsor Department.

4.1.4 The Plans will include the following, as directed by the Department:

- key objectives and associated key performance targets (financial and non-financial) for the forward years, and the strategy for achieving those objectives;
- alternative scenarios to take account of factors which may significantly affect the execution of the plan, but which cannot be accurately forecast;
- a forecast of expenditure and income, taking account of guidance on resource assumptions and policies provided by the sponsor Department. These forecasts should represent the Trust's best estimate of all its available income ie not just grant or grant-in-aid; and
- other matters as specified by the sponsor Department.

4.1.5 The Corporate/Business Plan shall be published by the Trust and made available on its website. A summary version shall be made available to staff.

4.2 Reporting performance to the HSCB and the Department

4.2.1 The Trust shall operate management information and accounting systems which enable it to review in a timely and effective manner its financial and non-financial performance against the budgets and targets set out in its agreed Corporate/Business Plan.

4.2.2 The Trust shall take the initiative in informing the **Department** of changes in external conditions which make the achievement of objectives more or less difficult, or which may indicate a change to the budget or objectives as set out in the **Corporate/Business plan**.

4.2.3 The Trust's performance in meeting its Corporate/Business Plan objectives shall be reported to the Department as part of the accountability review process.

4.2.4 Senior Departmental officials will hold biannual accountability reviews with the Trust to discuss the Trust's overall performance, its current and future activities,

any policy developments relevant to those activities safety and quality, financial performance and corporate control/risk management performance, and other issues as prescribed by the Department.

4.2.5 The Trust's performance against key Departmental/Ministerial targets shall be reported in the Trust's annual report and accounts [see Section 6.1 below].

4.2.6 The Department will, at its discretion, request evidence of progress against key objectives.

5 BUDGETING PROCEDURES

5.1 The Trust's budgeting procedures are set out in the *Financial Memorandum*.

5.2 Internal audit

5.2.1 The Trust shall establish and maintain arrangements for internal audit in accordance with *FD (DFP) 07/09 The Treasury's Government Internal Audit Standards (GIAS), HSS(F)21/03 Internal Audit Arrangements between a Sponsoring Department and its Non-Departmental Public Bodies (Trust's) and HSS(F)13/2007 Model HPSS Financial Governance Documents.*

5.2.2. Those arrangements shall also comply with the Department's requirements on foot of HSC (F) 11/2010 which promulgated DAO (DFP) 01/10 *Internal Audit Arrangements between Departments and Arm's Length Bodies*. These include:

- having input to the Trust's planned internal audit coverage, to ensure that shared assurance requirements (in relation to risk areas/topics) are built into the Trust's audit plan and audit strategy;
- arrangements for the receipt of audit reports, assignment reports, the Head of Internal Audit's annual report and opinion etc;

- arrangements for the completion of Internal and External Assessments of the Trust's internal audit function against GIAS including advising that the sponsor Department reserves a right of access to carry out its own independent reviews of internal audit in the Trust; and
- the right of access to all documents prepared by the Trust's internal auditor, including where the service is contracted out. Where the Trust's audit service is contracted out the Trust should stipulate this requirement when tendering for the services.

5.2.3. The Trust shall consult with the Department to ensure that the latter is satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving the appointment are in accordance with GIAS and relevant DFP guidance.

5.3 Audit Committee

5.3.1 The Trust shall set up an independent audit committee as a committee of its Board, in accordance with the Cabinet Office's guidance on Codes of Practice for Public Bodies (FD (DFP) 03/06 refers) and in line with the Audit Committee Handbook DAO (DFP) 07/07.

5.3.2 The sponsor Department will attend one Trust audit committee meeting per year as an observer, and will not participate in any Audit Committee discussion.

5.3.3 The audit committee's meeting agendas, minutes and papers shall be forwarded as soon as possible to the sponsoring team.

5.3.4 The sponsor Department will review the Trust's audit committee terms of reference. The Trust shall notify the sponsor department of any subsequent changes to the audit committee's terms of reference.

5.4 Fraud

5.4.1 The Trust should establish and maintain arrangements for preventing, countering and dealing with fraud by:

- assessing, identifying, evaluating, and responding to fraud risks;
- ensuring that the Trust's Audit Committee formally considers the anti-fraud measures in place;
- reporting immediately all suspected or proven frauds, including attempted fraud to the sponsor Department; and
- complying with all guidance issued by the Department.

5.4.2 The sponsor Department will report suspected and actual frauds immediately to DFP and the C&AG. In addition the Trust shall forward to the sponsor Department the annual fraud return, commissioned by DFP, on fraud and theft suffered by the Trust.

5.4.3 The sponsor Department will review the Trust's Anti-fraud policy and Fraud Response Plan. The Trust shall notify the sponsor Department of any subsequent changes to the policy or response plan.

5.5 Additional Departmental access to the Trust

5.5.1 In addition to the right of access referred to in paragraph 5.2.4 above, the Department shall have a right of access to all the Trust's records, meetings and personnel for purposes such as audits, operational investigations, and as the Departmental Accounting Officer sees fit (subject to any relevant legal restrictions).

6. EXTERNAL ACCOUNTABILITY

6.1 The annual report and accounts

6.1.1 After the end of each financial year the Trust shall publish as a single document an annual report of its activities together with its audited annual accounts. The report shall also cover the activities of any corporate bodies under the control of the Trust. A draft of the report shall be submitted to the Department two weeks before the proposed publication date although it is expected that the Department and the Trust will have had extensive pre-publication discussion on the content of the report prior to formal submission to the Department.

6.1.2 The report and accounts shall comply with the most recent version of the Government Financial Reporting Manual (FReM) issued by DFP. The accounts shall be prepared in accordance with any relevant statutes and the specific Accounts Direction issued by the Department.

6.1.3 The report and accounts shall outline the Trust's main activities and performance during the previous financial year and set out in summary form the Trust's forward plans. Information on performance against key financial targets shall be included in the notes to the accounts, and shall therefore be within the scope of the audit.

6.1.4 The report and accounts shall be laid before the Assembly and made available, in accordance with the guidance on the procedures for presenting and laying the combined annual report and accounts as prescribed in the relevant finance circular issued by the Department.

6.1.5 Due to the potential accounting and budgetary implications, any changes to accounting policies or significant estimation techniques underpinning the preparation of annual accounts shall require the prior written approval of the Department.

6.2 External audit

6.2.1 The Comptroller and Auditor General (C&AG) audits the Trust's annual accounts and passes the accounts to the Department who shall lay them before the Assembly. For the purposes of audit the C&AG has a statutory right of access to relevant documents as provided for in Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003 .

6.2.2 The C&AG has agreed to liaise with the Trust on who – the NIAO or a commercial auditor – shall undertake the actual audit on his behalf. The final decision rests with the C&AG.

6.2.3 The C&AG has agreed to share with the Department information identified during the audit process and the audit report (together with any other outputs) at the end of the audit. This shall apply, in particular, to issues which impact on the Department's responsibilities in relation to financial systems within the Trust. The C&AG will also consider, where asked, providing the Department and other relevant bodies with Regulatory Compliance Reports and other similar reports which the Department may request at the commencement of the audit and which are compatible with the independent auditor's role.

6.3 VFM examinations

6.3.1 The C&AG may carry out examinations into the economy, efficiency and effectiveness with which the Trust has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003. Where making payment of a grant, or drawing up a contract, the Trust should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor providing access to the C&AG in relation to documents relevant to the

transaction including those relevant to matters of professional competence, misconduct etc. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

7. STAFF MANAGEMENT

7.1 General

7.1.1. In line with the arrangements and guidance provided by the Department, the Trust shall have responsibility for the recruitment, retention and motivation of its staff. To this end the Trust shall ensure that:

- its rules for the recruitment and management of staff create an inclusive culture in which diversity is fully valued; where appointment and advancement is based on merit; and where there is no discrimination on grounds of gender, marital status, domestic circumstances, sexual orientation, race, colour, ethnic or national origin, religion, disability, community background or age;
- the level and structure of its staffing, including grading and numbers of staff, are appropriate to its functions and the requirements of efficiency, effectiveness and economy as agreed by the Department;
- the performance of its staff at all levels is satisfactorily appraised;
- its staff are encouraged to acquire the appropriate professional, management and other expertise necessary to achieve the Trust's objectives;
- proper consultation with staff takes place on key issues affecting them;
- adequate grievance and disciplinary procedures are in place;
- whistle blowing procedures consistent with the Public Interest Disclosure (Northern Ireland) Order 1998, as amended, are in place;

- a code of conduct for staff is in place based on Annex 5A of Public Bodies: A Guide for NI Departments (available at www.afmdni.gov.uk). This code should be copied to the sponsor team.

8. REVIEWING THE ROLE OF THE TRUST

8.1 The role of, and justification for the Trust shall be reviewed periodically, in accordance with the business needs of the sponsor Department and the Trust. Reference should be made to Chapter 9 of the Public Bodies: a Guide for Northern Ireland Departments.

Signed: _____ Date: 6th April 2011

On behalf of the Trust

Signed: _____ Date: 12 June 2011

On behalf of the Department

Appendix 1

1. Documentary requirements

1.1 Documentation to be copied to the Sponsor Branch for information

Monthly (or as the occasion arises)

- Board meeting papers (including draft minutes) for each meeting as and when issued to Committee members
- Audit Committee papers (including draft minutes) for each meeting as and when issued to Committee members
- Assurance Committee papers (including draft minutes) for each meeting as and when issued to Committee members
-

Annually

- Register of Board members' interests
- The annual report, with the draft submitted to the Department two weeks before the publication date (*separate timetable for the annual accounts, SIC etc, set by Finance Directorate*)
- The Assurance Framework (annually)
- Business Continuity Plan

Once and then when revised

- Code of Conduct for Board members
- Code of Practice for staff
- Audit Committee Terms of Reference
- Audit Strategy
- Assurance/Governance Committee Terms of Reference
- Complaints procedure
- Anti-Fraud policy
- Fraud Response plan
- Whistle-blowing procedures
- Grievance and Disciplinary procedures

- Equality scheme
- Publication scheme
- Consultation Scheme

1.2 Documentation to be copied to the Sponsor Branch for consideration/ comment/ approval

Quarterly

- **[***Report on quarterly assessment of progress being made in the delivery of the Trust Delivery plan's aims and objectives***]**

Bi-annual

- Corporate Risk Register every six months

Annually

- Annual Statement on Internal Control
- Mid-year Assurance Statement (by end-October)
- Annual report on Compliance with Controls Assurance Standards
- Annual Internal Audit work-plan
- Internal Audit Progress Report
- Annual Fraud return
- Corporate Plan (including the Business Plan)**[**, and the Trust Delivery Plan**]** must be produced, for approval by the Department
- The Head of Internal Audit's end-of-year and mid-year opinion on risk management, control and governance

Once

- Inspection reports by external bodies (e.g. RQIA, MHRA), as agreed with the Sponsor Branch
- All Internal Audit reports with less than satisfactory assurance in line with arrangements agreed with the Sponsor Branch
- NIAO management letters

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Text of model financial memorandum

I. INTRODUCTION

1 This *Financial Memorandum* sets out certain aspects of the financial framework within which the Trust is required to operate.

2The terms and conditions set out in the combined M*anagement Statement* and *Financial Memorandum* may be supplemented by guidelines or directions issued by the DHSSPS/Minister in respect of the exercise of any individual functions, powers and duties of the Trust.

3The Trust shall satisfy the conditions and requirements set out in the combined document, together with such other conditions as the DHSSPS/Minister may from time to time impose.

II. THE TRUST'S INCOME AND EXPENDITURE - GENERAL

The Departmental Expenditure Limit (DEL)

4The Trust's current and capital expenditure form part of the DHSSPS Department's Resource DEL and Capital DEL respectively.

Expenditure not proposed in the budget

5The Trust shall not, without prior written DHSSPS approval, enter into any undertaking to incur any expenditure which falls outside the Trust's delegations or which is not provided for in the Trust's annual budget as approved by the DHSSPS.

Procurement

6 The Trust's procurement policies shall reflect the public procurement policy adopted by the Northern Ireland Executive in May 2002 (refreshed May 2009); *Procurement Guidance Notes;* and any other guidelines or guidance issued by Central Procurement Directorate and the Procurement Board. The Trust shall also ensure that it complies with any relevant EU or other international procurement rules.

7 Regional Supply Service (RSS), within the Business Services Organisation, shall carry out procurement activity on behalf of the Trust, governed by a documented Service Level Agreement. Periodic reviews of the Trust's procurement activity should be undertaken. The results of such review will be shared with DHSSPS.

Competition

8 Contracts shall be awarded on a competitive basis and tenders accepted from suppliers who provide best value for money overall.

9 Single tender action is the process where a contract is awarded to an economic operator (i.e. supplier, contractor) without competition. In light of their exceptional nature, all single tender actions should be subject to Trust Accounting Officer approval. It is advisable that the Trust seek an assurance from RSS, or their legal adviser, to provide assurance for the Accounting Officer that the use of single tender action is legitimate in a particular case. Further information is published in Procurement Guidance Note 02/10 on the 'Award of Contracts without a Competition'. www.cpdni.gov.uk/index/guidance-for-purchasers/guidance-notes.htm]

10 The Trust shall send to the DHSSPS after each financial year a report for that year explaining any contracts above £5,000 in which competitive tendering was not employed.

Best Value for money

11 Procurement by the Trust of works, supplies and services shall be based on best value for money, ie the optimum combination of whole life cost and quality (or fitness for purpose) to meet the Trust's requirements. Where appropriate, a full option appraisal shall be carried out before procurement decisions are taken.

Timeliness In paying bills

12 The Trust shall collect receipts and pay all matured and properly authorised invoices in accordance with Annex4.5 and Annex 4.6 of *Managing Public Money Northern Ireland* and any guidance issued by DFP or DHSSPS.

Novel, contentious or repercussive proposals

13 The Trust shall obtain the approval of the DHSSPS, and DFP, before:

- incurring any expenditure for any purpose which is or might be considered novel or contentious, or which has or could have significant future cost implications, including on staff benefits;

- making any significant change in the scale of operation or funding of any initiative or particular scheme previously approved by the DHSSPS;

- making any change of policy or practice which has wider financial implications (eg because it might prove repercussive among other public sector bodies) or which might significantly affect the future level of resources required. (The DHSSPS will advise on what constitutes "significant" in this context).

Risk management/Fraud

14 The Trust shall ensure that the risks it faces are dealt with in an appropriate manner, in accordance with relevant aspects of best practice in corporate governance, and shall develop a risk management strategy, in accordance with the Treasury guidance *Management of Risk: A Strategic Overview (The "Orange Book").*

15 The Trust shall take proportionate and appropriate steps to assess the financial and economic standing of any organisation or other body with which it intends to enter into a contract or to which it intends to give grant or grant-in-aid.

16 The Trust shall adopt and implement policies and practices to safeguard itself against fraud and theft, in line with DFP's guide *Managing the Risk of Fraud* ..

17 All cases of attempted, suspected or proven fraud shall be reported to the DHSSPS who shall report it to DFP and the NIAO as soon as they are discovered, irrespective of the amount involved.

Wider markets

18 In accordance with the wider markets policy, the Trust shall seek to maximise receipts from non-Consolidated Fund sources, provided that

this is consistent with (a) the Trust's main functions (b) its corporate plan as agreed with the DHSSPS. DHSSPS will confirm with the DFP Supply Officer that such proposed activity is appropriate.

Fees and charges

19 Fees or charges for any services supplied by the DHSSPS shall be determined in accordance with Chapter 6 of MPMNI.

III. THE TRUST'S INCOME

Grant-in-aid

20 Grant-in aid will be paid to the Trust in instalments, on the basis of need. The Trust shall submit a monthly written application to the Department forecasting its cash requirements and shall certify that the conditions applying to the use of revenue funds have been observed to date and that further grant-in-aid is now required for purposes appropriate to the Trust's functions.

21 The Trust should have regard to the guidance in DAO (DFP) 04/03 and to the general principle enshrined in Annex 5.1 of *Managing Public Money Northern Ireland* that it should seek grant-in-aid according to need.

22 Cash balances accumulated during the course of the year shall be kept at the minimum level consistent with the efficient operation of the Trust. Grant-in-aid not drawn down by the end of the year shall lapse. However, where draw-down of grant-in-aid is delayed to avoid excess cash balances at year-end, the DHSSPS will make available in the next financial year (subject to approval by the Assembly of the relevant Estimates provision) any such grant-in-aid required to meet any liabilities at year end, such as creditors.

Fines and taxes as receipts

23 Most fines and taxes (including levies and some licences) do not provide additional DEL spending power and should be surrendered to the DHSSPS.

Receipts from sale of goods or services

24 Receipts from the sale of goods and services (including certain licences), rent of land, normally provide additional DEL spending power. If a body wishes to retain a receipt or utilise an increase in the level of receipts, it must gain the prior approval of DHSSPS.

25 If there is any doubt about the correct classification of a receipt, the Trust shall consult the DHSSPS, which may consult DFP as necessary.

Interest earned

26 Interest earned on cash balances cannot necessarily be retained by the Trust. Depending on the budgeting treatment of this receipt, and its impact on the Trust's cash requirement, it may lead to commensurate reduction of grant-in-aid or be required to be surrendered to the NI Consolidated Fund via DHSSPS. If the receipts are used to finance additional expenditure by the Trust, DHSSPS will need to ensure it has the necessary budget cover.

Unforecast changes in in-year income

27 If the negative DEL income realised or expected to be realised in-year is less than estimated, the Trust shall, unless otherwise agreed with the DHSSPS, ensure a corresponding reduction in its gross expenditure so that the authorised provision is not exceeded. [NOTE: For example, if the Trust is allocated £100 resource DEL provision by the DHSSPS and expects to receive £10 of negative DEL income, it may plan to spend a total of £110. If income (on an accruals basis) turns out to be only £5 the Trust will need to reduce its expenditure to £105 to avoid breaching its budget. If the Trust still spends £110 the DHSSPS will need to find £5 of savings from elsewhere within its total DEL to offset this overspend.]

28 If the negative DEL income realised or expected to be realised in the year is more than estimated, the Trust may apply to the DHSSPS to retain the excess income for specified additional expenditure within the current financial year without an offsetting reduction to grant-in-aid. The DHSSPS shall consider such applications, taking account of

competing demands for resources, and will consult with DFP in relation to any significant amounts. If an application is refused, any grant-in-aid shall be commensurately reduced or the excess receipts shall be required to be surrendered to the NI Consolidated Fund via the DHSSPS.

Build-up and draw-down of deposits

29 The Trust shall comply with the rules that any DEL expenditure financed by the draw-down of deposits counts within DEL. The Trust shall maintain and manage cash balances as working balances only. These shall be held at a minimum level throughout the year. Any interest earned on overnight deposits must be returned to DHSSPS.

30 The Trust shall ensure that it has the necessary DEL provision for any expenditure financed by draw-down of deposits.

Proceeds from disposal of assets

31 Disposals of land and buildings are dealt with in Section VI below.

Gifts and bequests received

32 The Trust is free to retain any gifts, bequests or similar donations, subject to paragraph 33. These shall be treated as receipts and must be notified to the DHSSPS. [NOTE: Donated assets do not attract a cost of capital charge, and a release from the donated assets reserve should offset depreciation in the operating cost statement. The latest FReM requirements should be applied]

33 Before accepting a gift, bequest, or similar donation, the Trust shall consider if there are any associated costs in doing so or any conflicts of interests arising. The Trust shall keep a written record of any such gifts, bequests and donations and of their estimated value and whether they are disposed of or retained.

Borrowing

34 Normally the Trust will not be allowed to borrow but when doing so the Trust shall observe the principles set out in Chapter 5 and the associated annexes of MPMNI when undertaking borrowing of any kind. The Trust

shall seek the approval of the DHSSPS and, where appropriate, DFP, to ensure that it has any necessary authority and budgetary cover for any borrowing or the expenditure financed by such borrowing. Medium or long term private sector or foreign borrowing is subject to the value for money test in *Section 5.7 of MPMNI*.

35 Any expenditure by the Trust financed by borrowing counts in DEL

IV. EXPENDITURE ON STAFF

Staff costs

36 Subject to its delegated levels of authority the Trust shall ensure that the creation of any additional posts does not incur forward commitments which will exceed its ability to pay for them.

Pay and conditions of service

37 The staff of the Trust whether on permanent or temporary contract, shall be subject to levels of remuneration and terms and conditions of service (including superannuation) as approved by the DHSSPS and DFP. The Trust has no delegated power to amend these terms and conditions.

38 Current terms and conditions for staff of the Trust are those set out in its Employee Handbook. The Trust shall provide the DHSSPS and DFP with a copy of the Handbook and subsequent amendments.

39 Annual pay increases of Trust staff must be in accordance with the annual FD letter on Pay Remit Approval Process and Guidance issued by DFP. Therefore, all proposed pay awards must have prior approval of DHSSPS and the Minister for Finance before implementation.

40 The travel expenses of Board Members shall be tied to the rates allowed to senior staff of the Trust. Reasonable actual costs shall be reimbursed.

41 The Trust shall operate a performance-related pay scheme which shall form part of the general pay structure approved by the DHSSPS and DFP.

42 The Trust shall comply with the EU directive on contract workers [Fixed Term Employees Regulations (Prevention of Less Favourable Treatment)].

Pensions; redundancy/compensation

43 Trust's staff shall be eligible for a pension provided by :

- **Either** the Health and Social Care Superannuation Scheme **or** the Health and Social Care Pension Scheme.

44Staff may opt out of the occupational pension scheme provided by the Trust. However, the employer's contribution to any personal pension arrangement, including a stakeholder pension, shall be limited to the national insurance rebate level.

45 Any proposal by the Trust to move from the existing pension arrangements, or to pay any redundancy or compensation for loss of office, requires the approval of the DHSSPS and DFP. Proposals on severance payments must comply with DAO (DFP) 17/05.

V. NON-STAFF EXPENDITURE

Economic appraisal

46 Trusts are required to apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending or saving public money, including European Union (EU) funds, and any other decisions or proposals that involve changes in the use of public resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

a. involve capital or current spending, or both;

b. are large or small;

c. are above or below delegated limits(see Appendix A).

47 Appraisal itself uses up resources. The effort that should go into appraisal and the detail to be considered is a matter for case-by-case judgement, but the general principle is that the resources to be devoted to appraisal should be in proportion to the scale or importance of the objectives and resource consequences in question. Judgement of the appropriate effort should take into consideration the totality of the resources involved in a proposal.

General guidance on economic appraisal that applies to Trusts can be found in:

- The Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE) See http://www.dfpni.gov.uk/eag

- The HM Treasury Guide, *The Green Book: Appraisal and Evaluation in Central Government.*

- Capital Investment Manual

Capital expenditure

48 Subject to being above an agreed capitalisation threshold, all expenditure on the acquisition or creation of fixed assets shall be capitalised on an accruals basis in accordance with relevant accounting standards. Expenditure to be capitalised shall include the (a) acquisition, reclamation or laying out of land; (b) acquisition, construction, preparation or replacement of buildings and other structures or their associated fixtures and fittings; and (c) acquisition, installation or replacement of movable or fixed plant, machinery, vehicles and vessels.

49 Proposals for large-scale individual capital projects or acquisitions will normally be considered within the Trust's corporate and business planning process. Subject to paragraph 51, applications for approval within the corporate/business plan by the DHSSPS and DFP if necessary, shall be supported by formal notification that the proposed project or purchase has been examined and duly authorised by the

Board. Regular reports on the progress of projects shall be submitted to the DHSSPS.

50 Approval of the corporate/business plan does not obviate the Trust's responsibility to abide by the economic appraisal process.

51 Within its approved overall resources limit the Trust shall, as indicated in the attached Appendix on delegations, have delegated authority to spend up to £500,000 on any individual capital project or acquisition. Beyond that delegated limit, the DHSSPS and where necessary, DFP's prior authority must be obtained before expenditure on an individual project or acquisition is incurred.

Transfer of funds within budgets

52 Unless financial provision is subject to specific Departmental or DFP controls (eg, where provision is ring-fenced for specific purposes) or delegated limits, transfers between budgets within the total capital budget, or between budgets within the total revenue budget, do not need Departmental approval. The one exception to this is that, due to HM Treasury controls, any movement into, or out, of depreciation and impairments within the resource budget will require departmental and possibly DFP approval. [NOTE: Under resource budgeting rules, transfers from capital to resource budgets are not allowed.]

Lending, guarantees, indemnities; contingent liabilities; letters of comfort

53 The Trust shall not, without the DHSSPS' and where necessary, DFP's prior written consent, lend money, charge any asset or security, give any guarantee or indemnities or letters of comfort, or incur any other contingent liability (as defined in Annex 5.5 of MPMNI), whether or not in a legally binding form.

Grant or loan schemes

54 Unless covered by a delegated authority, all proposals to make a loan to a third party, whether one-off or under a scheme, together with the terms and conditions under which such loan is made shall be subject to prior approval by the DHSSPS, and where necessary DFP. If loans are to be made under a continuing scheme, statutory authority is likely to be required.

55The terms and conditions of a grant or loan to a third party shall include a requirement on the receiving organisation to prepare

accounts and to ensure that its books and records in relation to the grant or loan are readily available for inspection by the Trust, the DHSSPS and the C&AG.

56 See also below under the heading *Recovery of grant-financed assets* (paragraphs 78-80).

Gifts made, write-offs, losses and other special payments

57. Proposals for making gifts or other special payments (including issuing write-offs) outside the delegated limits set out in the Appendix A of this document must have the prior approval of the DHSSPS and where necessary DFP.

58Losses shall not be written off until all reasonable attempts to make a recovery have been made and proved unsuccessful.

59Gifts by management to staff are subject to the requirements of HSS(F)13/2007.

Leasing

60Prior Departmental approval must be secured for all property and finance leases. The DHSSPS must have capital DEL provision for finance leases and other transactions which are, in substance, borrowing (paragraphs 34-35 above).

61Before entering into any lease (including an operating lease) the Trust shall demonstrate that the lease offers better value for money than purchase.

Public/Private Partnerships

62 The Trust shall seek opportunities to enter into Public/Private Partnerships where this would be more affordable and offer better value for money than conventional procurement. Where cash flow projections may result in delegated spending authority being breached, the Trust shall consult the DHSSPS. The Trust should also ensure that it has the necessary budget cover.

63 Any partnership controlled by the Trust shall be treated as part of the Trust in accordance with guidance in the FReM and consolidated with it [subject to any particular treatment required by the FReM]. Where the judgment over the level of control is difficult the DHSSPS will consult DFP (who may need to consult with the Office of National Statistics over national accounts treatment).

Subsidiary companies and joint ventures

64 The Trust shall not establish subsidiary companies or joint ventures without the express approval of the DHSSPS and DFP. In judging such proposals the DHSSPS will have regard to the Department's wider strategic aim[s] objective and current Public Service Agreement.

65 For public expenditure accounts purposes any subsidiary company or joint venture controlled or owned by the Trust shall be consolidated with it in accordance with guidance in the FReM subject to any particular treatment required by the FReM. Where the judgment over the level of control is difficult, the DHSSPS will consult DFP (who may need to consult with the Office of National Statistics over national accounts treatment). Unless specifically agreed with the DHSSPS and DFP, such subsidiary companies or joint ventures shall be subject to the controls and requirements set out in this *Management Statement* and *Financial Memorandum*, and to the further provisions set out in supporting documentation.

Financial investments

66 The Trust shall not make any investments in traded financial instruments without the prior written approval of the DHSSPS, and where appropriate DFP, nor shall it aim to build up cash balances or net assets in excess of what is required for operational purposes. Funds held in bank accounts or as financial investments may be a factor for consideration when grant-in-aid is determined. Equity shares in ventures which further the objectives of the Trust shall equally be subject to Departmental and DFP approval unless covered by a specific delegation.

Unconventional financing

67 The Trust shall not enter into any unconventional financing arrangement without the approval of the DHSSPS and DFP.

Commercial insurance

68 The Trust shall not take out any insurance without the prior approval of the DHSSPS and DFP, other than third party insurance required by the Road Traffic (NI) Order 1981 (as amended) and any other insurance which is a statutory obligation or which is permitted under Annex 4.5 of MPMNI.

69 In the case of a major loss or third-party claim, DHSSPS shall liaise with the Trust about the circumstances in which an appropriate addition to budget out of the DHSSPS' funds and/or adjustment to the Trust's targets shall be considered. DHSSPS will liaise with DFP Supply where required in such cases.

Payment/Credit Cards

70 The Trust, in consultation with the DHSSPS, shall ensure that a comprehensive set of guidelines on the use of payment cards (including credit cards) is in place. Reference should be made to HSS (F) 11/2003.

Hospitality

71 The Trust, in consultation with the DHSSPS, shall ensure that a comprehensive set of guidelines on the provision of hospitality is in place. Reference should be made to DAO(DFP) 10/06 (revised).

Use of Consultants

72 The Trust shall adhere to the guidance issued by DFP, as well as any produced by the DHSSPS in relation to the use of consultants. Please see the delegated limits set out in Appendix A.

73 The Trust will provide DHSSPS with an annual statement on the status of all consultancies completed and/or started in each financial year.

74 **Care should be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants.**

VI. MANAGEMENT AND DISPOSAL OF FIXED ASSETS

Register of assets

75The Trust shall maintain an accurate and up-to-date register of its fixed assets.

Disposal of assets

76 The Trust shall dispose of assets which are surplus to its requirements. Assets shall be sold for best price, taking into account any costs of sale. Generally assets shall be sold by auction or competitive tender [unless otherwise agreed by the DHSSPS], and in accordance with the principles in MPMNI.

77 All receipts derived from the sale of assets (including grant financed assets, see below) must be declared to the DHSSPS, which will consult with DFP if necessary, on the appropriate treatment.

Recovery of grant-financed assets

78 Where the Trust has financed expenditure on capital assets by a third party, the Trust shall set conditions and make appropriate arrangements to ensure that any such assets individually above a value of £500 are not disposed of by the third party without the Trust's prior consent.

79 The Trust shall therefore ensure that such conditions and arrangements are sufficient to secure the repayment of the NI Consolidated Fund's due share of the proceeds of the sale, in order that funds may be surrendered to the DHSSPS.

80 The Trust shall ensure that if the assets created by grants made by the Trust cease to be used by the recipient of the grant for the intended purpose, a proper proportion of the value of the asset shall be repaid to the Trust for surrender to the DHSSPS. The amounts recoverable under the procedures in paragraphs 78-79 above shall be calculated by reference to the best possible value of the asset and in proportion to the NI Consolidated Fund's original investment(s) in the asset.

VII. BUDGETING PROCEDURES

Setting the annual budget

81 Each year, in the light of decisions by the DHSSPS on the Trust's updated draft corporate plan the DHSSPS will send to the Trust:

- a formal statement of the annual budgetary provision allocated by the DHSSPS in the light of competing priorities across the DHSSPS and of any forecast income approved by the DHSSPS;

and

- a statement of any planned change in policies affecting the Trust.

82 The Trust's approved annual delivery plan (TDP) will take account both of its approved funding provision and of any forecast receipts, and will include a budget of estimated payments and receipts together with a profile of expected expenditure and of draw-down of any Departmental funding and/or other income over the year. These elements will form part of the approved TDP for the year in question.

83 Any grant-in-aid provided by the DHSSPS for the year in question will be voted in the DHSSPS' Estimate and will be subject to Assembly control.

General conditions for authority to spend

84 Once the Trust's budget has been approved by the DHSSPS [and subject to any restrictions imposed by Statute/the Minister /this MSFM], the Trust shall have authority to incur expenditure approved in the budget without further reference to the DHSSPS, on the following conditions:

- the Trust shall comply with the delegations set out in Appendix A of this document. These delegations shall not be altered without the prior agreement of the DHSSPS and DFP;

- the Trust shall comply with the conditions set out in paragraph 13 above regarding novel, contentious or repercussive proposals;

- inclusion of any planned and approved expenditure in the Trust's budget shall not remove the need to seek formal Departmental, and where necessary, DFP, approval where such proposed expenditure is above the delegated limits set out in Appendix A or is for new schemes not previously agreed; and

- the Trust shall provide the DHSSPS with such information about its operations, performance, individual projects or other expenditure as the DHSSPS may reasonably require (see paragraph 85 below).

Providing monitoring information to the DHSSPS

85 Trust shall provide the DHSSPS with, as a minimum, information on a monthly basis which will enable the satisfactory monitoring by the DHSSPS of:

- the Trust's cash management;

- its draw-down of any grant-in-aid;

- the expenditure for that month;

- forecast outturn by resource headings; and

- other data required for the DFP Outturn and Forecast Outturn Return.

VIII. BANKING

Banking arrangements

86 The Trust is currently a member of the HSC 'pool' of bank accounts. The Trust's Accounting Officer is responsible for ensuring that the Trust's banking arrangements are in accordance with the requirements of Annex 5.7 of *MPMNI.* . This responsibility remains even with the current banking pool arrangements. In particular, he/she shall ensure that the arrangements safeguard public funds and that their implementation ensures efficiency, economy and effectiveness.

87He/she shall therefore ensure that:

- these arrangements are suitably structured and represent value-for-money. The HSC pool of accounts will be comprehensively reviewed leading to competitive tendering, at least every three to five years;
- sufficient information about banking arrangements is supplied to the DHSSPS' Accounting Officer to enable the latter to satisfy his/her own responsibilities;
- the Trust's banking arrangements shall be kept separate and distinct from those of any other person or organisation; and
- adequate records are maintained of payments and receipts and adequate facilities are available for the secure storage of cash.

IX. COMPLIANCE WITH INSTRUCTIONS AND GUIDANCE

Relevant documents

88 The Trust shall comply with the following general guidance documents:

- This document (both the *Financial Memorandum* and the *Management Statement*);
- *Managing Public Money Northern Ireland (MPMNI);*
- *Public Bodies - a Guide for NI Departments* issued by DFP;

- *Government Internal Audit Standards*, issued by DFP;
- The document *Managing the Risk of Fraud* issued by DFP;
- The Treasury document *The Government Financial Reporting Manual (FReM)* issued by DFP;
- Relevant Dear Consolidation Officer and Dear Consolidation Manager letters issued by DFP;
- *Regularity, Propriety and Value for Money*, issued by Treasury;
- The Consolidation Officer Letter of Appointment, issued by DFP;
- Other relevant guidance and instructions issued by DFP in respect of Whole of Government Accounts;
- Other relevant instructions and guidance issued by the central Departments (DFP/OFMDFM) including Procurement Board and CPD guidance;
- Specific instructions and guidance issued by the DHSSPS;
- Recommendations made by the Public Accounts Committee, or by other Assembly/Parliamentary authority, which have been accepted by the Government and which are relevant to the Trust.

X. REVIEW OF FINANCIAL MEMORANDUM

89The *Management Statement* and *Financial Memorandum* will normally be reviewed at least every five years .

90 DFP Supply will be consulted on any significant variation proposed to the *Management Statement* and *Financial Memorandum*.

Signed: _____ Date: 6th April 2011

On behalf of the Trust

Signed: _____ Date: 13 Jun 2011

On behalf of the Department

APPENDIX A

DELEGATED EXPENDITURE LIMITS

General

These delegated expenditure limits have been agreed by the Department and the Department of Finance and Personnel.

1. PURCHASING ALL GOODS AND SERVICES

Table 1 Delegated Authority for the Purchase of Goods and Services
(All costs exclude VAT)

THRESHOLDS	NUMBER/TYPE OF TENDER REQUIRED	AUTHORISATION
Up to £2,000	No Quotations necessary	The Chief Executive/The appropriate officer as notified to the DHSSPS
>£2,000 - £30,000	4 Selected Tenders	The Chief Executive/The appropriate officer as notified to the DHSSPS
> £30,000 – EC Thresholds	Publicly advertised tender competition	The Chief Executive/The appropriate officer as notified to the DHSSPS

Economic Appraisal

The principles of economic appraisal should be applied in all cases where expenditure is proposed, whether the proposal involves capital or current expenditure, or both. The effort put into economic appraisal should be commensurate with the size or importance of the needs or resources under consideration. However, the Trust should undertake a comprehensive business case of all projects involving expenditure of £250,000 and over.

Where the minimum number of quotation/tenders is not obtained

For any purchase where the minimum number of quotations/tenders is not obtained, the purchase may proceed if the accounting officer is satisfied that every attempt has been made to obtain competitive offers and that value for money will be achieved. In these cases, the accounting officer should complete a report and records of all correspondence should be retained on file including any justification given and/or approvals obtained.

2. CAPITAL PROJECTS

The Chief Executive [appropriate officer as notified to the DHSSPS], may authorise capital expenditure on discreet capital projects of up to £500,000. Capital projects over this amount require the approval of the DHSSPS, and may be subject to quality assurance by the Department of Finance and Personnel if requested.

Any novel and/or potentially contentious projects, regardless of the amount of expenditure, require the approvals of the DHSSPS and DFP.

3. DISPOSAL OF SURPLUS EQUIPMENT

See paragraphs 76-77.

4. LEASE AND RENTAL AGREEMENTS

See paragraphs 60-61.

5. APPROVAL OF INFORMATION TECHNOLOGY PROJECTS

The appraisal of Information Technology (IT) projects should include the staffing and other resource implications.

The principles of appraisal, evaluation and management apply equally to proposals supported by information communication technology (ICT) as to all other areas of public expenditure. ICT-enabled projects should be appraised and evaluated according to the general guidance in the Northern Ireland Guide to Expenditure Appraisal and Evaluation (*NIGEAE*) and managed using the new *Successful Delivery (NI)* guidance which was issued in June 2009.

The purchase of IT equipment and systems should be in line with the guidance Procedures and Principles for Application of Best Practice in Programme/Project Management (PPM), (available at www.dfpni.gov.uk/successful-delivery) and be subject to competitive tendering unless there are convincing reasons to the contrary. The form of competition should be appropriate to the value and complexity of the project, and in line with the Procurement Control Limits in Table 1. Delegated authority for each IT project is set out in Table 2.

Table 2 **Delegation Arrangements for Information Technology Projects, Systems And Equipment**
(All costs exclude VAT)

THRESHOLDS	AUTHORISATION
Up to £250,000	The Chief Executive/The appropriate officer as notified to the DHSSPS
Projects over £250,000	The Chief Executive with prior approval from the DHSSPS

6. ENGAGEMENT OF CONSULTANTS

General

The Trust has authority to appoint consultants for a **single contract** without recourse to the DHSSPS up to a ***total*** cost of £20,000, and subject to any guidance as may be issued by DFP or the DHSSPS.

The Trust will provide the DHSSPS with an annual statement on the status of all consultancies completed and/or started in each financial year.

Care should be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants.

Economic appraisal

A full business case should be prepared for all consultancy assignments expected to exceed £10,000. A proportionate business case should be prepared for all assignments below this threshold.

7. LOSSES AND SPECIAL PAYMENTS

The [Chief Executive] [appropriate officer as notified to the DHSSPS], with prior approval from the DHSSPS, will have the authority to write off losses and make special payments up to:

(a) Cash losses – up to £10,000 per case/incident

(b) Stores/Equipment losses – up to £10,000 per case/incident

(c) Constructive losses and fruitless payments – up to £10,000 per case.

(d) Compensation payments

i. Made under legal obligation, e.g. by Court Order – Complete delegation

ii. For damage to personal property of staff – up to £2,000 per case

iii. Where written legal advice is that the Trust should not fight a court action because it is unlikely that it would win – up to £250,000 per case

(e) Claims abandoned or waiver of claim – up to £10,000 per case

(f) Extra contractual payments – Nil

(g) Ex gratia payments – up to £10,000 per case (Pensions payments are not covered by this threshold)

(h) Extra statutory and extra regulatory payments – no delegation, all proposals must be submitted to the DHSSPS for approval

The prior approval of the DHSSPS must be obtained for amounts above these values.

A summary note of the losses in any financial year should be included in the Trust's accounts.

Details of all losses and special payments should be recorded in a Losses and Special Payments Register, which will be available to auditors. The Register should be kept up-to-date and should show evidence of the approval by the appropriate officer as notified to the DHSSPS, for amounts below the delegated limit, and the DHSSPS, where appropriate.

TB/9/29/05/14

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Meeting of the Assurance Committee held on Monday 24 March 2014 at 11.00am, Boardroom, NIAS Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT	Prof M Hanratty	Non-Executive Director (Chair)
	Mr N McKinley	Non-Executive Director
	Miss A Paisley	Non-Executive Director
	Mr R Mullan	Non-Executive Director
IN ATTENDANCE	Mr L McIvor	Chief Executive
	Dr D McManus	Medical Director
	Mrs S McCue	Director of Finance & ICT
	Mr B McNeill	Director or Operations
	Ms R O'Hara	Director of Human Resources & Corporate Services
	Dr N Ruddell	Assistant Medical Director
	Mr T McGarey	Risk Manager
	Mr P Nicholson	Assistant Director of Finance
	Mrs L Rafferty	Assistant Director of Human Resources, Education, Learning & Development
	Ms L Gardner	Assistant Director of Human Resources, Employment, Performance and Corporate Services
	Mr P Archer (ex-officio)	Chairman
	Mrs J McSwiggan	Senior Secretary

1.0 Apologies

An apology was received from Dr J Livingstone.

2.0 Procedure

2.1 Declaration of Potential Conflicts of Interest

No potential conflicts of interest were declared.

2.2 Quorum

The Committee was confirmed as quorate.

2.3 Confidentiality of Information

The Chair reminded those present that some information, such as that relating to specific patients, requires confidentiality, and that meetings should otherwise be open and transparent.

3.0 Minutes of the Assurance Committee Meeting held on 27 January 2014

The Minutes were presented for noting by the Assurance Committee. The Minutes had been previously circulated, agreed and signed by the Committee Chair and will be presented to Trust Board on 27 March 2014.

4.0 Matters Arising

4.1 Whistle-Blowing Policy Monitoring Report

Two incidents have been recorded, investigated and reported to the DHSSPS within the last quarter. There will be an opportunity to review both incidents at the Trust Board this week. The Whistle-Blowing Policy is due for review in 2015, but it is planned to bring this forward to tie in with refining the definition of whistle-blowing.

4.2 IPC Audit Tool

Work with RQIA on developing an audit tool that is appropriate to an ambulance service is ongoing. As part of this RQIA have visited NIAS to obtain a better understanding of ambulance-specific procedures and requirements.

4.3 Clinical Response Bag

Further to the issue of the weight of the bag raised by Occupational Health, this will now be brought to SEMT for an executive decision on how to move it forward to a conclusion.

The Committee was advised that trade unions are supportive of the bag being vehicle-based rather than personal issue, provided there is appropriate additional capacity in place for staff at, for example, vehicle changeover.

5.0 Chairman's Business

5.1 Assessment of Committee Performance

The Committee thanked A Paisley for her work on the self-assessment checklist. A draft had been circulated to Non-Executive Directors. An amendment was suggested relating to the formal letter of appointment, which is not relevant to NIAS at this time. Non-Executive Directors will make amendments as required, and the final checklist will be circulated for completion, and then full discussion at the June Committee meeting.

5.2 Format of Future Meetings

The presentations to date have been very informative. However future presentations will focus on the local risk registers for each directorate, giving the Committee an opportunity to discuss the developments necessary to progress those risks.

5.3 Future Presentation of Performance Report

The Performance Report is more appropriately placed at Trust Board level and will no longer be brought to the Assurance Committee. The Committee will focus on the Assurance Framework. The Committee agreed that this would be a valuable development and would avoid duplication. Regarding the Performance Report, any items identified as risks at Trust Board would be referred back to the Assurance Committee for further consideration and action as appropriate.

5.4 Risk Management Internal Audit Report 2013/14

Agenda Item 9 is being dealt with at this point on the Agenda at the request of the Chair.

The Chair raised a concern arising from the internal audit report, that local risk registers may not have been updated in a timely manner, and the Committee asked for assurance in this area. The Committee has already agreed that the local risk registers will now be considered at future Assurance Committee meetings. The Committee was informed that the local risk registers will be considered by the Senior Executive Management Team on a quarterly basis, and are considered within each Directorate on a regular basis. The Committee recognised that major improvements have been made with extensive work in this area ongoing in the background, and in future this work will be more formally recorded.

6.0 Presentation

6.1 Management of Adverse Incidents

A presentation was given on the Management of Adverse Incidents by the Risk Manager, and the Committee thanked him for a very useful and timely presentation.

Clarification on Untoward Incidents and Serious Adverse Incidents (SAIs) was provided. Discussion and clarification followed regarding the identification of learning outcomes, following up incidents of violence against staff, and feedback mechanisms in general. The Committee was concerned that there should be early engagement with service users and their families/carers involved in SAIs and that they be provided with timely information. The Risk Manager confirmed that the Regional SAI Procedure was being amended to reflect this and NIAS procedures would be revised accordingly.

The Risk Manager was asked to give further consideration to how the new Regional Serious Adverse Incident Reporting and Follow-Up Procedure will impact on the Agenda of the Assurance Committee.

7.0 Standing Items

7.1 Assurance Framework as at 28 February 2014

This has been revised following the Trust Board workshop on 27 February with gaps in assurance and control identified, and an action plan and programme of work will be drawn up for the year ahead. The Committee agreed that this is a useful document and thanked the Chief Executive for his work on this. (The Committee) Members requested that action plans presented to the Committee be prioritised.

7.2 Risk Register as at 28 February 2014

No issues were raised.

The Committee requested that the report be presented in a larger font.

It was proposed that the subject of the next Trust Board workshop on 17 April will be a review of the corporate risk register, including the Trust's risk appetite.

7.3 Performance Report as at 28 February 2014

This report will be reviewed in depth at the Trust Board meeting later this week, so Directors made only brief comments as follows:

Director of Operations

The Trust is not likely to achieve the Cat A performance target for 2013/14 at this stage.

Director of Finance

The Trust will not achieve the prompt payment target by year end as new systems are still being embedded.

Director of Human Resources & Corporate Services

The Committee noted that while the absence target has not been achieved, all that can be done in relation to reducing absence is being done, and the Committee was assured that the Trust continues to deliver a safe, high quality service.

7.4 Controls Assurance Standards

Work is ongoing. The auditors are expected at the end of March and an update will be provided to the Committee at the next meeting in June.

7.5 Medical Device Alerts

Nothing to report.

7.6 Coroner's Rule 43

Nothing to report.

7.7 Reports from Groups and Committees

7.7.1 Health & Safety Committee – Notes of Meeting 20 November 2013

Noted.

7.7.2 Health & Safety Committee – Management Summary of Meeting 14 January 2014

The Committee noted that the Management Summary was not prepared by the Director of HR and Corporate Services as noted in the papers, but by a Senior Human Resources Officer. The Minutes of the meeting will reflect some matters differently than in the Management Summary. The Committee agreed that the timeliness of the Management Summary was beneficial.

7.7.3 Fire Compliance Sub-Committee – Notes of Meeting 24 October 2013

Noted.

7.7.4 **Fire Compliance Sub-Committee – Draft Notes of Meeting 30 January 2014**

The issue of storage of paper was raised again and this concern was noted. The Committee was assured that work is ongoing in finding a workable solution that complies with governance in relation to information, in balance with the capacity to be able to do this against other priorities.

In Craigavon the feedback from NIFRS was that there was no significant risk, but the Trust awaits a formal report. The Committee asked for an update at the next meeting in June.

8.0 Pharmacy and Medicines Management Update

No issues to raise. Station inspections are ongoing.

9.0 Risk Management Internal Audit Report 2013/14

This has been dealt with under Agenda Item 5.4.

10.0 Review of Terms of Reference

Subject to a minor amendment, the Terms of Reference were agreed by the Assurance Committee and will be presented to Trust Board at the meeting in May for endorsement.

11.0 Any Other Business

The Committee was advised of the challenging timetable and specific deadlines set by DHSSPS for the preparation of the Governance Statement (previously the Statement of Internal Control).

- 25 April 2014 – deadline for draft Governance Statement to be sent to DHSSPS.
- 6 May 2014 – draft accounts, including full annual report, remuneration report and Governance Statement.
- 13 May 2014 – draft accounts incorporating charitable Trust funds for the first time, full annual report, remuneration report and Governance Statement.

It was agreed that the Assurance Committee should have sight of these and have input into them.

This will be raised at both SEMT and Trust Board this week. The Trust is not aware of any significant changes to the format of the Governance Statement and Annual Report, therefore a similar approach can be taken to the previous year and this will ensure consistency.

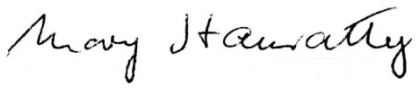
The Governance Statement will require an input from the Assurance Committee as well as the Audit Committee. The Audit Committee is scheduled to meet on Tuesday 20 May. It was agreed that the Assurance Committee would meet on **Tuesday 20 May at 9.30am**, in advance of the Audit Committee meeting at 10.00am. Assurance Committee members will be invited to join the Audit Committee meeting.

The document is to be circulated in advance of the meeting for comments.

N McKinley advised that he will not be available to attend on 20 May.

Date, Time and Venue of Next Meeting

The next meeting will take place on **Thursday 5 June 2014 at 1100hrs**.

Signed:  **Date:** 18 April 2014

(Professor Hanratty, Chairman)

TB/10/29/05/14

NORTHERN IRELAND AMBULANCE SERVICE

Minutes of a meeting of the Audit Committee held on Thursday 6 March 2014 at 2.00pm in the Board Room, Ambulance Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT:	Mr N McKinley	Non Executive Director (Chair)
	Ms A Paisley	Non Executive Director
	Prof M Hanratty	Non Executive Director
IN ATTENDANCE:	Mrs S McCue	Director of Finance & ICT
	Mr P Nicholson	Assistant Director of Finance
	Mr A Phillips	Financial Accounts Manager
	Mr D Charles	BSO Internal Audit
	Mrs C McKeown	BSO Internal Audit
	Mr John Poole	KPMG External Audit
	Ms C O'Hagan	NIAO External Audit
	Mrs Elaine Hamilton	Senior Secretary

Welcome and Introduction to the Meeting

1.0 Apologies

It was noted that an invitation to the meeting and NIAS Audit Committee papers had been provided to the DHSSPS, but no apology or reply had been received.

The Trust has been advised that Hilda Hagan, Head of HSC Sponsorship Branch in the Department, will be attending the NIAS Audit Committee Meeting on 5 June 2014.

2.0 Declaration of Potential Conflict of Interest & Confirmation of Quorum

There were no expressions of potential conflict of interest and the meeting was declared to be quorate.

3.0 Minutes of Previous Meeting of the Audit Committee held on 27 January 2014

Ms Paisley asked for clarification about the timeframe for the full and formal review of Standing Orders as minuted at 5.2. This was planned for the Summer of 2014 but would not impact on the review required to address the issue of Trust Board quorum.

Mrs McKeown pointed out that at 6.1 the overall level assurance in the Travel Expenses audit had been Satisfactory with Limited Assurance only applying to the Voluntary Car Service.

Mr Poole further pointed out that at 7.1 the heading should have read (For Noting). It was also agreed that Mr Nicholson would provide a brief extra sentence at point 10.1 to indicate that anonymous allegations are nonetheless treated seriously.

Subject to these amendments the minutes were agreed as a true and accurate record.

4.0 Matters Arising

4.1 Review of Standing Orders – Trust Board Quoracy Issue

After discussion with the Chair of the Audit Committee and Chief Executive, the Chairman of the Trust Board has identified a subgroup that has been tasked with initially addressing this issue as a matter of urgency. Unfortunately the Non-Executive identified had not been available at any time suggested by the Executives involved. Ms Paisley and Mr McKinley

both felt that the Executives could progress work via teleconference and electronic circulation of ideas with him and Mr McKinley undertook to approach the Chairman of the Trust Board for his agreement to this approach in order to expedite matters.

Professor Hanratty stated her view that there was potential for an actual or perceived conflict of interest in the subgroup comprising members with a perceived interest in the outcome of its work. Ms Paisley gave background to the situation and how it had arisen due to Remuneration Committees no longer having decision-making authority without reverting to the full Board, following a ruling by the Department in light of problems in another Trust in the past. This has complicated the workings of existing Standing Orders with regard to quoracy and the participation or otherwise of members with a declared interest in the matter of decisions about their own pay. This was deemed to be a helpful insight.

Ms Paisley and Mr McKinley emphasised that the subgroup looking at this issue will not be making decisions but bringing their suggestions to Audit Committee for full independent scrutiny prior to Audit Committee making recommendations to the Trust Board. They deemed that this rendered the subgroup's work, and the involvement of those parties as described above, on the matter as appropriate and able to proceed.

4.2 Follow up on Previous Audit Recommendations

Ms Paisley felt that discussions had indicated an understanding that management would be following up actions from Audit Recommendations rather than solely relying upon further review of progress by Audit.

5.0 Chairman's Business

There were no items of Chairman's business not covered in the agenda.

6.0 Internal Audit

6.1 Progress Report (for noting)

Mrs McKeown introduced the five completed audit reports being presented to the Audit Committee today. Two further assignments were being progressed with management with a view to fieldwork beginning imminently. Page three of the report referred to a date of today, 6 March 2014, for the Audit Committee's consideration of the Board Effectiveness audit. This report was nearing completion, but was not yet available for consideration by Audit Committee.

In respect of the completed audits, Mr Charles reported as follows:

Budgetary Control – Overall Satisfactory Assurance – There were no Priority 1 findings, but six Priority 2 findings and one Priority 3 finding. This was the first audit of the newly introduced finance systems and recognised the transition from the previously manual, centralised approach to requisitioning and ordering to the devolved, automated new system. There was a recognition that the preparation and implementation of the new systems had led to a delay in the provision of information to budget holders, but that steps had been taken to mitigate against any risk to financial control during this period. It was also recognised that the new systems provided opportunities for enhanced financial reporting and detail to both Trust Board and budget holders. These opportunities would continue to develop and be exploited in the future. Ms Paisley felt that the delay in the provision of information to budget holders in particular and the other findings in the report were regrettable but understandable given the circumstances and welcomed the alternative controls that had been put in place and the overall level of Satisfactory Assurance that had been provided.

General Ledger - Overall Satisfactory Assurance – There were no Priority 1 findings, but two Priority 2 findings and one Priority 3 finding. Again, the transition from the previously manual, centralised approach to requisitioning and ordering to the devolved, automated new system

was noted, in particular the authorisation limits established within eProcurement. Development in this area would continue as the system was deployed to operational areas and experience of the system and its application grew. Mrs McKeown stated that this was a comparatively clean report given the introduction of the new system.

Bank and Cash - Overall Satisfactory Assurance – There were no Priority 1 findings, but four Priority 2 findings. Mr Charles highlighted that bank reconciliations are still completed manually rather than using functionality within eFinancials. Elements of the NIAS Accounts Receivable function had also transferred to the BSO Shared Service centre (SSC) in February 2014, however, there was currently no signed Service Level Agreement (SLA) in place. Mr Poole emphasised the importance of clearly identifying lines of responsibility for the various stages of working with the new Shared Service Centres, especially when other elements of financial services, for example Accounts Payable, transfers to the SSC. Mrs McCue indicated that these issues have been picked up regionally across the organisations involved and Mr Nicholson advised that there is a very mature SLA largely agreed between all the Trusts which was being reviewed by the Assistant Directors of Finance Financial Services group.

HRPTS Readiness – This was a consultative piece of work rather than an audit and as such did not provide specific assurance on the system of internal control or the state of readiness to Go Live with the new HRPTS system, rather a review of the adequacy of readiness processes. The Directors signing off on the Go Live decision had however considered and relied upon this work as part of the decision making process. The review had focussed on segregation of duties, readiness to Go Live, the permissibility framework, data migration and travel. Mrs McCue advised that the Trust had also completed a comprehensive Go Live Readiness Checklist as part of the preparations for Trial and Actual Cutover to the new system. Mr McKinley inquired as to whether there could be a one page diagram illustrating the connections between elements of the systems. Mr Poole stated that external audit would be doing a walk-through of the system in due course which would necessitate the generation of such a pathway.

Mr Nicholson advised the committee that the decision to Go Live with the new system for NIAS had been taken on Monday 17 February 2014. This means that payroll for the month of March would be run and paid using the new system. He also advised that the first and second months of payroll on the new system would be very different and very challenging at the busiest time of the financial year. Ms Paisley asked how strong the relationships were with other Trusts who had been using the system for longer. Mrs McCue confirmed that NIAS staff had been present at the running of other Trusts' live systems at earlier stages and brought back learning and that relationships across HSC were very strong. However, NIAS were among the last organisations to Go Live and funding across the service was being withdrawn as the project came to a close. This would mean that staff may be returning to their substantive roles and there is concern about how much expertise and support can be maintained, both within HSC and also from the system supplier, in the critical early months using the new system.

Risk Management – Overall Satisfactory Assurance – There was one Priority 1 finding and four Priority 2 findings. Professor Hanratty expressed her concern that a Satisfactory Assurance was given despite the Priority 1 finding, which indicated local Risk Registers were far from up to date and therefore did not seem to feed into the Corporate Risk Register from which the Assurance Committee sought assurance. Mrs McKeown agreed that local registers should feed in to populate the Corporate Risk Register and this gave rise to the Priority 1 finding, whilst both she and Mr Charles felt that significant progress had been made in the content of the Corporate Risk Register, which gave rise to the overall Satisfactory Assurance and that this level of assurance was appropriate. Ms Paisley drew comfort from the progress she had seen in this area over recent years and asked whether internal audit had seen anything in the local registers to raise concern. Mrs McKeown said that in her opinion there was nothing on any of the local registers which should be on the Corporate Risk Register but that formal updating has fallen behind, which is of concern.

Ms Paisley asked that this issue be taken up at the next Assurance Committee meeting when all Directorates would be represented to account for and take this forward. Mrs McKeown highlighted that the recommendation that "NIAS should further consider and define its risk appetite across the organisation" (page 50) was included to ensure an appropriate discussion took place at Board level as to whether the risk appetite was fully defined by the DHSSPS or to what extent it was set by the Trust Board. Mr Poole said he had not come across much analysis of risk appetite in the health sector but upon his outline of such analysis used elsewhere Ms Paisley recognised that this is what is already in place in how the Board looks at target risk and mitigating actions.

7.0 For Approval

There were no items for approval on this agenda.

8.0 External Audit

8.1 Timetable for Year End Accounts

This had only been issued on Wednesday 5 March and hence did not feature formally on the agenda. Mrs McCue outlined the wide range of pieces of work required to be completed both internally and in conjunction with Internal and External Audit in order to achieve the deadlines outlined by DHSSPS. This represented the tightest timetable to date. Key dates include:

- Draft governance statement to DHSSPS by 25 April
- Draft public sector accounts, including full annual report, remuneration report and governance statement to NIAO and DHSSPS by 6 May
- Draft consolidated accounts (public sector and charitable funds accounts) and CTF financial statements to NIAO and DHSSPS by 13 May.

Both the Audit and Assurance Committees would be required to input to this process within the deadlines that had been set. There was discussion around the challenges within the timetable and the requirement for two meetings to afford members of both Audit and Assurance Committees appropriate opportunity to consider and influence the final submissions. It was suggested that an Audit Committee meeting be held on the morning of Tuesday 20 May, with papers provided at the earliest possible opportunity and utilising electronic circulation of documents where possible. This would be followed by the Audit Committee meeting already scheduled for 5 June prior to consideration at Trust Board on 12 June.

8.2 Governance Statement (formerly Statement of Internal Control SIC)

This will appear on the agenda of the Assurance Committee for its meeting on 24 March. Mr McKinley suggested and it was agreed that members of Assurance Committee should be invited to attend the extra Audit Committee meeting on Tuesday 20 May and members of both committees will receive the draft governance statement electronically when it is submitted to the DHSSPS on 25 April.

9.0 For Noting

9.1 Report on Administration and Clerical Staff (including Management) Costs

Mrs McCue presented this report and invited comments or input to its development. Professor Hanratty asked if the term 'Other Professional & Technical' as used in the table on page eight was defined across Trusts. Mrs McCue advised that the classification was linked to historical Terms and Conditions groupings that would be consistent across Trusts, but it

was important to note that individual Trusts may have different approaches to the groups of staff employed to carry out certain functions, for example ancillary staff and administrative and clerical staff in different Trusts may carry out similar roles.

Ms Paisley inquired as to whether these figures accounted for outsourced services and if all Trusts had done the same. It was confirmed that services included within the management cost definition are included in the costs whether they are carried out in house or outsourced.

It was noted that the proportion of administrative and clerical staff in NIAS was significantly lower than other HSC Trusts, but that management costs as a proportion of income was higher, largely due to the comparatively small turnover of NIAS (which is the denominator in the management costs calculation). NIAS management costs were just slightly above the average when compared to information available from other ambulance services despite the fact that NIAS was by far the smallest ambulance service in the UK in terms of income.

The reductions in both management and administrative costs were noted along with plans to deliver further reductions in management costs in 2013/14 and 2014/15. The Committee thanked Mrs McCue for this very useful report.

9.2 Draft DHSSPS Procurement Strategy 14 February 2014

Ms Paisley raised a number of questions and concerns arising from this strategy and its potential impact on NIAS. Mrs McCue stated that it will be considered by SEMT but has not been reviewed there as yet. With regard to Ms Paisley's concern about whether our annual budget allocation hindered the Trust's ability to procure items on its capital programme, Mrs McCue clarified that the business cases for capital allow some commitment for example to fleet. Whilst no guarantee exists that the funding for the second year spend will be forthcoming, chassis can be procured in one year with spend on fitting out planned for the following year on the strength of business case approval.

Given the application of this DHSSPS Procurement Strategy to all bodies it is conceivable that the HSC Board will commission non-emergency ambulance services more widely. The Procurement Working Group will develop strategy to be brought to the Audit Committee and from there on to the Trust Board.

The Audit Committee endorsed the work on this strategy and the adoption of the DHSSPS strategy as a basis for the NIAS Strategy.

Mrs McCue undertook to send committee members a link to the report on procurement in the Northern Trust that was available on the Department's website.

10.0 <u>Any Other Business</u>

10.1 Fraud Update

Mr Nicholson provided an update to the committee in respect of ongoing cases. National Fraud Initiative data matches continue to progress both internally and with PSNI as appropriate. The review by internal audit into an anonymous allegation was progressing.

10.2 Business Services Transformation Project (BSTP)

Mrs McCue reported that FPL and now HRPTS are live in the Trust and are currently being deployed across the service. The availability and extent of HSC expertise and also contractor support as the projects came to a close were a concern both to NIAS and regionally. Elements within the project have been and will continue to transfer to BSO Shared Service Centres. The costs and benefits of the new systems and the transition to Shared Services cannot yet be finalised, however the Trust will continue with this implementation and transition in line with Ministerial direction and Trust Board support.

11.0 **Date, Time and Venue of Next Meetings**

Attendees sought to find an appropriate date and time to meet in line with the Departmental deadline for Final Accounts.

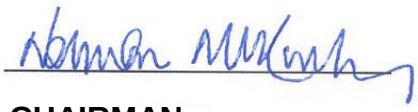
It was agreed that a meeting would take place on the morning of Tuesday 20 May with Assurance Committee members being invited to attend as per discussions minuted above at 8.2. Professor Hanratty may need to chair that meeting of the Audit Committee as Mr McKinley indicated he may not be available but would avail of the relevant information electronically.

Further meetings in 2014 are planned for:

Thursday 5 June 2014
Thursday 4 September 2014
Thursday 4 December 2014

The full Trust Board will meet on 12 June 2014 to consider the 2013/14 Annual Report and Accounts.

Please note that dates may be subject to change and/or additional dates may be scheduled to accommodate Departmental deadlines, in particular Final Accounts.

Signed 

CHAIRMAN

Date **11 April 2014**

TB/11/29/05/14

Minister approves framework for GP out-of-hours services

Health Minister Edwin Poots has approved the consultation process and Strategic Framework for GP out-of-hours (GP oohs) services in Northern Ireland.
~ Friday, 7 February 2014

The Health and Social Care Board (HSCB) held a public consultation in 2012 on the future provision of GP out-of-hours services across Northern Ireland and listened to wide range of views from medical professionals, key stakeholders and the wider public.

The Minister said: “This Strategic Framework is the next step in the work towards providing more effective and efficient GP out-of-hours services and is to be welcomed. The framework is consistent with the proposals in Transforming Your Care which will ultimately deliver improved access to GP oohs for everyone across Northern Ireland.”

Dr Margaret O’Brien, Head of General Medical Services at the Health and Social Care Board, said: “GP out-of-hours services provide urgent advice, care and treatment at times when GP surgeries are closed. Significant improvements have already been implemented in relation to processes, commissioning and quality standards for service delivery. The Strategic Framework complements and enhances this work and provides further opportunities to improve services.

“The framework also seeks to improve patient access through the development of a single number to access GP out-of-hours services, supporting the ultimate aim of delivering an urgent care number service for Northern Ireland.”

The number of patients using GP out-of-hours services in Northern Ireland has increased by over 18% in the last five years.The HSCB has committed to increase investment, to support the service in meeting increasing patient demand.

The BMA has welcomed the Ministerial approval of the new framework. Dr Tom Black, speaking on behalf of the BMA said: “I welcome the assurances provided by the HSCB, but would urge them to build on the successful model of the existing GP out-of-hours services, retaining the role of local clinical professionals to assess, and give advice, to patients presenting with clinical conditions. It is vitally important that we learn from the problems experienced during the implementation of a ‘111’ number in England.”