Establishing an Assurance Framework:
A Practical Guide for management boards of HPSS organisations

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Governance - "*the system by which an organisation directs and controls its functions and relates to its stakeholders"* ***HM Treasury***

Assurance - *"a statement or indication that inspires confidence"* ***Cambridge Dictionary***

Quality Assurance - *"the practice of managing the way goods are produced or services are provided to make sure they are kept at a high standard"* ***Oxford Dictionary***

Framework - *"a system of rules, ideas or beliefs that is used to plan or decide something"* ***Cambridge Dictionary***

PREFACE

This guide is intended to help HPSS organisations improve the effectiveness of their systems of internal control. It forms part of a series of Departmental guidance for improving and strengthening practices and governance arrangements, so that safe and high quality health and social services are provided to all who need them.

This document focuses on strengthening the controls assurance process which underpins all aspects of the business of the HPSS – clinical and social care, financial and organisational – and which supports each organisation's governance arrangements.

The commissioning and provision of health and social care services require quality assurance ***and*** risk management. They also require organisational governance, such as management of personnel, financial efficiency and systems efficiency, as much as clinical and social care governance; all the various elements of governance need to be managed. Focusing on any one element at the expense of others leads to mismanaged services. It is not a choice between risk management and quality assurance. Both are needed, as fewer errors mean safer and better quality services.

The guidance will be of particular interest to management board members, senior managers, committee members, risk & governance managers and clinical and social care professionals – to all those, in fact, with responsibility for good governance.

In describing the assurance framework, this guidance offers practical advice on:

- setting principal objectives;
- identifying risks impacting on those objectives;
- identifying and utilising assurances to strengthen the internal control system;
- identifying strengths and weakness in those assurances; and
- preparing action plans to cover gaps in controls and assurances.

A robust assurance framework provides a stronger basis for effective challenge in the boardroom and better-informed decision-making. It also allows Accountable Officers to more fully discharge their statutory responsibility to prepare an annual Statement on Internal Control.

This guidance will be subject to review, particularly as decisions on restructuring of the HPSS take effect in the light of the review of public administration.

GLOSSARY

Term	Definition
Assurance	Confidence, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved
Audit Committee	The function of an Audit Committee is to support the accountable officer (or board) by monitoring and reviewing the risk, control and governance processes that have been established in the organisation and the associated assurance processes (which are mainly internal and external audit assurances). In some organisations, this role is amalgamated with the relevant assurance committee.
Assurance Committee	A board level committee with overarching responsibility for ensuring that appropriate assurance is gained on the management of all principal risks. This may be an existing committee such as a governance or risk management committee
Assurance Framework	A structure within which a board identifies the principal risks to the organisation's meeting its principal objectives, and through which they map out both the key controls to manage them and how they have gained sufficient assurance about the effectiveness of those controls
Board Assurance Action Plan	An action plan approved by the board to improve its key controls to manage its principal risks, and gain assurances where required
Board Assurance Reports	Key information reported to the board on the assurance framework, providing details of positive assurances and significant gaps in internal controls and assurances relating to principal risks. In addition to providing information leading to a board assurance action plan, these reports will also supply evidence to support the annual Statement on Internal Control
Controls Assurance	A concept resting on best governance practice. Within the HPSS, it is a process designed to provide evidence that organisations are doing their 'reasonable best' to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds
Core Controls Assurance Standards	The three self-assessment standards which form the essential underpinning of the annual Statement on Internal Control: Governance Standard; Risk Management Standard; Financial Management Standard
Directorate-level Objective	How the organisation translates an overall goal into deliverables at directorate (or equivalent) level
Effective Control	A control that is properly designed and is systematically operated to deliver the intended objective
External Assurance	Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as External Audit, HPSS Regulation and Quality Improvement Authority or Royal Colleges

Term	Definition
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively
Gap in Control	Failure to put in place sufficiently effective policies, procedures, practices or organisational structures to manage risks and achieve objectives
Head of Internal Audit Opinion	An annual opinion provided to inform the board in completing the Statement on Internal Control. This provides opinions on (a) the overall assurance framework and (b) the effectiveness of that part of the system of internal control reviewed by Internal Audit during the year
Independent Assurance	Assurances provided by (a) reviewers external to the organisation, such as the HPSS Regulation and Quality Improvement Authority, and (b) internal reviewers working to prescribed government standards, such as Internal Audit
Internal Assurance	Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as Clinical or Multi-Professional Audit or management peer review
Internal Control	The ongoing policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected
Key Control	A control to manage one or more principal risks
Mapping of Assurance	A process, providing a clear management and audit trail, that links • principal objectives to principal risks • principal risks to key controls • key controls to assurances
Organisational (or Strategic) Objective	An overall goal of the organisation
Organisational Controls Assurance Standards	Self-assessment standards (excluding the core standards) which provide a framework to improve internal controls across a wide (although not necessarily all-encompassing) range of organisational areas
Positive Assurance	Evidence that risks are being reasonably managed and objectives are being achieved
Principal Objectives	Objectives set at organisation and directorate (or equivalent) level
Principal Risk	A risk which threatens the achievement of principal objectives
Prioritisation of Risk	A process by which risks are graded according to the likelihood of their occurrence and the impact of their consequences
Reasonable Best	A defensible decision or course of action, agreed by the board, that is based on sufficient evidence
Residual Risk	When action is taken to treat risks, this may eradicate the

Term	Definition
	possibility of the risk occurring. The action is, however, more likely to reduce the probability, leaving a residual risk
Risk	The possibility of suffering some form of loss or damage and/or the possibility that objectives will not be achieved or that opportunities will not be taken
Risk Assessment	The identification and analysis of risks relevant to the achievement of objectives
Risk Management	A systematic process by which potential risks are identified, assessed, managed and monitored
Risk Register	A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion
Sources of Assurance	The various reviewers, auditors and inspectors, internal and external, who carry out work at HPSS organisations (see Internal Assurance and External Assurance). Boards determine which sources of assurance are relevant to principal risks and the extent to which they provide sufficient assurance
Statement on Internal Control (SIC)	An annual statement, signed by the Accountable Officer on behalf of the board, that forms part of the Annual Financial Statements for the year. The SIC provides public assurances about the effectiveness of the organisation's system of internal control
System of Internal Control	A system, maintained by the board, that supports the achievement of the organisation's objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organisation's objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically

PART ONE:

ESTABLISHING AN ASSURANCE FRAMEWORK IN AN HPSS ORGANISATION

SECTION 1 – INTRODUCTION

Background

1.1 People need to be confident about the quality of care that they get from organisations supplying and commissioning health and social care. They want services that are safe and are provided by competent and confident staff who will always work in their best interests. The board of each Health and Personal Social Services (HPSS) organisation has therefore a duty, on behalf of service users, carers, staff and local communities, to ensure that the organisation is carrying out its responsibilities within a system of effective control and in line with the objectives set by Ministers. To discharge these duties, boards of HPSS organisations need to have in place robust systems of governance.

1.2 Traditionally, responsibility for governance has been discharged through a number of separate controls or disciplines which, because they developed separately over recent years, do not necessarily align or specifically interrelate. For example, the translation of Health and Wellbeing Investment Plans (HWIPs) or Trust Delivery Plans (TDPs) into organisation or directorate objectives is rarely informed by a thorough risk[1] assessment. Similarly, decisions on financial allocations may not be taken in the context of relevant information about clinical and social care governance. Controls assurance itself is sometimes seen as an additional, separate, annual exercise to support the statement of internal control. The Assurance Framework addresses these anomalies or shortcomings.

1.3 This Framework does not impose any new requirements on HPSS organisations: rather, it suggests ways in which the boards of HPSS organisations can usefully develop their governance capacity:

- in terms of how the various aspects of governance relate to organisational responsibilities and to each other;
- in relation to the information they need to discharge their responsibilities;
- to know how the different facets of governance are working; and
- to ensure their effective management of risk.

1.4 The HPSS has a duty to protect service users, carers, staff and others in the planning and delivery of services. Reducing risk is not just about financial or management probity; it is also concerned with improving the safety, quality and user experience of services. This means that equal priority needs to be given to the obligations of governance across all aspects of the business, whether financial, organisational or clinical and social care, and a need for governance to form part of each organisation's culture. Good governance hinges on having clear

[1] HMT's Orange Book – Management of Risk – Principles and Concepts (October 2004) defines "Risk" as this uncertainty of outcome, whether positive opportunity or negative threats, of actions and events

objectives, sound practices, a clear understanding of the risks associated with the organisation's business and effective monitoring arrangements – in other words, a sound system of organisation-wide risk management.

1.5 The six core principles of good governance, as set out in the Good Governance Standard for Public Service,[1] are:

Focusing on the organisation's purpose and on outcomes for citizens and service users
Performing effectively in clearly defined functions and roles
Promoting values for the whole organisation and demonstrating the values of good governance through behaviour
Taking informed, transparent decisions and managing risk
Developing the capacity and capability of the governing body to be effective
Engaging stakeholders and making accountability real

1.6 HPSS organisations will already, of course, have in place monitoring systems – in the case of Trusts and Agencies, to monitor the quality of their own services and, in the case of Boards, to monitor the quality of services they commission. The need for such arrangements has been further underlined by the statutory duty of quality placed on Boards and Trusts from April 2003.

1.7 The HPSS Regulation and Quality Improvement Authority (RQIA)[2] has a pivotal role to play in ensuring that integrated governance[3] processes are in place throughout the HPSS and that they provide to the public effective assurance that the services they rely on are appropriate, safe and of highest possible quality. By monitoring and inspecting services, by examining the governance arrangements, by investigating particular events and reviewing actual practice, the RQIA will be able to reach a definitive view on the quality of service provision in the HPSS. The RQIA will promote a culture of continuous improvement within the HPSS. It will provide direction and focus so that the public can be assured of the quality of care that they will receive. Where appropriate, the RQIA will also indicate to the Department of Health, Social Services

[1] Published by the Independent Commission for Good Governance in Public Services (January 2005) http://www.opm.co.uk/ICGGPS/index.htm

[2] Established as the HPSS Regulation and Improvement Authority by Part IV of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003

[3] **Integrated governance** can be defined as *'systems and processes by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.'* NHS Confederation (May 2004) – The development of integrated governance

and Public Safety (the Department) the need for special measures to secure standards and quality of care.

1.8 Associated with developments in the regulation of service and developments in clinical and social care governance has been a growing emphasis on continuous professional development, life-long learning and strengthened regulation of the professions and the workforce. This too will be reflected in the Framework.

Summary

This assurance framework does not impose any new requirements on HPSS organisations

If boards of HPSS organisations are to discharge their duties effectively, they need to have robust systems of governance in place

Reducing risk is not just about financial or management probity – it is also about improving the safety, quality and user experience of services

The RQIA has a pivotal role to play in ensuring that integrated governance processes are in place throughout the HPSS

Strengthened workforce regulation will also have a role in improved governance arrangements

SECTION 2 – GOVERNANCE IN CONTEXT

General

2.1 The boards of HPSS organisations need to be confident that their governance arrangements are operating effectively. They have to know that they will identify, manage and minimise the risks inherent in the provision of health and social care and that, thereby, they will help to achieve business objectives.

2.2 HPSS Chief Executives must, as Accountable Officers, sign a Statement on Internal Control (SIC) as part of the statutory accounts and annual report process[1]. This requirement heightens the need for boards to be able to demonstrate that they have been properly informed about the totality of their risks, whether in the immediate provision of health and social care or in organisational matters. To do this they need to be able to show – to give "assurance" – that they have systematically identified their objectives, managed the principal risks to achieving them and identified any significant weaknesses that need to be addressed. In turn, this assurance (in the form of the SIC) is provided to the Department's Accounting Officer.

2.3 But the concept of assurance can be a source of misunderstanding and mismatched expectations. Potentially, there can be a lack of clarity within, and beyond, the board as to what is meant by the term. This may extend to uncertainty as to:

- the level of assurance required,
- where that assurance comes from, and
- how to manage the reporting of assurance in a co-ordinated fashion.

While HPSS organisations have made considerable progress in this area in recent years, more remains to be done to establish meaningful and robust risk registers and sound board risk reporting mechanisms.

2.4 This guidance is being issued to resolve uncertainties and deepen organisations' understanding of these aspects of governance. More specifically, it gives advice on building an assurance framework and on harnessing existing risk management activity. The principles it sets out are illustrated by worked examples. The guidance also clarifies the relationship between performance management arrangements, the evolving clinical and social care governance agenda, the core controls assurance standards and other sources of assurance.

What a board must do

2.5 Criterion 6 of the Governance Standard[2] states:

[1] DAO(DFP)5/01 introduced the requirement for a Statement of Internal Control to be made alongside the accounts of central government bodies. DAO(DFP) 25/03 and HSS(F) 2/04 set out the requirements from 2003/04 onwards

[2] http://www.dhsspsni.gov.uk/hss/governance/documents/governance_05.doc

"The Board ensures that it has proper and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes."

To meet this criterion, the board needs to develop a process to support its Chief Executive in making a balanced, fully informed SIC - one that describes both the achievements in the embedding of risk management and the work that remains to be done.

2.6 This process will include:

- establishing principal objectives (at organisation, directorate and unit/team level);
- identifying, by drawing up a risk register, the principal risks that may threaten the achievement of those objectives;
- identifying and evaluating the key controls intended to manage these risks, underpinned by core controls assurance standards;
- setting out explicit arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk;
- assessing the assurances given;
- identifying positive assurances and areas where there are gaps in controls and/or assurances;
- putting in place plans to take corrective action where gaps have been identified; and
- maintaining dynamic risk management arrangements including, crucially, a regularly reviewed risk register.

What assurance means in the HPSS

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

2.8 All this points to the need for the board to fully debate and map the connections between organisational objectives, risk and the range and effectiveness of existing assurance reporting. In doing so it will be

important to establish the principle of **reasonable** rather than **absolute** assurance, and to reach consensus on what "reasonableness" means for the organisation concerned. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

2.9 The assurance framework will define the organisation's approach to **reasonable** assurance. Construction of such a framework will also make it clear to individual board members that assurance, from whatever source, will never provide **absolute** certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

2.10 For any HPSS organisation, effective risk management requires the embedding of controls assurance in the key processes that directly support service (business) objectives. The best assurance regime is integral not only to the delivery of safe and high quality health and social care but to the effective stewardship of public resources. It can, moreover, be used to manage change, to involve all levels of the organisation, improve or defend the organisation's reputation and maximise its opportunities to innovate. Although these advantages are enough to commend the assurance agenda to HPSS organisations, there is also a strong external driver in the form of the SIC. This imposes an important public disclosure obligation on each board of directors. In effect, the SIC requires confirmation that the effectiveness of the system of internal control has been reviewed and that the result of the effectiveness review have been discussed by the Accounting Officer with the board. That responsibility for the system of internal control encompasses:

- adopting appropriate policies on internal control;
- seeking regular assurance that the system is functioning effectively; and
- ensuring that the system of internal control truly identifies and manages risks, as the board intended.

2.11 This chain of requirements represents a shift in emphasis. Hitherto, compliance with standards has been the governance focus for many HPSS boards. This has directed energies to assessing gaps in performance against set criteria within areas of risk. This compartmentalised process has been important in terms of engaging all HPSS organisations in a consistent manner, but the SIC requirement is that each board and its members understand the links and their role in the organisation's particular assurance chain, and that the board continuously monitors the effectiveness of its internal control.

Summary

To make a balanced, fully informed SIC, boards need to demonstrate that they have been able to identify their objectives and manage the principal risks to achieving them

It is necessary for boards to determine the level of assurance required to manage their principal risks and take stock of the various forms of assurance available to them

In determining reasonable assurance, a balance needs to be struck between the likelihood of a risk occurring and the severity of the consequences should it do so, against the cost of managing it within available resources

The SIC requirement is that each board understands the links in the organisation's particular assurance chain and for the board to continuously monitor the effectiveness of its internal control.

SECTION 3 – THE STRATEGIC LANDSCAPE

Relationship to *Programme for Government*

3.1 Each year, the Government sets out its plans and priorities for tackling problems and improving public services in Northern Ireland. Like its ***Programme for Government*** predecessors, ***Priorities and Budget***[1] includes a Public Service Agreement (PSA) committing each Department to work towards particular aims and outcomes for the benefit of service users.

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

3.3 While individual outcomes and targets contained in ***Priorities and Budget*** can be traced to a series of health and social care policy planning documents, their application to the HPSS is routed through the Minister's annual ***Priorities for Action*** (PfA)[2]. These outcomes reflect the *Priorities and Budget* focus on reform and modernisation of services within the context of the resources available to the Department, as well as the attainment of efficiency targets, and together they form an action plan for the HPSS.

3.4 The HPSS response to the Minister's *Priorities for Action* is communicated respectively through Health and Well-being Investment Plans (HWIPs) and Trust Delivery Plans (TDPs). These documents describe how Boards and Trusts plan to use their resources to commission services for their resident populations and deliver health and social care services to service users, carers and families. They also present Boards' and Trusts' proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets. The approved HWIPs and TDPs are the basis of an organisation's business planning process.

Objective setting

3.5 The HWIPs will set out **what** services will be commissioned by each HSS Board in order to achieve the outcomes for its local community. The TDPs will set out **how** those services will be delivered in order to achieve the outcomes for its service users, carers and staff. The Business Plans of HSS Agencies will demonstrate what will be provided to the HPSS and other customers in order to contribute to the achievement of outcomes for the local population. Each of these Plans will therefore form an integral part of an organisation's objective setting exercise and hence of its risk management arrangements.

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

3.6 In addition to those decreed by the PSA and PfA, organisational objectives will include other, local, service (business) objectives as well as those needed to deliver the organisation's corporate commitments. Such organisational objectives should, in turn, cascade to directorate and unit/team level where more detailed objectives, targets and actions will be set in order to deliver on the strategic agenda. Individuals should be able to translate the unit/team level information into personal objectives - thereby establishing a link and identifying the part they are playing in the strategic agenda. *See* Figure 1 which demonstrates the link between organisational objectives and individual objectives.

Monitoring and accountability

- ***Accountability to Minister and the Department***

3.7 HWIPs and TDPs are the main vehicles for conveying where and by what means PfA targets, efficiency savings and service improvements will be delivered. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements. HPSS organisations are ultimately accountable to the Departmental Minister for the delivery of health and social services to the people of Northern Ireland. HPSS organisations are also directly accountable to the Minister and the Department for their governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance. A series of formal progress review meetings with HSS Boards and Trusts, and an annual accountability review meeting held at Ministerial level with each HSS Board, help to ensure that organisations are indeed held to account.

- ***Accountability between HSS Boards and Trusts***

3.8 It is commonly (and correctly) understood that HSS Boards and Trusts are accountable to the public for the services that they commission and provide. But, in discharging their governance obligations, it is important for board members to be clear about the accountability relationships that link HPSS organisations. The following paragraphs give a brief overview of the present arrangements.

3.9 The basis for HPSS accountability is the Health and Personal Social Services (Northern Ireland) Order 1972[1] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department the duty to:

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

- provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the

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

people of Northern Ireland; and

- secure the efficient coordination of health and personal social services.

3.10 Under Article 16 of the 1972 HPSS Order, the HSS Boards were established for the purpose of administering and providing health and personal social services within their respective areas. This broad remit changed in the early 1990s when the HPSS (NI) Order 1991[1] (augmented by the HPSS (NI) Order 1994[2]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards' planning and commissioning of services for their resident populations, and the Trusts' provision of those services, remains to this day, and their accountability relationship rests on it.

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

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

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

3.12 In accountability terms, there are differences between the two categories. In category one, Trusts' are, initially answerable to the commissioning HSS Board(s), via their Service and Budget Agreements, for the quantity, quality and efficiency of services. This relationship has been strengthened by the introduction of the statutory duty for the quality of services commissioned for, and provided to, the population which applies to both HSS Boards and Trusts[3]. In this category, therefore, Trusts are responsible to HSS Boards for the delivery of services to the quantity, cost and quality specified in Service and Budget Agreements. (There may also be a shared responsibility between HSS Board and Trust to the Department, as in the achievement of Priorities for Action targets.)

3.13 Within this category, however, there exists a sub-set of services where a heightened degree of accountability between Trust and HSS Board obtains. This originates in the 1994 Order, where certain functions – specified as "relevant functions" in regulations, and hitherto the immediate responsibility of HSS Boards - became exercisable under

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

instruments of authorisation by the newly established Trusts. The Trusts duly submitted, for approval by the relevant HSS Board and by the Department, 'schemes' setting out how they intended to discharge the functions or services in question. With the exception of those discharged under the Mental Health (NI) Order 1986[1], the functions in question are drawn from what are generally regarded as personal social services (including children and adoption services).

3.14 In accountability terms the upshot is that, where a Trust scheme for a relevant function is in operation, the delegating HSS Board should monitor its operation. The Board must check that the Trust is complying with the terms of the scheme and hold the Trust to account for how it discharges that function. This may, at times, require a more detailed and exacting approach than is envisaged under the Service and Budget Agreement governing the provision of services as a whole.

3.15 In category two (financial control, governance, and for overall organisational performance etc) each HPSS organisation is accountable direct to the Department. That is not to say that these functions are irrelevant to other HPSS organisations. For example, HSS Boards may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc on governance or financial control. A brief Service and Budget Agreement reference to this effect will suffice to address such issues. HSS Boards may also expect the Department to keep them informed of developments or findings in the field of governance, financial control, etc that are material to their commissioning role.

3.16 The above is an outline of the accountability arrangements that obtain at present across the HPSS. Significant realignment of roles and responsibilities is to be expected as a result of the Review of Public Administration, and guidance on that will be issued in due course.

Future arrangements

3.17 In the future RQIA will monitor, inspect, investigate and review the quality of services provided by HPSS organisations. Whilst the RQIA does not have a performance management role, it will be encouraging quality improvement and will keep the Department informed about the availability and quality of services. The Department's role in performance management will therefore be strengthened by the RQIA's work, with the two roles developing in such a way that they drive and support improvements in performance across the HPSS. In this way, better outcomes for service users, carers and families will result.

3.18 The Regional Strategy: *A Healthier Future* also proposes performance management changes - notably with a move to 3-year implementation plans (to be updated and reported on annually). National and Northern Ireland budgetary arrangements are also pointing in this direction.

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

HPSS performance management will continue to evolve in light of this and other developments.

3.19 From 2006, the present performance monitoring arrangements will be extended by the introduction of a set of key, regional indicators of HPSS performance. Linked to the achievement of the Department's PSA commitments, these regional indicators will provide the basis for the publication of performance data across a wide spectrum of HPSS activity. During 2006, the Department will also work with HPSS organisations to develop a portfolio of local performance indicators relating to activities undertaken in support of regional outcomes. It is the Department's intention that, from 2007, these local performance indicators will provide the basis for published information on the performance of individual providers.

3.20 The Department will be continuously seeking to improve and strengthen its performance management arrangements for the HPSS and the accountability mechanisms that accompany these. The aim is to ensure that, together with monitoring of standards and other governance issues, organisations are better placed to provide assurance to their boards that an integrated approach is being taken on planning, governance and service delivery and review.

Summary

A strong partnership is required between the Department and the HPSS in order to deliver on the Public Service Agreement set out in *Priorities and Budget*

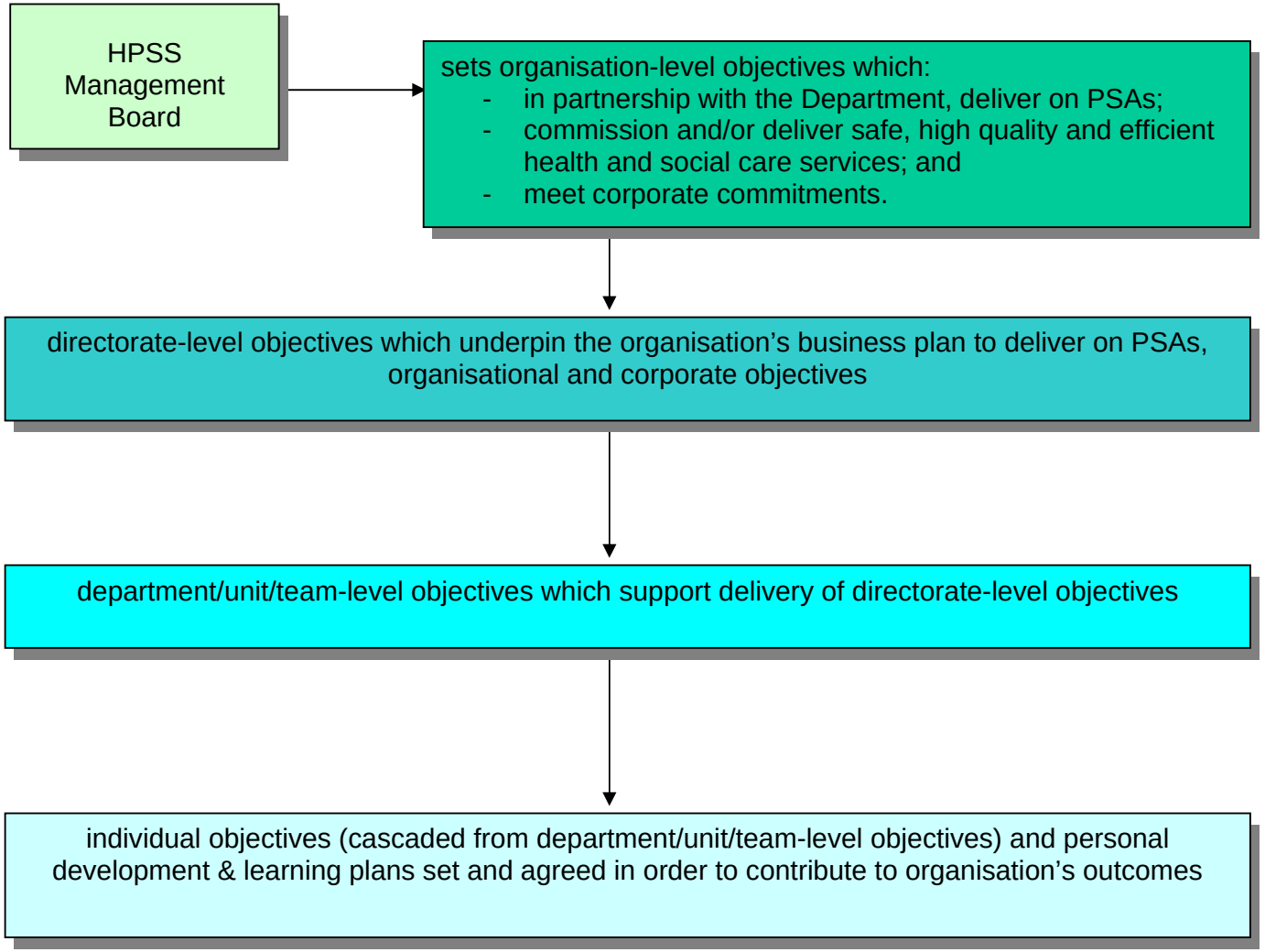
The Minister's *Priorities for Action* reflects the focus of *Priorities and Budget* and translates these into an action plan for HPSS organisations

Organisational objectives should cascade to individual level, thus linking the personal contribution to the strategic agenda

HPSS organisations are directly accountable to the Minister and Department for their governance arrangements

Boards and Trusts – Trusts' prime accountability for the quantity, quality and efficiency of services is owed to the commissioning HSS Board(s)

Figure 1 – Linking Organisation Objectives to Individual Objectives



SECTION 4 – KEY ELEMENTS OF SAFETY AND QUALITY

4.1 To provide modern, accessible services and effect improvements in quality and safety of those services, a number of crucial elements[1] are identified:

- new arrangements for the regulation, inspection and review of services and improvements in the regulation of the workforce;
- the setting of standards against which services and service providers can be measured;
- improvements in HPSS governance arrangements;
- links with national standard-setting and patient safety bodies; and
- improved accountability arrangements.

Progress has been made on a range of initiatives to implement these elements and further initiatives are in development.

HPSS Regulation and Quality Improvement Authority (RQIA)

4.2 The RQIA is responsible for monitoring and inspecting the availability and quality of health and social services in Northern Ireland and for encouraging improvements in the delivery of care. Its detailed remit is set out in Appendix 1. The RQIA will, among other things, monitor compliance with a range of standards developed by the Department. These standards are described in more detail in the following paragraphs. Their link to each other and their place in the assurance framework is depicted in Figure 2.

Workforce regulation and development

4.3 Staff and HPSS organisations must be able to justify the trust that the public places in them. For this to happen, HPSS organisations need to be able to demonstrate that safe and effective standards of practice and care are being developed and maintained. Regulation of the workforce has a major part to play in the promotion and assurance of quality and safety. The majority of health professionals are regulated including doctors, dentists, nurses, midwives, pharmacists and allied health professionals. Regulation of the social care workforce has more recently been introduced through the establishment of the Northern Ireland Social Care Council (NISCC) as part of the Northern Ireland Assembly's commitment to raising standards of social care practice and ensuring proper protection for the public. The detailed remit of NISCC is set out in Appendix 1.

4.4 Service users, carers and the public expect staff to be knowledgeable and skilled. All regulatory bodies require registrants to keep their knowledge and skills up-to-date through continuous professional development. HPSS organisations have a responsibility to ensure that

[1] *Best Practice – Best Care* (April 2001)

all of their staff are trained and have the necessary skills and competence to deliver safe and effective care and services.

Clinical and Social Care Governance

4.5 All HSS Boards and Trusts must fulfil their clinical and social care governance responsibilities, which are underpinned by the statutory duty of quality introduced in the HPSS (Quality, Improvement and Regulation) (NI) Order 2003[1]. Clinical and social care governance requires boards to be assured that the organisation has in place systems and processes to support individual, team and corporate accountability for the delivery of person-centred, safe, high quality care, within an open reporting and learning culture. HPSS organisations must take full account of clinical and social care governance when framing their SICs. There is a requirement to devote a specific section of the Annual Report to activities related to clinical and social care governance - not only what has been done but what is planned for the future. Organisations are also required to operate systems that enable routine reports on clinical and social care governance issues to be considered by their board[2].

4.6 To support the HPSS in implementing the statutory duty of quality, a Clinical and Social Care Governance (CSCG) Support Team has been established[3]. This multi-disciplinary team is assisting the development and implementation of governance in the HPSS, and is working to sustain longer-term cultural change and organisational development. The purpose of the Support Team's work is to provide leadership, guidance and support; build and develop capacity within the HPSS; and share the learning from this work.

4.7 In addition, as a significant step towards providing a transparent and coherent approach to quality improvement, new high-level Quality Standards for Health & Social Care[4] are to be introduced to support good governance and best practice in the HPSS. These Quality Standards have five themes:

- corporate leadership and accountability of organisations;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social wellbeing; and
- effective communication and information,

and will integrate key elements of the quality and safety agenda, providing a platform for RQIA to inspect and report on the quality of care and services commissioned or provided by HPSS organisations.

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[1] S.I. 2003/431 (NI 9) http://www.opsi.gov.uk/si/si2003/20030431.htm
[2] HSS (PPM) 10/2002
http://www.dhsspsni.gov.uk/hss/governance/documents/circular_hss_(ppm)_10_2002.doc
[3] http://www.dhsspsni.gov.uk/hss/governance/supportteam.asp
[4] Best Practice Best Care – The Quality Standards for Health and Social Care – Supporting Implementation of Clinical and Social Care Governance in the HPSS (Consultation Document, April 2005)

In short, the Quality Standards articulate what people should expect from HPSS organisations. The new standards will be augmented by formal links with national and professional standard-setting bodies, such as the National Institute of Health and Clinical Excellence[1], the Social Care Institute of Excellence[2] and the National Patient Safety Agency[3] (incorporating the National Clinical Assessment Service). Further steps include the development of a Safety Framework and HPSS action plan[4].

Care standards

4.8 Statutory, private and voluntary providers of services regulated under the HPSS (Quality, Improvement and Regulation) (NI) Order 2003 are required to meet minimum care standards published by the Department.

4.9 The RQIA has the function of registering, inspecting and encouraging improvement in services delivered by these providers. The regulated services include:

- residential care homes[5];
- nursing homes[6];
- nursing agencies[7];
- independent health care providers[8]; and
- children's homes[9].

4.10 The care standards focus on ensuring that people using the regulated services are protected, and that their treatment or care is quality-assured. They specify the arrangements, facilities and procedures that are needed to ensure the delivery of a quality service. The standards cover such key service aspects as requirements for registration, recruitment, management and training of staff, qualifications, record keeping, complaints handling and the provision of a safe environment.

4.11 Through the standards, service users and carers are able to see what they can reasonably expect from services. Service providers are able to benchmark their services against the standards and will be able, through self-assessment, to see where improvement is required. Staff, in turn, will understand what they can expect from a quality employer.

4.12 The RQIA will report on the quality of care delivered by service providers (such as residential care homes and domiciliary care provision). In addition it will inspect the way in which HSS Boards and Trusts deliver fostering and adoption services and regulate the delivery

[1] http://www.nice.org.uk/page.aspx?o=home
[2] http://www.scie.org.uk/
[3] http://www.npsa.nhs.uk/
[4] Safety First: A framework for sustainable improvement in the HPSS (Draft, October 2005)
[5] The Residential Care Homes Regulations (NI) 2005 (SR 2005 No.161)
[6] The Nursing Homes Regulations (NI) 2005 (SR 2005 No.160)
[7] The Nursing Agencies Regulations (NI) 2005 (SR 2005 No.175)
[8] The Independent Health Care Regulations (NI) 2005 (SR 2005 No.174)
[9] The Children's Homes Regulations (NI) 2005 (SR 2005 No.176)

of services to children under twelve years of age. The RQIA will look for evidence that the standards are being met through:

- discussion with service users, carers, staff, managers and others;
- observation of activities in the establishment or agency; and
- inspection of written policies, procedures and records.

4.13 A range of further standards is planned, including:

- domiciliary care;
- fostering and adoption services;
- residential family centres; and
- day care.

Controls Assurance Standards

4.14 The requirement for organisations to achieve substantive compliance with the three **core** controls assurance standards of governance, risk management and financial management remains unchanged and is integral to the assurance framework. Compliance with the core standards should be subject to **annual** review by HPSS internal audit and organisations, in making their self-assessments, should ensure that all of their principal activities are adequately considered under each criterion. The position on annual audit will be kept under review by the Department as the core standards become embedded in organisations. The detailed remit of Internal and External Audit is set out in Appendix 1.

4.15 The core standards' criteria should form part of the assessment of whether controls are likely to be effective in the environment within which those controls operate. In addition, the required levels of compliance should be achieved against the remaining organisational controls assurance and other relevant standards, as part of the overall management of risk and as the basis for the provision of quality health and social care services.

4.16 The post of Regional Governance & Risk Management Adviser[1] was established to support the HPSS in implementing and strengthening governance arrangements. The Adviser acts as a conduit of communication between the Department and HPSS in the development of policy and guidance on governance, risk management and controls assurance standards. Initially focused on providing support on the embedding of the fundamental structures and processes of risk management, the Adviser promotes a joined-up approach to governance arrangements, to partnership working and sharing learning experiences. The post is also becoming increasingly involved in service user safety issues. This work is complementary to the CSCG Support Team, with both support services working to promote quality and safety outcomes in health and social care.

[1] http://www.dhsspsni.gov.uk/hss/governance/index.asp

Financial Management

4.15 Detailed financial monitoring takes place to ensure that the HPSS remains financially stable and that, where necessary, robust contingency and recovery plans are followed to secure financial balance. Apart from the accountability and probity problems associated with not living within allocated means, concern for service users also points towards the need for strong budgetary control. Failure in financial duties – such as an overspend - could have repercussions for other public services and would reduce the HPSS's claims to an appropriate share of resources. This could damage the longer-term interests of service users, carers, families and others who depend on the HPSS. Through prudent use of resources, the HPSS is able to demonstrate delivery of real improvements to service users, not only in productivity (through efficiency and higher levels of activity), but also in terms of quality and modes of delivery.

4.16 Board members must be satisfied that financial information is accurate and that financial controls and systems of risk management are robust and defensible. When considering what it would be justifiable to tolerate by way of risks, boards need to compare the cost (financial or otherwise) of minimising the risk and the cost to be endured should the risk materialise; as in other aspects of risk management, an acceptable balance must be struck. Likewise when considering opportunities, and how much risk can be taken in order to capture their benefits, it is a matter of weighing the value (financial or otherwise) of potential benefits against the losses which the organisation might suffer.

Summary

Clinical and social care responsibilities are underpinned by a statutory duty of quality and these responsibilities must be taken into account when signing an individual SIC

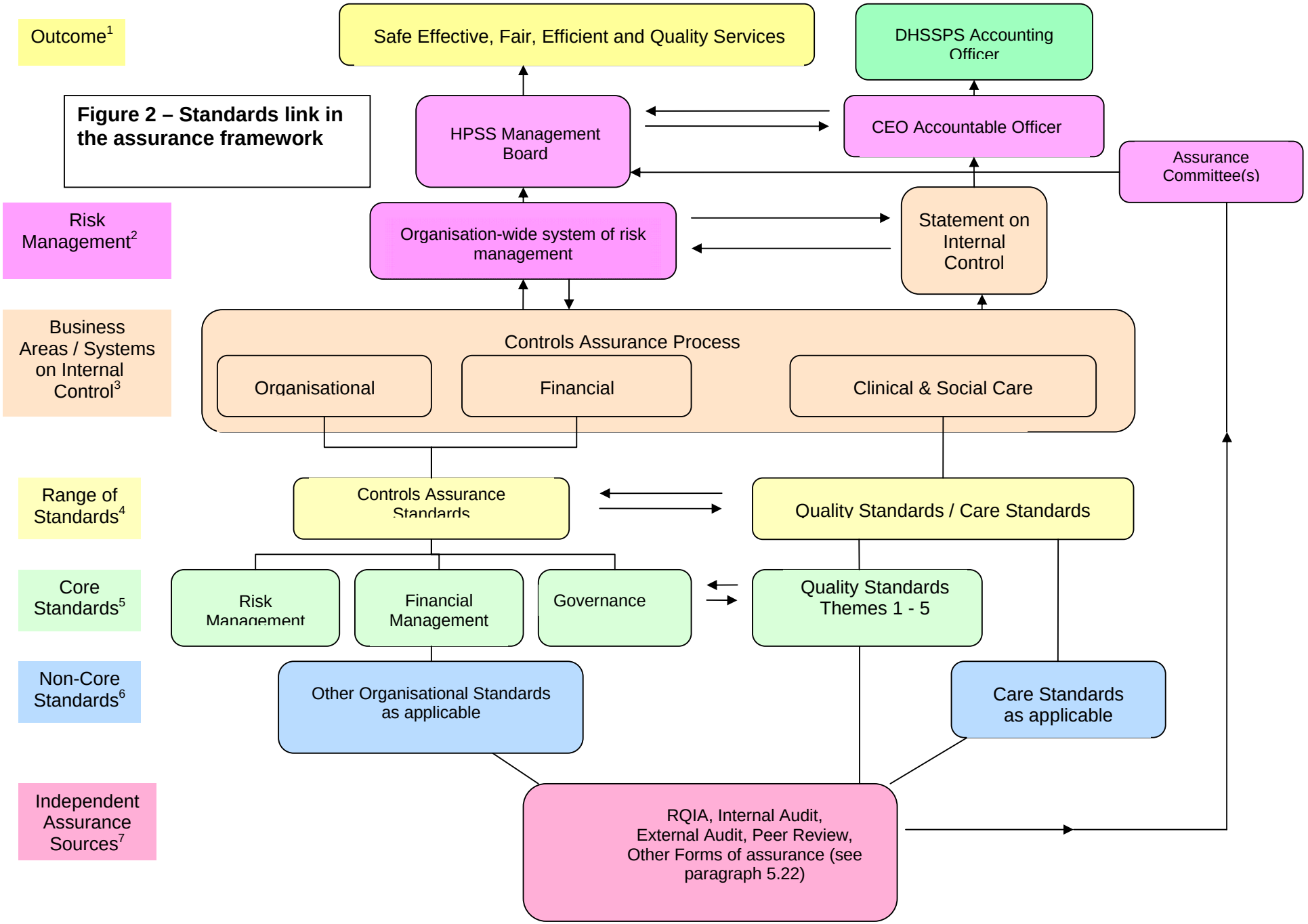
Sound governance arrangements are essential if boards are to reach an informed opinion on robustness of controls in place for clinical and social care

A number of new initiatives are being introduced to support improvement in clinical and social care, such as quality standards, care standards, a safety framework and links with national and professional standard-setting bodies

The continuing operation of controls assurance standards, in particular substantive compliance with the three core standards of governance, risk management and financial management, is integral to the effective operation of the assurance framework

Support is available from the C&SCG Support Team and Regional Governance & Risk Management Adviser to promote development and improvement in governance arrangements

Figure 2 – Standards link in the assurance framework



Notes on Figure 2

1. Outcome - the key product that HPSS organisations work towards commissioning and delivering.

2. Risk Management – the fundamental structures and processes which need to be in place to identify, analyse, evaluate, treat, monitor, review and report risks. This entails putting the necessary controls in place to gain assurance that risks are being managed effectively.

3. Business Areas/Systems of Internal Control – a recognition that the three main business areas of a HPSS organisation – clinical and social care buttressed by organisational and financial activity - need to be underpinned by a robust system of internal control. Such a system enables the Chief Executive as Accountable Officer, after discussion with the board, to sign an annual Statement on Internal Control. It is necessary to ensure that controls are effective and that the operation of the system includes reporting through the organisation's risk management/governance arrangements.

3. Range of Standards – a suite of standards which allow HPSS organisations to demonstrate that they are doing their reasonable best to manage risk and to that they are complying with the necessary quality and safety requirements of good governance.

4. Core Standards – applicable to **all** HPSS organisations.

5. Non-core Standards – applicable to **some** HPSS organisations, depending on the nature of their business.

   There are two elements to core and non-core standards:

   (i) the operational activity undertaken to achieve outcome or product ("the what"); and

   (ii) the scrutiny, reporting and validation mechanism to demonstrate compliance ("the how").

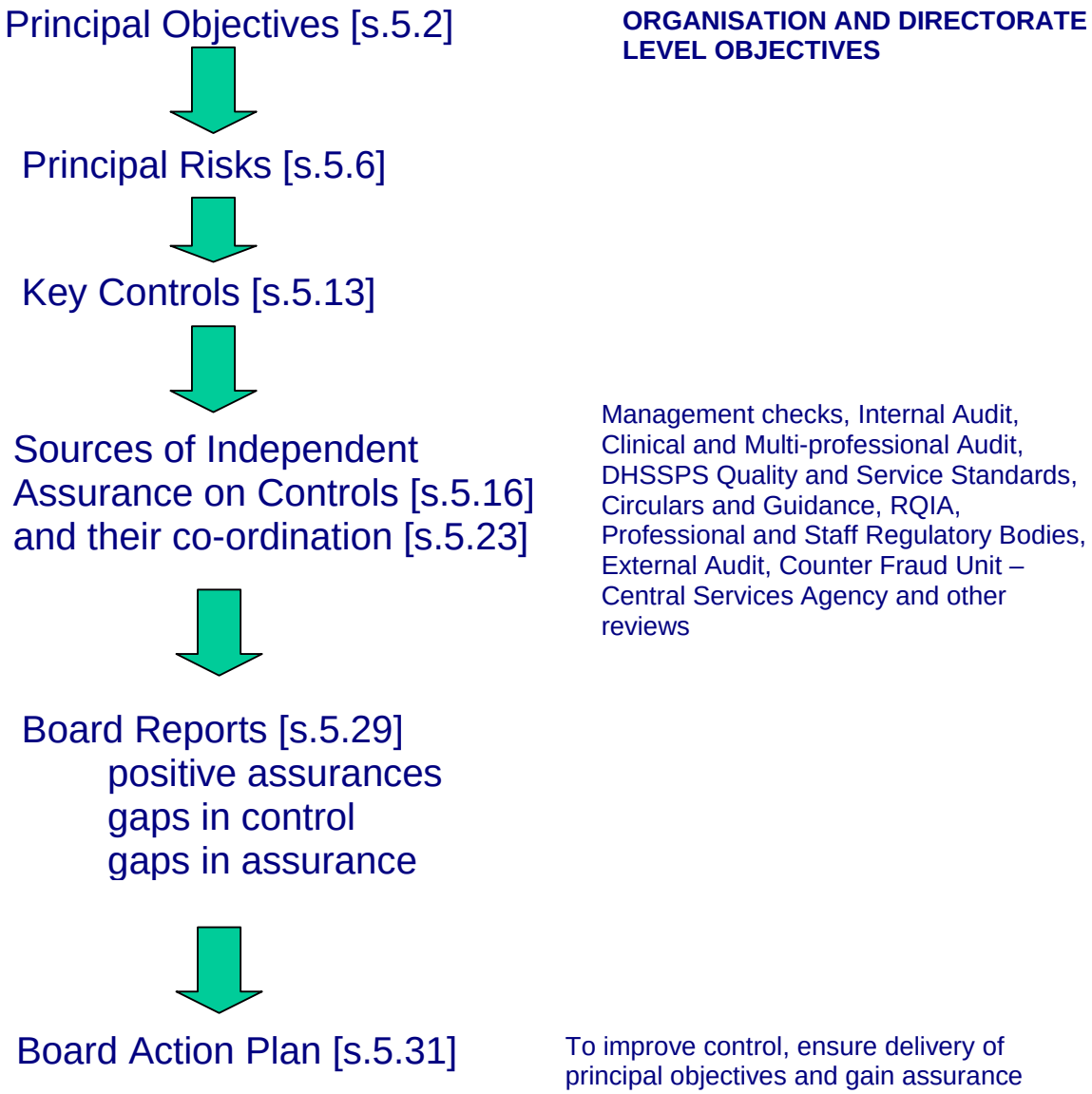
6. Independent Assurance Sources – the various forms of information and assurance sources available to strengthen the validation element of the standards. These assurances are appraised by the relevant committees and by those involved in the business planning process. They then form the basis of the report to the board on how the organisation is performing and managing the principal risks impacting on the achievement of its corporate objectives and ultimately its key outcome.

SECTION 5 – AN ASSURANCE FRAMEWORK IN PRACTICE

Building an assurance framework

5.1 An assurance framework provides the organisation with a simple but comprehensive method for effectively managing the principal risks to meeting its objectives. It also provides a structure for acquiring and examining the evidence to support the SIC. By contributing to more pertinent board reporting and the prioritisation of action plans, the framework will, in turn, allow for more effective performance management.

Figure 3 – the Key Stages



Principal objectives

5.2 The **first step** in preparing an assurance framework is for the board to identify its organisation's objectives whether in clinical and social care, financial management or other areas of governance, such as corporate governance, information governance, research governance, etc. The board needs to focus on those that are crucial to the achievement of its overall goals - the ***principal objectives***.

5.3 It is important that the board should take its principal objectives as the starting point in the assurance process. While it may often be easier to identify risks at directorate rather than the corporate level, for a full appreciation of the risk environment it is essential to take an overall, service-oriented view. The board must, in fact ensure that the linking of risk to objectives is inherent in the way the organisation goes about planning and managing its business. The process is intended to be of real operational value and relevance; reducing it to a paper or 'tick box' exercise, only adds to organisational risk and jeopardises performance.

5.4 At the highest level, HPSS objectives will include those linked to *Investing for Health*, the new Regional Strategy – *A Healthier Future*, Public Service Agreements, *Priorities for Action*, financial responsibilities, compliance with governance and risk management standards, health and wellbeing improvement and developing effective working partnerships**.** Appendix 2 provides some examples of principal organisation and directorate level objectives. They are meant to be illustrative, and boards will need to consider them in the light of their own context and priorities.

5.5 Directorate objectives are in turn supported by those of constituent departments/units/teams and of individuals. Organisations will wish to record the linkages of these "lower level" objectives to their organisational objectives over time. This will provide assurances that the whole organisation is working cohesively and effectively to improve the quality of care and services.

Principal risks

5.6 The **second step** involves the identification of ***principal risks*** which are defined as those that threaten the achievement of the organisation's principal objectives. It is essential that boards understand that they need to actively manage potential principal risks, rather than reacting to the consequences of risk exposure.

5.7 Ideally, principal risks should be routinely identified from the risk management arrangements that boards have in place. Many HPSS organisations have made good progress in identifying risks and keeping comprehensive records that support full prioritisation and management of risks across all their main activities.

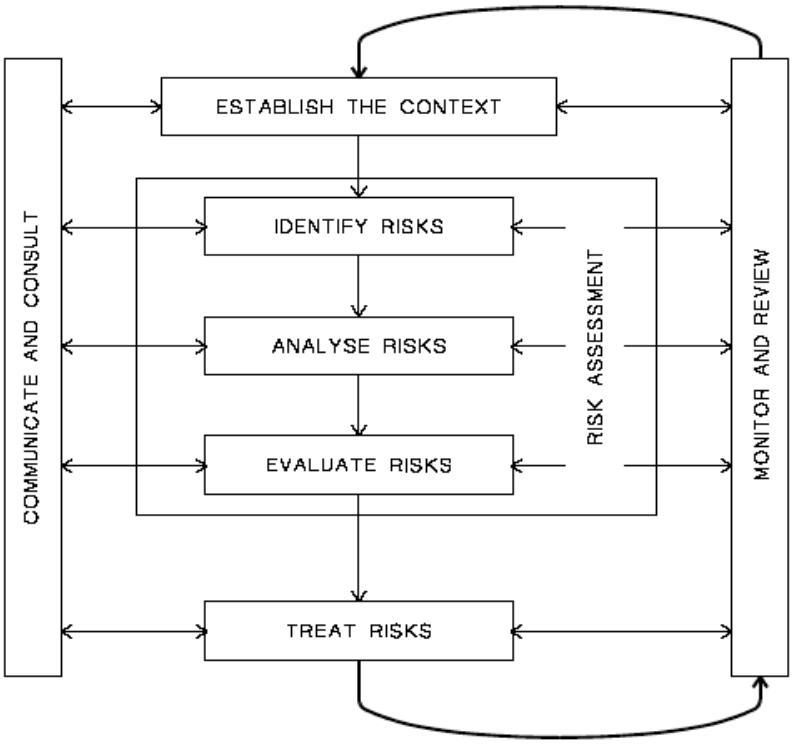
5.8 By focusing on risks to organisation and directorate objectives, it should be possible to identify and manage the critical range of principal risks.

The relevant assurance committee will then consider, prioritise and facilitate regular reporting on the current top risk issues to the board.

5.9 Boards may find it helpful, in mapping arrangements for the management of risk to objectives, to match their principal risks to their organisation structure. Examples of such a classification are shown at Appendix 3.

5.10 It would be wrong to consider principal risks in isolation from each other. They will have been aggregated from separate sources across the organisation, and it is only when they reach the top organisational tier that the opportunity arises to conduct a comparative analysis. A good starting point for the analysis is a structured risk identification, assessment and evaluation exercise involving board members and senior managers, with subsequent wider exercises involving front line staff. The first aim is to define and generate a more detailed understanding of the organisation's objectives as well as a consensus about the principal risks. This can then be viewed alongside subsequent analysis of existing and potential control and assurance sources. A sound assessment of the principal risks that the organisation actually faces can only be made once the risk management framework described below is fully in place. HPSS organisations have adopted the principles set out in AS/NZS 4360:2004 Model (*see* Figure 4), which underpins such a framework.

Figure 4 – The AS/NZS 4360:2004 Model[1] – Risk Management Process – An Overview



[1] Based on material originally developed by SAI Global

5.11 The key elements of a risk management system are:

- **board and senior management commitment to risk management.** A clear sense that risk management is integral to achieving objectives and being accountable - not something that is done “on top of everything else we have to do”;

- **an understanding that risk taking can bring both rewards and penalties, and that certain risks simply <u>have</u> to be accepted.** Numerous individual health and social care cases attest to that; more broadly, modernisation of the HPSS cannot be achieved without risks being taken. The point is to understand more fully the potential consequences of taking those risks, both positive and negative. With such understanding, risks can be taken with legitimate confidence;

- **a common framework for the analysis of all risks.** For principal risks to be brought meaningfully together for a board, there needs to be a common framework of analysis, whether those risks are strategic or operational, health and social care, financial or organisational. This calls not only for a common definition of risk and risk identification but also a common means of calibrating likelihood and consequence;

- **a single point of co-ordination for the process.** Once the board has set the framework and the strategy, there needs to be an appropriate infrastructure of committee and individual responsibility to carry through the agenda. A committee with responsibility for risk management or governance, constituted as a committee of the board, can be used to co-ordinate and filter the risk assessments that are being conducted operationally throughout the organisation. The audit committee will review the overall operation of these arrangements, informed by the internal auditors, but will not have an executive role.

5.12 Once an understanding of the organisation's objectives has been gained and a consensus on principal risks reached, risks can be assessed in terms of their likelihood and consequence (or impact). Risk assessment is the process of prioritising the "potential risks" to identify those "applicable risks" that will need to be actively managed. Typically, the assessment is assisted by utilisation of the model illustrated in Figure 5. Organisations can adapt the model to suit their individual requirements.

Figure 5: Likelihood and Consequence/Impact Assessment
(based on the AS/NZS Risk Management Model)

LIKELIHOOD	CONSEQUENCE/IMPACT				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	Low	Significant	High	High	High
Likely	Low	Significant	Significant	High	High
Possible	Low	Low	Significant	High	High
Unlikely	Very Low	Low	Significant	Significant	Significant
Rare	Very Low	Very Low	Low	Low	Significant

Further guidance on analysis of risk and using a risk-rating matrix is available on the Department's governance website at:
http://www.dhsspsni.gov.uk/hss/governance/risk_register.asp

Key controls

5.13 The **third stage** is for HPSS organisations to ensure that they have ***key controls*** in place to manage their principal risks.

5.14 Controls should be documented and their design subject to scrutiny by independent reviewers, including internal auditors, in conjunction, where necessary, with health and social care professionals and specialists, the RQIA and external audit. The key controls should be mapped to the principal risks. When assessing the adequacy of controls, consideration must be given not only to the design but also the likelihood of their being effective, given the governance and risk management framework within which they will actually operate; even

the best designed controls can fail if staff are not properly trained and regularly updated in their training.

5.15 The relationship between a risk and a control is not necessarily straightforward. One specific risk may be mitigated by a number of controls. Some of those controls may only be effective when operating in conjunction with other controls, and one control may relate to more than one risk.

Sources of possible independent assurance

5.16 The **fourth stage** in building an assurance framework is for the board to determine what level of ***independent assurance*** reporting is appropriate, given the risks and controls that have been identified. An adequately resourced internal audit function, operating to agreed standards, should be best placed in terms of objectivity and professional background to support the board on this point. But there are many other individuals, functions and processes that may also produce independent assurance. All these separate activities have been designed for different purposes at different times. They are operating within the HPSS for their own valid reasons, not all of which are necessarily connected to the risks that a particular HPSS organisation is facing. So, before attempting to co-opt these external functions for assurance purposes, it is important to understand what is being done, why it is being done, how that assurance work is performed and the limitations that might apply – in effect, establishing whether there is the necessary overlap between the work of a potential assurer and the organisation's own assurance needs.

5.17 Appendix 1 provides analysis of the roles and remit of a number of the key assurance functions. The possible sources of assurance listed in this section are not exhaustive but, nevertheless, do demonstrate the extent of the inspection and assurance regime. It is recommended that each HPSS organisation carry out a similar analysis of what is available to it.

5.18 One of the conclusions that can be drawn is that the bulk of objective and independent assurance reporting is externally driven and is not necessarily or primarily conducted to provide assurance to the organisation under review. Such reports are often produced as the result of one-off assessment exercises; the extent of the testing, which is often very specific and tightly defined, is limited to the conclusions that need to be reached by that external body; that testing is often quite restricted; and there is little opportunity for the HPSS organisation to influence the methodology used.

5.19 The board, the audit committee and other relevant assurance (sub-) committee(s) need to understand that different types of auditors and assessors, even when they are examining the same systems, are not producing the same types of opinion. Clarification needs to be gained on how evidence is collected and evaluated if it is through enquiry, observation, desk review, compliance testing, substantive testing or statistical sampling. The auditors and assessors should be asked, if

possible, to explain in clear terms how these tests are deployed, the sample sizes used and the value that can be derived from the resulting opinion. Appendix 4 provides additional detail to inform this process.

5.20 Internal audit does offer a source of independent ongoing assurance that is within the remit of the HPSS organisation itself to resource and, to some degree, direct. This places a particular responsibility on the board and the audit committee to be certain that the audit team has sufficient capacity and competence to conduct the required work. Although the main focus will be on outputs of the audit, information is needed on the depth and range of audit testing that is conducted to arrive at conclusions. Each organisation needs to be sure that its internal auditors are not only competent but are undertaking sufficient work to support reliable and worthwhile opinions.

5.21 Gaining clarity on the above point is essential, given the crucial part played by internal audit in providing an annual opinion to the board on the effectiveness of the whole system of internal control. In arriving at its opinion, internal audit will need to work closely with other reviewers and perform a co-ordinating role on assurance issues. The sample template of an assurance framework at Appendices 2 and 3 shows the type of documentation needed to fully sustain this process. It links objectives, risk areas, prioritised risks, management assurances and controls, and independent assurance reports. Additional columns can be added to capture committee reporting, action-by dates and responsible officers. Sub-sets of this document can be generated at directorate and department level, and assurances on the completion of this activity could be passed up the organisation. Internal audit plans will need to be aligned with the assurance framework to demonstrate that boards are discharging their responsibilities and that internal audit activity concentrates on the significant risks. Similarly, audit committees will need to review their own capacity to respond to these relatively new assurance challenges.

5.22 Possible sources of independent assurance available to HPSS organisations include*****:

- Chartermark
- Department of Environment – Water Service
- Environment and Heritage Service
- Environmental Health Inspection
- European Foundation for Quality Management (EFQM Model)
- External Audit – professional audit by contract with commercial company
- Fire Authority for Northern Ireland
- General Medical Council, General Dental Council, etc.
- Health and Personal Social Services Regulation and Quality Improvement Authority
- Health and Safety Executive for Northern Ireland
- Internal Audit – professional audit by dedicated HPSS organisation
- ISO Standards
- Investors in People
- Medicines, Inspection & Investigation (DHSSPS)
- Mental Health Commission for Northern Ireland
- National Patient Safety Agency (incorporating the National Clinical Assessment Service)
- Northern Ireland Social Care Council
- Northern Ireland Audit Office
- Nursing & Midwifery Council
- Pharmaceutical Society of Northern Ireland
- Professional accreditation schemes
- Professional advice or inspection from appropriately qualified individuals
- Royal Colleges
- Social Services Inspectorate
- Training Accreditation
- Other regulatory bodies.

***** This list contains a range of examples and is not exhaustive

Some of these sources can by directly commissioned by boards to provide an external or independent assurance of governance processes. Others cannot be commissioned by boards to provide such assurance, however, where such reviews and reports exist from these organisations or bodies, boards may use them for this purpose.

Assurances and co-ordination

5.23 In implementing a system to gain ***assurances*** about the effectiveness of the controls they have in place to manage their principal risks, boards will wish to have a system that provides good ***co-ordination*** and assessment of the work of the auditors, inspectors and reviewers and which will bring increased benefits to both the organisation and the review bodies. Such a system will help minimise the burden on the

organisation by reducing overlap and allow potential gaps in assurance to be identified and closed.

5.24 To ensure effective management and provide evidence to support the SIC, there will be a need to review the totality of assurance activity relating to the organisation's principal risks. Boards not only need to ensure they have the right level of assurance; they need to make use, wherever possible, of the work of the many external reviewers and ensure that the whole process is efficient, provides value for money, is proportionate and minimises duplication of work by different reviewers. In essence, this requires boards to map their assurance needs and identify the potential sources for providing them.

5.25 The process for gaining assurance about the effectiveness of the key controls is fundamentally about gathering all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are those derived from independent reviewers - which will include the RQIA, Departmental special inquiries or reviews, internal audit and external audit. These are supplemented from non-independent sources such as multi-professional audit, internal management representations, performance management, self-assessment reports, etc.

5.26 In considering such regular reports, boards will need to consider the adequacy of the assurances on the management of their principal risks and be proactive in addressing issues that arise. Where the assurer's report is confirmed as relevant, the organisation must endeavour to confirm that sufficient work has been undertaken in the review to be able to place reliance on the conclusions drawn.

5.27 In summary, the organisation will need to assess whether a review of this kind:

- **provides full assurance:** there are sufficient, relevant, positive assurances to confirm the effectiveness of key controls and **the objectives are met**; or

- **reveals gaps in control:** there is a clear conclusion, based on sufficient and relevant work, that one or more of the key controls on which the organisation is relying are not effective; or

- **reveals gaps in assurance:** there is a lack of assurance, either positive or negative, about the effectiveness of one or more of the key controls. This may be as a result of lack of relevant reviews, or concerns about the scope or depth of reviews that have taken place.

5.28 In the last case, the board may wish to consider how other assurances may be used, for example through future RQIA reports on an organisation's compliance with the *Quality Standards* and the results of organisational self-assessments to support the SIC. These should be seen as complementary to, rather than in place of, assurances from internal audit or other independent assurers.

Board Reporting

5.29 This **fifth stage** of an assurance framework provides an explicit framework for ***reporting*** key information to boards. It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organisation has insufficient assurance about them. At the same time, it provides structured assurances about where risks are being effectively managed and objectives are being delivered. This allows boards to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

5.30 By focusing on the principal risks, the board's assurance committee(s) can give priority to reporting the current top risk issues to the board. This will ensure that risk management becomes firmly embedded as a board responsibility.

5.31 The assurance committee(s) will also need to prepare a summary report to the board about the effectiveness of the organisation's system of internal control, covering all of the principal risks and providing details of:

- positive assurances on principal risks where controls are effective and objectives are being met;
- where the organisation's achievement of its principal objectives is at risk through significant gaps in control;
- where there are gaps in assurances about the organisation's ability to achieve its principal objectives;

LEADING TO

- the **sixth stage** of producing a ***Board action plan*** to improve its key controls to manage its principal risks and gain assurances where required.

5.32 In addition to improving the effectiveness of management, this will provide the evidence to support the annual SIC.

Summary

1st step – identifying **principal objectives** to achieve outcomes across all relevant business areas – clinical & social care, financial and organisational

2nd step – identifying **principal risks** which threaten achievement of the principal objectives and managing these risks effectively through the organisation's risk management arrangements

3rd step – documenting the **key controls** in place to manage risk

4th step – determining the **independent assurance** required for the organisation to be governed effectively. Consider types of assurance available, co-ordinate these effectively and identify areas where further assurance is required – tailoring assurance to the organisation's needs

5th step – **reporting** key information to the board, including positive information on controls and assurance, identification of inadequate controls or where insufficient assurance exists

6th step – **action plan** to be agreed by the board to address gaps in controls and assurance with proposals to take corrective, restorative or remedial steps, as required

SECTION 6 – ASSESSMENT AND REVIEW

Assessing the assurance framework

6.1 It is important for the quality and robustness of the assurance framework itself to be evaluated by the board, which should also have arrangements in place to keep itself updated in the light of evidence from reviews and achievements.

6.2 For example, if the organisation's actual or apparent performance in a particular area seems at odds with the assessment from the assurance framework reports, the reasons for the discrepancy need to be investigated. Leaving aside the possibility of, for example, inaccurate reporting, it may be that:

- the objectives themselves need to be revised;
- the risks reassessed and evaluated; or
- the assurance on the effectiveness of the controls reviewed.

6.3 The board's action plan should be updated to reflect the remedial or corrective steps to be taken.

SECTION 7 – LINKS BETWEEN AN ASSURANCE FRAMEWORK AND RELATED INTERNAL BUSINESS PROCESSES

Performance reporting

7.1 Performance reporting should, among other things, be regarded as a form of assurance. It can function as an early warning that the delivery of objectives may be at risk and is therefore an important component of the overall system of internal control. It is good practice to integrate the management of risk and organisational performance as part of a coherent approach to corporate governance[1]. Performance reports typically cover activity-related performance as well as progress on other work programmes. They provide strong evidence of the effectiveness of control action and will also suggest necessary improvements where controls are lacking. Consequently, performance reports generate valuable information for an assurance framework and there is a need for performance reporting and assurance framework to be strongly linked.

7.2 Performance reports generally record an HPSS organisation's performance against operational targets, such as those in business plans, HWIPs and TDPs. They will also provide a commentary on other matters such as the implementation of projects or programmes. As part of the annual business planning cycle, the board will specify the content of performance reports so that every objective is considered at the appropriate time throughout the year. There will follow regular reports to the board on progress and on difficulties being encountered. Boards may therefore place considerable reliance on performance reports as a method by which to manage principal risks that relate to key objectives.

7.3 As an assurance framework focuses on key objectives and risks, it should be strongly aligned to strategic and annual business plans. In practice, the framework will incorporate key business objectives set out in these plans and the business planning process will include a risk identification element to allow the assurance framework to record risks and controls.

7.4 There are limitations to the usefulness of performance reports and an assurance framework if these are left to operate separately. Performance reports will highlight emerging problems and describe the action proposed to remedy the situation. Risks which have not yet materialised may not be identified in this process, thus impairing the ability of the performance report to give comprehensive assurance that controls are sufficient to mitigate all risks relating to an objective. On the other hand, assurance frameworks may not take into account performance data, which is an essential element when assessing the effectiveness of control. In order to be more effective, an assurance framework should take account of performance reporting:

- firstly, performance reporting should be classed as a necessary internal control, with the measurement of outcomes serving as a

[1] The Turnbull Report

trigger for necessary internal control improvements. Consequently, many objectives will require performance reporting as a key control requirement;

- secondly, performance reports will detail known performance problems and the planned corrective action. These, in turn, should be reflected in the assurance framework within the descriptions of *control gaps* and *planned action*; and

- thirdly, the assurance framework maintenance process should treat the results of performance reporting as a valuable form of internal assurance, and use them to regularly review the effectiveness of internal control.

7.5 Such an approach will require the officers responsible for the assurance framework and for performance management to work closely together. Action processes stemming from the assurance framework should be reported regularly to the board alongside, or as part of, performance reports.

Risk registers

7.6 Risk registers are a record of all forms of residual risks ie. those risks which remain after treatment; action may have reduced the probability of their occurring, but it is unlikely to have eradicated all possibility of the risk occurring. So as to be accurate and complete, the risk register should be constantly updated to reflect new risks and changes to existing risks. Thus it will be driven from a broad range of information sources. For example, the risk register will be linked to risk assessment and inspection programmes and regimes, incident reporting systems and complaints and legal case handling procedures.

7.7 The assurance framework acts as high-level risk identification in regard to corporate objectives, information such as gaps in control, gaps in assurance process and details necessary action. In order to maximise this information, the principal residual risks identified in the framework should be incorporated into the risk register to ensure that all forms of risk are shown in one document. By assessing assurance framework-derived risks, the risk register can generate prioritised action processes and progress reports.

7.8 As the risk register gathers risk details from many other assessment sources, it is very important that the risk identification process determines the relevance and significance of such risks to corporate objectives. Without a strong link between the risk register and the assurance framework there is a danger of material risks, and their relevance to the delivery of key objectives, being overlooked.

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PART TWO:

PRACTICAL INFORMATION AND EXAMPLES ON ESTABLISHING AN ASSURANCE FRAMEWORK

APPENDICES

Appendix 1	instances some sources of independent assurance and sets out their role and remit.
Appendix 2	provides illustrative examples of the link between organisational and directorate level objectives, which together form the organisation's ***principal objectives.***
Appendix 3	illustrates how the ***principal objectives*** are linked to the ***principal risks***, the key controls, assurances and board reports which together form the ***assurance framework***. These examples are not intended to be comprehensive but to demonstrate the principles to be applied.
Appendix 4	sets out some of the methodologies used when gathering evidence for assurance on systems of internal control.

Appendix 1: The Role and Remit of Example Sources of Independent Assurance

Health and Personal Social Services Regulation and Quality Improvement Authority

Role

The Health and Personal Social Services Regulation and Quality Improvement Authority ('RQIA') is an executive Non-Departmental Public Body (NDPB) which was established in April 2005. It will have overall responsibility for monitoring and regulating a wide range of health and social care services delivered by, or on behalf of, the HPSS, and for monitoring the quality of care in the HPSS. In particular:

RQIA will have a major role to play in encouraging improvement in the quality of services commissioned and provided by HPSS and other organisations. It will promote a culture of continuous improvement and best practice through review of clinical and social care governance arrangements and inspecting, monitoring, investigating and reviewing the quality of services.

Where serious and/or persistent clinical and social care governance failings come to light, it will have a key role, in collaboration with other regulatory and inspectoral bodies, as appropriate, in investigation of such concerns and will work with service providers to encourage quality improvement whilst exercising a monitoring role.

It will have a duty to report to the Department on the provision of services, their availability and on the quality of care provided by HPSS and other organisations delivering health and social care services.

Registration, inspection and enforcement of independent sector and statutory providers of regulated services will be carried out to consistent standards across Northern Ireland. However, the approach used by RQIA with regard to inspection methodology, monitoring, investigation and review will be critically assessed by the Authority in 2005/06. Any proposed changes in working practice will be notified to all stakeholders. The Authority will exercise its obligation to inform the Department of unacceptable poor quality, either in general or in particular areas, so that the Department may consider recommending special measures with a view to improving the Health and Personal Social Services. For all regulated services, including those provided by the independent sector, the Authority may issue improvement notices or ultimately withhold registration.

Approach

RQIA will:

- promote participation and partnership approaches with public providers and service users;
- formally approve and grant registration to persons, establishments or agencies providing or managing regulated services;
- work in partnership with all stakeholders to promote a culture of continuous improvement and best practice;
- play a key role in the investigation of serious and/or persistent clinical and social care governance failings; and
- have a duty to report to the Department on the provision, availability and quality of care.

Limitations

The capacity of RQIA in carrying out clinical and social care governance reviews will be phased in over two years as RQIA has a small staff group at present. It is envisaged that such reviews could only be conducted in the short term by the employment of external experienced experts, who would assist RQIA staff and strengthen their experience, knowledge and expertise.

The choice of methodology, the tools for conducting risk assessment, the balance between self-assessment and inspection frequency and the approach used by RQIA in carrying out its regulatory and improvement functions will also be important factors in securing improvements in safety and effectiveness in HPSS organisations in the future.

Scope for coordination
RQIA will use information from a number of sources and will wish to enter into concordats or memoranda of understanding with other regulatory or inspectorial bodies to ensure a sharing of information and avoidance of unnecessary overlap or duplication of function. In using the Quality Standards for its consideration of HPSS organisations' clinical and social care governance arrangements, RQIA will inevitably evaluate compliance with controls assurance standards.

The Northern Ireland Social Care Council

Role

The Northern Ireland Social Care Council (NISCC) was established as an executive NDPB on 1 October 2001 under Part 1 of the Health and Personal Social Services (Northern Ireland) Act 2001 (the 2001 Act). It is an integral part of the Department's programme to further promote and develop the quality framework for the Health and Social Services in Northern Ireland. People who use social care services are often among the most vulnerable in our community.

It is NISCC's role, through effective regulation of the social care workforce and social work training, to:

- strengthen protection for members of the public who use social care services;
- increase public confidence in those services; and
- promote confidence and competence in the social care workforce.

In particular, NISCC has the duty to promote:

- high standards of conduct and practice among social care workers in Northern Ireland; and
- high standards in their training.

Approach

NISCC is responsible for carrying out the following functions:

- maintaining a register of social workers and social care workers;
- preparing and publishing codes of practice and conduct expected of social care workers and their employers;
- approving courses in relevant social work; and
- undertaking any functions that may be delegated to it by the Department, under Section 14 of the 2001 Act.

Limitations

The Social Care Register opened on 1 April 2003 and NISCC commenced the registration of the priority groups designated by the Department (an estimated 3,500 social workers and staff working in specified settings). The initial uptake of registration was slow. However, since preparations commenced for the introduction of the Health and Personal Social Services (2001 Act) (Commencement No. 7) Order (NI) 2005 which had the effect of protecting of the title of "Social Worker" on 1 June 2005, over 5,300 applications to the register have been received.

Intelligence about the size of social care workforce is generally poor. However it is estimated that over 30,000 social care workers now need to be registered. A programme for registration of the next groups has been proposed by NISCC, which indicates that, with the appropriate level of staff resource, supported by direction, the registration programme could be complete by 2010. In time, it is intended that, once the registers of social care staff are established, fees from registration will contribute to the cost of the registration function. However, the level of registration fee for the next groups will have to be appropriate to a generally low paid workforce. Responses to consultation about the fee level for the next groups are currently being considered and subject to equality screening.

Scope for coordination

NISCC will use information from a number of sources and will wish to enter concordats or agreements with other regulatory or inspectorial bodies to ensure an appropriate sharing of information and avoiding unnecessary overlap or duplication. For example, NISCC is responsible for regulating and registering social care workers and all social care workers registered with NISCC are bound to meet standards set out in its Code of Practice for Social Care Workers. However, RQIA will assume responsibility for monitoring employers' adherence to the NISCC Codes of Practice for Employers of Social Care Workers.

External Audit

Role

The Comptroller and Auditor General for Northern Ireland (C&AG) is responsible for the external audit of all central government bodies in Northern Ireland and their executive agencies, and a wide range of other public sector bodies, including health and personal social service bodies and executive non-departmental Public Bodies. His responsibility for the audit of health and personal social service organisations was established by the Audit and Accountability (NI) Order 2003. The C&AG, through the Northern Ireland Audit Office (NIAO), undertakes financial audit and value for money audit and the results of his work are reported to the NI Assembly or to Parliament during the suspension of devolution. He is required to give an opinion on the truth and fairness of each organisation's financial statements, and on whether the organisation's expenditure and income have been applied to the purposes intended by Parliament. He has also agreed, subject to continuing review, to provide a range of assurances to the Departmental Accounting Officer, arising out of his audit work.

Approach

The C&AG conducts his audit in accordance with UK Auditing Standards issued by the Auditing Practices Board. This audit includes an examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of the financial transactions included in the financial statements. It also includes an assessment of the estimates and judgements made by Board members in the preparation of the financial statements, and the appropriateness of the accounting policies used. In planning audits, NIAO has regard for financial and operational risks within the organisation. All significant issues arising from the audit are discussed with the organisation and reported in a management letter. The C&AG also has the power to report separately to the NI Assembly / Parliament on any issues he considers to merit this course of action.

Limitations

The timing of the NIAO audit is constrained by the accounts timetable established for the HPSS, which, in turn, will be increasingly influenced by the reporting arrangements for central government and whole of government accounts. The scope and extent of the C&AG's audit is limited only by the requirements of UK auditing standards, general good practice and the interests of the NI Assembly / Parliament.

Scope for co-ordination

In terms of controls assurance, NIAO will consider the arrangements that the HPSS has established. It will consider performance in key standard areas in which the Department has established minimum levels of required compliance. It will take into account the work of independent assessors, including internal audit, accreditation bodies, RQIA etc, and will seek to judge whether the HPSS organisation's own assessment of compliance with departmental guidance is properly reflected in the Chief Executive's Statement of Internal Control attached to the annual accounts.

Internal Audit

Role

Internal audit provides an independent and objective opinion to an organisation on risk management, control and governance by measuring and evaluating the effectiveness by which organisational objectives are achieved. All HPSS organisations are required to have an internal audit service and each HPSS organisation is responsible for putting in place a service that meets the Government Internal Audit Standards. This provides for consistency of audit across government bodies including the HPSS. As part of their responsibilities, HPSS Internal Auditors play a key role in the assurance process to the board regarding the effectiveness of controls in place across all of the organisation's activities. Internal auditors also conduct consultancy work and may have counter fraud responsibilities.

Approach

The work of internal auditors is agreed annually by the board through the Audit Committee based on an assessment of risk. The HPSS is highly complex and internal auditors will not necessarily have the full range of skills to provide all of the assurances needed by the board. Therefore to fulfil their function they will review the overall arrangements the board has in place for securing adequate assurances, and provide an opinion on those arrangements to support the SIC. Internal auditors have rights of access to complete their work and have independent reporting lines. Work is conducted primarily through a systems based approach that is risk based. This will entail reviewing the way in which the board has identified objectives, risks, controls and sources of assurances on those controls and assessed the value of assurances obtained. Testing is designed to form an opinion on the adequacy and effectiveness of the system under review.

Limitations

Considerable variation in the resources that are being applied to internal audit across HPSS organisations indicates that many functions may not be ready to deliver their full assurance responsibilities. Market testing has contributed to driving down cost and the range and depth of coverage.

Scope for co-ordination

Internal auditors will provide specific assurances about the areas covered in their audit plan, as approved by the Audit Committee. In addition they plan jointly with external audit with differing degrees of success. In forming opinions internal auditors routinely take account of, and will work alongside other professionals wherever possible, to advise on systems of control and assurance arrangements. This is a distinct role, which is quite different to reviewing and commenting on the reliance of the assurances themselves, which is the responsibility of the board. Given the new assurance responsibilities this will need to develop extensively.

Appendix 2 - Illustration of examples of Principal Objectives showing the link between Organisation & Directorate level objectives.

Area	Organisation Objective	Directorate Level (or Equivalent) Objective
This may or may not sit within one directorate. It is recommended that the monitoring of delivery be co-ordinated by the Committee responsible for governance/risk management	*This will relate to an overall goal of the organisation*	*This will relate to how the organisation translates an overall goal into outcomes*
Health and Social Care (including Access)	To ensure that health and social care is developed and maintained to meet the needs of patients, clients and carers effectively, fairly and within appropriate timeframes	To develop and communicate a shared strategic direction which reflects the population it serves currently and in the future
		To implement recommendations of National and Local Inquiries/Reviews, National Confidential Enquiry on Patient Outcome on Death (NCEPOD), Confidential Enquiry on Maternity and Child Health (CEMACH), National Confidential Inquiry into Suicides and Homicides (NCISH), etc
		To review health and social services, and where necessary reform and modernise services so that they meet the needs of patients, clients and carers in an effective and timely way (*see* illustrated example No.2 in Appendix 3)
		To develop & implement a service user/carer involvement strategy which allows users of health and social services to actively influence the development of those services **(* cross-referenced with Governance and Partnership Working)**
		To form health and social care alliances and participate in health and social care networks with other providers to ensure best care for patients, clients and carers and to promote health and wellbeing, reduce inequalities, promote inclusion and provide better opportunities for children and support for families
		To ensure that health and social care services are developed, commissioned and delivered in accordance with statutory equality duties and any other statutory commitments
		To ensure that health and social care services are provided in such a way that patients' and clients' dignity and human rights are protected and preserved
		To raise awareness of elder abuse and strengthen the arrangements for the protection of vulnerable adults

Area	Organisation Objective	Directorate Level (or Equivalent) Objective
		To ensure that the organisation meets the targets contained within the Department's PSA and *Priorities for Action*, as appropriate to the services delivered by the organisation
		To ensure that prescribing costs and practice are effectively managed (*see* illustrated example No.4 in Appendix 3)
	To ensure that patients and clients can receive care at a time that suits them in accordance with assessed clinical and social care need	To improve patient access to emergency care through implementing the recommendations contained in the Regional Emergency Pressures Programme
		To increase day case activity by 10% by March 2008
		To ensure the ambulance service respond to 75% of emergency life threatening 999 calls within eight minutes by March 2007
		To reduce average length of stay by 10% by March 2008
		To reduce the maximum waiting time for all patients requiring inpatient or day case treatment to [15] months by March 2006, to 9 months by March 2007 and to 6 months by 2010
		To implement partial booking in a minimum of two outpatient specialties with the longest waiting times
		To ensure 100% of patients who request a clinical appointment through their general practice for other than emergencies, to be able to see an appropriate primary care professional within 2 working days by March 2008
		To promote the expansion of direct payments as a service delivery option
		To expand flexible and responsive respite services
		To improve the quality of life and independence of people in need so that 40% of all people who receive care managed community services and at least 88% of all people aged 75 or over are supported, as necessary, in their own homes
Governance (including service user safety, clinical & social care and quality improvement)	To establish effective governance arrangements and ensure the organisation is run appropriately and in a way that inspires public confidence (*see* illustrated example No.5 in Appendix 3) To ensure compliance with	To ensure that the organisation has in place the systems, resources and training to deliver services that are the safest possible high quality care, transparent and professionally effective, including clear clinical and social care leadership and team accountability arrangements
		To implement a risk identification, assessment, and treatment strategy & plan that assists in the delivery of the organisation's principal objectives
		To complete, implement and update a plan for maintaining and improving effective clinical and social care governance arrangements, and report on governance on an annual basis

Area	Organisation Objective	Directorate Level (or Equivalent) Objective
	the statutory duty of quality and the delivery of as safe as possible, high quality, effective patient and client care within a reporting and learning culture.	To ensure that arrangements are put in place for the purpose of monitoring care and evaluating the outcome of care (*see* illustrated example No.3 in Appendix 3)
		To achieve the required levels of compliance with controls assurance standards relevant to the organisation.
		To comply with mandatory and other guidance issued by Health Estates (eg. MDEAs, clinical waste, firecode compliance, operational estates management guidance) (*see* illustrated example No.9 in Appendix 3)
		To promote an open and learning culture where staff identify, report and learn from adverse events and near misses and to ensure that learning is shared across the HPSS
		To meet or exceed minimum care standards for regulated services
		*To develop & implement a service user involvement strategy which engages service users, carers and the wider community in the assessment of need, planning, development, delivery, evaluation and review of services
		To implement any action plan agreed in response to a RQIA review or inspection
		To ensure that the organisation responds to all external & internal audit findings as appropriate
		To ensure the implementation of- - best practice guidance from sources such as SCIE and NPSA, - departmental-endorsed NICE guidance, - RQIA reports, and - guidance issued by the Department
		To work in partnership with others to improve the patient and client experience of care and to implement agreed service objectives
		Ensure that health and social care professionals participate in National Confidential Enquiries, and relevant national and local multi-professional audits
		To develop service improvement programmes that reflect the priority needs of service users, carers and families, which define responsibilities for implementation, describe expected outcomes and indicate ways in which outcomes can be evidenced or measured
Mental Health Services	To provide a modern and responsive service to people with mental health needs, developing alternative community services to those offered in psychiatric	To develop community services, such as home treatment or crises resolution services, which provide alternatives to acute admissions
		To deliver assertive outreach to people with severe mental illness within the community in order to reduce inappropriate hospital admissions, reduce length of stay when hospitalisation is required and increase the stability in their lives and those of their carers
		To contribute to the development of integrated health and social services responsive to the particular needs of victims of the Conflict

Area	Organisation Objective	Directorate Level (or Equivalent) Objective
	hospitals for acute and long-stay patients, progressing resettlement programmes and modernising hospital services To modernise services having regard to human rights and the UN Convention on the Rights of the Child	To continue to develop Child and Adolescent Mental Health Services (CAMHS) according to agreed local priorities, particularly those services that reduce demand for inpatient services so as to provide for improved life outcomes for additional children and adolescents with mental health problems
		To provide integrated forensic mental health services
		To contribute to the development of an integrated regional and local eating disorder service
Child Protection	To ensure that the needs and rights of children are addressed / considered as appropriate and to develop a holistic approach to working with families in the area of child protection (*see* illustrated example No.8 in Appendix 3)	To ensure that Boards and Trusts have in place arrangements to implement the inter-agency nine DHSSPS Child Protection Standards, including arrangements for inter-agency multi-disciplinary working
		To ensure that Boards and Trusts have in place arrangements to ensure that the Department's child protection policy, as set out in "Co-operating to Safeguard Children" (May 2003) and the Regional ACPC Policies and Procedures (April 2005) are followed
Workforce	To ensure that the organisation recruits, retains & develops staff in order to provide high quality patient and client services	To develop and implement a recruitment & retention strategy which reflects available resources and predicts changes in demand
		To assist the Department in regional workforce planning for specific staff groups
		To ensure that staff are registered with the appropriate regulatory body and support them, through training, to maintain their registration
		To ensure that the workforce is properly skilled (*see* illustrated example No.7 in Appendix 3)
		To develop staff through the provision of training, education and development opportunities (including the implementation of the Knowledge and Skills Framework (KSF)) in order to improve the quality of services
		To work with staff to deliver efficient, effective, patient and client centred services through pursuing 24/7 working

Area	Organisation Objective	Directorate Level (or Equivalent) Objective
		To introduce new pay systems in an effective way which maximises service accessibility, is within budget and maximises potential for modernising working practices and providing measurably better services to local community
		To ensure compliance with relevant employers Codes of Practice (such as NISCC)
Partnership Working (including service user experience)	To work with partners to improve the way health and social services and other services work together to improve health & social care service provision reduce inequalities, promote inclusion and provide better opportunities for children and support for families To ensure that focus is on service user experience	To work with commissioners and providers of health and social care and the Department to agree areas of responsibility on an individual, joint and multipartite basis
		To develop a communications strategy for both internal & external stakeholders
		*To develop and implement a user involvement strategy which engages service users, carers and the wider community in the assessment of need, planning, development, delivery, evaluation and review of services
		To ensure that skills and competencies in partnership working are developed throughout the whole organisation
		To form health and social care alliances and participate in networks with other providers to ensure best care for patients, clients and carers and to reduce inequalities, promote inclusion and provide better opportunities for children and support for families
		To ensure that effective shared service arrangements are in place which provide reliable and accurate management information, and are cost effective (*see* illustrated example No. 6 in Appendix 3)
		To ensure that there is a regular and systematic approach to obtaining, analysing and responding to local patient/client and public feedback about services
		To ensure the availability of an accessible easy-to-use complaints process, geared to providing patient/client/user satisfaction and enabling learning from complaints received to be shared within and without the organisation
		To ensure a community development approach is adopted in policy development and service delivery
ICT	To modernise service delivery by exploiting the use of ICT to progress towards more person-centred providing more support for direct care and more support for care professionals.	To plan for and co-operate with the implementation and roll-out of new and enhanced ICT systems
		To review working practices and develop roles and responsibilities taking account of the opportunities offered by new ICT capabilities
		To ensure those who need it are trained and have access to the new Theatre Management system by March 2006
		To progress towards the use of an electronic health care record for each individual across community services by 2008

Area	Organisation Objective	Directorate Level (or Equivalent) Objective
	To exploit ICT to the full to realise the potential benefits for patients and staff. To promote multi-disciplinary and cross-organisational working to achieve more efficient services for the public, taking advantage of new ICT services.	To progress towards full use of electronic care records across the HPSS by 2010
		To ensure all care professionals have access to, are trained and routinely use ICT in their daily work by 2010
		To encourage and develop electronic care communications between teams, and organisations, to achieve a better informed and more efficient service
		To maintain the mandatory element of the HPSS Internet web site
Finance	To ensure that mandatory financial targets are met	To ensure that statutory financial duties are met
		To ensure the organisation achieves financial balance (*see* illustrated example No.1 in Appendix 3)
		To ensure that the capital programme reflects the strategic direction of the organisation and is delivered within timescales and budget

Appendix 3 - An Assurance Framework – this Appendix demonstrates how the sample principal objectives in Appendix 2 link to the principal risks. These are not intended to be comprehensive but to illustrate the principles to be applied

Principal Objectives	**Principal Risks**		**Priority**	**Key Controls**	**Assurances on Controls**	**Board Reports**		
	Principal Risk	**Classification of Principal Risk**	**Likelihood/ Impact**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
What the organisation aims to deliver	***What could prevent this objective being achieved***	***Which area within our organisation this risk primarily relate to***	***What is the Likelihood of the Risk occurring and its Consequence/ Impact if it occurs***	***What controls/systems we have in place to assist in securing delivery of our objective***	***Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective***	***We have evidence that shows we are reasonably managing our risks and objectives are being delivered***	***Where are we failing to put controls/ systems in place. / Where are we failing in making them effective***	***Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective***
No.1 To ensure the organisation achieves financial balance	Unforeseen expenditure due to irrestible demand, new mandatory requirements (eg more costly blood products, demand for home care service, increase in child protection referrals, introduction of new drug therapies) etc	Finance	Link to Risk Register	Detailed policy & procedure in place for budget setting. Robust system for budget profiling. System for budget setting involves all relevant parties Process for entry of emerging drugs and therapies	External Audit Internal Audit Internal manager/peer review Etc.		Insufficient training given to new Budget Holders to support the budget setting process Lack of quality and timeliness of financial data to front line managers	
	Income shortfall below what had been agreed eg unanticipatable moratorium enforced by the Department							

Principal Objectives	Principal Risks		Priority	Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	**Classification of Principal Risk**	**Likelihood/ Impact**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
	Misforecasting nationally agreed pay awards							
No.2 To review Health and Social Care services and, where necessary, reform and modernise services so that they meet the needs of service users in an effective and timely way	Lack of Strategic Direction Lack of Service User/Carer Involvement Inefficient deployment of available resources	Health and Social Care provision	Link to Risk Register	HWIPs/TDPs Business Plans Board Involvement Requirements of *Priorities for Action* Systems in place to learn from adverse incidents/ litigation and complaints Active programme to engage with stakeholders Benchmarking SCIE/NICE guidance	Planning Review meetings Progress Review meetings Progress Reports to the Department and board RQIA Reviews and recommendations for quality improvement External Audit Internal Audit Risk assessments		No monitoring of patient/ client satisfaction Learning from complaints system needs to be reviewed to ensure learning is across the whole organisation	
No.3 To ensure that arrangements are put in place for the purpose of monitoring care and evaluating the outcome of care.	Poor investment in IT and inadequate provision/ availability of clinical or professional information to staff and teams Lack of administrative support	Direct patient and client care	Link to Risk Register	Organisation-wide IT strategy Delegated management and team accountability	Directorate/team performance reporting and monitoring processes Board performance/ monitoring reports RQIA Review Benchmarking Performance indicators Clinical and multi-	Performance indicators Benchmarking Progress against clinical and social care governance plans and against care standards Clinical and	No regular review of performance. Poor monitoring of outcome measures. Inadequate upward reporting	No assurance of action to address exception reports

Principal Objectives	Principal Risks		Priority	Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	**Classification of Principal Risk**	**Likelihood/ Impact**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
	Lack of effective system to disseminate alerts, standards, guidance, etc Lack of skills to interpret data				professional audits and national confidential enquiries SCIE/NICE guidance Effective supervision/appraisal system Effective workforce development strategy	multi-professional audits and National confidential enquiries Maintenance of registration of the workforce Sub-contracting only with registered providers		
No.4 To ensure that prescribing costs and practice are effectively managed	Poor management of funding Inability to implement appropriate guidance Inadequate pharmacy (particularly clinical) resource	Clinical Services	Link to Risk Register	Strategy for cost-effective prescribing. Monitoring arrangements in place for in-year spends and prescribing activity. Capacity Planning undertaken.	Regional Procurement Pharmacist Area Prescribing Fora Trust Drugs and Therapeutic Committee Etc. Roll out of integrated medicines management to optimise medicines appropriateness index (MAI)			No assurance gained on effectiveness of Capacity Planning
No.5 To establish effective governance	Non-identification of the risks to the organisation's principal objectives	Organisation-wide	Link to Risk Register	Principal objectives set and agreed at board level and communicated to staff	RQIA Review Internal Audit			No assurance on the effectiveness

Principal Objectives	Principal Risks		Priority	Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	**Classification of Principal Risk**	**Likelihood/ Impact**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
arrangements and ensure the organisation is run appropriately and in a way that inspires public confidence	Inconsistent prioritisation of risks across the organisation Inability to deliver risk treatment/ action plans			Policy and Strategy in place regarding the identification and management of risks Framework in place to gain assurance on the management of risks and the delivery of objectives	Implementation of Medicines Governance Pharmacists Red/Amber management arrangement for complex drugs Etc.			of the overall assurance framework
No.6 To ensure that effective shared service arrangements are in place which provide reliable and accurate management information, and are cost effective	Poor investment in IT, Finance & HR systems Breakdown in core business systems, controls and processes Business discontinuity	Partnership Working	Link to Risk Register	SLA in place with shared service provider System in place to monitor performance of shared service provider against SLA Clear lines of accountability set out within provider and user organisations for shared service provision	External Audit Internal Audit Management reports from shared service host organisation Etc.		No performance monitoring against SLA taken place in current year	
No.7 To ensure that the workforce is properly skilled	Lack of appropriate training Inability to recruit the right staff Inability to retain key skilled staff	Workforce	Link to Risk Register	Organisation-wide training needs analysis Organisation-wide training strategy linked to individual staff appraisal System for monitoring the effectiveness of training strategy	RQIA Review Royal Colleges Internal Audit Etc.	Full Assurance on nursing training Compliance with NISCC Code of Practice	Gaps in linkage to staff appraisal for support staff	No assurance on effectiveness of training strategy

Principal Objectives	Principal Risks		Priority	Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	**Classification of Principal Risk**	**Likelihood/ Impact**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
No.8 To ensure that the needs and rights of children are addressed / considered as appropriate and to develop a holistic approach to working with families in the area of child protection	Lack of adequate and competently skilled workforce	Workforce Partnership Working Auditing/ monitoring arrangements	Link to Risk Register	Co-operating to Safeguard Children and Regional Policies and Procedures Internal Audit/ monitoring systems Quarterly accountability review meeting with HSS Boards	DHSSPS inspection and follow-up plans RQIA Reviews Chief Inspector, Social Services Inspectorate attends quarterly accountability review meetings	Action plans forwarded to the Department	Inadequate audit arrangements	
No.9 To comply with mandatory and other guidance issued by Health Estates (eg. MDEAs, clinical waste, firecode compliance, operational estates management guidance)	MDEAs: failure to action recommendations in alerts due to internal system failures (eg. Lack of medical device/ equipment co-ordinators Firecode compliance: death or injury to staff or service users due to non-compliance. Prosecution by Regulator.	All areas All areas	Link to Risk Register Link to Risk Register	Detailed policy and procedures in place Detailed systems in place for distribution and for assurance that action has been taken Detailed policy and procedures in place Adequate and competently skilled Fire Officers in place Compliance Action	Internal audit External audit RQIA Reviews Internal audit External audit Regulatory Inspections	Performance indicators. Benchmarking progress against controls assurance standards. Internal audit reports. Action plans. Investment on compliance measures.	Inappropriate assessment of risk by board Staff training not being updated or undertaken Lack of quality and timeliness of estates performance data to board	Identification as a priority for effective clinical and social care governance Identification as a risk management priority Insufficient competent external inspection of compliance

Principal Objectives	Principal Risks		Priority	Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	**Classification of Principal Risk**	**Likelihood/ Impact**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
	Clinical Waste: failure to manage clinical waste leading to health risk to staff, service users and the public. Failure to comply with statutory legislation leading to prosecution by Regulator	All areas	Link to Risk Register	Plan Detailed policy and procedures in place based on Health Estates guidance Management of the Regional Clinical Waste Contract	Internal audit External audit Regional Clinical Waste contract management reports RQIA Reviews Regulatory inspections			
	Operational Estates Management Guidance (HTMs etc): Failure to comply with statutory legislation leading to adverse criticism of management and/or prosecution by HSE(NI)	All areas	Link to Risk Register	Detailed policy, procedures and systems in place based on Health Estates guidance Appropriately skilled workforce in place	Internal audit External audit RQIA Reviews Regulatory inspections Peer review inspections			

Appendix 4 - Assurances on Systems of Internal Control

To fulfil their role, boards must obtain assurances that the arrangements they have put in place to achieve the organisation's objectives and manage risks are effective and operating as intended. This is also a statutory requirement for completion of the Statement on Internal Control. It is important that boards have sufficient understanding of the techniques used by auditors and other reviewers to satisfy themselves that the assurance arrangements they have in place are both comprehensive and efficient.

The assurance process requires a systematic and analytical approach with the level of supporting evidence required carefully matched to the importance of the activity to the organisation's objectives and the level of risk. Good systems with effective embedded controls and sound risk assessment arrangements are fundamental to good management and efficient assurance arrangements.

The principles for achieving assurances are the same irrespective of whether clinical and social care, financial or other areas of activity are involved. They all require systems to be evaluated for their ability to prevent or minimise error and then checked to ensure they are actually working as intended, or if not, the effect of weaknesses. This is known as the systems audit approach. It provides an assurance about the whole system and help in reducing ongoing problems. Whilst it is possible to gain some assurance through the examination of individual incidents or transactions, this can be very time-consuming and does not provide an insight into the whole system.

The table below sets out the more common of the different techniques and testing methods that can be used to confirm the effectiveness of the board's arrangements. It should be noted that where systems are inadequate this leads to significant increases in both the numbers and depth of tests required to provide assurances.

TECHNIQUE	METHOD	STRENGTHS	WEAKNESSES	SOME POSSIBLE APPLICATIONS
Systems-based Auditing/Review				
Reflects the theory that the achievement of objectives/prevention of error on an ongoing basis is more likely when a sound system has been implemented.	The system is identified and documented, with particular note being taken of the controls and checks that have been built into it. The auditor/reviewer will determine what the objective(s) of the system is and assess whether the system is adequately designed to deliver that objective. The auditor/reviewer will also confirm that there are adequate controls built into the system at key points to ensure that breaches of the system and/or significant errors are identified and flagged up. If the system appears to have significant weaknesses in control, the auditor/reviewer should suggest how this might be rectified. At this point consideration should also be given as to whether to undertake detailed (substantive) testing to ascertain whether the weaknesses have had any serious consequences.	Confirms that there are controls in place to prevent/identify major operational failures. Gives comfort that a system exists to manage the risks.	Is not designed to pick up individual problems, unless accompanied by other testing. Not possible where no system has been in operation, which is the case in some emerging or dissolving organisations	Any area of operation
Walk-through Test				
Used to confirm that the system described is that used in practice and that the expected controls do exist	A very small number of transactions/cases/incidents etc are followed through the system	Quick confirmation for the reviewer that the system is as understood and so helps prevent erroneous testing	Too small a sample on which to form a judgement on effectiveness of the system or the consistency of its use	Should always be used before any large-scale/detailed testing is undertaken

TECHNIQUE	METHOD	STRENGTHS	WEAKNESSES	SOME POSSIBLE APPLICATIONS
Compliance Test				
Used to provide evidence that internal control/quality procedures are being applied as prescribed	A sample of transactions/ cases/ incidents etc is selected and followed through the system to ensure that the expected controls have been applied. The number of items selected will depend on the level of assurance required.	Enables assurance to be given that the system of internal control is being followed. Testing may reveal breakdowns in the system and consideration of the underlying cause of these can help in refining the system.	Does not enable assurance to be given on the effectiveness of the system. Investigation into breaches of the system can be difficult and time-consuming	All systems
Substantive testing				
The usual purpose is to enable an opinion to be formed as to the completeness, accuracy and validity of information and records. May be necessary where the organisation has poor/no formal systems in place. New and dissolving organisations may be in this position.	There are a number of ways in which this can be done, including *analytical review (see below),* however it frequently involves testing on a large scale using scientifically designed, statistical methods.	Correctly done, this can provide a high level of assurance on the effectiveness of the system and its controls. Alternatively can provide a high level of comfort where control systems are poor or absent.	Can be very time-consuming both to set up and to conduct. The cost of obtaining this level of assurance where there is a low tolerance of error can be prohibitive. Needs to be used with care	Systems covering high-risk areas. Clinical and multi-professional audit. Where there are known system weaknesses and information is unreliable.

TECHNIQUE	METHOD	STRENGTHS	WEAKNESSES	SOME POSSIBLE APPLICATIONS
Analytical review				
A textbook definition is 'A form of substantive testing (see above). Often used in conjunction with detailed substantive testing and enables that testing to be more accurately directed.' However it is also a term widely used to describe a review aimed at ascertaining whether there is any glaring evidence that might point to the need for a more thorough and detailed review. Care should be taken to ensure that the extent of the work undertaken is clear when relying on this for assurance purposes.	Uses significant ratios, trends, or other statistics to determine areas for more detailed review. Where the review confirms an expected outcome no further work may be necessary	Low cost. Very efficient in the right circumstances.	Relies upon the accuracy of the data on which it is based, the reviewer's understanding of the organisation and knowledge of any operational changes which might have taken place which could have affected the expected outcome. Will only identify major discrepancies unless used in conjunction with more detailed tests. Does not give assurance on the system design	As an indicator of where in depth testing should be undertaken. In place of detailed testing in low risk areas As supplementary evidence on the effectiveness of a system As a means of ensuring that obvious large scale irregularities have not been overlooked.

Appendix 5: Commonly-used Acronyms

AfC	Agenda for Change
ACPC	Area Child Protection Committee
BP-BC	Best Practice – Best Care
CAMHS	Child and Adolescent Mental Health Service
CEMACH	Confidential Enquiry on Maternity and Child Health
CSCGST	Clinical and Social Care Governance Support Team
CPP	Child Protection Panel
DBS	Developing Better Services
the Department (DHSSPS)	Department of Health, Social Services and Public Safety
EFQM	European Foundation for Quality Management
GMC	General Medical Council
HPSS	Health and Personal Social Services
HPSSRIA	Health and Personal Social Services Regulation and Improvement Authority - the legal name of the Regulation & Quality Improvement Authority
HSENI	Health and Safety Executive for NI
HTM	Health Technical Memorandum
HWIPs	Health and Wellbeing Investment Plans
IfH	Investing for Health
IiP	Investing in People
KSF	Knowledge Skills Framework
MDEA	Medical Device/Equipment Alert
MHCNI	Mental Health Commission for NI
NCAS	National Clinical Assessment Service
NCEPOD	National Confidential Enquiry on Patient Outcome on Death
NCISH	National Confidential Inquiry into Suicides and Homicides
NIAIC	Northern Ireland Adverse Incident Centre
NIAO	NI Audit Office
NICCY	NI Commissioner for Children and Young People
NICE	National Institute for Health and Clinical Excellence
NICSCGST	NI Clinical & Social Care Governance Support Team
NDPB	Non-Departmental Public Body
NISCC	NI Social Care Council
NMC	Nursing & Midwifery Council
NPSA	National Patient Safety Agency
PfA	Priorities for Action
PfG	Programme for Government
PSA	Public Service Agreement
R&D	Research and Development
RG&RMA	Regional Governance and Risk Management Adviser
RQIA	Regulation & Quality Improvement Authority
SCIE	Social Care Institute for Excellence
SIB	Strategic Investment Board
SIC	Statement on Internal Control
SSI	Social Services Inspectorate
TDPs	Trust Delivery Plans