Taking it on trust

A review of how boards of NHS trusts and foundation trusts get their assurance

audit commission

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Summary

This study is not about the governance structures and processes that trust boards should use to assure themselves that the organisation for which they are responsible is operating effectively and meeting its strategic objectives. All have them in place and there is a great deal of guidance – over 1000 pages – on the subject. It is about the rigour with which they operate the processes and get the assurance they need.

The study stems from Monitor's[1] concerns about the quality and accuracy of the forward-looking self certifications made by some foundation trusts (FTs) for regulatory purposes; discrepancies between trust declarations of compliance with Standards for Better Health and subsequent Healthcare Commission inspections; differences between statements on internal control (SICs) and core standards declarations; and some major failures in patient care, such as that at Maidstone and Tunbridge Wells NHS Trust (Ref. 1) and Mid Staffordshire NHS Foundation Trust (Ref. 2). All have revealed significant gaps between the processes on paper and the rigour with which they are applied. Outside the NHS the banking crisis has shown how important it is for boards to understand and assess risk reliably.

The study is based on a review of the relevant literature and guidance; a detailed examination of the key processes, controls and assurances at 15 acute and mental health trusts; and further interviews with individuals and organisations with an interest and experience in the area. We found some good practice. And there is no doubt that the introduction of FTs has generally reinvigorated governance processes and resulted in the recruitment of non-executives with a greater knowledge of effective risk management and board challenge drawn from private sector experience. However, overall, there was room for much improvement. In the worst cases, the assurance process had become a paper chase rather than a critical examination of the effectiveness of the trust's internal controls and risk management arrangements. The NHS has, in many cases, been run on trust.

We also reviewed how boards assured themselves that the data they use are of good quality, drawing on the findings from the Commission's payment by results data quality assurance framework. The development of quality metrics, payment for quality schemes and quality accounts, all increase the importance of boards using and providing trustworthy data. Recent events in Haringey have demonstrated the importance of good data quality, particularly when such data are being used for key management and regulatory purposes.

Few trusts had a manageable number of clear strategic objectives that would enable risks to be readily identified and managed. One trust could not produce its strategic objectives. Risks were also often poorly specified. Some trusts found it difficult to embed risk management in the day-to-day running of the organisation and had not linked it effectively to performance management and performance information. Where they had, it had depended on strong leadership and management ownership of

[1] Monitor is the Independent Regulator of NHS Foundation Trusts

action plans, backed by scrutiny, challenge and effective performance management.

In the NHS, the Board Assurance Framework (BAF) is a tool that sets out the risks for each strategic objective, along with the controls in place and assurances available on their operation. The BAFs we reviewed were often very large documents that users found unhelpful and, in some trusts, had effectively stagnated until reviewed as part of a bespoke exercise. It was also clear that the BAF was seen as disassociated from operational management, although there is a link between the two.

Effective assurance requires a number of elements to be present together:

- the right governance framework and risk culture and a clear understanding of strategic objectives and risks (Chapter 2);

- good internal controls (Chapter 3);

- evidence that internal controls are operating effectively (Chapter 4); and

- good data quality (Chapter 4).

Our review showed that:

- controls and assurances were often poorly defined, making it difficult to see how boards could be clear that the controls were working effectively and that assurances were sound. Risks and controls were not always aligned to strategic objectives (Paragraph 34);

- greater attention needed to be paid to compliance mechanisms and these needed to be more clearly distinguished from internal audit, which should review the effectiveness of the compliance framework, not be a substitute for it (Paragraph 130);

- use of internal audit could be improved, with greater emphasis given to the quality of the assurance derived from it rather than cost minimisation. Its use should also be placed in a wider framework of review as there are alternatives to internal audit in many cases (Paragraph 121);

- use of clinical audit as part of the BAF was poorly developed. This is a significant weakness. Few trusts could set out how clinical audit was being used in a systematic way to address risks with the results reported to the board through the BAF (Paragraphs 133 and 134);

- many trusts had elements of assurance processes in place for data quality but very few were comprehensive and very few boards saw this as a significant issue. There was limited evidence of formally planned audit or review programmes to verify the accuracy of data reported (Paragraph 162);

- greater effort was made to review and assess assurances provided in respect of self-assessments for compliance with Standards for Better Health. Even so, these efforts were not wholly successful, as judged by the results of follow-up inspections by the Healthcare Commission (Paragraphs 150 and 151);

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- trusts' approach to the SIC was variable and in some cases appears to have become a matter of lip service. Greater emphasis could be given to the SIC as a key component of the regulatory framework, rather than introduce new, parallel mechanisms. It could also be made less process oriented and more forward looking, thereby encouraging boards to reflect on their identification of risk and success in managing their risks through effective internal controls (Paragraphs 153 to 156); and

- there may also be merit in cascading the SIC through the organisation by sub-certification by managers. However, to avoid this becoming a meaningless bureaucratic exercise it would need to be allied with a more effective compliance function, performance information and performance management (Paragraphs 158 and 159).

Board assurance can be seen as a dull, dry subject dominated by process. The Healthcare Commission's report on its investigation into Mid Staffordshire NHS Foundation Trust (Ref. 2) shows that processes without intelligent and rigorous scrutiny are not enough. Governance arrangements that are persuasive on paper must work in practice. The aim of board assurance is to give confidence that the trust is providing high quality care in a safe environment for patients by staff who have received the appropriate training; that

it is complying with legal and regulatory requirements; and that it is meeting its strategic objectives. On the evidence we have seen, many board members would not be able to have that confidence. Trusts may indeed be meeting all these requirements but it is not evident from the material presented to the board. This is an important issue for regulators as the regulatory framework is increasingly dependent on self-assessments and self-certification. Mid Staffordshire NHS Foundation Trust certified that it was compliant with all core standards except that relating to waste disposal, but it subsequently became clear that it was very far from providing safe, high quality care.

Internal controls and board assurances are often not up to the weight now being placed on them by the regulatory framework. NHS trusts have the processes and arrangements in place. Indeed, the Commission's own Auditors' Local Evaluation (ALE) confirms this, but greater attention now needs to be paid to the rigour and effectiveness with which the processes and arrangements are applied. Below we make a number of recommendations that we consider will help to bring this about. We will also review our ALE methodology to ensure it has the right balance between processes and outcomes.

The Audit Commission has also produced a separate briefing paper covering data quality, which should be read alongside this report, entitled *Figures You Can Trust* (Ref. 3).

Trusts should:

- ensure that their strategic aims and objectives are clearly defined and few in number so they can be widely understood and clearly cascaded throughout the organisation, and that their strategic risks are identified and aligned to their strategic objectives;

- review their risk management arrangements – including the way in which risks are reported to the board – in line with the findings of this report and consider how best to promote and demonstrate the value of risk management work to staff;

- ensure they have systems in place to comply with all statutory, regulatory, clinical and contractual requirements;

- consider cascading the SIC through the organisation by sub-certification by managers. To avoid this becoming simply a bureaucratic exercise it should be allied with a more effective compliance function, performance information and performance management;

- review how they identify and then evidence assurances on the operation of controls and how these are then evaluated;

- review and increase the assurances they receive from sources other than internal audit, including clinical audit, and in doing so ensure that their full portfolio of risk is covered;

- maximise the assurance obtained from internal audit by reviewing the scope of internal audit plans – using Appendix 2 as a guide – and improving its commissioning;

- better align clinical audit programmes to key strategic and operational risks to maximise the assurance provided by the clinical audit function;

- strengthen their compliance mechanisms and distinguish them more clearly from internal audit, which should review the effectiveness of the compliance framework;

- ensure they have robust arrangements for assuring the quality of their data by assessing themselves against the standards for better data quality set out in the Commission's *Figures You Can Trust* briefing (Ref. 3) and by developing systematic and formalised review programmes for their data, including checking accuracy back to records; and

- develop policies and guidance on data quality and assurance processes, including defining and allocating responsibility for data quality, to promote consistency and improve awareness of board members.

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The Department of Health, the NHS Appointments Commission and regulators should:

- consider further incentives and sanctions to reward good governance through greater autonomy and take action to address shortfalls where they arise (Department of Health (DH) and Monitor);

- review how to attract the best candidates to become non-executive directors and, as part of this, consider whether the cap on remuneration should be increased or removed (DH and the NHS Appointments Commission);

- consider revising guidance on the format and content of the head of internal audit opinion to provide the accountable officer with a clearer picture of the scope and quantum of internal audit work underpinning the opinion (DH and Monitor); and

- consider how the SIC could be less process oriented and more forward looking to encourage trusts to develop a proactive rather than reactive approach to risk. They should also regard the SIC as the primary document for regulatory purposes and not introduce parallel processes (DH and regulators).

We have developed some questions that board members should ask themselves to assess the strength of internal controls. We recommend that boards of all trusts should consider the questions to help identify what improvements are required.

Questions for board members to ask themselves

1 Good assurance requires the right governance framework to be in place

- How clear are we about what the trust is trying to achieve? What strategic aims and objectives have we set out for the trust? Are they clearly defined?

- How do we provide leadership to the staff delivering the objectives that we have set? What process do we have in place for translating the objectives into the contribution expected from divisions, care groups and frontline staff and how will their performance will be monitored?

- Are the governance structures clear and straightforward with minimal overlap? How well do we understand them and how do we think current governance arrangements could be improved?

- How do we oversee the strategy for achieving our objectives? How do we ensure that the systems of internal control are operating robustly?

- Is our board agenda dynamic and focused on the right things: the strategy and its implementation? How much time do we spend on strategic issues at board meetings? To what extent do we have the right information prepared for board meetings to allow us to monitor this? Have we considered and acted on *The Intelligent Board* report?[1]

- Are board meetings managed effectively? What improvements could be made to ensure that we operate as a team? Do we have trust and respect between executive and non-executive directors?

- What skills do we need as a board? To what extent do we have the right skills? How clear are we about what the role of the chair and non-executive directors should be? Do we delegate responsibilities effectively and appropriately?

2 Good assurance requires good internal controls, effective risk management and a good assurance framework

- How can we be sure that we have identified all of our strategic risks? Are we monitoring them properly and what level of independent scrutiny or constructive challenge from within the organisation is there?

- How timely and relevant is the performance information that we use to monitor risks? What reports do we receive that provide evidence of the effectiveness of risk management and progress in achieving strategic objectives?

- How do we provide leadership on risk management? Do we monitor the trust's main operational risks? How can we be sure that the risk management processes in place will avoid operational risks becoming strategic risks?

[1] *The Intelligent Board*, Dr Foster Intelligence, 2006.

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- How clear are we about our risk appetite? Do we quantify risk appropriately? Do we have an accountability framework for the trust that sets out the level of risk that is expected to be managed at each level of the trust?

- Have we devolved risk management sufficiently and how can we be sure that it is embedded within operational processes and that there is ownership of risk?

- Do we understand what risk culture we are trying to embed? Do we know what a good risk culture looks and feels like? How and when do we communicate this?

3 Good assurance is required on internal controls

- How are we using the internal audit function to obtain assurance on internal controls? Is the scope and level of investment in internal audit appropriate? How are we maximising the assurances we can gain from internal audit and do internal audit staff have the right skills and experience? Are we making best use of other independent forms of assurance?

- Do we need to establish or increase investment in a separate compliance function to ensure operations comply with laws, rules, regulatory requirements and our policies?

- To what extent do we use the clinical audit function appropriately? Is it systematic and focused on our own risks as well as on nationally identified issues? Are the results regularly reported to the board through the assurance framework? Does it give us a comprehensive view of the quality of clinical services across the trust's portfolio?

- What are our potential sources of assurance? Do we use these appropriately, balancing them across the risk profile of the trust? How have we satisfied ourselves that they are not skewed towards big and topical projects and that we keep our eye on the ball more widely? How do we systematically test and evaluate the sources of assurance?

- Where have we set out the roles and responsibilities of sub-committees to the board and do we receive full and appropriate reports from them? Specifically, how will the audit committee programme enable it to meet the board's expectations? Do all non-executive directors have the opportunity to communicate with those on the sub-committees?

- How do we ensure that the SIC is robust and consistent with other declarations and self certifications? Would these documents stand up to rigorous external scrutiny?

4 Good assurance requires good data quality

- Is there a corporate framework in place for the management and accountability of data quality? Is there a commitment to secure a culture of data quality throughout the organisation? How have we made clear the responsibility for data quality governance and accountability at all levels of the organisation? Do our clinicians understand the purpose and use of the data collected?

- What policies or procedures are in place to secure the quality of the data used for reporting? What policies and guidance on data quality do we have? Are they appropriate?

- What policies or procedures are in place to secure the quality of the data used as part of the normal business activity of the organisation?

- How has the trust ensured that staff have the knowledge, competencies and capacity in relation to data quality? What kind of training is made available on data quality issues?

- What arrangements are there to ensure that data supporting reported information are actively used in the decision-making process? Are they subject to a system of internal control and validation?

- What controls do we have to ensure that the quality of data used for decision making is good enough? Is the quantity and timeliness of information we receive for board meetings adequate? How do our board reports explain the assurance process for the data contained in them? Do they clearly highlight any issues?

1 | Introduction

1 Healthcare is inherently complex and risky. There were four and a half million emergency admissions to hospitals in England in 2007/08 and over seven million elective admissions. In addition, there were 45 million outpatient attendances (Ref. 4). Around 796,000 incidents – 583,567 of which occurred in acute hospitals – were reported to the National Patient Safety Agency in the year, 7,101 of which involved cases of severe harm. In the year to March 2008, 3,282 patients are known to have died as the result of medical errors (Ref. 5) and it is thought that as many as 1 in 10 patients admitted to hospital suffers harm. Healthcare also consumes very large sums of money. The annual turnover of an acute trust can be over £800 million and it can employ up to 9,000 staff.

2 Boards therefore need to assure themselves that their trusts are well managed, providing safe and appropriate care and are, in short, places where patients would want to be treated. How they do this is described as the 'system of internal control'.

3 Internal control is 'a process, effected by an entity's board of directors, management and other personnel, designed to provide reasonable assurance regarding the achievement of objectives in the following categories:

- effectiveness and efficiency of operations;
- reliability of financial reporting; and
- compliance with applicable laws and regulations.' (Ref. 6)

4 The assumption is that such systems operate effectively but there is evidence to the contrary. There were five principal factors that led the Commission to undertake this study:

- In 2007/08, Monitor reviewed a number of FTs that were forecasting compliance with core standards or key targets, but had been compliant neither in the previous year nor in the first two quarters of the following year. These reviews raised concerns over the quality of analysis and consideration of risk in certifying anticipated compliance with all healthcare targets in annual plans.

- The Healthcare Commission's review of Core Standard for Better Health declarations (Ref. 4) has shown that trusts often declare themselves compliant, when subsequent investigation proves this was not the case.

- The Audit Commission and the Healthcare Commission reviewed the consistency between trusts' SICs for Better Health declarations for 2005/06 and 2006/07 and found differences between the two. The exercise identified improvements in 2006/07, as scrutiny and guidance have increased, but there is evidence that boards are still not making adequate disclosures in the SIC.

- Major failures in patient care – such as that at Maidstone and Tunbridge Wells NHS Trust and now Mid Staffordshire NHS Foundation Trust – have revealed

significant weaknesses in how internal control systems and the assurances derived from them were tested.

- The Audit Commission's Payment by Results Data Quality Assurance Framework has shown weaknesses in clinical coding and data quality in a number of trusts, although the data sets are used to determine income and underpin a number of other important activities.**I**

5 Taken together, these factors indicated that trust boards need to increase the rigour with which they assure themselves about the strength of their internal controls.

Purpose of the study

6 The study assesses how well NHS trust and FT boards assure themselves of the strength of their internal controls and make honest and complete disclosures in the accountable officers' SIC and valid self-assessment certifications.**II** These have become increasingly important for regulatory purposes. Throughout the report when we refer to

trusts we are referring to NHS trusts and NHS FTs.

7 We focused on the evidence provided to the board to enable it to make the necessary declarations and for the accountable officer to sign the SIC. We also reviewed the work and effectiveness of sub-committees in providing assurance over systems of internal financial control and risk management processes.

8 The quality of data underpinning performance reporting is critical for boards and sub-committees to assess whether key business aims and processes are being met. The study therefore also reviewed whether the appropriate information is reported to the board, and the rigour with which boards assess data quality and take action, if necessary, to improve it. The Commission has published a separate briefing *Figures You Can Trust: Briefing on Data Quality in the NHS* (Ref. 3), which explores in more depth the issues relating to data quality. The briefing should be read alongside this report.

I The Payment by Results (PbR) Data Assurance Framework is designed to support the improvement of data quality standards that underpins the accuracy of coding and costing under PbR. The Framework is a rolling programme of work developed, managed and delivered by the Audit Commission.

II As accountable officers, chief executives are responsible for ensuring that their organisation operates efficiently, economically and with probity, and that they make good use of their resources and keep proper accounts. The chief executives of FTs are called accounting officers and we have used the term accountable officer in the report to refer to both accountable and accounting officers.

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Methodology

9 The approach adopted was a combination of desk-based research and interview. The desk-based research included a review of the existing reports and guidance on governance and board assurance, as well as a detailed review of board and sub-committee papers, key corporate documents, and internal and external audit plans from a sample of trusts to determine the extent to which the information and processes available to boards were adequately and effectively used.

10 Further detail was sought through interviews at the sample of trusts and FTs that volunteered to take part in the study, in order to corroborate the findings from the desk research. The sample included both acute and mental health trusts. We are grateful to them for assisting us with the study. We also spoke to a number of other organisations with an interest in this area including internal auditors, the NHS Information Centre and Connecting for Health.

History

11 In the late 1980s and early 1990s, a number of high profile incidents in the UK – including Coloroll, Polly Peck, BCCI and the Mirror Group – caused a loss of investor confidence in the way that listed companies were managed and in the integrity of their reported results. The resultant need to reassure the stock market sparked a series of committees and reviews, whose recommendations have shaped the regulatory environment in place today. This section summarises the key developments but a more complete picture can be found in Appendix 1.

Private sector context

12 The *Cadbury Report* in 1992 (Ref. 7) incorporated a number of recommendations on the financial aspects of corporate governance in a Code of Best Practice. This covered the responsibilities of the board, the role of auditors and the accountancy profession, and the rights and responsibilities of shareholders. Most relevant to this study it introduced the concept of a representation by the directors on the effectiveness of internal control, although only on financial controls. The *Hampel Report* (Ref. 8) in 1998 extended the remit of the SIC to include all internal controls, including risk management. This largely set the governance requirements that operate today. It was supplemented in 2003 by the *Higgs Report* (Ref. 9) and the *Smith Report* (Ref. 10). They respectively made recommendations on the role of non-executives and board sub-committees, and on the role and composition of an audit committee. It was the *Smith Report* that formalised the audit committee's assurance role in respect of internal control and risk management. Some UK companies have also been affected by the Sarbanes-Oxley Act 2002 (Ref. 11) in the United States, which established new or enhanced standards for all U.S. public company boards, management and public accounting firms.

Corporate governance in the NHS

13 There is a general principle that best practice in the private sector will be followed by the public sector but it is interpreted and adapted for use in a different environment. The introduction is typically phased in over a longer period. The *Codes of Conduct and Accountability*, issued in April 1994 (Ref. 12), set out a basic governance approach for the NHS based around the principles of accountability, probity and openness. In 1997, controls assurance was introduced, requiring the accountable officer to make a declaration on the operation and design of controls in a simple statement on internal financial control. In 1999, *Health Service Circular 1999/123* (Ref. 13) significantly extended the controls assurance agenda by including clinical and other non-financial risk management issues, and introduced a phased move to a more comprehensive published assurance in a SIC.

14 The DH has produced extensive guidance to help NHS trusts develop their governance arrangements. Some of the highlights are set out below:

- In 2002, *Assurance: The Board Agenda* (Ref. 14) stressed the need for boards to demonstrate they were properly informed about the totality of the risks to not meeting their objectives or delivering appropriate outcomes, and had independent assurances on the design and operation of the systems and processes in place.

- In 2003, *Building the Assurance Framework: A Practical Guide for NHS Boards* (Ref. 15) gave practical advice on how to bring together the existing fragmented risk management activity into a single process. It also clarified the relationship with performance management arrangements, the new clinical governance reporting framework, the core Controls Assurance Standards and other sources of assurance.

- In 2006, the *Integrated Governance Handbook* (Ref. 16) set out the need to align and integrate quality, performance and governance arrangements, whether clinical or non-clinical.

- In addition, the DH has produced and keeps updated an *Audit Committee Handbook* (Ref. 17) that explains the role and responsibilities of the committee in giving assurance to the board, and gives guidance on its constitution, how it conducts its business, and how auditors and Local Counter Fraud Specialists support its work.

15 Other organisations have produced further guidance, often in conjunction with the DH. These include the NHS Appointments Commission, Monitor (in particular the *Code of Governance* (Ref. 18), the Healthcare Commission, the NHS Confederation and the Audit Commission.

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16   In short, there has been no lack of guidance. We counted over 1,000 pages in the NHS alone and a quick search on the internet results in a great deal of further commentary, research and advice. The challenge for boards is therefore not finding out what to do, but instead translating the theory into an approach that works in their trust and then following it through with appropriate rigour.

The foundation trust model and the regulatory regimes

17   The introduction of FTs has brought about cultural as well as regulatory changes, even if the underlying corporate governance principles remain the same. The FT model makes trusts more autonomous. It offers them more freedom to determine their own futures in light of the needs of the local population. They have also moved from a hierarchical system, dominated by performance management, to one based on regulation. Accordingly, while meeting national priorities and targets remain key criteria, FTs have had to sharpen their governance arrangements, with more being expected of non-executive directors. The demands and style are more like that of a private company.

18   The FT diagnostic process was particularly effective in demonstrating Monitor's expectations of how differently FTs should be run. Key areas typically highlighted for improvement were board effectiveness and the competences of individual members; more integrated planning with a longer-term perspective; and better risk management processes. Monitor also set an expectation that boards should have a more strategic focus and therefore needed better-developed internal control systems to support the reducing operational focus.

19   The changes have proved difficult for a number of trusts. Systems of internal control have not always been adequate to identify emerging risks early enough, or to give realistic assurance that known risks are being managed. Moving to become FTs has also resulted in some changes to non-executive appointments, with a greater emphasis being placed on management and business skills, an approach now being followed by the Appointments Commission. We were told that it felt different sitting on an FT board than on a trust board. Directors felt more exposed to the ramifications of governance failure and that their personal profiles were more associated with the performance of the FT.

20   Associated with the introduction of FTs was a move towards greater use of self-certification for regulatory purposes. Historically, trusts would be called to account if targets were not being met or there were concerns over financial standing, but there was otherwise little effective performance management in relation to how the organisation was being run. This led to a common impression that boards were focused on targets and money above all else, and that other matters that should be addressed through effective governance processes were of much lower priority.

21 FTs are required to certify that they comply with their terms of authorisation and meet national targets and standards. FTs are expected to identify potential issues of non-compliance and make prompt disclosures. All trusts are required to certify that they are fully compliant with the Core Standards for Better Health. Although some tests are applied retrospectively on the basis of national data and a sample of trusts and standards inspected, there is no routine programme of inspection. These systems put a premium on effective internal controls, strong risk management, board assurance and the abilities of non-executives, and the accuracy and honesty of a trust's self-certification.

23 There is no shortage of guidance on the processes involved but processes themselves, which are generally in place, will not achieve this. The risk culture and environment are also key. This study examines what arrangements are in place in the NHS to assure boards that effective internal controls are in place and how rigorously they are applied. It highlights examples where this is working well and where it is not. It also makes recommendations to the DH and regulators to consider whether existing arrangements meet their requirements and sufficiently help and motivate directors to focus on how well the business is run and to properly assure themselves that this is the case.

Conclusion

22 Boards need a clear understanding of risks and meaningful assurance that internal control systems are operating effectively, particularly in view of changes in the regulatory framework through the introduction of FTs and core standards assessments. There will always be an understandable focus on targets and money. However, the move to new registration standards and quality accounts, as well as developments in the commissioning arena, mean that governance arrangements need further to adapt and to ensure that questions of clinical quality are integrated into mainstream processes.

2 Governance frameworks

Introduction

24 The way a trust is directed and controlled is critical to its likelihood of achieving its strategic objectives. Responsibility for this lies with the trust board. All trusts have largely the same basic component parts within their governance frameworks but there are local differences in how they are configured and operated. The frameworks are the product of history and personality, as well as the size and nature of the trust's business.

25 Boards need to follow some common principles to work effectively. Clarity of purpose, strategic focus, a sensible scheme of delegation and well-constructed agendas are essential, but they alone are not sufficient. The abilities and integrity of the key individuals involved and softer issues around organisational culture and behaviour are vital to making any structure and its underlying processes work properly.

26 In this chapter we highlight the key roles and responsibilities within the governance framework and explore how boards are discharging these. While the need for arrangements that work locally rules out a prescribed model, there were consistent elements in the most successful trusts that others could usefully seek to emulate.

Definitions

27 The *Cadbury Report* (Ref. 7) refers to (corporate) governance as 'the system by which companies are directed and controlled. Boards of directors are responsible for the governance of their companies. Responsibilities include setting the company's strategic aims, providing the leadership to put them into effect, supervising the management of the business and reporting (to shareholders) on their stewardship.' The roles and responsibilities of the board and its members are set out in Table 1. These are taken from the *Higgs Report* (Ref. 9) and are directly applicable to NHS boards, as recognised in *Governing the NHS* (Ref. 19).

28 The key elements of any governance framework are:

- clear strategic objectives for the organisation;

- a well-organised board, focused on the achievement of these objectives and the management of related risks;

- a sensible scheme of delegation from the board to the executive and sub-committees; and

- all component parts of the framework understanding their roles and responsibilities, as well of those of others, and how the pieces fit together.

Table 1

Definitions from the Higgs Report

The roles and responsibilities of the board and its members

The role of the board	The role of the chairman	The role of the non-executive director
The board is collectively responsible for:	The chairman is responsible for:	Non-executive directors should:
• promoting the success of the company by directing and supervising the organisation's affairs;	• leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda;	• constructively challenge and contribute to the development of strategy;
• providing entrepreneurial leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed;	• ensuring the provision of accurate, timely and clear information to directors;	• scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance;
• setting the organisation's strategic aims, ensuring that the necessary financial and human resources are in place for the company to meet its objectives, and reviewing management performance; and	• ensuring effective communication with shareholders;	• satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible; and
• setting the organisation's values and standards and ensuring that its obligations to its shareholders and others are understood and met.	• arranging the regular evaluation of the performance of the board, its committees and individual directors; and	• be responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing senior management and in succession planning.
	• facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.	

Source: Higgs Report

Governance frameworks

29 The quality of the board members is crucial to whether the board is effective and the framework works in practice. Moreover, whatever processes are in place can be subverted by the culture of the organisation and particularly the ethics and behaviours of key individuals. Leadership, particularly from the chair and chief executive, is vital in establishing the right culture and in maintaining organisational focus on what matters, alongside the personal qualities and professional skills of board members.

Setting strategy

30 The primary role of the board is to set the strategic objectives of the trust. Unless there is a clear idea of what the trust is trying to achieve and where it is heading in the future, it is harder to make business decisions about the allocation of resources.

31 Trusts have always given a high priority to achieving centrally prescribed targets, but this cannot be the sole strategic objective. A trust's business has always been wider than the targets set by the government. A single strategic objective that related to meeting targets would be an inadequate reflection of a trust's business and a poor basis for the board to monitor performance and assure itself that the trust was a high performing organisation providing good quality care.

32 We found various approaches to strategy setting, development of strategic objectives and identification of the

key risks to achieving them. However, several trusts reported that while they had had strategic objectives for years, there had been a definable point in their evolution where the board had revisited these in detail and achieved a deeper and shared understanding of what they actually meant and therefore what the trust was trying to achieve. This resulted in a clearer understanding of the risks to achieving those objectives.

33 We undertook an analysis of the board assurance frameworks (BAFs) at the trusts we visited. The BAF is a document that sets out the trust's strategic objectives and the risks to achieving them, along with the controls in place and assurances available on their operation. Most trusts had strategic objectives relating to financial targets, staff training, quality of care, estates and resources, governance structures and business development. However, these were articulated in very different ways, with some trusts having higher level objectives while others broke these down into lower level and more detailed objectives.

34 The number of strategic objectives within BAFs ranged from 5 to 50, with half the trusts visited having between 6 and 15. One trust could not produce its strategic objectives. Those with the greatest number tended to aggregate them into common themes to make the BAF easier to navigate. Those with the most strategic objectives included objectives that were clearly operational, such as meeting the 18-week target for waiting

times, compliance with child protection standards and 100 per cent completion of staff personal development plans. These are not strategic objectives in themselves. They are important operational issues and may be indicators of progress towards strategic objectives.

35 The other key issue noted was not quantitative but qualitative. Some strategic objectives were sometimes unhelpfully vague, for example 'workforce', 'cash flow' or 'NHSLA'. These do not set out exactly what the objective is, which makes it unlikely that there will be a common understanding within the board, let alone beyond. Others were broad and aspirational and required much sharper definition, for example 'be an excellent employer to staff' or 'to deliver the range of hospital care required to support the health needs of local people'. Other examples included 'to be a dynamic organisation' and 'clinical excellence is our priority'.

36 There is real scope for trusts to sharpen their strategic focus. We suggest that strategic objectives should be limited to ten or fewer. Recent governance failures, for example data losses by government departments, resulted from problems that were not on organisations' strategic radar. Organisations therefore need to make certain they are not only focused on their strategic objectives, but that they also have systems in place to make certain that they comply with all statutory, regulatory, clinical and contractual requirements.

Board operation

Chairman

37 The definition in Table 1 demonstrates the key role that the chairman has within the governance framework. It is clearly a role that requires a very skilled individual to get the most out of meetings and the individual members of the board, and to ensure their collective effectiveness.

Non-executives

38 While the role of the non-executive has not theoretically changed in the NHS over recent years it has, in practice, been one of the most significant development areas. The Committee on Standards in Public Life (Ref. 20) recommended a sharper focus on specifying the desired skills and backgrounds of prospective non-executives. Changes in the selection criteria used to appoint non-executives have followed in the wake of the Committee's findings and the more commercial and autonomous nature of FTs.

39 The FT diagnostic process identified this as a key development area for aspirant trusts and prompted the departure of many non-executives. Recent appointees have generally had more board-level private sector experience and better risk management knowledge.

Governance frameworks

40 Our study found that the skills and approach brought in by new non-executives often seemed to have been the catalyst for transformational change. Many were surprised at the way the trust was run. While part of this involved understanding the different context in which the NHS operates, the issues were more about the culture, the corporate governance framework and supporting processes. These included the focus of the board, the maturity of the executive function and its 'corporateness', the underlying business and financial planning processes, levels of clinical engagement in corporate processes and the adequacy of risk management arrangements.

41 Encouraged by Monitor, new non-executives have also brought more robust challenge to the board than had previously been the case. This sometimes has proved an uncomfortable process, as the executives found they were being expected to assume more delegated authority and that their performance was under much more exacting scrutiny.

42 Non-executives of NHS trusts have been expected to commit two and a half days a month to the role and to be paid £6,000 a year. For audit committee chairs, the remuneration is approximately £13,000. The expected time commitment for non-executives who are not audit committee chairs is unrealistic, given the real level of input required. FTs that appoint their own non-executives have sought to address this by using the flexibility available to them to set their own rates of pay. Typical remuneration for FT non-executives is £10,000 to £15,000 with chairs being paid up to £60,000.

Scheme of delegation

43 The Higgs definition of a board refers to 'directing and supervising the company's affairs'. Clearly a trust's business cannot be effectively run by the board in any but the very smallest of organisations because of the number, breadth and complexity of decisions that need to be made and the volume of underlying information that needs to be assimilated in making them. Even if it could, it might be rather undesirable, as it would be harder to maintain a strategic overview while dealing with so much operational detail. Therefore a scheme of delegation is essential to allow the board to focus its limited time on the key priorities and issues.

44 The formal powers of an NHS trust are vested in the board, but the *NHS Code of Accountability* (Ref. 12) requires boards to define which decisions are reserved for it alone to take and to have arrangements in place to delegate responsibility to the executive for the remaining decisions. While the Code requires NHS trusts to have audit and remuneration committees, the board can also appoint other committees and delegate powers to them as it deems appropriate. This is a 'scheme of delegation'.

Table 2

Sub-committees of the board

The two statutory sub-committees and their remit

Audit Committee	Remuneration and Terms of Service (RATS) Committee
The audit committee's primary role is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. In performing that role, the committee's work will predominantly focus on the framework of risks, controls and related assurances underpinning the delivery of the organisation's objectives (the BAF).	To avoid potential conflicts of interest, the RATS committee is made up of non-executive directors. It makes decisions on the remuneration and terms of service of the chief executive, directors and some senior managers to ensure they are fairly rewarded for their contribution to the organisation.
As a result, the committee has a pivotal role to play in reviewing the disclosure statements that flow from the organisation's assurance processes. In particular, these cover the SIC and Standards for Better Health declarations.	They also advise on and oversee contractual arrangements of these members of staff, including the proper calculation and scrutiny of termination payments, taking account of such national guidance and legal advice as appropriate.

Source: NHS Audit Committee Handbook and Audit Commission

45 The roles of the two statutory sub-committees are set out in Table 2.

46 All the trusts in our sample followed the DH's model set of standing orders, standing financial instructions[I] (SFIs) and scheme of delegation with little local tailoring. While all trusts had the standard audit and remuneration committees, there were understandably local differences in the other committees that had been constituted and, therefore, how they worked together and with the board. While there were fewer differences in the sub-committees of the board, there were enormous variations in executive committees.

[I] The standing orders set out how the trust should conduct its business. The key financial elements are the SFIs and the scheme of delegation. The SFIs detail the financial responsibilities, policies and procedures adopted by a trust. The scheme of delegation sets out where responsibility lies for decision making within the organisation.

Governance frameworks

47   Despite the *Integrated Governance Handbook* (Ref. 16) guidance on how to align and integrate the threads of quality, performance and governance, we found this was the area with the greatest differences. We found different permutations of quality, clinical governance and risk management committees, and numerous other sub-committees, steering groups or boards sitting underneath these, potentially with overlapping responsibilities. Streamlining the structures would enable greater clarity on who is doing what and why.

48   However we did find an approach that seemed to be working, whereby trusts operate an additional board sub-committee to those on audit and remuneration, focused on risk management, both clinical and non-clinical, most commonly called a risk and quality committee. This committee is responsible for reviewing the BAF and risk registers and for ensuring risk management is a key agenda item in divisional and care group meetings. To do this effectively it would routinely call in the executive to explore issues and explain their actions. This approach gave a clear overview of the disparate executive arrangements and was used to develop a more streamlined and integrated approach throughout the organisation.

49   The operation of the risk and quality committee was then scrutinised by the audit committee on behalf of the board. This seemed to keep the audit committee's workload manageable while the trust improved internal control processes to the point when a second board sub-committee was unnecessary.

50   It was clear in a number of cases that this approach had been necessary because of the need to free up board time to focus on key issues and to drive the significant improvement needed in internal control. An alternative approach, which seemed to work effectively, is to move to a single audit and assurance committee, as operated by Southampton University Hospitals NHS Trust (Case study 1).

Size matters

51   While governance frameworks may look similar in trusts of all sizes, they can be easier to operate effectively in a small, single-site trust than in a large multi-faceted, multi-site teaching hospital. This is largely due to the difference in the numbers of people involved, the frequency and quality of contact between them and the way risks are often perceived as being vested more in individuals than in component parts of the organisation.

Case study 1

Southampton University Hospital NHS Trust's audit and assurance committee

Following publication of the *Integrated Governance Handbook* (Ref. 16), the non-executive directors at Southampton University Hospital NHS Trust reflected on the common issues raised at the audit committee and the risk management committee. As a result, the board decided to nominally integrate the committees but effectively ran the two back-to-back, with common membership but different chairs. The healthcare assurance session focused on healthcare aspects of the BAF (including all aspects of non-financial assurance); and the financial assurance session focused upon financial aspects of the BAF. The scale of the shared agenda was considerable and the meetings at first were very long, but the trust started to get a joined-up view on assurance. Work continued over the next couple of years to refine the arrangements, including the agendas.

In 2008, a new chair of the audit committee was appointed and initiated a review of the integrated audit and assurance committee arrangements. This involved a detailed discussion about the merits of moving back to a more traditional audit arrangement which, with a forthcoming application for FT status, led to a review of the trust's governance processes and the best use of the skills and time of its non-executive directors.

Following the review it was decided to continue with the integrated audit and assurance committee but to rebrand the sessions and further fine tune the structure of meetings as follows:

- the core and financial assurance session focused on the more traditional financial aspects of audit committee business. This considered most of the internal and external audit plans and reports; reviewed the BAF and risk registers; adopted the accounts and reviewed the SIC. Significant risks, whether current or developmental, were considered and management were frequently asked to attend to present on issues and how they are being managed. This has been effective in identifying silo-working issues and the need to ensure divisional linkages with core management processes; and

- the clinical quality and outcome assurance session focused on healthcare quality and compliance issues; reviewed appropriate sections of the BAF and risk registers; the operation of executive committees; preparing for and responding to regulatory visits; and reports and operational risks around infection control and hygiene.

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Source: Audit Commission

Governance frameworks

52 Smaller trusts have an environment that tends to make it easier to develop informal relationships, whether between non-executive and executive directors, or between both and the wider management team. Such personal links allow for additional discussion about risks and concerns outside formal channels which serve to manage the business needed at formal committee meetings.

53 No organisation can operate without a measure of trust among the key individuals. However, the larger and more complicated the organisation, the less the board can rely on such informal relationships and the more important it is for people to understand the system and what is done by others, both to prevent duplication and to minimise the chances of anything being missed. There needs to be more formal focus on understanding the practicalities of roles and responsibilities and the chairs of the assorted committees and groups need to be active in managing their agendas and liaising with each other.

54 For larger trusts, the move to divisions operating as separate trading units under service line management principles, and the development of quality metrics, as set out in the Darzi review (Ref. 21), are important developments. The resultant changes in roles and responsibilities create a powerful platform for larger trusts to improve and scrutinise the operation of governance processes at the frontline, and to move to a degree of delegation that would typically be found in the private sector.

Conclusion

55 NHS trusts have had appropriate governance frameworks in place for many years, but they have not always operated as effectively as they could. There were often too many strategic objectives and many were poorly formulated. Boards could become over-focused on centrally set targets and fire fighting, rather than holding to account and devoting sufficient attention to the bigger picture. The introduction of the FT model has helped to reinvigorate this, but we found that strategic objectives often remained vague and were therefore a poor starting point for governance.

56 The scheme of delegation from the board was fairly consistent across all sites but the governance frameworks were often complicated and we found that, as a result, people were not always clear about their roles and responsibilities, and how the whole framework came together.

57 Following the learning from the FT diagnostic process, which had forced thorough reviews of the operation of the board and its members, the introduction of a new generation of non-executives with more commercial board experience has been a significant development. Historically, there has been less clarity about the non-executive role and less rigorous challenge of executive management. Risk management and strong governance arrangements now have a much higher profile.

58 The right culture and people are vital to good governance, but the larger and more complicated the organisation, the more important it is to have a clear and widely understood governance framework. The challenge is to make sure that delegated authority is working, that processes are embedded and that responsibilities within them are clear.

59 We will explore the operation of key internal control processes in the next two chapters by considering the systems of internal control in place in different trusts and how assurances are reached on their operation.

Recommendations

60 In order to improve governance arrangements we recommend that:

- trusts should review their strategic aims and objectives and make sure that they are clearly defined and few in number so they can be widely understood and clearly cascaded throughout the organisation;

- boards should ensure that they have systems in place to comply with all statutory, regulatory, clinical and contractual requirements;

- the DH and the NHS Appointments Commission should review how to attract the best candidates to become non-executives and, as part of this, whether the cap on remuneration should be increased or removed; and

- the DH and Monitor should consider further incentives and sanctions to reward good governance through greater autonomy and take action to address shortfalls where they arise.

3 | Risk management and board assurance

Introduction

61 Internal control is the process that provides assurance that an organisation is achieving its objectives and meeting its legal and other obligations. As such, it includes the governance framework (covered in the previous chapter), risk management, information and communications, monitoring processes and assurance activities. It is the effectiveness of all this that the accountable officer is certifying when signing the SIC.

62 This chapter explores how trusts set out to identify, evaluate, manage and control risk, and the reporting and monitoring tools that are used to underpin the process. In the next chapter we consider how the board gets assurance that these are operating effectively.

63 The real challenge is not just to design appropriate processes, but to ensure they are properly embedded into the operations and culture of the organisation. Integral to this is the quality of the reporting of risk and operational performance and so we also considered the adequacy of reporting arrangements

Identifying risk

Identifying strategic risks

64 Strategic risks are those that represent major threats to achieving the trust's strategic objectives or to its continued existence. Strategic risks will include key operational service failures. For example, failure to meet key targets or

provision of poor quality care would be very damaging to all trusts' strategic objectives. These can be readily identified, but some can be much harder to identify and manage for a number of reasons:

- they can be more qualitative than operational risks, for example to do with reputation or partnership working;

- they are frequently multi faceted and hence more complicated, deriving from a series of events that combine and cumulatively escalate; and

- they can be hard to anticipate as they can be outside the experience of board members or have not happened before.

65 Strategic risks are normally maintained in a corporate risk register, which ensures they are made an integral part of the risk management process and appear in divisional or departmental risk registers. This way, they feature in the business planning processes of divisions, whose plans reflect actions to manage strategic risks as well as their own immediate operational ones.

66 Our analysis of BAFs found that there was considerable scope to improve the identification and specification of strategic risks. For example, a common objective was 'ensuring staff receive necessary training'. Although it can be argued that this would not be regarded as a strategic objective in its own right, in identifying the risks to this objective some trusts simply described the risk as failure to achieve the objective or identified what the consequence of not

attaining it would be. For example, failure to achieve the objective may put patients at risk. Very few trusts actually identified and articulated what a risk might be, for example, not releasing staff to attend training, or lack of funding to do so.

67 This implied that those trusts that were not appropriately identifying risks had the processes in place, for example a BAF with strategic objectives and risks, but had not fully understood their purpose or applied rigorous scrutiny to them. Without appropriate identification of the risk it is difficult to identify the mitigations and the controls that can then be applied, and the assurance that the board can be given that these are working effectively. If trusts were monitoring whether staff were receiving the necessary training, it was independent of this aspect of the BAF which was, in effect, a paper exercise.

68 We also noted that many trusts identified large numbers of principal risks for each objective; often 15 or more. This, together with a large number of strategic objectives, made the BAF unmanageable for the board, thereby significantly reducing its effectiveness. Aggregating the risks would enable the board and relevant sub-committees to sharpen their focus. For example, some trusts identified risks against a number of different access targets when a simple composite risk would suffice.

69 Being clear about the strategic risk allows boards to ensure that the information they receive in board reports is pertinent to the objective. It is also a much clearer starting point for mitigation and control as well as business planning.

Identifying operational risks

70 Operational risks are by-products of the day-to-day running of a trust and include a broad spectrum of risks including clinical risk, fraud risk, financial risk, legal risks arising from employment law or health and safety regulation, and risks of damage to assets or systems failures. They are the responsibility of line management and should be identified and managed by the executive, and only considered by the board on an exception basis.

71 There are several models for identifying risk but, in essence, they require examination of the sources or nature of the threat (or opportunity) and then involve identifying what events might trigger the risk. The main approach we found trusts had taken to identifying risks was management self-assessment. Usually this was through workshops facilitated by the risk department or internal audit, but a diagnostic tool could be used instead or a specially commissioned team could interview staff from across the trust. Thereafter, identifying new operational risks arising from training or changing working practices or environment should be a routine part of the day job for frontline staff.

72 This should be enhanced by cross-organisational learning and review of past practice. For example, analysis of serious untoward incidents (SUIs) can highlight risks that trusts have

Risk management and board assurance

not successfully managed. A mature approach to learning from such risk management failures, underpinned by a culture of openness, allows cross-organisational learning. The trusts we visited routinely reviewed SUIs and disseminated lessons learned through the organisation.

73 Clinical audit can perform a similar function. For example, Queen Victoria Hospital NHS Foundation Trust holds bi-monthly clinical audit meetings which are open to all staff. The meetings are well-attended and chaired by a consultant anaesthetist. They cover a wide range of topics (for example, mortality rates, infection control, delayed transfers) and open discussion and challenge is encouraged. The high profile of these meetings helps to identify and manage risks through the raising of awareness and facilitate the transfer of best practice across the trust.

74 There are different approaches to capturing risk. Case study 2 shows the approach taken by Cambridge University Hospitals NHS FT.

Measuring risk

In theory

75 Once an organisation has identified its risks it needs to assess their significance, to help decide whether the risk is something that needs to be managed and, if so, by whom. The gross risk is the effect of something that might happen before taking account of controls in place to manage or mitigate it.

76 Risks are typically assigned a score based on a combination of the likelihood of occurrence and the expected consequence should this happen. The higher the score, the more attention it should require and the more likely the board would seek assurance as to how it was being managed, whether directly or via a sub-committee.

77 The net impact of a risk is effectively the residual risk after taking account of the controls in place to reduce the likelihood of it materialising, or to minimise its impact should this happen. This evaluation determines the appropriate level of managerial supervision and action and so, while gross risk is important in considering the risk profile of the organisation, it is the residual risk that largely drives operational risk management.

In practice

78 All the trusts we visited scored residual risks according to their likelihood and probable impact. As the scoring systems involve a degree of subjectivity, it is important to ensure that risks and the scores assigned to them are routinely challenged, either by risk departments or boards and board sub-committees. For example, at one trust we visited, poor scoring of risks led to inefficient use of board subcommittee's time and diluted their attention on the genuine high-level risks facing the trust. The corporate risk register included 109 risks, 50 of which were scored 'very high risk'. Examples of these very high risks included 'GP complaints about the trust's standard referral form' and 'lack of clarity relating to the services offered by this trust via Choose and Book'.

79 We identified good practice at a number of sites where risk registers included the cost of any investment needed either to reduce the risk to an acceptable level or to remove it. This allows clear evaluation of investment decisions, whether during the planning round or as part of in-year financial management processes. One trust we visited, Queen Victoria Hospital NHS Foundation Trust, found that by spending roughly £30,000 on repairs and maintenance it was able to remove a significant number of lower and medium-level risks from the register, which reduced noise in the system and allowed a sharper focus on the other risks.

Managing risk

A general approach

80 Each trust should publicise a clear definition of risk to reduce potential inconsistency in approach. It should also set out what level of risk it is prepared to accept for each different type of risk, known as risk appetite or risk tolerance. A trust needs to balance its drive towards innovation and improvement in service delivery with its responsibility to safeguard public money and provide safe and effective healthcare, so in some areas it will wish to be more risk tolerant than in others. We did not find this approach in many of the trusts we visited.

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Developing an accountability framework – an example model
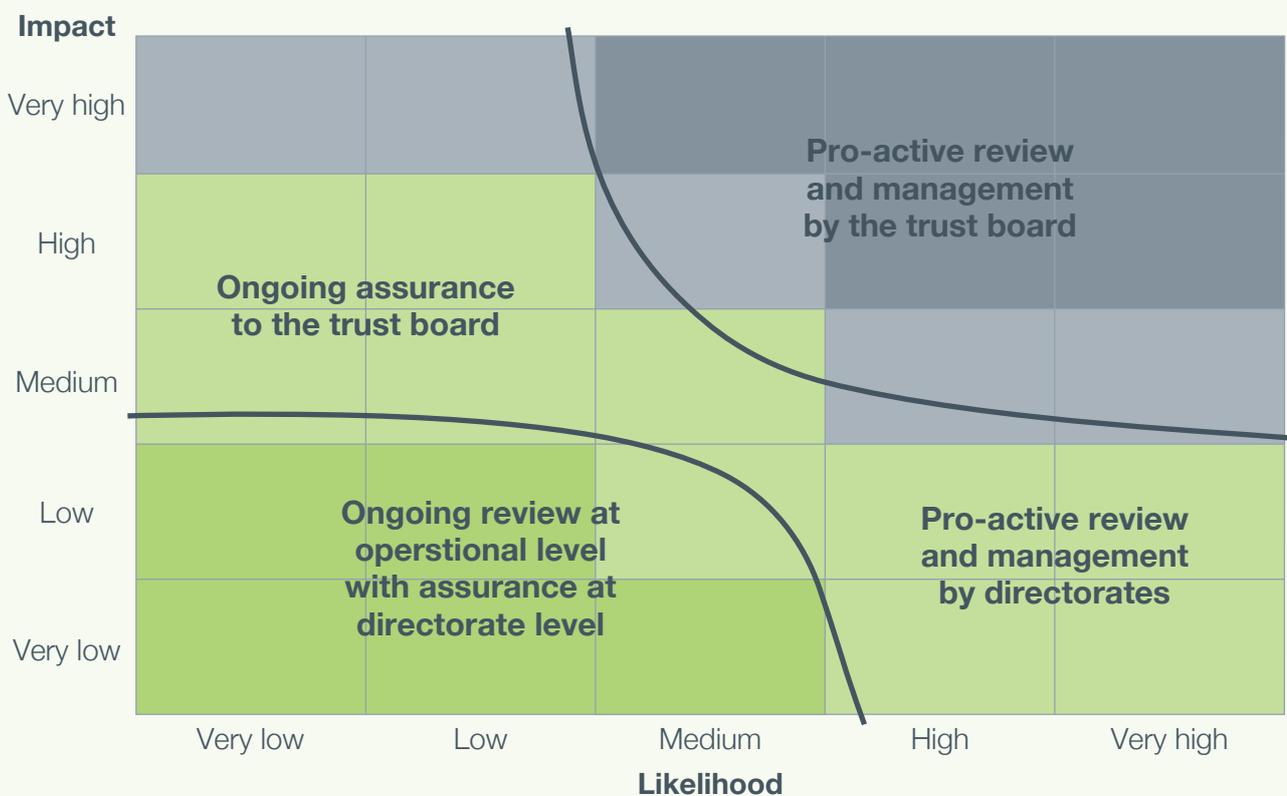
Source: Audit Commission

81 Setting out clearly the types and degree of risk that a trust is willing to accept in pursuit of its goals is the real starting point for risk management. This acts as a tool for the trust board when it makes strategic resource allocation or operational decisions, and provides a clear statement for managers and decision makers within the organisation to ensure that agreed tolerance for risks is reflected in their decisions and actions. Therefore, by considering risk against the risk appetite, the organisation identifies gaps that it will seek to manage.

82 Once it has decided what risks it wishes to manage, the next step is to assign ownership to a named senior officer who will be responsible for managing the risk. A useful tool developed by the Audit Commission and used by Plymouth Hospitals Trust, alongside its risk appetite statement, was an accountability framework that clearly set out what level of risk was expected to be managed by whom (Figure 1). While the example above is figurative, one would expect operational risk to be managed incrementally based on scores

from ward level, at care group level, at divisional level, at executive management level and only very exceptionally at full board.

Our findings

83 Our review identified an apparent difference in the maturity of risk management processes in trusts compared with companies in the private sector. In the latter, operational risk management is seen as an integral part of the line management function and therefore almost wholly the preserve of the executive, with a layer of scrutiny and challenge in place within executive structures that was not always found at our study sites.

84 The more advanced trusts we reviewed had gone some way to increasing ownership and accountability for risk management processes from the executive team down to the frontline, but this had often proved a slow process. In many cases we found that individuals, normally with private sector experience, had assumed a pivotal role in driving forward risk management, and this top-down pressure had enforced the importance ascribed to risk management processes and their operation. As this was often a non-executive director, we typically found more scrutiny of risks and oversight of the roll-out of risk management at board sub-committee level than one might have expected.

85 In practice, we found the best trusts operated risk management at a number of levels within the executive structure, within a defined framework:

- At the frontline: wards, care groups and departments had risk management as a key agenda item at their meetings. This typically involved reviewing the risk register to ensure it reflected current risks and monitoring progress with local action plans.

- At divisional level: divisional business agendas would operate in a similar way for divisional risks, but would also review how the frontline was managing its risks and delivering against action plans. A key challenge is for trusts to ensure that connections are made between different risks with common solutions, and between common risks in different areas of the trust, so that joint solutions can be found.

- Corporately: as well as reviewing their own corporate risks, the executive team would oversee the operation of divisional processes and ensure risk management was a key feature of the performance management process. At this level, trusts must pick up the divisional risks that should be factored into wider business planning processes and then into commissioning negotiations and ensure that divisions are working collaboratively to manage risks.

Risk management and board assurance

86　In addition, where we found risk management working well, for example at the Christie NHS FT, we found strong leadership, clear ownership of risk and an enhanced scrutiny role:

- Leadership: the right tone from the top is vital for risk management to be fully effective and to engender innovation, as it may require significant cultural change if it is to be embedded in the behaviour and activity of all staff. Staff understood why this was a key priority for the board, and that it was a core part of executive performance management processes. Engagement was therefore stronger.

- Ownership: action plans for managing risk were developed and delivered by those best placed to do so. Risk management was accepted as a core part of the job, included within personal targets and considered within performance management meetings.

- Scrutiny: owners of a risk were held to account through a process of overview and challenge, so they knew that failure to manage a risk was likely to lead to intervention or close supervision.

87　Much staff activity is, in effect, risk management. This is particularly so in clinical care, although it may not be recognised as such; for example, a clear risk to providing good quality care is that the best standard clinical practice will not be provided. The recent adoption by a trust in the North West of England of processes to ensure that standard clinical practices are used has led to significant improvements in patient care. A further example of effective risk management is the introduction of checklists at the start of surgery, similar in concept to those used by pilots, which is expected to lead to a significant reduction in the number of adverse events. The best trusts recognised the importance of promoting risk management to help it become embedded in the day-to-day thinking of frontline staff. These are examples of real improvements that have been made in response to identified risks and can be highlighted to demonstrate to clinicians and staff the benefits of risk management.

88　Christie Hospital NHS FT has significantly reduced patient falls as a result of improved risk assessment, overseen and publicised by a dedicated group reporting through the clinical governance structure. (Case study 3).

Christie Hospital NHS Foundation Trust's use of risk management to reduce patient falls

Risk assessment and the use of risk registers as a means of managing operational concerns may be achieved by ensuring a clear link between frontline activity and the assurance and risk management processes. At the Christie, in common with many other hospitals, patient falls represent one of the highest causes of clinical incidents and patient harm. As a response to this, an action group was set up to oversee and support improved risk assessment of individual patients and monitor the implementation of recommendations from individual assessments. This work has delivered a 19 per cent reduction in the number of falls experienced by patients. It has been used to inform other activities aimed at improving safety of clinical care and of the hospital environment.

The assessment and scoring of risk has also been developed into business planning and decision making. All business cases require an assessment of risk and decisions on the granting of resources are based on the risk score. This has been particularly important in ensuring that important infrastructure needs are supported by the rest of the organisation; for example, investment in infection control, security and planned preventive maintenance.

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Source: Audit Commission

Monitoring risk

89 The *Turnbull Report* (Ref. 22) said that 'management has an obligation to provide the board with appropriate and timely information and the chairman has a particular responsibility to ensure that all directors are properly briefed. This is essential if the board is to be effective.' Clearly the provision of appropriate and timely information is also critical for the executive. Monitoring of risk is therefore largely defined by the reporting of risk and performance.

Executive risk monitoring

90 Operational risks are recorded on corporate or departmental risk registers which, at the sites we visited, were reported in full or transferred or summarised into a variety of reports tailored to specific audiences. Clearly there are real differences in the sort of information that would be considered at care group level compared with what might be appropriate at board level. Reports typically included all risks owned by the particular group, but separately highlighted any changes to risks or their scoring and used a red/amber/green system to highlight relative significance.

Risk management and board assurance

91 Most trusts we visited were good at monitoring operational risks, but not so good at demonstrating that risks were being effectively managed or mitigated.

Board risk monitoring

92 Board reporting varied across the sites we visited. It was generally poorly integrated, with separate performance, finance and risk reports. Different criteria were also used for the reporting of operational risks. Some trusts only reported the top five or ten corporate risks to the board routinely, whereas others took the whole corporate risk register to the board. Reports for the board tended to be in different formats from reports to the executive and divisions, meaning extra effort and the possible disassociation between the board and the executive on risk management and monitoring. Strategic risks were generally monitored separately by the board and its sub-committees through the BAF.

93 In practice, we found that the approach to the BAF as a document was variable. At a number of sites it represented a largely administrative process, rarely reviewed or meaningfully scrutinised, but in others it was a key and dynamic tool that drove the board agenda. Although there were a variety of formats, the common structure consisted of objective, principal risk, key controls, sources of assurance, gaps in controls/assurance, and action plans for addressing gaps in controls/assurance. However, some trusts sub-divided these fields to describe them in more detail, or grouped objectives into themes.

94 A key challenge for boards is to ensure that they, or a sub-committee, considered both the strategic risks and the major operational ones, without being overloaded by the number or the detail, and did not take on the role of line management. Direct consideration of how operational risks are managed should be delegated to line management. The task of the board and its sub-committees is to challenge management on the adequacy and effectiveness of the arrangements in place. All the study sites found this difficult.

95 We found that trust boards often did not have a cohesive view of the main strategic risks facing the business, which is perhaps the inevitable consequence of vague strategic objectives. The BAF was not therefore always being used as a tool to address and monitor strategic risk, nor was it always an integral part of trust business. The reasons for its unpopularity were diverse:

- It was felt to be an additional imposition for organisations with already advanced risk management arrangements … 'it is a mandatory comfort blanket'.

- The title seemed to divorce it from wider risk management processes in the eyes of staff… 'the name is not helpful'.

- Its size often made it unmanageable… 'the sprawl of the document, it's too damned long'.

96 These comments encapsulate the need to make the document easy to use. The BAF should be a tool for boards to oversee progress against strategic objectives and be linked to wider risk management processes for corporate and operational risks, rather than replacing or complementing them.

97 One of the best BAFs we saw was recently implemented at Plymouth Hospitals NHS Trust, which had merged its BAF with its performance report and used dashboards to help signpost key issues relating to each objective (Case study 4). This approach has recently won a Healthcare Financial Management Association award for governance. The judges said of the report: 'The assurance framework had been upgraded to incorporate a real-time analysis of risk, control and assurance that had a dynamic relationship with performance reporting.'

98 However, another trust, in attempting to develop a similar approach, found it immensely difficult to identify and report performance indicators across the range of its objectives and risks. As a result, much of its performance report is currently unpopulated. The board has

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Case study 4

Plymouth Hospitals NHS Trust's integrated performance and assurance framework

Plymouth Hospitals NHS Trust identified that dips in performance occurred because risks were not identified or were identified but not well managed. In response to this the trust developed an integrated performance and assurance framework.

The framework links performance management information and the trust's assurance framework. Performance outcomes are linked to the trust's strategic objectives enabling the trust board to be assured that, by examining the risks and controls to mitigate the risks, key outputs are delivered. An integrated board report is now produced that brings together the assurance framework and performance reporting.

Specific benefits of the approach have included the delivery of cancer service targets. Control measures, including a patient tracking list, were developed to manage the complex risks that were identified as having an impact on the trust's performance against the targets. As a result, the trust was able to improve the management of waiting lists; reduce waiting times and deliver cancer targets in 2007/08. The integrated framework enables the trust to understand future risks and intervene in a timely way to mitigate them.

The full version of the integrated performance report can be accessed via the following link: www.audit-commission.gov.uk/takingitontrust

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Source: Audit Commission

Risk management and board assurance

come to the uncomfortable realisation that there are critical gaps in the performance information available to it.

Auditors' Local Evaluation

99 The Auditors' Local Evaluation (ALE), the Audit Commission's annual assessment of NHS trusts (but not FTs), includes an assessment of the arrangements to manage significant business risks. In the 2007/08 assessment, two thirds of NHS trusts were scored as good or excellent, with only three per cent assessed as having arrangements that did not meet minimum standards (Ref. 23). Where trusts had failed to meet minimum requirements, a common reason was the lack of effective risk management arrangements and BAFs. However, ALE has focused so far on the adequacy of the processes and arrangements that have been put into effect, and less on the effectiveness of how they are used. Other evidence, including the Healthcare Commission's inspections of core standards declarations, suggests that while NHS trusts might have adequate or good arrangements in place, they are not always effective and the quality of outcomes is not as good. Our site visits confirmed this. Generally good arrangements exist, but are not necessarily applied to an equally rigorous high standard. We will consider how the ALE and other similar assessments can be strengthened to focus more on the effectiveness of risk management processes.

Conclusion

100 Effective risk identification requires good knowledge of risk management principles and of the business itself. It also requires clarity and rigour in specifying strategic objectives and their risks. We found that such clarity and rigour were often lacking, although the trusts in our sample had the right processes in place. This is consistent with our ALE assessments, which scored many trusts highly on risk management, where the assessment focuses more on processes rather than outcomes.

101 Our review found that it had often proved difficult to embed risk culture and management in the day-to-day running of the business and that the board in particular had a real challenge in balancing its consideration of strategic risks against operational risks. To address this, the most successful trusts had put a strong scrutiny process in place as part of wider performance management arrangements.

102 We also found that the reporting that underpinned the monitoring of risk was variable. In some cases the BAF was at the heart of board reporting and in others a largely academic paper exercise. In most cases, risk reports used red/amber/green colour coding to increase user friendliness for managers, but were often not a very helpful tool for the board.

Recommendations

Trust boards should:

- ensure their strategic risks are identified and aligned to their strategic objectives;

- review their current risk management arrangements, including how risks are reported to the board, in line with the findings of this report; and

- consider how best to promote and demonstrate the value of risk management work to staff and how effective it has been.

4 Gaining assurance on internal controls

Introduction

103 In the previous chapter we considered the design of internal control processes. Here we consider how the board gains assurance that these processes are working as expected. While much of the assurance agenda is delegated to board sub-committees, most notably the audit committee, it remains the board's responsibility and the SIC is signed by the accountable officer on its behalf.

104 While there are numerous sources of potential assurance on the operation of internal controls and the management of risk, internal audit is one of the two key tools at the disposal of the accountable officer and the audit committee. The other tool is the compliance function, which includes clinical audit. We consider how annual programmes are commissioned in order to maximise assurance and examine typical scopes and coverage. We also consider other common sources of assurance.

105 Assurances are positive evidence that controls are managing a given risk and it is likely that the underlying objective will be achieved. An informal way of looking at it was given by the chief executive of an FT who said 'assurance is about me being able to sleep at night'.

106 Therefore, we consider here how boards can draw evidence together from assorted sources to provide a robust body of evidence to support assertions made in the SIC.

Three lines of defence

107 The 'three lines of defence' approach is a model for assurance that pulls risk management and compliance into a common and robust framework. Its underlying concepts of significant ownership by frontline staff; their accountability to corporate and executive processes; and separate scrutiny lie at the heart of this report.

108 The first line of defence at the trust is the department. Responsibility lies with frontline staff to understand their roles and responsibilities and to carry them out properly and thoroughly. Controls are designed into systems and processes so, assuming the design is sound, compliance should mean the internal control environment is sound. Therefore, others within a department, preferably not frontline staff, are responsible for routinely verifying compliance with policies and procedures, both in respect of service delivery and decision-making processes. They are also responsible for providing the second line of defence with current information on key risk and control indicators.

109 The second line of defence is a corporate governance framework, incorporating compliance and risk management functions, which reviews the operation of the internal control framework. This is made up of assorted executive committees which set and police policies, define work practices and oversee the operation of the first line of defence. Typically this would be by holding them to account for the

effectiveness of their risk management and compliance arrangements but, for particular high-risk matters, they would also routinely inspect for compliance with policies and procedures.

110 The third line of defence is independent review, which is used to monitor the operation of the overall compliance and risk management system and examine the operation of the first and second lines of defence. This is the role of internal audit but there are other sources of independent review that can be used as well. Review findings are considered by the audit committee, which can then ensure that the executive is addressing identified weaknesses properly on behalf of the board.

Internal audit

111 The role of internal audit in a modern organisation has evolved considerably over the last 10 to 15 years, from one focused on the accuracy and appropriateness of individual transactions, to one that addresses financial systems and controls and risk management. This has created significant resourcing challenges for internal audit functions, as they now need access to a wider and richer set of skills.

112 In the NHS, most internal audit services are now provided on a contract basis rather than by an in-house team. Small in-house teams struggled to provide a modern multi-skilled service and so the creation and subsequent

consolidation of NHS consortia arrangements provided a critical mass that allowed providers to invest in a more diverse range of skills, and to develop partnership arrangements with audit firms. Three-year contracts are the norm in the NHS, and they are typically managed and owned by the director of finance, rather than the chief executive.

113 It is the chief executive as the accountable officer who will sign the SIC so it is important that he or she has clear sight and ownership of the internal audit programme and its findings. In practice, we found chief executives were generally aware of internal audit programmes and reviewed draft plans to ensure they were content with the proposed coverage, but thereafter there was greater variability. We consider that the link between chief executives and internal audit should be strengthened.

114 It is rare for NHS internal audit providers to have access to specialist clinical knowledge whereas, for example, an insurance company's internal audit function would almost certainly employ, or have access to, an actuary. We believe this is an area where internal audit providers need to reflect whether they have the appropriate skills to enable them to provide meaningful assurance over the effectiveness of the compliance function and to scrutinise clinical risk management arrangements. Trusts similarly need to consider how they can best gain assurance over clinical risk management. This would involve, for example, reviewing whether clinical audit

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arrangements were working properly, rather than actually undertaking clinical audit itself.

115 The Sarbanes Oxley Act (Ref. 11) has also caused many private sector companies to review the role of their internal audit function and has often heralded fee increases because of a desire to increase traditional financial auditing, without losing the risk-based operational and strategic auditing. A more recent development in the private sector has been increasingly to use internal audit to review the implementation of major organisational changes as they happen and so provide real-time assurance over their planning and management. In the NHS these changes seem to have either lagged behind or not yet happened. An important factor is the quality of the commissioning process. While in the private sector there has been more challenge to the internal audit profession on maximising assurance and demonstrating added value, in the NHS the focus has been more on cost minimisation.

116 Our work identified a broad range of internal audit contract sizes and scopes, from ones largely vested in financial systems to ones that provided a broad range of assurances over the operation of internal control systems. Clearly these would have given very different levels of confidence to the chief executive in signing the SIC. There were two main underlying factors: the assurance ambitions of the trust, and the lack of

guidance underpinning the requirements of the head of internal audit opinion.

117 Clearly the level and quality of assurance and service that trusts get from their internal auditors depends on two factors. First, the scope commissioned and secondly, what the trust is prepared to pay as a day rate. If the trust does not set out in the tender criteria that it is seeking a broad range of assurance on operational and strategic risk, as well as on the operation of controls over financial systems, it won't get the required assurance. Similarly, a low day rate will mean that providers are forced to recruit inexpensive resources and therefore are unlikely to be able to provide high quality assurance.

118 Rather than viewing the tendering exercise as an opportunity to seek a cheaper service, trusts need to be clear about what level of assurance they desire from their internal auditors, set this out clearly in the specification of the service tendered, and ensure evaluation is as focused on quality as on cost.

119 If assurance is about full confidence and freedom from doubt and uncertainty, trusts need to review how they are using internal audit. This may mean either increasing the scope of the work undertaken by internal audit and budget to include a broader spectrum of assurance work, or seeking to maximise the assurance and value for money from the current contract by focusing it better.

120 The review of the internal audit plans at our study sites found that inputs varied enormously, from 125 to 1,260 days per

year, but broadly correlated to the size and complexity of the trust, averaging about 2.5 days per £1 million of turnover. The most striking differences, however, were in the split of that time. The proportion of time spent on governance and risk work ranged from 5 per cent to 58 per cent of the plan, and work on core financial systems and information technology from 20 per cent to 52 per cent. Some included clinical governance work, or reviews of data quality, while others did not. Some included reviews of key strategic risks and key operational issues such as the management of 18-week waits, while others did not. It was not always clear how assurance was being gained in these areas when they were not covered by internal audit.

121 In some cases, the limited amount of time spent on non-financial internal controls and the extensive time spent on financial ones indicates that there is scope to review internal audit plans and rebalance the assurance they provide, and to link them with other methods of gaining assurance. We have set out some suggested features of a good internal audit plan in Appendix 2, but the right solution will vary. The following examples show how some trusts have revised their internal audit plans to meet local circumstances and find the solution that is right for them:

- Guy's and St Thomas' NHS Foundation Trust includes 150 days within its annual internal audit plan for the assurance department to use to look at emerging issues and risks.

- The Christie Hospital NHS Foundation Trust, on becoming an FT, realised it would lose assurances previously provided by the external auditor and invested more resources in internal audit to compensate.

122 Other plans reviewed included one entirely based on Monitor's compliance framework and demonstrated how the plan would give assurance over all areas.

123 DH guidance on the head of internal audit opinion (Ref. 24) sets out four potential opinions that can be given: full, significant, limited and no assurance. While there are advantages in standardising opinions to improve comparability between trusts and ease consolidation, there are also disadvantages that have served to devalue the opinion at a local level. While much of this is in the pragmatism of application, there is a risk that a trust might choose not to use internal audit to give assurance over its most challenging risks if the consequence is an unrepresentatively negative opinion at the year end. This is particularly the case if there was insufficient time to demonstrate that remedial action had been taken. The perception that the standard wording of the four potential opinions cannot be tailored has resulted in unhelpful debates over the consequences of identified weaknesses and the progress in delivery of action plans, particularly as this standard wording is also required to be included in the SIC.

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124 Guidance also defines the bases on which the opinion is derived, one of which is 'an assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year' (Ref. 24). However, there is no prescription as to the volume or type of work required to underpin the opinion. While differences in trust size and risk profiles make it impossible to set model plans or prescribe levels of input, it would be helpful if guidance was developed to help commissioners and providers alike to develop and agree internal audit plans which aim to provide a consistent level of assurance on the operation of internal controls.

125 The *NHS Internal Audit Manual* (Ref. 25), which sets out in some detail the required scope of internal audit work required at NHS bodies, has effectively lapsed into disuse as additional requirements to cover risk management, controls assurance and the like have been introduced. Internal audit standards are high level and focused on professionalism and process. The standards, in their present form, do not seek to prescribe what internal audit work should cover, but how it should be undertaken. The internal audit standards are currently being revised and this offers an opportunity to provide more guidance on the scope of internal audit in the NHS.

Compliance

126 A compliance function has two main elements:

- a policy role, involving the analysis and interpretation of regulations, both statutory and regulatory, to inform the development of fit-for-purpose policies and procedures; and

- a monitoring role, underpinned by a regular inspection, to ensure business units are complying with laws and regulations, and trust policies and procedures.

127 The compliance function, part of the second line of defence referred to above, is therefore part of the control structure and operates at business unit level. Internal audit is responsible for evaluating and reporting on the overall system of internal control, including the compliance function. The compliance function will therefore substantively test the effectiveness of controls operated by supervisors during, or immediately after, a given procedure is completed by frontline staff and of those regularly operated by middle management to make sure such controls are working.

128 This testing is normally focused on high risk aspects of legal or regulatory compliance and policies. For example, infection control represents a key part of any trust's compliance agenda and will operate at many levels. High-level work would typically involve review of relevant policies for compliance with regulatory standards, annual audits of, say, antibiotic prescribing to assess

compliance with the organisation's antibiotic policy, and immunisation records for staff. More detailed and real-time work might include observation of compliance with, say, hand-washing policies, a review of case notes to assess if additional infection control precautions are documented, or of sterilisation practices. The outputs from this work need to be reported up and fed into assurance processes.

129 Internal audit should periodically review the compliance function, including operational adherence to the compliance framework and applicable legislation, and review the operation of principal financial controls within complete processes. We found, however, that internal audit was often used as a part of the compliance function, rather than a check on its operation.

130 In practice, we did not find many trusts had a clear and systematic compliance framework, although most trusts perform elements of compliance testing. We recommend that trusts consider adopting a more formal and systematic approach to compliance testing.

Clinical audit

131 The *Integrated Governance Handbook* (Ref. 16) sets out the logic of merging clinical governance into the overall governance framework, rather than operating it in parallel. The different dimensions of clinical governance have been described as education, clinical audit and effectiveness, risk management, and research and development. Clinical audit is effectively the review of clinical performance, the measurement of performance against agreed standards, and the refining of clinical practice as a result. It is one of the key compliance tools at management's disposal and has an important role within the assurance agenda. However, only two trusts included clinical audit as a direct source of assurance in their BAF. It would be reasonable to expect it to appear as a significant source of assurance for all trusts.

132 Trusts make a substantial, but often unquantified, commitment to clinical audit. Over and above the costs of any central clinical audit team, there is also a significant hidden cost to trusts arising from the 'supporting professional activity sessions' within the consultant contract. These comprise up to 25 per cent of the contract and are typically used for clinical audit work, continuing professional development, and additional managerial responsibilities.

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133 However, despite the considerable total cost of clinical audit activities within trusts, we found there was generally limited board awareness of how clinical audit programmes were devised or assimilated into the BAF. When we asked whether clinical audit programmes were targeted at identified risks, trusts were often unable to provide an answer. The Standards for Better Health require that 'healthcare organisations should ensure that clinicians participate in regular clinical audit and reviews of clinical services' (Ref. 26) so the regulatory emphasis is on getting clinicians involved rather than necessarily having an effective targeted framework for the audits.

134 We found little evidence that clinical audit programmes were formulated to reflect trusts' strategic objectives or key risks. The programmes we saw were substantially driven by national considerations. There is scope to maximise the assurance provided by the clinical audit function by considering how programmes can be better aligned to the trust's own risks as well as taking account of national priorities.

135 This is an issue that a number of trusts were actively grappling with. For example, Medway NHS FT has revised its approach to clinical audit to make it more systematic and embrace the trust's own risks more clearly. (Case study 5).

Other sources of assurance

136 There is a wide range of other potential sources of assurance readily available to trusts, but many more that could be commissioned where a specific need is identified. While not being independent, critical self-assessment by the board can provide additional assurance if carried out well. Our review found that trusts use a variety of different sources of assurance, both internal and external. We have included a list of common sources of assurance in Appendix 3. Some trusts have adopted, or are in the process of adopting, a systematic approach to identifying sources of assurance, whereas others have identified sources of assurance either via brainstorming sessions at board awaydays or by using the expertise and experience of the head of risk, governance or assurance to identify the potential sources of assurance. Given the developmental nature of these approaches it is too early to assess their impact.

The clinical audit strategy developed by Medway NHS Foundation Trust

Medway NHS Foundation Trust, a newly authorised FT which runs the Medway Maritime Hospital, the largest hospital in Kent, decided to rethink its clinical audit strategy. It engaged the help of its internal auditors in drawing up a more structured approach for clinical audit based on their methodology for planning, delivering and reporting audits. The new clinical audit strategy developed considered a wide range of factors including:

- the Healthcare Commission's Annual Health Check;

- National Service Frameworks (NSFs);

- National Institute for Health and Clinical Excellence (NICE) guidance;

- Clinical Negligence Scheme for Trusts (CNST);

- areas flagged as below average by Dr Foster and CHKS;

- the Risk Register and Assurance Framework; and

- other local issues.

The strategy is intended to provide a context and framework for promoting clinical audit within the trust. The aim is to ensure that effective clinical audits are planned and undertaken to measure and improve the effectiveness and safety of healthcare across the organisation, in addition to providing independent assurance to the board.

The trust is in the process of using this strategy to produce a three-year strategic audit plan. The strategic audit plan will have two separate sections: the first section will be significantly larger and cover core work to inform the board and integrated audit committee on assurances driving the assurance framework; the second section will cover continuing professional development and professional accreditation. Both sections will be divided into three sub-categories: mandatory, policy and discretionary.

Reports will be presented to the directorate governance and risk committees and the board on an exception basis. It is intended that the reports will be used to inform the Head of Governance's opinion and the SIC.

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Source: Audit Commission

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Case study 6

Harrogate and District NHS Foundation Trust's assurance registers

Harrogate and District NHS Foundation Trust, which became a FT in January 2005, provides a wide range of hospital services, including a number provided in partnership with York Hospitals NHS Foundation Trust, and has an annual turnover of around £100 million. Five years ago, when the trust was developing its BAF, it was aware that it received visits and accreditation from a wide range of external inspectors and that these should be used to provide assurance that the controls in place to manage the risks to the trust's strategic objectives were effective. The trust undertook to develop departmental assurance registers to capture the details and outcomes of visits by inspectors, to enable sources of assurance to be identified and coordinated, and gaps in assurance to be identified.

The trust has developed assurance registers for many departments and amalgamates these into a combined register which is reviewed regularly by the standards group comprising the deputy chief executive, the director of governance – who was a clinician – and the head of information, and is used to inform the BAF and risk registers. The assurance registers record details of the accrediting body; the accreditation received; the assurance received; frequency of visits; dates of next planned visits and the implications of not gaining assurance.

The main benefit to the trust is greater awareness of the sources of external assurance available to it and easier identification of gaps in assurance.

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Source: Audit Commission

137 A number of trusts we visited were implementing new processes to try to ensure they captured potential sources of assurance. As set out above, Harrogate and District Hospital NHS FT has developed assurance registers to help it capture a wide range of assurance, particularly that stemming from visits by inspectors (Case study 6).

138 However, in light of the changed regulatory environment on becoming an FT and the introduction of core standards declarations, it was perhaps surprising that only a few had fundamentally reviewed the scope of assurances from internal audit and other sources. The forthcoming move to registration standards and the need to publish care quality accounts provide a sound rationale for trusts to review what assurances they need and from whom they commission them.

Evaluating assurances

139 The BAFs we reviewed identified a range of assurances to demonstrate that particular risks were being effectively managed, but we found little evidence of their systematic evaluation. Clearly, the findings of reviews can potentially indicate positive assurance that controls and management action are working; offer no assurance either way; or indicate that controls are not operating effectively. The starting point is having clear controls in place to mitigate risks. Our review of BAFs found that controls were sometimes poorly defined. As such, it would be hard for a user of the document to understand what the control actually was and to assess whether it might reasonably be expected to have a positive effect in managing the risk.

140 For example, we compared controls identified in the BAF that were seen as mitigating a common risk to a common strategic objective: ensuring staff receive mandatory training. The risks fell into three broad categories: the existence of policies; information reported to a group or committee; or just statements that it would be done. Different trusts used different combinations of these, with one simply listing its training policy as a control, while another listed four sub-committees, a framework strategy and two different training programmes as controls. However, in no case was it clear exactly how these controls might mitigate the risk effectively. The existence of a policy or strategy is really just a corporate statement of intent and says nothing about its implementation. Similarly, the existence of a committee is not in itself a control. The committee needs actively to monitor the action plan associated with a particular risk. A good control system would specify what action was being taken to mitigate the risk and define where this risk was being monitored. Once there is clarity about the controls to mitigate strategic risk, both to those using the BAF and to those operating the controls, the board needs assurances that these controls are working.

141 As with controls, the clarity with which assurances are explained in the framework can bolster the confidence they can give. Many trusts give their single source of assurance as reporting to, and monitoring by, various boards and committees, but do not give any indication of the rigour of the activity. The only real assurance this provides is who might be accountable in the event of a risk becoming an issue. The more measurable, verifiable and objective an assurance is, the stronger a declaration and source of evidence it is. The assurance must also be up to date. Sources of assurance should be regularly reviewed to ensure they are still relevant.

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142 Effective assurance needs to be at two levels, internal and external. Internal assurances are largely self assessed but can provide regular, and often correct, 'litmus test' indication. An example of a poor assurance relating to staff training was 'HR training programme', which is a description of how the risk was being mitigated, not an assurance that it was. Examples of good internal assurances for monitoring the effectiveness of a control to ensure full staff training included 'monitoring attendance registers' or 'examining qualifications obtained'. Many assurance frameworks listed compliance with Standards for Better Health, NHS Litigation Authority standards, and other benchmarks, as an assurance. While compliance would provide some assurance, as a self-assessed exercise this would be limited. Were they to be assessed by the Care Quality Commission (the successor organisation to the Healthcare Commission) and their self-assessment found accurate, this would provide strong external assurance and further bolster self-assessment as a method of internal assurance.

143 In many of the cases we reviewed it seemed as if a tick box approach had been taken when a potential source of assurance was identified and that there was little subsequent scrutiny when it was received. A number of the trusts we visited were developing ways of either grading the reliability of different sources of assurance, or putting arrangements in place to independently review and challenge the quality and relevance of identified assurances. Two examples of methods of evaluating sources of assurance are set out on the following pages (Case studies 7 and 8).

Plymouth Hospitals NHS Trust's approach to evaluating assurances

Plymouth Hospitals NHS Trust has developed and is using an approach that scores assurances against eight dimensions, with easy-to-use criteria within each, that are integrated into a composite score for use in BAF. The scoring methodology was developed by the trust in conjunction with its internal audit providers, Devon and Cornwall Audit Consortia. The dimensions considered are:

- the independence of the reviewer;

- the frequency of their review;

- the timeliness of reporting on completion of fieldwork;

- the scope of the review;

- how much evidence was reviewed during the review;

- whether reports include action plans and are followed up by the reviewer;

- the skills and status of the reviewers; and

- whether the output includes opinion on adequacy of controls in place.

The expected benefit of this approach is that board members have greater confidence that assurances are relevant. This is because:

- assurances represent the full and best knowledge of the trust (the process identifies more sources of assurance and the BAF is kept up to date if further evidence is identified);

- the relevance of assurances is considered;

- the reliability is measured and factored in; and

- action plans are picked up and monitored in a controlled manner.

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Source: Audit Commission

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144 Guy's and St Thomas' NHS FT is also undertaking a sizeable piece of work to develop an assurance directory and map, but these are still under development. It involves assessing some 300 potential pieces of assurance in order to develop an approach to scoring assurances against risks to achieving strategic objectives, which will in turn enable the trust to identify clearly gaps in assurance and effectively target resources to provide additional assurance.

145 Trusts should also consider how critical self-assessment can be used to assess the adequacy of assurances. For example, Cambridge University Hospitals NHS FT used the skills and experiences of its non-executive directors and governors to carry out its own review of the evidence supporting its Standards for Better Health declarations. Although this does not provide an independent assurance to the board, it does provide additional assurance and comfort to the board when making their declaration.

Role of the audit committee and links to the board

146 In Chapter 2 we stated that the board usually tasks the audit committee with overseeing its internal control and assurance processes on its behalf, although in Chapter 3 we also saw that a separate sub-committee may be used to provide focused challenge on the operation of risk management processes. Here we consider how the audit committee discharges that responsibility and feeds back to the board.

147 The role of the audit committee has moved on from looking at purely financial controls and approval of the financial statements, to considering the whole system of internal control. This has put a considerable pressure on their agendas and meant developing new ways of working and marshalling the resources at their disposal.

148 The board needs to agree with the audit committee what assurances it requires and when, to feed its annual business cycle. In order to meet these expectations the audit committee needs a clear view of its programme across the year. In reality, these expectations are likely to relate to certifications that the board must make, including returns to Monitor and the Care Quality Commission, the signing of the SIC and the soundness of the financial statements. However, increasingly, this might also involve assurances over the control of major projects or business processes.

149 We found enormous variability in the operation of audit committees and other board sub-committees responsible for assurance over internal controls across the sites we visited, but some common themes emerged:

- assurance was not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that historically had been problematic; for example, major new capital or IT projects, or PFI schemes;

- there was less developed oversight of clinical risks in particular by the audit committee and rarely did the medical director or their team attend. However, this was less likely to be the case if there was a specific sub-committee considering integrated risk management;

- there was limited consideration of data quality underpinning performance reporting or clinical coding, despite its significance to the income stream;

- in some cases, chief executives attend audit committees. There are pros and cons to this. What is important is that the committee does not, in practice, become chief executive led as this would subvert its purpose; and

- feedback to the board was often a weakness, with minutes of the audit committee and other sub-committees being noted rather than discussed, or feedback happening informally between non-executives outside the meeting.

150 We noted that the evidencing of assurances and their evaluation was generally weak. However, more effort tended to be put into validating the assurances in respect of the Standards for Better Health declaration. In some cases these were reviewed by a nominated non-executive director or governor.

151 Despite this extra effort, the latest Healthcare Commission inspection programme has suggested that trust self-assessments of compliance with standards were often inaccurate:

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- the annual health check inspections found they did not agree with the trust's self- assessment for a third of the standards they reviewed. Risk-based inspections had 38 per cent failure rate and random inspections 22 per cent. Indeed, for three trusts they did not agree with the self-assessment for any of the standards reviewed;

- the latest published results of the Healthcare Commission's spot-check reviews of hygiene standards found only 10 per cent of those inspected fully complied with guidelines. While most instances of non-compliance were not considered to represent an immediate risk to the safety of patients, almost all trusts needed to do more to get systems for infection prevention and control in place; and

- the Healthcare Commission's recent reviews of maternity services identified serious concerns in some trusts about levels of staffing and consultant obstetrician input; poor attendance at training courses; inadequate continuity of care for women; poor adherence to antenatal care standards; poor communication, care and support after birth; and inadequate facilities and information systems. It was clear that these issues were not being effectively risk managed and, by implication, inadequate assurances had been received by the boards.

The Statement on Internal Control (SIC)

152 The SIC should reflect the operation of the control environment throughout the year and is therefore not a simple 'point in time' statement. It needs to be underpinned by sound assurances on the design and operation of risk management process, on systems of internal financial control, and on compliance.

153 We did not find this to be universally the case. There was a tendency for the SIC to be template driven and for NHS trusts to concentrate on those areas performance managed by the strategic health authority. The SIC should reflect the understanding of the entire internal control framework's operation and be based on sound assurances. This effectively means taking the representations of management and sub-committees and measuring them against wider understanding of the trust and external assurances. At present, it is in danger of being another form-filling exercise to fulfil statutory and regulatory requirements, rather than the honest self-appraisal it is intended to be.

154 We found evidence from board papers of discussion of draft versions of SICs at some of the trusts we visited and that the trusts had sought to ensure that the SIC fairly reflected the circumstances of the trust. However, some trusts' board papers did not record evidence of discussion and challenge. Although we were informed such discussions took place, we were unable to verify this.

155 There also continues to be some discrepancy between SICs and self-assessments provided to the Healthcare Commission on compliance with Standards for Better Health. The position has improved following the review by the Audit Commission and Healthcare Commission and guidance from the DH, but the relationship between these two documents is still not fully understood. There should be no discrepancies and the SIC should effectively subsume the same information as any self-assessment on compliance with Standards for Better Health. The SICs relating to 2008/09 will, for the first time, state whether the organisation is or is not fully compliant with Core Standards for Better Health. This should help to ensure greater consistency.

156 It is also clear that, in some cases, the SIC does not represent a fair appraisal. One trust, which had significant internal control issues, declared in its SIC only that 'internal and external audit had made recommendations to improve processes, including some relating to the assurance framework and that the trust had identified management actions to address the issues and auditors would review progress in 2008/09'. The Maidstone and Tunbridge Wells NHS Trust 2006/07 SIC included infection control as a significant control weakness, but noted that 'much work has been undertaken during the year and this is being further strengthened in 2007/08'. In hindsight, the board could clearly not have had sufficient assurance or adequate meaningful discussion to ensure the wording reflected the level of risk that existed.

157 Our review suggested that giving greater profile to the SIC would strengthen the approach to board assurance. There are a number of possible approaches to this:

- first, the regulatory framework should more clearly draw on the SIC as a fundamental document. So, for example, there would not be a separate return about compliance with Standards for Better Health. The SIC would cover this. The move to registration standards means that trusts should address whether they have the appropriate controls and assurances to satisfy themselves that they comply with the standards. This would be reflected in the SIC, which would be a key regulatory document if self-certification was required. It would also be subject to regulatory inspection, if that were deemed necessary, with consequent action against the trust and its board if the controls and the declaration proved inadequate;

- second, greater emphasis should be placed on quality of care and clinical aspects. These are fundamental to a trust's business. Trusts will be required to produce statutory quality accounts and these should not become a separate exercise, as was the case with self-assessments for compliance with Standards for Better Health;

- third, the SIC could be illustrative of not just the process, but also the outcomes. Rather than simply

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referring to how the trust manages risk, it should set out what the biggest issues it faced in the year were, how it managed them and how it has assessed the outcomes; and

- fourth, the SIC could also include reference to the key risks for the year ahead, as risk management is an ongoing process, and set out how the trust is intending to manage them. This is not unlike the requirement to state the main risks to achieving strategic objectives in the annual plan submitted to Monitor and would draw a clear link between the two, making them a single process. It would also enable and encourage reflection by the board on whether key risks had been identified and managed well across the year.

158 A further possible step would be for trusts to follow the path that some private sector organisations have gone down, of sub-certification and control risk self-assessment, where those further down the organisation assert their confidence in the design and application of the internal control environment. Simply put, this means that those responsible for operating and overseeing controls as part of their day-to-day jobs make assertions to senior management as to their operation, and the accountable officer cascades to others at different levels within the trust the certifications that need to be made. This allows some assurance that managers have designed and put in place necessary controls.

159 This effectively cascades ownership of the SIC through the trust and requires managers to certify on the effectiveness of the operation of internal control within their divisions. This in itself could potentially result in a further paper chase. However, if combined with an effective compliance function and linked to internal performance information and performance management, it would provide sound evidence-based assurance for the signing of the SIC. It would also increase personal accountability in case of failures in the control environment.

Data quality

160 Good quality information is vital for trusts to facilitate performance monitoring and support decision making. With this in mind, we reviewed arrangements for ensuring data quality at the sites we visited. The findings form a separate briefing *Figures You Can Trust: Briefing on Data Quality in the NHS* (Ref. 3).

161 Trusts need to be aware of the quality of their data. They should neither assume it is robust without having systems in place to verify its quality, nor should they assume that apparently poor performance is due to poor data. The latter was the case at Mid Staffordshire NHS Foundation Trust where the trust explained its reported mortality rate was high because the data were wrong (Ref. 2).

162 Our review concluded that the profile and importance of data quality needs to be raised, with boards being made more aware of the issue so that assurance processes can be improved. We found that governance and accountability arrangements need to be clarified so that any issues identified through monitoring and assurance processes are considered at the appropriate level. We found significant differences in the approaches taken by individual organisations to assure themselves about data quality, with varying degrees of success. Many of the trusts we visited had elements of assurance processes for data quality but very few were comprehensive. In particular, few had examined the accuracy of the data. Our overall view was that boards should take a greater lead in improving and assuring themselves about the quality of the data they receive and that their organisation publishes. The briefing sets out a number of areas which, if adopted, could provide a useful platform for developing assurances over data quality at board and wider organisation level.

Conclusion

163 Our review showed that trusts had many or all of the necessary processes in place but the clarity and rigour with which they were applied varied considerably. In particular:

- controls and assurances were often poorly defined, making it difficult to see how boards could be clear that the controls were working effectively and the assurances were sound;

- greater attention needed to be paid to compliance mechanisms and these needed to be more clearly distinguished from internal audit, which should review the effectiveness of the compliance framework, not be a substitute for it;

- the use of internal audit could be improved with greater emphasis given to the quality of the assurance derived from it rather than on cost minimisation. Internal audit rarely had the skills available to cover all a trust's needs and its use should also be placed in a wider framework of review as there are alternatives to internal audit in many cases;

- the use of clinical audit as part of the BAF was poorly developed. This is a significant weakness. Few trusts could report how clinical audit was being used in a systematic way to address risks with the results reported to the board through the BAF;

- greater effort was made to review and assess assurances provided in respect of self-assessments for compliance with Standards for Better Health. Even so, these efforts were not wholly successful, as judged by the results of follow-up inspections by the Healthcare Commission;

- trusts' approach to the SIC was variable and in some cases appears to have become a matter of lip service. Greater emphasis could be given to

Gaining assurance on internal controls

the SIC as a key component of the regulatory framework, rather than introduce new, parallel, mechanisms. It could also be made less process oriented and more forward looking, thereby encouraging boards to reflect on their identification of risk and success in managing it through effective internal controls; and

- there may also be merit in cascading the SIC through the organisation by sub-certification by managers but, to avoid this becoming a further paper chase, it would need to be allied with a more effective compliance function, performance information and performance management.

Recommendations

Trusts should:

- review how they identify and then evidence assurances on the operation of controls and how these are then evaluated;

- maximise the assurance obtained from internal audit by reviewing the scope of internal audit plans – using Appendix 2 as a guide – and improving the commissioning of internal audit;

- review and increase the assurances they receive from sources other than internal audit, including clinical audit, and in doing so ensure that their full portfolio of risk is covered;

- better align clinical audit programmes to key strategic and operational risks in order to maximise the assurance provided by the clinical audit function;

- consider cascading the SIC through the organisation by sub-certification by managers. To avoid this becoming simply a bureaucratic exercise it should be allied with a more effective compliance function, performance information and performance management;

- strengthen their compliance mechanisms and distinguish them more clearly from internal audit which should review the effectiveness of the compliance framework;

- ensure they have robust arrangements for ensuring the quality of their data by assessing themselves against the standards for better data quality set out in the Commission's *Figures You Can Trust* briefing (Ref. 3) and by developing systematic and formalised review programmes for their data, including checking accuracy back to records; and

- develop policies and guidance on data quality and assurance processes, including defining and allocating responsibility for data quality, to promote consistency and improve awareness of board members.

The DH and Monitor should:

- consider revising guidance on the format and content of the head of internal audit opinion to provide the accountable officer with a clearer picture of the scope and quantum of internal audit work underpinning the opinion.

The DH and regulators should:

- consider how the SIC could be less process oriented and more forward looking to encourage boards to reflect on their identification of risk and success in managing it through effective internal controls. They should also regard the SIC as the primary document for regulatory purposes and not introduce parallel processes.

5 Conclusions

164 Boards need a clear understanding of the risks and meaningful assurance that internal control systems are working effectively. Our review has found some worrying weaknesses in governance processes. While we did find some good practice, overall there was much room for improvement. In the worst cases the assurance process had become a paper chase rather than a critical examination of the effectiveness of the trust's internal controls and risk management arrangements. The NHS has, in many cases, been run on trust.

165 We have included recommendations throughout the report and would encourage trust boards to assess themselves using the questions for boards included in the report summary.

Appendix 1: Corporate governance in the NHS

The *Code of Conduct and Code of Accountability* (Ref. 12) issued in April 1994 set out a governance approach for the NHS based around the principles of accountability, probity and openness. With the Secretary of State for Health in the place of shareholders in the private sector, the Code of Conduct is naturally focused on the proper stewardship of public monies. The Code of Accountability sets out the roles of the board, chair and non-executive directors.

From 1997/98 to 2001/02 there was a period of sustained governance development:

- HSG(97)17 and EL(97)55 heralded a new approach, with the introduction of controls assurance. This required the accountable officer to make a declaration on the operation and design of controls in a statement on internal financial control in 1997/98.

- Structures changed as a result of HSC 1999/065, which introduced a clinical governance committee to sit alongside existing health and safety and risk management processes.

- HSC 1999/123 significantly extended the controls assurance agenda by including clinical and other non-financial risk management, and introduced a more comprehensive published assurance in a SIC. The extent of this disclosure continued to grow over the succeeding years as it moved from partial to full disclosure in 2003/04, by when full compliance was expected. There have been further minor changes over time but it remains largely unchanged.

- This all coincided with a period of risk pooling within the NHS, which meant the NHS Litigation Authority managed a self-insurance scheme for trusts. This was initially for clinical risks from 1995 but extended to non-clinical risks in 1999. While this approach controlled costs, it also meant NHS trusts were largely insulated from the direct financial impact of risks. A discount scheme for members, based on a compliance with risk management standards, incentivised trusts to put processes in place to manage clinical risk.

Against this background there has been a wide range of guidance produced, in addition to that included within the numerous health service circulars and letters, to help NHS trusts develop their governance arrangements. These are summarised in Table 3.

Table 3

NHS Corporate Governance Guidance

Key publications on corporate governance in the NHS

Publication, author and date	Key messages
NHS Internal Audit Manual DH, 1987, 1990, 1995 and 2002	This sets out nine standards which represent mandatory guidance and the rest of the manual constitutes advice and support to practitioners. The standards cover areas such as the scope of work, the independence of the auditor, staffing and training, professional standards and the evaluation on the internal control system.
Audit Committee Handbook DH, 1995, 2001 and 2005	This has been adapted over the years to reflect governance changes in the NHS and the expanding role of the audit committee within the wider assurance framework. It explains the role and responsibilities of the audit committee in giving assurance to the board, and gives guidance on its constitution, how it conducts its business, and how auditors and Local Counter Fraud Specialists support their work.
Assurance: The Board Agenda DH, 2002	To support the move to a SIC, this guidance stressed the need for boards to demonstrate they were properly informed of the totality of the risks to not meeting their objectives or delivering appropriate outcomes, and had independent assurances on the design and operation of the systems and processes in place.
Building the Assurance Framework: A Practical Guide for NHS Boards DH, 2003	In response to requests for additional direction and advice on building an assurance framework, this gave practical advice on how to bring together the existing fragmented risk management activity into a single process. It also clarified the relationship with performance management arrangements, the new clinical governance reporting framework, the core Controls Assurance Standards and other sources of assurance.
Governing the NHS DH and NHS Appointments Commission, 2003	Against the modernisation agenda introduced by the NHS Plan and on the back of the *Higgs Report*, this joined up many of the existing strands of NHS guidance and defined a set of principles to refocus board attention. The report was clear that good governance enhances the care and wellbeing of patients, and the staff who look after them.
Standards for Better Health DH, 2004	This set out 24 standards that defined the level of quality all organisations providing NHS care in England were expected to meet or aspire to. These form a key part of the performance assessment by the Healthcare Commission of all healthcare organisations and cover safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health.

Publication, author and date	Key messages
Effective Boards in the NHS NHS Confederation, 2005	Despite NHS bodies having all the necessary governance elements in place, it was not felt things were working as they should be. The report identified the behaviour and culture of a board as key determinants of the board's performance.
Providing Assurance on Clinical Governance: A Practical Guide DH, 2004	This provided an outline approach for internal auditors to follow when carrying out reviews of clinical governance frameworks and systems of internal control, within clinical departments and in areas of clinical activity.
Integrated Governance Handbook DH, 2006	The handbook provides support and best practice guidance to organisations that are keen to review their governance and assurance arrangements to ensure all the threads of quality, performance and governance are aligned and integrated, whether clinical or non-clinical.
Board Assurance: A Guide to Building Assurance Frameworks for Reducing Healthcare Associated Infections DH, 2008	This sets out a five-stage process, endorsed by the DH, for the development of assurance frameworks for healthcare associated infections.
The Compliance Framework Monitor, 2008	This sets out the approach Monitor takes in assessing whether NHS FTs comply with the terms of their authorisation and how they will intervene where necessary.
The NHS Foundation Trust Code of Governance Monitor, 2006	This is a corporate governance framework for FTs. While it constitutes advice, FTs are expected to comply with its provisions or explain why they feel departure is justified.
Effective Governance in NHS Foundation Trusts: Briefing Monitor, 2008	This sets out the findings from review of the self-certification arrangements in 11 FTs, following concerns over the reliability of trust declarations. It raises a number of governance issues for boards to consider.
Identifying Risk, Taking Action: Monitor's Approach to Service Performance Monitor, 2008	This sets out Monitor's approach to regulating the delivery of standards of patient care. In essence, boards are held accountable for the early identification and resolution of problems.

Source: Audit Commission

Appendix 2: Features of good internal audit plans

The following are considered to be features of a good internal audit plan. The detailed requirements and the level of input required will vary according to the nature and complexity of the trust: The plan should:

- set out the basis of risk assessment;

- demonstrate how the BAF and risk registers have been used to identify areas for internal audit work;

- include the rationale for each piece of work;

- show clear links to strategic objectives, the BAF, Standards for Better Health etc;

- cover all systems/functions of trust, including compliance, on a cyclical basis;

- explain the basis of reporting, ideally to the chief executive;

- explain the process by which the plan is reviewed and amended to take account of changes and emerging risks;

- group the proposed work into areas. For example: key financial systems, governance (including the BAF, risk management, Standards for Better Health, information technology and information governance and operational reviews);

- cover key financial systems annually and explain how this supports the work of external audit;

- cover the BAF including an assessment of the overall system, how it is reported to the board, the progress on associated action plans and examination of adequacy and robustness of sources of assurance;

- cover risk management, including a review of overall arrangements, corporate risk registers and actions taken to mitigate risks;

- include an overall review of arrangements and for FTs compliance with terms of authorisation (FTs only);

- include a review of systems for producing returns to Monitor (FTs only);

- include a review of the systems in place for production of self declarations and evidence to support declarations (for example, Standard for Better Health declarations and any future registration requirements);

- set out the work required to produce the head of internal audit opinion;

- include operational reviews, depending on the size and nature of the trust;

- cover information governance, including a review of the information governance toolkit submission and systems in place to produce this and review of data security;

- include data quality, either a specific review of high risk areas (for example, clinical coding) or evidence that data quality is built into all reviews;

- include a review of the clinical audit systems in place;

- include reviews of the trust's partnership arrangements; and

- include a contingency which can be used to cover emerging risks.

Appendix 3: Assurance identikit

Table 4 below considers a number of commonly identified objectives and risks from BAFs that we reviewed, and sets out potential sources of assurances for the operation of controls. We have also compiled a list of the most commonly used sources of assurance from BAFs listed in Table 5.

Table 4
Assurance identikit

Commonly identified strategic objectives	Example key risk	Potential sources of internal assurance	Potential sources of external assurance
To provide excellent quality healthcare to service users and be recognised as such by regulators	Failure to comply with or monitor standards relating to quality and patient safety	Performance reports Key performance indicators (KPIs) Clinical audit SUI reports Internal audit reports	Annual patient satisfaction surveys NHS Litigation Authority Royal College visits Deanery visits
	Failure to recognise, motivate and value staff	Training records Results of staff satisfaction surveys Staff appraisals Human resources reports Exit questionnaires	Benchmarking
	Failure to recruit and retain staff	Human resources reports	Benchmarking
	Failure to ensure patients are treated with dignity and respect	Complaints records Feedback on NHS Choices	

Appendix 3: Assurance identikit

Commonly identified strategic objectives	Example key risk	Potential sources of internal assurance	Potential sources of external assurance
To meet all statutory financial targets and generate a surplus of £Xm	Loss of financial control	Performance reports Finance reports Sub-committee reports Internal audit reports	External audit reports Strategic Health Authority reports Financial benchmarking reports
To be regarded as a leader in the provision of high quality healthcare	Reputational risk arising from patients being harmed	Clinical audit SUI reports Training records Infection controls reports Standards for Better Health self-assessment Complaints records	Annual patient satisfaction survey results Healthcare Commission hygiene code audit Patient environment assessment team scores
To implement the trust's plans to develop a new hospital site	Failure to deliver plans on time and to budget	Budget reports Sub-committee reports Internal audit reports	External advisors External audit reports

Table 5
Commonly used sources of assurance from BAFs

Internal sources of assurance	External sources of assurance
• Internal audit	• External audit
• KPIs	• Audit Commission
• Performance reports	• NHS Litigation Authority
• Sub-committee reports	• Clinical Negligence Scheme for Trusts
• Compliance audit reports	• Strategic health authority reports/reviews
• Local counter fraud work	• Monitor
• Clinical audit	• Healthcare Commission hygiene code reports
• Staff satisfaction surveys	• Healthcare Commission reviews
• Staff appraisals	• Healthcare Commission inspections of Standards for Better Health declarations
• Training records	• Royal College visits
• Training evaluation reports	• Deanery visits
• Results of internal investigations	• External benchmarking
• SUI reports	• Patient environment action team reports
• Complaints records	• Accreditation schemes
• Infection control reports	• National and regional audits
• Standards for Better Health self-assessment	• Peer reviews
• Information governance toolkit self-assessment	• Feedback from service users
• Patient advice and liaison services reports	• Feedback from commissioners
• Human resource reports	• External advisors
• Internal benchmarking	• Local networks (for example, cancer networks)
	• Investors in People

Appendix 4: References

1   Healthcare Commission, *Investigation into Outbreaks of Clostridium Difficile at Maidstone and Tunbridge Wells NHS Trust*, Healthcare Commission, October 2007.

2   Healthcare Commission, *Investigation into Mid Staffordshire NHS Foundation Trust*, Healthcare Commission, March 2009.

3   Audit Commission, *Figures You Can Trust: Briefing on Data Quality in the NHS*, Audit Commission, 2009.

4   Healthcare Commission, *The Big Picture*, Healthcare Commission, 2008.

5   National Patient Safety Agency, *Reporting and Learning System Quarterly Data Summary, Issue 9*, National Patient Safety Agency, 2008.

6   COSO Framework, *Committee of Sponsoring Organisations of the Treadway Commission*, COSO, 1992.

7   Gee, *Financial Aspects of Corporate Governance (the Cadbury Report)*, Gee, December 1992.

8   Gee, *Hampel Report (Committee on Corporate Governance)*, Gee, 1998.

9   Department of Trade and Industry, *Review of the Role and Effectiveness of Non-executive Directors (the Higgs Report)*, Department of Trade and Industry, 2003.

10 Financial Reporting Council, *Audit Committees: Combined Code of Guidance (Smith Report)*, Financial Reporting Council, 2003.

11 Public Company Accounting Reform and Investor Protection Act of 2002 (Sarbanes Oxley Act), July 2002.

12 Department of Health, *Code of Conduct and Code of Accountability,* Department of Health, April 1994.

13 Department of Health, *Health Service Circular (HSC) 1999/123*, Department of Health, 1999.

14 Department of Health, *Assurance: The Board Agenda*, Department of Health, 2002.

15 Department of Health, *Building the Assurance Framework: A Practical Guide for NHS Boards,* Department of Health, March 2003.

16 Department of Health, *Integrated Governance Handbook*, Department of Health, February 2006.

17 Department of Health, *Audit Committee Handbook*, Department of Health, 2005.

18 Monitor, *Code of Governance for NHS Foundation Trusts*, Monitor, September 2006.

19 Department of Health, *Governing the NHS*, Department of Health, 2003.

20 Committee for Standards in Public Life, *First Report*, Committee for Standards in Public Life, 1994.

21 Department of Health, *High Quality Care for All (the Darzi Review)*, Department of Health, 2008.

22 Institute of Chartered Accountants, *Internal Control: Guidance for Directors on the Combined Code (the Turnbull Report)*, Institute of Chartered Accountants, 2005.

23 Audit Commission, *Auditors' Local Evaluation 2007/08: Summary Results for NHS Trusts and Primary Care Trusts*, Audit Commission, October 2008.

24 Department of Health, *Head of Internal Audit Opinion on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2006*, Department of Health, February 2007.

25 Department of Health, *NHS Internal Audit Manual*, Department of Health, 2002.

26 Department of Health, *Standards for Better Health*, Department of Health, 2006.