Taking it on trust

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

Health
Summary
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This document is a summary of the *Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance* report. The report 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 1,000 pages – on the subject. It is about the rigour with which they operate the processes and get the assurance they need.

Our research stems from: Monitor’s¹ 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 II and Mid Staffordshire NHS Foundation Trust. III 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.

¹ Monitor is the Independent Regulator of NHS Foundation Trusts.

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

Summary

We reviewed relevant literature and guidance; carried out a detailed examination of the key processes, controls and assurances at 15 acute and mental health trusts; and held 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 we visited 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 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;
- good internal controls;
- evidence that internal controls are operating effectively; and
- good data quality.

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;
- 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;
- 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;
Summary

• 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;

• 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;

• 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 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; 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.
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 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.
Summary

**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 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\(^1\) 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

Summary

• 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?\(^I\)

• 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?

\(^I\) *The Intelligent Board*, Dr Foster Intelligence, 2006.
Summary

- 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?
Summary

• 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?

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