

**TO:** 2gether NHS Foundation Trust Board  
**FROM:** David McGrath, Director of Corporate Affairs  
**DATE:** 26 January 2009  
**SUBJECT:** BOARD ASSURANCE

**PURPOSE**

This paper provides a quarterly update on the Board Assurance Framework.

**SUMMARY OF KEY POINTS**

- Two new risks are reported relating to the Trust growth strategy
- The score of two health and safety linked risks have been reduced..

**RECOMMENDATIONS**

It is recommended that

- the Assurance Framework be updated as set out in Annex A:
  - i) to take account of the assurances received
  - ii) to amend the risks as proposed.

**WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?**

|                          |   |                          |  |
|--------------------------|---|--------------------------|--|
| Supporting clinical care |   | Skilled workforce        |  |
| Getting the basics right | P | Using better information |  |
| Social inclusion         |   | Financial efficiency     |  |
| Seeking involvement      |   | Legislation              |  |

\*progressed (P) or challenged (C)

**WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?**

|  |  |                           |   |
|--|--|---------------------------|---|
| Seeing from a service user perspective |  |                           |   |
| Excelling and improving                |  | Inclusive open and honest |   |
| Responsive                             |  | Can do                    |   |
| Valuing and respectful                 |  | Efficient                 | P |

|                     |                     |
|---------------------|---------------------|
| <b>REVIEWED BY:</b> |                     |
| Executive Team      | Date: 19 January 09 |

## 1. BACKGROUND

1.1 Since the last Board Assurance paper was presented to the October Board the Trust has received or produced a number of reports that may be regarded as possible sources of assurance. These include the following:

- Director of Finance Reports to the Board
- Performance Management Reports (Dashboard)
- Service Experience Quarterly Report
- Infection Control Quarterly Report
- Mental Health Act Commission Annual Report
- Non-executive Review of Complaints
- Annual Report of Complaints
- Internal Audit Report of Self Certification Processes for Monitor
- Annual Patient Safety Report

1.2 The Board should:

- consider the extent to which an objective review has been undertaken of the systems in place
- consider the opinion the assurer has given, and
- allocate one of the following classifications:

| <b>Classification</b>     | <b>Description</b>   |
|---------------------------|--|
| Full assurance (F)        | a sound system of controls has been effectively applied and manages the risks to the achievement of the objectives   |
| Significant assurance (S) | a sound system of controls has, for the most part, been consistently applied, minor inconsistencies have occurred but there is no evidence to suggest that the system's objectives have been put at risk |
| Limited assurance (L)     | gaps in the application of controls as designed by management put the achievement of objectives at risk  |
| Negative assurance        | gaps in the application of controls as designed by management have opened the system to risk of significant failure to achieve its objectives and left it open to abuse or error                         |

## 2. ASSURANCE DOCUMENTS RECEIVED BY THE BOARD

2.1 The following reports were received directly by the Board.

| REPORT                                      | DATE        | PROPOSED ASSURANCE LEVEL  |
|---|-------------|---|
| Director of Finance Reports                 | Oct-Dec 08  | Significant assurance on 2008/09 outturn in relation to Monitor ratios, although limited assurance on manageability of the consequences of the surplus amount |
| Performance Management Reports-(Dashboard ) | Oct-Dec 08  | Significant assurance on external targets   |
| Service Experience Report                   | November 08 | Significant assurance   |
| Infection Control Quarterly Report          | November 08 | Significant assurance   |
| Non-executive Review of Complaints          | November 08 | Limited Assurance   |
| Mental Health Act Commission Annual Report  | December 08 | Significant assurance   |
| Annual Report of Complaints                 | December 08 | Limited Assurance   |

## 3. ADDITIONAL ASSURANCE DOCUMENTS RECEIVED

### 3.1 Internal Audit of Self Certification Processes

The internal Auditor reviewed the Monitor annual self-certification which forms part of the annual business plan submission and the process for the self-certification of the quarterly returns, specifically whether they were in line with the requirements set out in Appendix D of the Compliance Framework. The quarterly returns are supported by three reports – the Trust’s performance dashboard report, the Trust’s finance report and a report from the Trust Secretary.

In general, they found that the processes to support the annual and quarterly self-certifications to Monitor were satisfactory however, they noted:

- lack of clarity about the Clostridium Difficile target that should be addressed

- compliance with the Hygiene Code should be specifically referred to
- given the significant volume of performance information in the performance dashboard report, there is a risk that the Board is not appropriately focused on the set of indicators which it needs to self certify: This should be highlighted more effectively.

A significant assurance was given.

### 3.2 **Annual Patient Safety Report**

The Practice Standards Committee considered the Annual Patient Safety Report at its November meeting. It noted that:

- overall fewer incidents were being reported than in previous years,
- Self harm and violence continue to account for a significant number of these events
- The majority of incidents in older peoples services are within the slips, trips and falls category.

A limited assurance is proposed.

## 4. **THE ASSURANCE FRAMEWORK TABLE**

- 4.1 With a few exceptions to illustrate changes, only those risks scoring a risk level of 10 or above are shown in the table. The highest scoring risks are shaded. Particular attention should also be given to those risks that are new or where the score is rising (marked ↑).
- 4.2 The framework at Annex A has been amended to reflect the changes outlined above. Of particular note is the reduction in risks in relation to estates and health and safety (2&5). All Trust properties have received a fire risk assessment this year. Only two urgent recommendations were made which are being addressed. New risks are set out at 6&7 relating to the Trust growth strategy.

**<sup>2</sup>GETHER NHS FOUNDATION TRUST  
BOARD ASSURANCE FRAMEWORK**

**F=Full assurance**  
**S= Significant assurance**  
**L=Limited assurance**  
**N =Negative assurance**

**Only risk Scores of 10 and above are shown unless special reasons apply**  
**Arrows ↓↑ show direction of change in risk since last report**

| <b><sup>2</sup>GETHER NHS FOUNDATION TRUST<br/>SOURCES OF ASSURANCE</b>   |                            |            |  |  |   |                    |               |   |
|---|----------------------------|------------|--|--|---|--------------------|---------------|---|
| PRINCIPAL OBJECTIVES  | PRINCIPAL RISKS            | RISK OWNER | CONTROLS   | POTENTIAL SOURCE OF ASSURANCE  | POSITIVE ASSURANCE                                  | NEGATIVE ASSURANCE | ASSURANCE GAP | ACTION/COMMENTS   |
| <b>CORE STANDARD –Safety</b>  |                            |            |  |  |   |                    |               |   |
| <b>Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.</b> |                            |            |  |  |   |                    |               |   |
| 1   | To maintain a safe service |            | NHSLA/ standards<br>Clinical governance<br>Policies/procedures including CPA<br>Reporting procedures External & internal reviews<br>Supervision and training<br>Recruitment process<br>Professional regulatory bodies<br>National care standards<br>Complaints procedures<br>Major incident handling procedures<br>Staff skills/training<br>Safety notice system<br>Child protection and adults at risk procedures<br>MARMAP<br>Suicide strategy | <ul style="list-style-type: none"> <li>Healthcare Commission Review of Substance Misuse Services</li> <li>Healthcare Commission Review of Community Services</li> <li>Healthcare Commission Spot check on NICE implementation</li> <li>Clinical Audit -Ligature Point Review</li> <li>NHSLA assessment</li> <li>Internal Reviews</li> <li>Patient survey</li> <li>Annual Patient Safety Report</li> <li>Audit of NICE implementation</li> <li>Infection Control Reports</li> <li>Acute Inpatient Mental Health Service Review</li> <li>Preventing Suicide Audit</li> </ul> | S<br>S<br>S<br>L<br>S<br>S<br>S<br>S<br>S<br>S<br>S |                    |               | A full review of the measures in place to prevent serious untoward incidents is due to report to the Board in February. |
|   |                            |            | <b>RISK 16</b>   |  |   |                    |               |   |

|   |  |   |    |   |   |        |  |     |  |
|---|--|---|----|---|---|--------|--|-----|--|
| 2 |  | All estate safety checks may not be completed in accordance with statutory and best practice requirements<br><br><b>RISK 12 (↓)</b> | DM | Six facet survey planned<br>Training for staff<br>Agreements with Estates Service<br>Revised reporting arrangements and increased in-house monitoring<br>Monthly supervision meetings with Estates<br>Re-issues of contracts<br>Additional resources for fire surveys<br>Health and Safety staff<br>Incident reporting<br>H&S Training<br>Fire Safety Advisor and training health and safety system | <ul style="list-style-type: none"> <li>• Governance Committee Reports</li> <li>• Head of Property Management reports to Infrastructure Committee</li> <li>• Internal Audit reports</li> </ul> | L<br>L |  | Gap | Paper to the Infrastructure Committee report that considerable effort has been made to scope the work required and address any short falls. All fire risk assessments have been completed and indicate that the level of risk on this item can be adjusted can |
|---|--|---|----|---|---|--------|--|-----|--|

**CORE STANDARD -Clinical and Cost Effectiveness-**

**Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.**

|   |  |  |           |  |  |   |  |  |  |
|---|--|--|-----------|--|--|---|--|--|--|
| 3 | Operate effective clinical governance arrangements | Avoidable bad outcomes for patients<br>Missing the opportunity for patients of positive risk taking<br>Loss of reputation of the Trust<br><br><b>RISK 10</b> | PW/<br>HW | NHSLA standards<br>Clinical governance policies/procedures including CPA<br>Clinical Effectiveness Strategy<br>Reporting procedures.<br>External & internal reviews.<br>Supervision and training.<br>Recruitment process.<br>Professional regulatory bodies.<br>Complaints procedures.<br>Child protection and adults at risk procedures<br>Safety alert system<br>Mental Health Managers<br>NICE Guidelines<br>Leadership and supervision structures. | <ul style="list-style-type: none"> <li>• NHSLA assessment</li> <li>• Royal College visit reports</li> <li>• Service Director's Reports to Practice Standards Committee</li> <li>• Annual Patient Safety Report</li> <li>• Audit of NICE implementation</li> <li>• Standards for Better Health</li> <li>• Health and Safety Internal Audit</li> <li>• Reports to Practice Standards and Governance Committees</li> <li>• MH Act Commission</li> <li>• PEAT</li> <li>• Patient survey</li> <li>• Acute Inpatient Mental Health Service Review</li> <li>• Preventing Suicide Audit</li> </ul> | S<br>S<br><br>L<br>S<br>S<br><br>S<br><br>S<br>S<br>L<br>S<br><br>S |  |  |  |
|---|--|--|-----------|--|--|---|--|--|--|

|   |                                      |  |    |   |   |  |  |  |   |
|---|--------------------------------------|--|----|---|---|--|--|--|---|
| 4 | Staff update skills relevant to work | Training needs cannot be met<br><br><b>RISK 12</b> | KH | Training plan<br>Mandatory training<br>CPD<br>Supervision and appraisal<br>Education and CPD Strategy<br>Group<br>Strategic Training Review | <ul style="list-style-type: none"> <li>• Mandatory training plan monitoring reports to the Workforce Committee</li> <li>• Attendance monitoring at Workforce Committee</li> <li>• Standards for Better Health</li> <li>• NHSLA assessment</li> <li>• Reports from Workforce Committee/Governance Committee</li> <li>• Assurance Report from Training Manager to Governance Committee</li> <li>• Internal audit of recording</li> <li>• Statutory and Mandatory Training Report to the Board –July 08</li> </ul> | L<br><br>L<br>L<br>S<br><br>L<br><br>S<br>L<br>L |  |  | Reports to the Workforce Committee indicate significant improvement in the take up of Statutory and Mandatory training. |
|---|--------------------------------------|--|----|---|---|--|--|--|---|

**CORE STANDARD-Governance**

**Managerial and clinical leadership and accountability, as well as the organisation’s culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.**

**Risk Management**

|   |                                     |  |    |  |  |                           |  |     |  |
|---|-------------------------------------|--|----|--|--|---------------------------|--|-----|--|
| 5 | Maintain a safe working environment | The Trust fails in duty of care or to meet health and safety legislation, leading to litigation,<br><br><b>RISK 12 (↓)</b> | KH | H&S Advisor<br>H&S Training<br>H&S Committee<br>H&S strategy<br>Fire Safety Advisor and training<br>Health and safety system<br>Governance Committee<br>Risk Register<br>Six facet survey planned<br>Agreements with Estates Service<br>Revised reporting arrangements and increased in-house monitoring<br>Monthly supervision meetings with Estates<br>Re-issues of contracts<br>Additional resources for fire surveys<br>Incident reporting | <ul style="list-style-type: none"> <li>• Health and Safety Executive Reports</li> <li>• Internal Audit Report</li> <li>• Minutes of Health and Safety Committee</li> <li>• NHSLA assessment</li> <li>• HSE Audit</li> <li>• Head of Property Management reports to Infrastructure Committee</li> </ul> | S<br><br>S<br>S<br>L<br>L |  | Gap |  |
|---|-------------------------------------|--|----|--|--|---------------------------|--|-----|--|

| Business/Finance |   |   |    |  |  |             |  |  |  |
|------------------|---|---|----|--|--|-------------|--|--|--|
| 6                | To increase the value of the Trust's turnover                       | The Trust could lose existing business contracts to competitors<br><br><b>RISK 9 (↑)</b>                        | SB | Business Development Team support to managers<br>Business Development Committee work programme<br>Marketing Strategy<br>Engagement with commissioner   | Business Development Committee Reports<br>Chief Executive Reports to the Board   | £           |  |  | Added for information as a result of recent notifications about contracts  |
| 7                |   | The Trust's surplus may lead to less favourable contract terms<br><br><b>RISK 10 (↑)</b>                        | SB | Financial Management arrangements<br>Forecasting<br>Representations on the Contract Board<br>Quality improvement programme<br>Bringing spending forward  | Monthly Finance Report   | £           |  |  |  |
| Information      |   |   |    |  |  |             |  |  |  |
| 8                | To ensure that IM&T support the operations of the Trust effectively | IT systems cannot deliver real time reporting of performance against non block contracts<br><br><b>RISK 10</b>  | DM | Risk mitigated by block contracting for in-county PCT<br>Other contracts mainly on named patient cost per case basis or higher tolerance level for small scale work<br>IM&T strategy   | <ul style="list-style-type: none"> <li>Performance Management Committee Reports</li> <li>Infrastructure Committee Reports</li> </ul>   | L<br>L      |  |  |  |
| 9                |   | Lack of clinical staff engagement with IT systems leads to poor performance<br><br><b>RISK 10</b>               | DM | Training programme<br>Monitoring of usage and performance<br>Policies and procedures<br>Appraisal<br>IT access improvements<br>Information Quality programme<br>IM&T strategy  | <ul style="list-style-type: none"> <li>Information Governance reviews</li> <li>Quarterly performance report</li> <li>Performance Management Committee monitoring</li> <li>Practice Standards Committee monitoring</li> </ul> | L<br>L<br>L |  |  | For the next quarterly report risks 8 and 9 will be consolidated into a revised risk description relating to the implementation of a Care Records System |
| 10               |   | That National Care Records Service may not meet the future information needs of the Trust<br><br><b>Risk 12</b> | DM | Contingency Plan for short to medium term information needs<br>Maintain Clinical Manager and local databases<br>Acceptability criteria in project<br>Agreed sign off process<br>Reduce usage by remodelling process<br>IM&T strategy | <ul style="list-style-type: none"> <li>Reports to Infrastructure Committee</li> </ul>  | L           |  |  |  |

|    |  |  |    |   |  |  |  |  |  |
|----|--|--|----|---|--|--|--|--|--|
| 11 |  | Security of person identifiable data may not be adequate<br><br><b>Risk 12</b> | DM | Training for staff<br>Information flow mapping<br>Audit programme<br>Information governance action plan<br>Controls on data flows<br>Incident follow up | <ul style="list-style-type: none"> <li>• Statement of Compliance</li> <li>• Annual tool kit assessment</li> <li>• Audit reports</li> <li>• Incident reports</li> </ul> |  |  |  | A spate of break-ins has increased the likelihood of information security incidents occurring<br>Completion of the encryption rollout and other security measures should reduce the IT systems based risk by the end of February |
|----|--|--|----|---|--|--|--|--|--|

**CORE STANDARD-Patient Focus**

Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

**CORE STANDARD-Accessible and Responsive Care**

Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway

**CORE STANDARD-Care Environment and Amenities**

Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients

|    |  |   |    |   |   |   |  |  |  |
|----|--|---|----|---|---|---|--|--|--|
| 12 | Achievement of standard making best use of resources | The Trust may not strategically manage its estate<br><br><b>RISK 12</b> | DM | Review Estates Strategy<br>Review Estates Contract<br>Appoint Head of Property Management | <ul style="list-style-type: none"> <li>• Annual review of Estates Strategy</li> <li>• Reports from the Infrastructure Committee</li> <li>• Reports from lead Directors</li> </ul> | L |  |  |  |
|----|--|---|----|---|---|---|--|--|--|

**CORE STANDARD-Public Health**

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas