Questions for boards

Audit Commission Questions	Trust Draft Response
Strategic aims and objectives	
1. How clear are we about what the trust is trying to achieve?	Annual Objectives approved by the board and included in Annual Plan. In–year review. Regular discussion at board and seminars on strategic direction
2. What strategic aims and objectives have we set out for the trust?	See Annual Plan 2009-2010 and draft plan 2010-11
3. Are strategic aims and objectives clearly defined?	See above
4. How do we provide leadership to the staff delivering the objectives that we have set?	Corporate objectives cascaded to director objectives and incorporated in appraisal and development system
5. 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?	Objectives cascaded through the appraisal system. Annual appraisal for all staff and in-year progress review. Corporate objectives reflected in operational objectives for specialist areas and workforce and education plans
Sources of evidence	
• Annual Plan • Board reports and minutes • Executive Committee minutes • HR report on appraisal performance • Education and training strategy	
Governance structures	
6. Are the governance structures clear and straightforward with minimal overlap?	Streamlined structure following appointment of new chairman and NEDs. Accepted by Monitor in FT application 2008
7. How well do we understand our governance structures and how do we think current governance arrangements could be improved?	Regularly reviewed by EC and board. The integrated audit and assurance function (through a single Audit Committee) has been operating for nearly two years. Further discussion is needed on where detailed scrutiny of the financial position should take place most effectively. Currently board discussion is supplemented by 1:1 discussions with the chairman of the Board and the chairman of the Audit Committee. Discussion has also taken place at the Audit Committee but is not within its terms of reference.

Sources of evidence	
• Governance structure chart • Standing Orders, Reservation and Delegation of Powers, Standing Financial Instructions • Terms of reference of Audit Committee and sub-committees • Board papers and minutes	
Achieving objectives	
8. How do we oversee the strategy for achieving our objectives?	Six-month and year end monitoring of progress against corporate objectives. Quarterly return on performance against the Annual Plan to Board and NHS London Board Assurance Framework (BAF) constructed around corporate objectives
9. How do we ensure that the systems of internal control are operating robustly?	Quarterly review of BAF Reports from internal and external auditors to board Audit Committee
Sources of evidence	
• BAF • Audit Committee reports and minutes • Audit Committee reports to Board • Annual plan monitoring return including governance self-assessment • Head of Internal Audit Opinion • Statement on Internal Control • District Audit Annual letter	
Board meetings	
10. Is our board agenda dynamic and focused on the right things: the strategy and its implementation?	Board agendas programmed in advance and sub-divided into Chairman/Executive reports, strategy, operational issues and governance. Time targets included and monitored. Detailed strategic discussion on confidential matters also included in Part 2 and at board seminars.
11. How much time do we spend on strategic issues at board meetings?	See above. Difficult to estimate exactly and is variable. Most trust board seminars cover strategic issues which are subsequently referenced in board meetings. Including Part 2 discussion there would typically be at least an hour's discussion on strategic issues and often more.
12. To what extent do we have the right information prepared for board meetings to allow us to monitor this?	See above. Agenda structured and timed. We shall keep this under review and ensure (i) adequate time allowance for some of the more

	substantial and strategic matters and (ii) consistently high quality executive summaries.
13. Have we considered and acted on *The Intelligent Board* report?	Yes it was discussed when first published and principles taken on board. Dashboard report developed using the Intelligent Board model.
14. Are board meetings managed effectively?	Yes, given the constraints and the amount of business that has to be done. There is scope for further improvement in the quality of executive summaries to reduce the time spent introducing papers and allow more time for discussion and challenge.
15. What improvements could be made to ensure that we operate as a team?	Comprehensive sharing of objectives Trust Board Away Day NEDs to meet monthly with CEO on an informal basis Pairing of NEDs and executives directors.
16. Do we have trust and respect between executive and non-executive directors?	Healthy challenge and open discussion. This needs to be kept under review as the organisational development programme is implemented.
Sources of evidence	
• Board programme 2009-10 • Board agendas and minutes • Director feedback on chairman's performance	
Board operation and skills	
17. What skills do we need as a board?	Board skills assessment carried out on an annual basis led by Director of HR. Initial Board development programme established , but needs renewing. Examples of skills required: strategic vision and planning, performance management, financial management and planning, knowledge of statutory and regulatory framework, clinical expertise, ability to engage with stakeholders,
18. To what extent do we have the right skills as a board?	All covered via qualified and experienced exec team and non-execs with financial, legal, political and management consultancy backgrounds.
19. How clear are we about what the role of the chair and non-executive directors should be?	Fully discussed and agreed in the process of board development, particularly in the period of the foundation trust application process.
20. Do we delegate responsibilities effectively and appropriately?	Scheme of delegation approved annually. Decision-making structure carefully designed and tested.

Sources of evidence	
• Annual skills assessment • Board development programme • CVs of directors • Governance structure chart • FT application section 9 • Annual plan • Chairman's and directors' appraisals	
Strategic risks	
21. How can we be sure that we have identified all of our strategic risks?	Robust process for constructing the BAF, cross-referenced to corporate objectives, the Annual Plan and the risk register.
22. Are we monitoring strategic risks properly and what level of independent scrutiny or constructive challenge from within the organisation is there?	BAF updated regularly by the executive team and reviewed at least quarterly by the Audit Committee and Trust Board. Annual BAF review of BAF process by internal audit.
23. How timely and relevant is the performance information that we use to monitor risks?	Monthly finance report and performance dashboard. Regular challenge by NEDs to ensure reports evolve to meet information needs as they develop and change.
24. What reports do we receive that provide evidence of the effectiveness of risk management and progress in achieving strategic objectives?	Quarterly BAF review, quarterly review of performance against the annual plan, reports of sub-committees of the Audit Committee (clinical governance, H&S), in-year review of performance against objectives.
Sources of evidence	
• See answer to question 24 above • Board reports and minutes	
Management and monitoring of risk	
25. How do we provide leadership on risk management?	Head of risk management is an Assistant Director of Nursing reporting to the Director of Nursing and Clinical Development. The latter is joint chair with the Medical Director of the Clinical Governance Committee and joint chair with the Director of Facilities of the Health and Safety Committee.
26. Do we monitor the trust's main operational risks?	Yes through the active maintenance of a risk register based on real-time incident reporting and risks identified by operational groups and committees. RR updated quarterly and reviewed by Executive Committee. Newly identified risks discussed by EC as they arise and reported to the Trust Board.

27. How can we be sure that the risk management processes in place will avoid operational risks becoming strategic risks?	Regular review of operational risks on risk register to ensure action plans are on track. Risk register and BAF compared and cross-referenced to enable strategic risk ratings to be informed by the position on relevant operational risks.
Sources of evidence	
• Reports on risk register and BAF • Audit Committee reports to Board • Board minutes • Risk management strategy and policy	
Risk measurement	
28. How clear are we about our risk appetite?	Low risk threshold in operation, particularly in the case of clinical risk and patient safety
29. Do we quantify risk appropriately?	The conventional 5x5 risk scoring matrix is used. Regular peer review and oversight by Risk Manager and corporate secretary aim to secure consistency in scoring. NED reviews risk ratings on the risk register in detail.
30. 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?	Key responsibilities are specified in the risk management strategy and policy, but not yet explicit for all levels within the trust. Work in progress.
31. 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?	Risk management training in induction programme and mandatory training programmes. New electronic system of incident reporting being rolled out with comprehensive training programme. Further work is being done on this and will be closely monitored by the Audit Committee.
Sources of evidence	
• Risk Management Strategy and Policy • Datix project plan and implementation programme	
Risk culture	
32. Do we understand what risk culture we are trying to embed?	Covered in induction and mandatory training
33. Do we know what a good risk culture looks and feels like?	Regular review of risk register by managers and Executive Committee. Standing item on agendas of H&S, Clinical Governance and Audit Committee and quarterly review by Trust Board.
34. How and when do we communicate our risk culture?	Through publication of board papers, distribution of risk management bulletin “Cat’s Eyes”. Visible Leadership programme including weekly walkabouts by senior nursing staff.

Sources of evidence	
• NHS Litigation Authority assessments • Minutes of Executive Committee, Audit Committee, Trust Board • ALE assessment	
Use of internal audit	
35. How are we using the internal audit function to obtain assurance on internal controls?	Annual risk-based audit plan approved by the Audit Committee. Results of internal audit reviews inform the Head of Internal Audit's Opinion and feed into the trust's Statement on Internal Control (SIC).
36. Is the scope and level of investment in internal audit appropriate?	External Audit able to place reliance on internal audit. Benchmarking evidence from other acute trusts.
37. How are we maximising the assurances we can gain from internal audit and do internal audit staff have the right skills and experience?	Action plans arising from audit recommendations are closely monitored by the Audit Committee. Regular updates on validating implementation are provided by internal audit. A qualification and capacity is explicit in the contract and is monitored by the Director of Finance.
38. Are we making best use of other independent sources of assurance?	External audit, and numerous regulatory and inspection bodies. All reports and recommendations are followed-up through the monitoring of action plans by the appropriate committee or sub-committee.
Sources of evidence	
• Audit Committee papers and minutes. • Head of Internal Audit Opinion • Statement on Internal Control	
Compliance	
39. 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?	The trust has appointed a corporate secretary (part-qualified ICSA) whose remit includes the monitoring of compliance. There is a qualified head of legal services and also dedicated staff in risk management, health and safety, and procurement functions. The capacity will be kept under review in response to any organisational development or change.
Sources of evidence	
• Job descriptions of posts identified above.	
Use of clinical audit	
40. To what extent do we use the clinical audit function appropriately?	Clinical audit well-established with consultant lead, annual programme, participation in national audits and specialty-based activity. Monitored by Clinical Governance Committee. Annual report received by the Audit Committee.

41. Is the clinical audit function systematic and focused on our own risks as well as on nationally identified issues?	Yes, the programme draws on risks derived by incident reporting system and SUIs
42. Are the results of clinical audit work regularly reported to the board through the assurance framework?	They are reported to the Audit Committee in detail with exception reports to the board.
43. Does clinical audit give us a comprehensive view of the quality of clinical services across the trust's portfolio?	Clinical audit is an important element of the overall picture. Other evidence is provided by clinical quality indicators on the dashboard, Root Cause Analysis and Serious Untoward Incident reports, and external regulation and inspection.
Sources of evidence	
• Clinical audit annual report • Reports from the Clinical Governance Committee to the Audit Committee • RCAs and SUI reports	
Sources of assurance	
44. What are our potential sources of assurance?	Scrutiny by the Audit Committee across the whole of trust activity. BAF, audit reports, external regulation and inspection reports, patient and staff surveys, feedback from governors and focus groups. Handheld electronic devices now provide more systematic analysis of patient experience.
45. Do we use assurances appropriately, balancing them across the risk profile of the trust?	The BAF provides the overview and is based on the assessment of the trust's risks as identified in the annual planning process.
46. How have we satisfied ourselves that assurances are not skewed towards big and topical projects and that we keep our eye on the ball more widely?	Financial and clinical audit programmes are risk based. The risk register draws on incident reports which pick up areas of weakness which are not necessarily high profile. EC review of risks. Non-executive director challenge at Audit Committee and Trust Board. Brainstorming of potential risks which may not have materialised.
47. How do we systematically test and evaluate the sources of assurance?	Triangulation of various sources of both internal and external assurance, e.g. CQC annual health check, ALE
Sources of evidence	
• Audit Committee papers and minutes • External inspection reports	
Board sub committees	
48. Where have we set out the roles and responsibilities of sub-committees to the board and do we receive full and	Terms of reference agreed by Trust Board. The only sub-committees are Executive Committee (EC), Audit Committee (AC) and Remuneration Committee (RC).

appropriate reports from them?	EC reports to each TB, AC reports to TB after each meeting. RC reports to TB after each meeting.
49. Specifically, how will the audit committee programme enable it to meet the board's expectations?	Audit Committee programme guided by the Audit Commission handbook. All non-executive directors (except chairman) are members of the committee. Chairman receives papers. AC submits annual report to the board.
50. Do all non-executive directors have the opportunity to communicate with those on the sub-committees?	Yes - Audit Committee programme guided by the Audit Commission handbook. All non-executive directors (except chairman) are members of the committee. AC submits annual report to the board.
Sources of evidence	
• Trust Board minutes • Audit committee minutes	
Self declarations	
51. How do we ensure that the statement on internal control is robust and consistent with other declarations and self certifications?	The SIC is reviewed by both internal and external auditors. The SIC has on occasions been amended following discussion with auditors.
52. Would our self declarations stand up to rigorous external scrutiny?	There is peer group cross-checking by non-lead directors on aspects of self-declaration. Chairman and chief executive review self-declarations and supporting evidence in detail before sign-off.
Sources of evidence	
• Head of Internal Audit opinion (annual statement) • External auditor's report to those charged with governance Auditor's certification	
Data quality – culture and responsibilities	
53. Is there a corporate framework in place for the management and accountability of data quality?	The Director of Performance, who is also the Senior Information Risk Owner, chairs an Information Governance Steering Group and a Data Quality Group A Data Quality Policy is in place. External audit checks, e.g. annual Audit Commission review of clinical coding (Whittington rated excellent 2009/10), Information Governance Toolkit submissions (Whittington rated green), monthly activity submissions to Secondary User Services (SUS) always pass data quality checks before being processed onto HES and to PCTs for PbR income

54. Is there a commitment to secure a culture of data quality throughout the organisation?	Data Quality Group Data Quality Policy 3 x wte dedicated data quality staff to support improvements
55. How have we made clear the responsibility for data quality governance and accountability at all levels of the organisation?	The Director of Performance, who is also the Trust Senior Information Risk Owner has executive responsibility for data quality and chairs the Data Quality Group. Within the IM&T directorate there is a team of 3 wte dedicated data quality staff to work with operational leads to identify and deal with data quality issues.
56. Do our clinicians understand the purpose and use of the data collected?	All clinicians are given training on how to use applications, including the importance of accurate and timely data for patient care, clinical audit, PbR. Good use is made of Dr Foster data, dashboard information, and quality accounts
Sources of evidence	
• Audit Commission report on clinical coding • Information Governance Toolkit submissions • Data Quality Group action plans • Terms of reference of the Data Quality Group and Information Governance Steering Group • PAS User manual	
Data quality – policies and training	
57. What policies or procedures are in place to secure the quality of the data used for reporting?	Data Quality policy Trust Data Quality meeting, Duplicate registration meeting, Maternity data quality meeting Daily validation reports go back to operational services to highlight data quality issues for action e.g. duplicate patient registrations, valid GPs, valid postcodes, ED attenders, outpatient outcomes etc Weekly validation reports for NHS numbers Monthly submissions to Secondary User Service (SUS) for all admitted care, outpatient and ED attenders
58. What policies and guidance on data quality do we have? Are they appropriate?	Data Quality policy Detailed user guides e.g. PAS (both reviewed every 2 years and updated in March 2010)
59. What policies or procedures are in place to secure the quality of the data used as part of the normal business	Data Quality policy Trust Data Quality meeting, Duplicate registration

activity of the organisation?	meeting, Maternity data quality meeting Daily validation reports go back to operational services to highlight data quality issues for action e.g. duplicate patient registrations, valid GPs, valid postcodes, ED attenders, outpatient outcomes etc Weekly validation reports for NHS numbers Monthly submissions to Secondary User Service (SUS) for all admitted care, outpatient and ED attenders
60. How has the trust ensured that staff have the knowledge, competencies and capacity in relation to data quality?	Detailed user guides for applications Classroom and one to one training sessions for new users and on-going refresher training
61. What kind of training is made available on data quality issues?	Re-fresher training e.g. PAS Issue specific training e.g. 18 week stop and start clocks Dedicated input from 3 wte data quality staff
Sources of evidence	
• Data Quality policy • Daily validation reports • User guides • SUS data quality reports • Training material	
Use of data	
62. What arrangements are there to ensure that data supporting reported information are actively used in the decision-making process?	Weekly "flash" reports used at Executive Team to monitor Trust performance e.g. bank and agency use, HAI, elective activity. Monthly dashboard reports based on the Intelligent Board guidance to HMB and Trust Board used to monitor finance, workforce and activity Data used to in business case development \ service improvement proposals to justify investment
63. Are data subject to a system of internal control and validation?	Internal data quality checks to ensure submitted data meets SUS data quality measures e.g. % of valid NHS number, % of valid GP etc. Control total checks e.g. volumes of data extracted, submitted, and processed to ensure no data loss
Sources of evidence	
• Weekly flash reports • Monthly HMB\Trust Board dashboards	

• Business case submissions • Log files • SUS data quality reports	
Data quality assurance	
64. What arrangements are there to ensure that data supporting reported information are actively used in the decision-making process?	Repeat of 62
65. Are data subject to a system of internal control and validation?	Repeat of 63
66. What controls do we have to ensure that the quality of data used for decision making is good enough?	Internal data quality checks e.g. comparison of control totals with previous period Use of analytical tools including standard statistical tests and SPC charts.
67. Is the quantity and timeliness of information we receive for board meetings adequate?	Performance dashboard report and finance report received at every meeting and kept under continuous review in terms of adequacy and appropriateness Further work in hand on the definition of targets and explanations of variations. Timeliness could be improved for some reports, to be facilitated by the recent change in the cycle of board meetings
68. How do our board reports explain the assurance process for the data contained in them?	Reports labelled to clearly identify the data source, period and activity type. All board reports have a cover paper which provides an executive summary and indicates the relevant assurance medium.
69. Do our board reports clearly highlight any issues with data quality?	Riders or concerns about data quality are flagged up in the narrative in the dashboard reports. Trust always meets data quality thresholds required by SUS and is always rated green for its IGT submissions
Sources of evidence	
• Weekly flash reports • Monthly HMB\Trust Board dashboards • Business case submissions • Log files • SUS data quality reports	