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Sherwood Forest Hospitals NHS Foundation Trust

Board Assurance Statement September 2014

Authors	
Kerry Rogers	**Director of Corporate Services and Company Secretary**
Shirley A Clarke	**Deputy Director of Corporate Services**

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1. Background

1.1 As a public benefit corporation, the Trust needs to be held to account for its actions, decision-making and ultimately the achievement of its purpose and objectives. Good governance is essential to the achievement of strategic objectives. The governance arrangements within the organisation should focus on ensuring the achievement of the strategic priorities through effective performance & quality management and risk management.

1.2 Strong governance arrangements create a framework for providing the Board with sound assurances in relation to the achievement of the priorities, which in turn enables Board to be confident at all times about the current position. Since 2001/2 all NHS Chief Executives (Accounting Officers) have been required to sign an Annual Governance Statement (previously the Statement on Internal Control) as part of the statutory accounts and annual report, indicating that they were fully acquainted of the current position of the organisation.

1.3 This document - the **Board Assurance Statement** was introduced by the Director of Corporate Services/Company Secretary in March 2014 to be presented twice a year, (March and September) to inform the assurances required in order to confidently recommend to the Accounting Officer, that he sign the AGS on behalf of the Board. This is the second of the new Board Assurance Statements intended to evidence the work of the Board across the year in reviewing the effectiveness of internal controls, to gain assurance and to test governance processes that have been established in the organisation across the whole year. These statements should support self-certifications to the regulators and, most importantly, support the annual Board declaration concerning the systematic review / testing of key controls in the form of the Annual Governance Statement – and ensure that the AGS is not perceived by the Board to be a 'once a year' action.

1.4 Through reading the document it should evoke a number of questions for Board members to ask themselves about the arrangements they have in place and the assurances they are provided with not only to support preparation and sign off of the Annual Governance Statement, but also to enable members to develop or evolve our governance arrangements in a way which effectively supports achievement of our organisation's strategic objectives.

2. The Purpose of the System of Internal Control

2.1 The system of internal control is designed to manage risk and performance to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based **on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives** of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. **As part of the Annual Governance Statement, the Trust is required each year to state that the system of internal control has been in place for the year ended 31st March and up to the date of approval of the annual report and accounts.**

2.2 The Board must understand its obligation to ensure that the organisation complies with its own governing documents – the Constitution and Authorisation/Licence, with relevant laws and with the requirements of regulatory bodies, standing orders, standing financial instructions and scheme of delegation. A review of the Constitution, Standing Orders, Standing Financial Instructions and Reservation of Powers/Scheme of Delegation has been undertaken during the year. The revised Constitution, Standing Orders, Standing Financial Instructions and Reservation

of Powers/Scheme of Delegation were approved by the Trust Board in July 2014, the Council of Governors in August 2014 and the members as part of the Annual General Meeting in September 2014.

In order to meet the statutory requirements, but importantly for the Board of Directors to be confident in its self-certifications, the Board needs to be assured of the validity of information and the effectiveness of systems that ensure compliance as a minimum with mandatory and best practice frameworks to include:

- All relevant laws and the requirements of Monitor through Board's understanding of the processes supporting compliance. To formalise a process to assure Board of compliance going forwards, the Company Secretary and Deputy Director of Corporate Services will introduce to the Trust a Compliance Framework that will systematise self-assessment of compliance with mandatory frameworks across the Trust and provide clear line of sight for the Executives and Board of areas of potential non-compliance.
- The requirements of and the Trust's compliance with, the Care Quality Commission, Department of Health, NHS Litigation Authority, NICE, Safety alerts and others - through the Board's understanding of the process adopted to reach a declaration of compliance illustrated in particular within the relevant reports received through the Quality reporting process, the Corporate and Legal services reports and the Patient Experience Reports, coupled with the confidence in the role of Committees in determining compliant status.
- Health & Safety legislation – through the quarterly patient and staff quality/HR reports and annual H&S report;
- External agency requirements – in the absence of a formal route for the outcome of all such visits, to formalise line of sight of TMB and Board of Director members the Company Secretary has developed a policy for External agency visits; inspections and accreditations which will be operationalised during the latter half of 14/15 to ensure readiness for, and understanding of the outcome of external reviews providing clear line of sight of Board and Executives of successes and potential risk areas.
- Any other legislation or regulation which may apply concerning such as conditions on the Trust's Licence to operate - through the work plans of the Clinical Governance & Quality, Audit and Assurance and Finance Committees of the Board.
- The effectiveness of Service Line, Division and Corporate/Business - clinical and corporate governance and risk management practice.

2.3 As stated above, there does not currently exist in the Trust a robust, formal and systematic process for assessing compliance against existing, new or changing legislation or best practice. As a consequence, the Company Secretary, as part of her work to define the Assurance Framework for the Trust is working on implementation of a Compliance Directory, which would comprise of registries for consultations, new and revised regulation and legislation and counter fraud alerts with exception reports provided to Quality Committee on a regular basis. A robust approach to spot checking of items included on the compliance directory will also be introduced to enable areas of concern to be identified and rectified by undertaking regular spot checks of the Compliance Directory to strengthen the clinical directorates' approaches to self-assessment of compliance. None of this is to say that the Trust is not in compliance, this is merely to systematise the process of ensuring and assuring compliant status, ensuring ownership and responsibility for self-assessments of compliance and the monitoring of any necessary action plans to deliver compliance or address non-conformity notices, and to introduce independence to assessment of complaint status.

Training will be undertaken to implement or to strengthen any, existing systems designed to ensure Service departments remain compliant with legislation and regulations alongside the creation of a 'Departmental Compliance Directory Standard Operating Procedure (SOP)' This SOP would provide guidance to all Heads of Department as to how they should log new / revised legislation, regulation or Royal College guidance for instance, pertinent to their own department onto Datix as well as how to create an action plan to ensure compliance and upload

evidence of compliance onto Datix and cross reference to any relevant risk assessments or risk register entries. An evaluation of the extent to which the SOP had been implemented across the Trust would also form part of the Assurance Framework and methodology.

In the absence of such a process (merely serving to centralise and operationalise this intelligence), Board members will need to rely on Board Reports, walk-around visits, confirm and challenge sessions and the work of their Committees across the preceding year in order to satisfy themselves of compliance across such mandatory/best practice contexts.

2.4 The Internal Audit operational plan for 2014/15 was approved by the Audit and Assurance Committee in April 2014 and regular reports against the plan have been presented to the Audit and Assurance Committee. A snapshot of the annual programme and resulting findings, which have been monitored by the Audit and Assurance committee are provided later in the report to enable Board members to satisfy themselves of the depth and scope of control testing across the Trust providing independent assurance of control effectiveness.

3. Capacity to Handle Risk

3.1 *The AGS requires that the Trust describes key ways in which*

- *Leadership is given to the risk management process, and*
- *Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. We are encouraged to include comment on guidance provided to them and ways in which we seek to learn from good practice.*

3.2 The Foundation Trust's Board of Directors provides leadership and a high level of commitment for establishing effective risk management systems across the Trust. The Chief Executive has overall accountability for the management of risk by the Trust and responsibility for specific risk management areas, has been delegated to the Trust Executive.

Throughout the year, The Risk Management Framework (review date due Feb 2013) is the relevant strategy that has been in operation within the Trust, and is currently being revised, the Risk Management Policy has been drafted by the interim risk manager and the Head of Governance and is currently being consulted on in the wider organisation the final document will be scrutinised by the Clinical Quality and Governance Committee before being submitted to Trust Management Board ratification. The revised policy identifies the organisation's approach to risk, the executive and non-executive director roles and responsibilities and the structure in place for the management of risk. Risk management has been integrated into the Governance Support unit from April 2014 under the direction of the Executive Director of Nursing, in order to integrate with the focus on compliance and risk (to delivery of quality etc.). The policy contains a clear definition of risk and the scope to handle risk and clarifies individual and collective responsibility for risk management from the Board of Directors through to all staff within the organisation. It sets out the Trust's attitude to risk and includes guidance on risk identification, risk assessment, risk scoring and risk monitoring as well as outlining the agreed principles for effective risk management within the Trust along with clarity of roles of the Committees and sub-committees which support the Trust Management Board (TMB) sub structure.

A range of risk management training has been provided to staff since November last year which from the extensive written and emailed feedback has been very well received, and there are policies in place to describe staff roles and responsibilities in relation to the identification and management of risk. The revised Risk Management policy will need to be approved by Board of Directors at a future meeting, and, following consultation will be scheduled for review annually.

The Trust has many opportunities to learn from good practice through a range of mechanisms including clinical supervision, individual and peer reviews, performance management, professional development, clinical audit and application of evidence based practice and root cause analysis and the learning coming out of complaints, incidents and inquests/claims. The effectiveness of those processes will need to be understood by the Board and will need to be more robustly tested going forwards through the Board Committee structure, but it is understood that as the Governance Support Unit completes its restructure, a much greater emphasis is to be put on formalising an organisational understanding of the learning from the things we haven't done so well in order to mitigate against recurrence.

The Company Secretary introduced a 'True for Us' programme in 2013/14, to ensure the Trust assesses its own situation against such as high profile failures / inquires (e.g. the Francis report) and cross industry best practice (e.g. industry failing outside the NHS). This work will continue to be progressed over the coming months to ensure there is a process to capture such opportunities from which to learn. The next report in respect of learning from the Review of Cancer Services at Colchester Hospital University NHS Foundation Trust will be presented to the Board by the end of the year.

The Board receives, on a monthly and quarterly basis, the Quality and Integrated Performance reports which detail any issues and improvements relating to both patients and staff collated from incident data, complaints / concerns, mortality reviews and other data sources and includes narrative regarding quality issues and staff training relating to the safety, experience and quality agenda. Key new actions and learning are highlighted within the reports and Board members will need to be confident they understand that such actions have been implemented and are sustained.

The Board will need to ensure that it has confidence in the processes that support learning and will need to consider future requirements to better understand information on the organisation's response to safety alerts received such as the Central Alert System (CAS) these are a prominent feature on the agenda of the Quality Committee.

Below is a record of the safety alerts received and registered in MEMD. The process has during the year included involvement of the Clinical Quality and Governance Committee determining compliant status and declaration of such outside the Trust, providing affirmation externally the Trust has complied with the notice in the required timescales. Within the period 4 alerts were completed outside the timescale, these are now completed and as at the date of this BAS the service is fully compliant. The Company Secretary is looking to strengthen the process of determination of compliance with such safety alerts to increase confidence in the declaration of compliance being made to bodies/regulators outside the Trust and will work with the GSU to ensure the strengthened process aligns with the plans outlined regarding the External Recommendations Policy to offer greater line of sight of the full Executive team.

Safety Alerts 29/8/14

Reference	Alert Title	Originator	Issue Date	Response	Deadline
PSA/D/2014/010	Standardising early identification of AKI	NPSAS	09 Jun 14	LIMS system upgrade on Pathology workplan	09 Mar 15
PSA/D/2014/005	Improving medication error incident reporting & learning	NPSAS	20 Mar 14	Steve May Medecines Management	19 Sep 14
PSA/D/2014/006	Improving Medical device incident reporting & learning	NPSAS	20 Mar 14	Richard Scott Medical Physics	19 Sep 14
MDA/2014/032	Gastrostomy devices:.Manufactured by Medicina Ltd.	MHRA	20 Aug 14	Procurement assessing relevance	18 Sep 14
MDA/2014/033	Insulin syringe 1ml safety syringe 27G (for professional use). Product code: RN01/27i. All batches. Manufactured by Medicina Ltd.	MHRA	20 Aug 14	Procurement assessing relevance	18 Sep 14
MDA/2014/034	Basin/bowl liner or equipment cover (drape). Manufactured by Microtek Medical. Product codes: 17700, 16700A, 3109N, 3109NT, 3108N, 33099, 9386001, 3309N, TP1909A, TP1909B. All lot numbers.	MHRA	27 Aug 14	Procurement assessing relevance	24 Sep 14
PSA/W/2014/014	Risks arising from breakdown/failure to act on secondary discharge handover communication	NPSAS	29 Aug 14	Governance Support leading	13 Oct 14

The Clinical Quality and Governance Committee members should recognise the process as dictated and followed through the *'**Best Practice Policy** Implementation of national alerts, reports and reviews'* and be confident in their role of affirming declarations externally supporting Trust compliance with the alert. With regard to NICE guidance, this same policy is utilised, but currently it is not clear on the role of the Committee structure in supporting determination or monitoring of Compliance, beyond the work undertaken by the Governance Support Unit's role, and as such, this too will be included in the work as described above to strengthen processes and visibility.

4. The Risk & Control Framework

4.1 *The AGS requires that the Trust describe key elements of the risk management strategy, including the way in which risk is identified, evaluated, and controlled. To explicitly describe the key elements of the quality governance arrangements, including how assurance is obtained routinely on compliance with CQC registration requirements. Explicitly include how risks to data security are being managed and controlled. To include a brief description of the organisations' major risks, including significant clinical risks, how they will be managed and how outcomes will be assessed.*

4.2 **Quality Governance Framework / Assurance**

The Monitor Quality Governance Framework is an assessment tool for Boards to review their governance arrangement to ensure essential levels of quality and safety are met and to drive forward continuous improvement. The framework sets out 10 key questions underpinning four categories of quality governance. A summative assessment of documented evidence of practice against best practice examples and a risk rating to each of the 10 key questions using the Monitor scale was carried out on a number of occasions in the second half of 2013/14. Subsequently each of the QGF questions has been allocated an executive lead, each providing a trajectory for reduction in the QGF score, this together with the progress made is reported on a monthly basis to Board. The board reviewed the evidence at the March 2014 meeting and approve a reduction the score from 4.0 to 3.5. The trust wrote to Monitor at the end of March with the evidence of the improvement and the results of this self-assessment. The Board reviewed further evidence at its July 2014 meeting and approved the recommendation of the Trust Management Board to reduce the score further from 3.5 to 3.0. The Company Secretary will ensure the QGF remains a constant focus of the Board to ensure the Trust does not become complacent, and will continue to ensure focus of agendas, Committees and confirm and challenge sessions allows for the continuation of challenge across all domains and that the future iterations of such include time for non-executive leads to carry out further testing of the evidence through continuing the processes of observation and interview.

It is important to note that the evidence used to reach conclusions on our QGF score , and on our compliant status across all mandatory frameworks, and our own effectiveness at managing risk does not solely rely on documents, and reports received internally and so must be triangulated with assurance from:

- External assurance: KPMG and PWC, CQC, NHSLA, commissioner visits, external reviews.
- Internal Assurance: GSU, IAT visits, Board Assurance Framework, commissioners, clinical audit, Audit and Assurance Committee, performance metrics, service reviews, CIPs, PMO, walk rounds, governors PQ&E meeting, Quality and aligned Strategies, SI/incident reporting etc
- Audit and Monitoring: Annual Audit plan, Ward to Board, CQC outcome guardians/IAT action plans.

- Management and leadership: responsibilities agreed, policy framework review, CPD, Mandatory training compliance.
- Patient/Carer feedback: F&F, surveys, complaints, whistleblowing.

4.3 Care Quality Commission (CQC) Registration requirements:

Work will have been undertaken by the Executive Director of Nursing to understand and be confident in the Trust's Registration with the CQC to ensure of all the locations at which the Trust provides services that the appropriate CQC registration of each location and for all service activities has taken place. The Trust's 'Statement of Purpose' which is a document required by the CQC on Registration and is required to be updated following any changes to registered locations or activities will make clear, the Trust's current scope of registration and Board members should familiarise themselves with the Trust's statement.

The CQC have revised their inspection regime from 28 outcome areas to 5 domains, Safe, Responsive, Caring, Effective and Well led, the inspection team ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

the inspection team always inspects the following care services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients

The Board should be clear on how the Trust monitors compliance against all 5 domains. The monthly and quarterly quality reports provide the Board with narrative concerning compliance with the domains.

As the Board improves its ability to triangulate information from discussions with senior staff, reports from Executives to Board, Confirm and Challenge sessions and 'walk-abouts', it should as a consequence be able to compare assessments of compliance in the quality reports with that intelligence and with the data reported to Board regarding 'outcomes' in the form of third party feedback from claims, incidents and complaints in addition to members' own assurance activities as referenced above and thereby be in a strong position to focus questioning and the commissioning of drill down/deep dive reports through the governance committee structure.

In order to be more robustly assured of the effectiveness of compliance and risk management activities at Divisional level, the Board through its committee structures, needs to get closer to the workings and effectiveness of the Divisional and Service Line Clinical Governance Committees in order to be confident that services are clear on shortcomings and have strong plans and support for, recovering those positions.

The July 2013 CQC inspection resulted in five compliance judgements, of which one indicated a 'warning notice' in respect of Outcome 16, *assessing and monitoring of the quality of service provision.* The table below sets out the judgment the Trust received for the outcomes assessed.

2.0 Summary of the CQC findings

Standard	**'Outcome' Judgement**
Care and Welfare of people who use the service	Minor impact to patients
Meeting Nutritional needs	Moderate impact to patients
Cooperating with other providers	Standard met
Cleanliness and infection control	Standard met
Staffing	Moderate impact to patients
Supporting Workers	Standard met
Assessing and monitoring the quality of service provision	Moderate impact '**Enforcement Action'** A 'warning notice' was issued with a specific deadline for meeting the standard by the 31st October 2013
Complaints	Moderate impact to patients

The judgements were issued to the Trust in September 2013 in a CQC formal report. The Trust was revisited on 4th December 2013 to assess the Trusts position against the warning notice. The formal report was published on the CQC website on 3rd January 2014 http://www.cqc.org.uk/sites/default/files/media/reports/RK5BC_Kings_Mill_Hospital_INS1-1085602472_Responsive_-_Follow_Up_03-01-2014.pdf. The CQC felt that sufficient improvement had been made to enable the warning notice to be reduced to a compliance action. – during the visit in December 2013 the CQC only formally assessed outcome 16 'Assessing and monitoring the quality of service provision' The judgements against the other 4 non-compliant outcomes remain unchanged. The Company Secretary has contacted the CQC on numerous occasions to gain clarity regarding the status of these outcomes and is awaiting a response.

The CQC carried out an announced visit on 24th and 25th April and unannounced, out-of hours visits on 29th April and 9th May and rated the Trust overall as follows:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires Improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

The CQC also recommended to Monitor the Trust remain in special measures for an extension period of six months.

An action plan has been developed to address the recommendations identified in the report and this has been submitted both to the CQC and Monitor.

Regular reports will be provided to the Clinical Quality and Governance Committee, Quality Committee and Trust Board in respect of progress against the plan.

4.4 Internal Audit (360 Assurance)

The Audit plan for 2014/15 was developed in line with the mandatory requirements of the NHS IA Standards and EMIAS (now 360 Assure) have worked with the Trust to ensure the plan was aligned to our risk environment. In line with the Internal Audit Work Plan full scope audits of the adequacy and effectiveness of the control framework in place are complete or underway for the following areas for the twelve months from April 2014 to March 2015

Proposed Timeframes for Delivery of the 2014/15 Internal Audit Plan

Audit Title	*Planned Start Date*	*Status*	*Assurance Level Provided*	*Date Reported to Audit and Assurance Committee*
Financial Management				
Key Financial Systems	Q3	Planning		
Pay Expenditure	Q4			
IM&T				
Information Governance Toolkit	Q3			

Performance				
Review of Performance Management Arrangements	Q1	On Hold		
Self-Certification/Data Quality (including 18 Weeks RTT)	Q1	In Progress		
Joint Working with Commissioners	Q2	On Hold		
PFI Compliance to Contract	Q2	In Progress		
Clinical Quality				
Complaints	Q3			
Falls Management	Q2	In Progress		
Consent	Q2	In Progress		
Incident Management	Q1	Discussion Draft Report		
Radiology Department Review	Q4			
End of Life Pathways	Q1	Planning		
Clinical Governance Focussing on NICE and Safety Alerts	Q2			
People Management				
Appraisals	Q4			
Governance, Risk & Legality				
Risk Management and BAF	Q4			
The Role of the PMO/Learning from Assurances	Q3	Planning		
Records Management – Review of Case Notes	Q1	Discussion Draft Report		
Governance Structures	Q3			

Delivery of the 2013/14 Internal Audit Plan

Audit Title	*Planned Start Date*	*Status*	*Assurance Level Provided*	*Date Reported to Audit and Assurance Committee*
Financial Management				
Key Financial Systems	Q3	Complete	Significant	22nd May 2014
Pay Expenditure	Q4	Complete	Significant	22nd May 2014
CIP/QIPP/Transformation	Q2	Complete	Significant	16th January 2014
Financial Management and Reporting	Q4	N/A		
The Trust's Readiness to Respond to Changes in Commissioning Arrangements	Q4	Complete	N/A	24th July 2014
Charitable Funds	Q4	Complete	Significant	24th July 2014
IM&T				
Information Governance & Data Protection	Q3	Complete	Significant	16th January 2014
Freedom of Information Act Compliance and Management of Subject Access Requests	Q2	Complete	Limited	16th January 2014
Information Management & Data Quality/Data Quality Dashboard	Q3	In Progress		
Quality Account – Data Quality Review	Q4	Complete	Significant	24th July 2014
Performance				
Performance Management Framework	Q3	Deferred to 2014/15		
Newark Hospital Strategy	Q4	Complete	N/A	7th April 2014

Newton Europe Contract	Q4	Complete	N/A	7th April 2014
Clinical Quality				
CQC Compliance Review	Q3	Complete	Limited	22nd May 2014
CQC Corporate Assurance				
Incidents Management	Q2	Complete	N/A	25th October 2013
People Management				
Sickness Management	Q1	Complete	Significant/ Limited	25th October 2013
Bank and Agency	Q3	Complete	N/A	24th July 2014
Annual Leave Management	Q2	Complete	Significant/ Limited	25th October 2013

(Assurance level - sig / limited means that the opinion has been split – IA has given significant in part (e.g. for sound procedures) but limited for the other part of the scope (for example adherence to procedures).

Recommendations made for all the above audits are followed up by Internal Audit to ensure that all recommendations are sustainably implemented within the organisation. Following their review, any remaining unimplemented recommendations are escalated to the Audit and Assurance Committee and the Company Secretary has now included an escalation report within the Trust Management Board agenda to be presented by the Chief Financial Officer to ensure escalatory actions are taken by the appropriate Executive Lead if remedial actions are not addressed expediently.

4.5 External Audit (KPMG)

External Audit carried out the required audit of the 2013/14 annual report and accounts and the quality accounts.

As per the requirements of Monitor's Code of Governance for Foundation Trusts, section F3.5, the Audit & Assurance committee will need to keep under review the need to market test both the internal and external audit providers to the Trust on an appropriate cycle. The KPMG contract is for 3 years from November 2012 (i.e. starting with 2012/13 accounts), with an option for 2 further years. The contract includes Quality Accounts and Charitable Funds accounts.

The Internal Audit contract with 360 Assurance (which was still EMIAS at the start of the financial year) is a rolling contract, which doesn't get renewed as such, but a daily rate is agreed by a consortium for each year. Recently it appears we also have a clause in the contract that shares the liability between consortium members for potential redundancies should any members pull out of the contract. EMIAS have provided the Trust's Internal Audit function since before the Trust became a Foundation Trust in 2007/08.

The Board through delegated authority to its committees, has reviewed the effectiveness of the organisation's system of internal control, performance reporting, policies and procedures, and received exception reports where appropriate, much of which is evidenced through the detail in this Board Assurance Statement. The Board has continued to strengthen its assurance function through its Audit and Assurance Committee which throughout the period of the report has monitored and reviewed the direction of the Trust's internal assurance work, the work of Internal and External Audit and where necessary commissioned additional assurance activity. This has ensured that there has been a system for the regular review of the effectiveness of its internal controls and the Committee has, through exception reports to the Board, satisfied Board on the effectiveness of its internal controls, or on actions to address shortcomings in those controls.

4.6 Board Assurance Framework & Risk Management

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic priorities and objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified and incorporated within a robust governance process. The Board will achieve this based on the changes in the processes for assurance, primarily through the work of the Audit and Assurance Committee, through the Quality and the Finance Committees, through independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of objectives.

The Board Assurance Framework holds the following key information:

- Trust's Principal Objectives where there are significant risks to its attainment.
- Trust's Principal Risks which are based on top down (Board of Directors / Committees) and bottom up information (Risk Registers etc.).
- Links to relevant legislation / regulation.
- Links to Key Performance Indicators e.g. national targets.
- Sources of assurances based upon evidence around compliance with, and effectiveness of, the controls to manage risk.
- Lead(s) responsible for assuring the adequacy of assurances.
- Control / assurance gaps threatening the achievement of a standard / target / objective and any recommendations / conditions arising from audits and inspections, staff and patient surveys etc.
- Action and Timescales to address identified gaps in controls / assurances.

The current BAF document was developed in collaboration with Board members and KPMG at the beginning of 2013/14. Updates on the Principle Risks have been presented to the Audit and Assurance Committee and to Board and have been discussed. Assurances have also been sought on the effectiveness of controls through Exec Team Meeting and latterly through the Finance and Clinical Quality and Governance Committees and risks have been escalated during the year for inclusion in the BAF.

The Board approved the strategic priorities and principal risks in July 2014. A revised Board Assurance Reporting process to support the development of a revised BAF document was approved by Audit and Assurance Committee in May 2014. This will strengthen the depth of information presented that will enhance the provision of assurance directly from an Executive Director that they are confident priorities are safeguarded by a strong and effective suite of controls, and the Audit and Assurance Committee will be the custodian of the BAF and make determinations concerning the effectiveness of the control environment. Finance are submitting a pilot Board Assurance Report to the September 2014 Audit and Assurance Committee for approval.

A Board Assurance Report will presented by each lead executive to the Committee across the year, and contained within this process, will be the creation of a lead non-executive and a lead committee role for each risk to ensure there is a system for the regular review of the effectiveness of internal controls as well as 'confirm and challenge' through the TMB Committee structures of each BAF report prior to its presentation at the Audit and Assurance Committee.

Alongside the new Board Assurance reporting framework, the Corporate Risk Register has also been reviewed and will be presented to the Clinical Quality and Governance Committee for scrutiny and approval before onward submission to the Audit and Assurance Committee.

The Company Secretary introduced the NED Confirm and Challenge process in 2013/14 which has been a constructive stimulant in the development of the NEDs understanding of the way that quality and risk management is understood and embedded across the Trust and the sessions have provided the NEDs with reasonable assurance in order to approve positive movements in the QGF score through demonstration of the application of a much stronger control environment thereby better safeguarding delivery of the Trust's objectives

Future BAS reports will include a holistic picture of the documents, policies and strategies approved by the Board relevant to the process of systematic review of the effectiveness of controls and relevant to self-assessments of compliance which have been considered and approved by the Board across the financial year

The Trust recognises the strategic role of Risk management in underpinning the organisation's reputation and performance. Successful implementation of the new Risk Management policy will be key to delivery of organisational objectives in relation to governance and controls assurance and the training is already spreading a wider understanding of its importance. In addition, the embedding of effective Risk Management systems and the development of a positive learning environment support improvement of services and delivery of Trust priorities in all areas and the Board Committees will be instrumental in continually testing control effectiveness.

4.8 Standards of Business Conduct

Following the ratification of the Trust's Standards of Business Conduct Policy at the Audit and Assurance Committee in July 2014, communications promoting the SBC to staff will need to follow and advice on circulation and training is currently being taken via the Local Counter Fraud Service. An action plan has been developed to disseminate the policy across the trust in order to ensure all employees are aware, this includes the policy being issued to all new starters, inclusion in the induction programme for clinical and non clinical staff and arrangements are progressing with IT to enable staff members to sign electronically once they have read the policy.

The action plan was submitted to the Audit and Assurance Committee in September 2014 for approval.

The number of declarations in relation to the Trust's Standards of Business Conduct (SBC), are low and the Audit and Assurance Committee will monitor the impact of the implementation of the action plan through the number of declarations made. An annual register is maintained which is used to populate the Annual Report submitted to Monitor in June each year.

4.9 Counter Fraud

The Annual Work plan for 2014/15 was approved by the Audit and Assurance Committee in April 2014. The Annual report for 2013/14 was presented to the Audit and Assurance Committee in July 2014 detailing the proactive and reactive work undertaken during 2013/14 in accordance with the approved annual work plan. Progress against the 2014/15 work plan, at July 2014 is detailed below:

5 investigations are open cases, 2 of which are pending closure, 5 information report open, 3 of which are pending closure.

The NHS Protect Self Review Tool was submitted on 7th July 2014, the overall rating for the Trust is Amber an action plan has been developed, by the Deputy Director of HR including named responsible officers to move the Trust from Amber to Green and will be submitted to the Audit and Assurance Committee in September.

4.10 Information Governance

The Chief Financial Officer has undertaken the role of SIRO (Senior Information Risk Owner) for the year up until June 2014, with this role subsequently transferring to the Interim Chief Finance Officer. The Medical Director, as Caldicott Guardian has subsequently taken the Chair of the Information Governance Group.

The Information Governance Toolkit submission has been included within the Board of Directors' work plan to ensure line of sight at Board of this submission in December and in the month of the Board declaration of compliance in March. The IG toolkit is a performance tool produced by the Department of Health (DH) and now hosted by the Health and Social Care Information Centre (HSCIC). It draws together the legal rules and central guidance relating to IG and presents them in one place as a set of information governance requirements.

Oversight and Assurance: - The 2014/15 IG forward Work plan identified accountable officers within the Trust for each standard to be achieved, with the expectation that performance against standards will be monitored and supported via the IG Group on an on-going basis throughout the year. It maps the key tasks that need to be carried out until the March 2015 submission.

Sherwood Forest Hospitals NHS Foundation Trust's Information Governance (IG) assessment report overall score for 2013/14 was 79%. This was graded as "Green" – "Satisfactory". There is a requirement for all IG Toolkit standards to achieve Level 2 or above for the Trust to be graded as green. We have therefore set out to achieve a score of 80% in 2014/2015.

In order to achieve and maintain this standard the Trust has set out to do the following:

- Ensure IG remains a mandatory annual training requirement for all staff
- Owners of standards are established within the culture of the organisation, as a business responsibility
- Build on the establishment of Information Asset Owners and Administrators to ensure that there are responsible officers in each Division to support the embedding of IG principles within the Trust
- Develop a formalised programme of information asset risk assessment, providing assurance from each Division that information assets are actively reviewed
- Develop a formalised programme of Information Governance audits within the Trust to enable the Trust to maintain a level 3 score across those standards that achieved it in 2013/2014, and meet the requirement for level three with some of the other standards.

The IG team has also produced the following:

- A new information asset register
- Identified information flows in all areas
- Identified information risks for the Trust

Progress against the standards is monitored at the Information Governance group.

- An IG improvement plan has been provided to the IG group at the meeting in August. This plan made recommendations to the Trust for continued improvement across all IG standards
- For each standard to continue to have one lead responsible for the identification, collation and uploading of the evidence required for the toolkit.
- For each Information asset owner to be required to report progress against toolkit requirements to the IG group on a quarterly basis
- Developing a formalised programme of information asset risk assessment, providing assurance from each Division that information assets are actively reviewed
- For all staff to have mandatory annual IG training

There have been three serious incidents relating to information governance in the past year – reported as a 'near miss'. These have been logged on the IG toolkit (which automatically sends the incident to the DoH and the ICO), these were reported as follows:

Log book left on a chair in main reception containing patient details for 555 patients, was picked up by a member of staff. Area that owned the book has been identified. An investigation was undertaken, learning actions included: IG manager attended ward leaders meeting to raise issue. Ward leaders to remind all staff at team meetings re security of information. Comms due to go out to all staff reminding them of responsibility

A ward handover sheet, containing clinical details for 23 patients was found in the normal rubbish bin by a member of staff instead of the confidential waste bin. The bin was in a public area. Risk of members of the public finding information. An investigation is underway and the learning actions will be publicised.

The Trust was contacted by a primary care centre to inform them that one of their letters had been incorrectly addressed to the primary care centre but with the house number of a private residence. The investigation is still underway, learning will be disseminated across the trust.

For each of these incidents the ICO has been informed via the Toolkit submission. The ICO has written to the Trust stating:

we have decided that it is not necessary to investigate this matter further and at the present time we are not intending to take formal regulatory action.

However, in light of the incident our expectations are that you implement an effective and robust improvement plan in which you:

- *fully establish how the incident occurred to determine what lessons can be drawn to prevent a similar occurrence;*
- *review your processes and ensure that the appropriate technical and organisational measures are taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data*

The ICO keeps a record of all incidents that come to our attention and we take these into account if we receive complaints or other intelligence about the standards of compliance within an organisation. Whilst we have decided not to take this matter further at this time, if further information regarding this case emerges or we are not satisfied with the action plan you provide, we may need to review the case and reopen our investigation.

Training figures from August 2013 – end of July 2014 show 4,349 staff including Medirest staff, have been trained, either face to face or by accessing online training

The Board will need to maintain a focus on achievement of Information Governance in order to ensure as a minimum we maintain level two status (in accordance with Monitor requirements).

4.11 External Reviews

Following approval and implementation of the External Recommendations Policy, future BAS reports will include a holistic view of the external agency visits and outcomes that have taken place across the period. The CQC carried out their inspection of the Trust in April 2014 and recommended to Monitor the Trust remain in special measure for a further 6 months, therefore a revisit before the end of the year is expected. KPMG carried out a review into Financial Governance and the action plan is being submitted to the Board in September 2014. Baker Tilley have been appointed to carry out a review of the process in respect of engaging Locum, Agency and Consultancy services in order to streamline the process and reduce costs.

5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

5.1 The work of the Board and its committees have facilitated the organisation's effective and efficient operation, albeit in very challenging times, by enabling it to respond appropriately to significant business, operational, financial, compliance and other risks to achieving the Trust's

objectives. This has included the continued safeguarding of assets from inappropriate use or from loss and fraud and ensuring that liabilities are identified and managed. The realisation of regulator interventions (significant breach, warning notice, special measures) has led to a number of changes to the control environment along with a risk based approach to the assurance attached to evidence provided to PMO to assert completion/compliance with action plans to deliver regulatory requirements and to improve the quality of governance and finance.

5.2 A tight PMO focus will need to continue with regard to CIP delivery and the Executives are driving continued work around transformation which will from here on in, be fundamental to realising the inevitable spend reductions in order to meet the cost reduction strategies required across the next three-five years.

5.3 In view of recent events, the current pace of change and economic challenge faced by the organisation it is imperative that the Board continues to closely monitor progress and commissions the appropriate level of assurance to satisfy itself that risk is being managed effectively and the Audit and Assurance Committee feel confident that significant progress is being made in this regard and with delivery of the savings outlined in the Annual Plan.

5.4 **Code of Governance**

Part of the Annual Report submission also obligates against the 'comply or explain' principal, that the Trust explains reasons for any non-compliance with Monitor's Code of Governance and illustrates how its actual practices are consistent with the principle to which the particular provision relates. The Annual Governance Statement (AGS) is submitted annually to the Audit and Assurance Committee and forms part of the Trusts Annual Report. When the draft AGS is submitted, the Code of Governance statements will be included for consideration, it will be reported that during the course of the year, the Board considers Monitor's *"NHS Foundation Trust Code of Governance"* has been complied with. In July 2014 Monitor amended the code and these changes will be reflected in the AGS, together with any necessary amendments to other relevant documents including the Constitution, Standing Financial Orders and Code of Conduct.

6. Significant Control Issues

Following the PWC confirmation of the Trust's achievement of a QGF score of 4 at the end of January, the Board approved a reduction in the score to 3.5 at its March meeting, which now satisfies that element of our Discretionary Requirements. Subsequently in July 2014 the Board approved the Trust Management Board recommendation to reduce the score to 3.0 after scrutinising evidence provided against the best practice identified in the Monitor guidance.

The Trust continues to be monitored on its financial and operational performance by Monitor and provides monthly exception reports in respect of operational performance and weekly reports in respect of financial performance and CIP delivery.

KPMG have completed a Financial Governance review which highlighted a number of issues, particularly regarding financial control of variable pay and CIP delivery. The review of financial control in relation to variable pay currently being undertaken by Baker Tilley forms part of the action plan developed to respond to the report. The report and high level action plan are being presented to the Trust Board in September with a further more detailed action plan being developed by the executive leads for submission later in the year.

The trust continues to receive PDC support in order to address cash flow issues particularly in respect of the PFI funding situation.

The Audit and Assurance Committee/Board is invited to consider whether any report it has received, such as serious incidents, claims, complaints, audits/inspections or surveys, constitute a significant control weakness in order that the Annual Governance Statement as part of the Annual Report reflects the position as agreed by Board members.

7. Actions planned over the next six months

The next six months will continue to be challenging and amongst many activities will include significant work regarding the following:

- Delivery of the Annual Plan 2014/16 as submitted to Monitor in June 2014.
- Close management of CIPs to include Divisional and Corporate cost reduction schemes through PMO (to include CQUINs/QIPP).
- Begin Contract negotiations with the Trust's principal commissioner
- Agree financial and business planning timelines with Divisions, Exec Team and Trust Board
- Continuing pressures to do more with less, requiring significant cost reduction plans including assurance of deliverability and protection of quality to ensure not diluted to unacceptable levels – with particular consideration necessary to the systems of assurance upon which the Board will rely
- Progression of short, medium and longer term priorities in accordance with the full Recovery Plan milestones along with the agreement to metrics to monitor progress and achievements against key strategies (Quality, OD& Workforce, IT, Procurement etc)
- Continuing tight focus on reductions in admissions and length of stay and building on self-care and care in the community through the key work streams of the Transformation Board .
- Continuing work to gain PFI support – working with Monitor, LAT and CCG.
- Continuing with the CCG to build on relations and to integrate Better Together
- Implementation of Quality for All – vision and values
- Development of an integrated plan to deliver recommendations from the CQC report
- Focus on assurance processes re CQC compliance and remove of Special Measures
- Re inspection by CQC
- Clarity to be sought from Monitor in respect of Discretionary Requirements
- Progress with Business Intelligence to ensure better understanding of 'outcomes' and concerted focus on Transformation to support service redesign that by default will galvanise 15/16 CIPs and enable pathway redesign including across the multiagency landscape

- Roll out of an Operational Assurance Framework that places responsibility for assuring compliance firmly with the Clinical Directors as the heads of service delivery units.
- Board effectiveness review being undertaken by Foresight Partnerships – initial 360^0 surveys with board members and external stakeholders taking place in October 2014

The Board will need to ensure its information and reports support understanding and assurance of safe care through intelligent and transparent performance information of the quality of both inputs and outputs.

The financial position of the NHS in general continues to be very challenging and locally there can be no doubt that the Trust is feeling the pressure of central initiatives to reduce costs (e.g. tariff changes, caps on growth, impact of CQUINS). The Trust has already introduced a plan regarding a range of short, medium and longer term proposals to reduce costs and overheads and realign service delivery. All will be closely monitored by Board of Directors and the success of these will return the Trust to a more viable financial position.

The Board will continue to focus attention on risk and performance across these key areas and will need to ensure its confidence is strengthened in the systems and processes that assure the Board of the effective management of risk and the attainment of objectives.

8. Action Required

The Board of Directors is asked to consider if this Statement substantiates the evidence that will be required to support signing of the Annual Governance Statement (AGS) by the Accounting Officer on behalf of the Board, at the Annual Report submission stage.

The Board of Directors is invited to continually consider the detailed content of the six-monthly Board Assurance Statements in assuring it of the credibility and robustness of its self-assessments to the Regulators and is reminded of the importance of deliberations regarding the seriousness in terms of 'significance' of control failures / weaknesses in support of the AGS submission as part of the Annual Report (as detailed in section *6. Significant Control Issues*).