

An Assurance Framework: *a Practical Guide for Boards of DHSSPS Arm's Length Bodies*



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CONTENTS

| | |
|---|-----------|
| PREFACE | 5 |
| SECTION 1 – INTRODUCTION | 6 |
| Background..... | 6 |
| SECTION 2 – GOVERNANCE IN CONTEXT | 9 |
| General | 9 |
| What a board must do | 10 |
| What assurance means for HSC and other arm’s length bodies | 12 |
| SECTION 3 – ACCOUNTABILITY IN CONTEXT | 14 |
| The Policy and Planning hierarchy..... | 14 |
| Accountability: the four domains | 15 |
| SECTION 4 – AN ASSURANCE FRAMEWORK IN PRACTICE | 20 |
| Building an Assurance Framework | 20 |
| Principal objectives..... | 20 |
| Principal objectives..... | 21 |
| Principal risks | 21 |
| Risk Quantification Matrix | 25 |
| Sources of possible independent assurance | 26 |
| Assurances and co-ordination..... | 28 |
| Board Reporting | 30 |
| SECTION 5 – ASSESSMENT AND REVIEW | 32 |
| Assessing the Assurance Framework..... | 32 |
| SECTION 6 – LINKS BETWEEN AN ASSURANCE FRAMEWORK AND RELATED INTERNAL BUSINESS PROCESSES | 33 |
| Performance reporting | 33 |
| Risk registers | 34 |
| PART TWO: | 36 |
| APPENDICES | 37 |

| | |
|--|-----------|
| Appendix 1: The Role and Remit of Example Sources of Independent Assurance | 38 |
| Health and Social Care Regulation and Quality Improvement Authority..... | 38 |
| The Northern Ireland Social Care Council | 40 |
| External Audit..... | 41 |
| Internal Audit..... | 42 |
| | |
| Appendix 2 - Illustration of examples of Principal Objectives showing the link between Organization & Directorate level objectives. | 43 |
| | |
| Appendix 3 - An Assurance Framework – this Appendix demonstrates how the sample principal objectives in Appendix 2 link to the principal risks. These are not intended to be comprehensive but to illustrate the principles to be applied | 49 |
| | |
| Appendix 4 Examples of existing HSC Best Practice- Example 1..... | 55 |
| | |
| Appendix 5 - Assurances on Systems on Internal Control..... | 59 |
| Systems-based Auditing/Review | 61 |
| Walk-through Test..... | 61 |
| Compliance Test | 62 |
| Substantive testing | 62 |
| Analytical review | 63 |
| | |
| Appendix 6: Assessment of Assurance Frameworks..... | 64 |
| | |
| Appendix 7: Board assurance – a quick reference guide | 66 |
| | |
| Appendix 8 : Glossary..... | 67 |

PREFACE

This guidance is intended to help the boards of HSC organizations, and other arm's length bodies of The Department of Health, Social Services & Public Safety (DHSSPS), improve the effectiveness of their systems of internal control. It does this by showing how the evidence for adequate control can be marshalled, tested and strengthened within an Assurance Framework.

Three years have passed since, in January 2006, the first version of the Assurance Framework guidance was published. At that time the concept was commended to HSC organizations as an important example of governance best practice. All the Department's arm's length bodies subsequently adopted the Framework and have begun to rely on it as the pivotal mechanism through which boards exert control over their organizations.

The guidance has been re-examined in light of the practical experience thereby gained, and its revision has benefitted particularly from the views expressed by colleagues from across the HSC. It is now being reissued to support the mandatory adoption of an Assurance Framework by each board, from 1 April 2009.

As was stated when the guidance first appeared, the essential point of a robust Assurance Framework is that it provides a stronger basis for effective challenge and better-informed decision-making in the boardroom. It will also be of direct relevance to senior executives, risk and governance managers, and clinical and social care professionals – to all those, in fact, with responsibility for good governance.

That is not just a pious assertion. The Assurance Framework concept, and its application, is standing the test of time. In the NHS, where restructuring and reinvention have been a recurrent feature of organizational life, it has held firm as the linchpin of the board régime for control and assurance.

The NI public sector is undergoing comparable reform, with the arm's length bodies of DHSSPS in the lead. The Department therefore believes that the publication of updated Assurance Framework guidance is both timely and of critical relevance to the maintenance of control in a time of change. Without that firm control, the services for which we are responsible would suffer, and so would the people who rely on them. One way of ensuring that that does not happen is for boards, and individual board members, to conscientiously and proficiently fulfil their duties. It is the aim of the Assurance Framework to help them do that.

SECTION 1 – INTRODUCTION

Background

- 1.1 People need to be confident about the quality of care that they get from organizations commissioning or providing health and social care. They want services that are readily accessible, are safe, and, are provided by competent and confident staff who will always work in their best interests. The board of each Health and Social Care (HSC) organization, and of each of the Department's NDPBs, has therefore a duty, on behalf of its service users, carers, staff and local communities, to ensure that the organization is carrying out its responsibilities within a system of effective control and in line with the objectives set by Ministers. Their organizations must also demonstrate value for money, maximizing resources to support the highest standards of service. To discharge all these duties, boards need to have in place robust systems of direction, control and communication; good governance, in other words.
- 1.2 Traditionally, responsibility for governance has been discharged through a number of separate controls or disciplines which, because they developed separately over recent years, do not necessarily align or specifically interrelate. For example, the translation of commissioning plans or delivery plans into organization or directorate objectives may not be sufficiently informed by a thorough risk¹ assessment. Similarly, decisions on financial allocations may not be taken in the context of relevant information about clinical and social care governance. Controls assurance itself is sometimes seen as an additional, separate, annual exercise to support the Statement on Internal Control (SIC). But risk does not recognise internal management boundaries or timetables. The systems and controls put in place to manage it must be comprehensive and flexible. The Assurance Framework is designed to help boards address these anomalies or shortcomings.
- 1.3 The Framework does not impose any new requirements on the staff of arm's length bodies: rather, it supplies their boards with an instrument for making fuller use of the existing governance capacity:
- in terms of how the various aspects of governance relate to organizational responsibilities, accountability and to each other;
 - in relation to the information they need to discharge their responsibilities and accountability;
 - to know how the different facets of governance are working; and
 - to ensure the effective management of risk.
- 1.4 All these bodies have a duty to protect service users, carers, staff and others in the planning and delivery of services. Reducing risk is not just

¹ HMT's Orange Book – Management of Risk – Principles and Concepts (October 2004) defines "Risk" as this uncertainty of outcome, whether positive opportunity or negative threats, of actions and events

about financial or management probity. It is also – indeed, it is primarily – concerned with improving the safety, quality and user experience of services. This means that equal priority needs to be given to the obligations of governance across all aspects of the business, whether financial, organizational or in clinical and social care, together with a need for governance to suffuse each organization’s culture. Good governance depends on having clear objectives, sound practices, a clear understanding of the risks associated with the organization’s business and effective monitoring arrangements – in other words, a sound system of organization-wide risk management.

- 1.5 The six core principles of good governance, as set out in the Good Governance Standard for Public Service,¹ are:

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| Focusing on the organization’s purpose and on outcomes for citizens and service users |
| Performing effectively in clearly defined functions and roles |
| Promoting values for the whole organization and demonstrating the values of good governance through behaviour |
| Taking informed, transparent decisions and managing risk |
| Developing the capacity and capability of the governing body to be effective |
| Engaging stakeholders and making accountability real |

- 1.6 Arm’s length bodies will already, of course, have in place monitoring systems – in the case of Trusts and agencies, to monitor the quality of their own services and, in the case of commissioners, to monitor the quality of services commissioned. The need for such arrangements has been further underlined by the statutory duty of quality placed on the HSC from April 2003.

- 1.7 The HSC Regulation and Quality Improvement Authority (RQIA)² has a pivotal role to play in ensuring that integrated governance³ processes are in operation throughout the HSC and that they can provide the public with real assurance that the services on which they rely are appropriate, safe and of the highest possible quality. By monitoring and

¹ Published by the Independent Commission for Good Governance in Public Services (January 2005) http://www.opm.co.uk/our_work/ICGGPS.shtml

² Established as the HPSS Regulation and Improvement Authority by Part IV of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003 and, with effect from 1 April 2009, renamed the HSC Regulation and Quality Improvement Authority by section 1(2)(a) of the HSC (Reform) (NI) Act 2009 (c.1(NI))

³ **Integrated governance** can be defined as ‘*systems and processes by which trusts lead, direct and control their functions in order to achieve organizational objectives, safety, and quality of services, and in which they relate to the wider community and partner organizations.*’ NHS Confederation (May 2004) – The development of integrated governance

inspecting services, by examining the governance arrangements, by investigating particular events and reviewing actual practice, the RQIA is able to reach a definitive view on the quality of service provision. The RQIA also promotes a culture of continuous improvement within the HSC and, where appropriate, indicates to the Department the need for special measures to secure standards and quality of care.

- 1.8 Associated with developments in the regulation of services and in clinical and social care governance has been a growing emphasis on continuous professional development, life-long learning and strengthened regulation of the professions and the workforce. This too should be reflected in the Framework.

Summary

This assurance framework does not impose any new requirements on arm's length bodies

If boards are to discharge their duties effectively, they need to have robust systems of governance in place

Reducing risk is not just about financial or management probity – it is also about improving the safety, quality and user experience of services

The RQIA has a pivotal role to play in ensuring that integrated governance processes are in place throughout the HSC

Strengthened workforce regulation will also have a role in improved governance

SECTION 2 – GOVERNANCE IN CONTEXT

General

- 2.1 The boards of HSC organizations and NDPBs need to be confident that their governance arrangements are operating effectively. They have to know that they will identify, manage and minimise the risks inherent in the provision of health and social care and that, thereby, they will help to achieve business objectives.
- 2.2 Chief Executives must, as Accounting Officers, sign a Statement on Internal Control (SIC) as part of the statutory accounts and annual report process¹. From 2009-10 onwards they must also produce a mid-year Assurance Statement to attest to the maintenance and improvement of control systems. These obligations heighten the need for boards to be able to demonstrate that they have been properly informed about the totality of their risks, whether in the immediate provision of health and social care or public safety or in organizational matters. To do this they need to be able to show – to give “assurance” – that they have systematically identified their objectives, managed the principal risks to achieving them and identified any significant weaknesses that need to be overcome. In turn, this assurance (in the form both of the SIC and the mid-year statement) is provided to the Department’s Accounting Officer.
- 2.3 But the concept of ‘assurance’ can be a source of misunderstanding and mismatched expectations. There may be a lack of clarity within, and beyond, the board as to what is meant by the term. This may extend to uncertainty as to:
- the level of assurance required,
 - where such assurance is to come from, and
 - how to manage the reporting of assurance in a co-ordinated fashion.

While arm’s length bodies have made considerable progress in this area in recent years, more remains to be done to establish cohesion between risk registers and board risk reporting mechanisms.

- 2.4 In summary, therefore, this guidance is intended to resolve uncertainties and deepen organizations’ understanding of these aspects of governance. More specifically, it gives advice on building an Assurance Framework and on harnessing existing risk management activity. The principles it sets out are illustrated by worked examples, some of them taken from HSC organizations’ existing Assurance Frameworks. The guidance also clarifies the requirements concerning, the four core elements of the new accountability arrangements.

¹ DAO(DFP)5/01 introduced the requirement for a Statement on Internal Control to be made alongside the accounts of central government bodies. DAO(DFP) 25/03 and HSS(F) 2/04 set out the requirements from 2003/04 onwards

What a board must do

- 2.5 Criterion 6 of the Governance Standard¹ states:
“The board ensures that it has proper and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.”
To meet this criterion, the board needs to develop a process to support its Chief Executive in making a balanced, fully informed SIC – one that describes both the achievements in the embedding of risk management and the work that remains to be done.
- 2.6 The requirement for all Chief Executives to sign a SIC, as part of the statutory accounts and annual report, and (as of 2009-10) to issue a mid-year Assurance Statement, heightens the need for boards to demonstrate that they have been properly and continuously kept informed about the totality of their risks, whether clinical or non-clinical.
- 2.7 An effective Assurance Framework provides a clear, concise structure for reporting key information to boards. It identifies which of the organization’s objectives are at risk because of inadequacies in the operation of controls, or where the organization has insufficient assurance about them. It should also provide structured assurance about how risks are managed effectively to deliver agreed objectives. This will supply a basis for the spread of good practice throughout the organization and allow the board to determine where to make the most efficient and effective use of their resources.
- 2.8 Board members will, however, wish to bear in mind the fact that responsibility for managing risk lies not with them but with the executive team. The board’s primary function has to do with the organization’s overall control and direction. As regards risk, therefore, it is probable that the board will have before it only a dozen or so risks – of which, at any given time, just two or three will be posing an immediate threat to organizational stability. All the time, of course, managers will be dealing with the other corporate and lower level risks; the point is, however, that only a handful are, at a particular juncture, likely to pose a threat to stability or progress across the organization as a whole.
- 2.9 The Assurance Framework is designed to allow the board to concentrate on that very limited number of top-level risks, but without restricting its freedom to maintain a watch on the full array of risks to principal objectives. Paragraphs 2.11-2.12 below explain how this two-fold aim can be achieved.
- 2.10 Section 4 of this guidance describes in detail the logic of an Assurance Framework and how it is constructed – in brief, the sequence of identifying an organization’s principal objectives, the principal risks thereto, the controls operating to mitigate the risks, assurances on the effectiveness (or otherwise) of controls and the adequacy (or otherwise) of the assurances themselves. Action – both managerial and, if

¹http://www.dhsspsni.gov.uk/governance_06.doc

necessary, board-level – then flows from the conclusions on controls and assurance. Appendix 6 contains a checklist to help boards assess the general adequacy of their own Assurance Framework.

- 2.11 Because the Framework incorporates all of an organization's principal objectives, related risks etc, its basic content does not immediately direct board attention to the most currently severe risks. For that to happen, there must be rigorous testing and filtering of the information on risk. One way of working towards the necessary board focus is as follows:
- i. the organization's risk management committee meets periodically to debate the content of the corporate risk register;
 - ii. in order that the outcome should straightforwardly present the live risks to business, it is essential that discussion should be frank and detailed. An adversarial tone would not be out of place;
 - iii. the revised corporate risk register, together with minutes of the risk management committee, are submitted to an audit committee whose membership is wholly non-executive. It would not be this committee's job, of course, to appraise the risks per se; rather, the audit committee would check that the systems for identifying and assessing risk are being conscientiously operated, and for evidence from the minutes of sufficiently serious and forensic examination of the issues;
 - iv. the audit committee's view is formally reported to the board;
 - v. in parallel, the risk management committee tables for board consideration the Assurance Framework adjusted to take account of the just-debated changes to the risk register and containing, typically, a maximum of three risks highlighted for board attention;
 - vi. the board decides what action to take on the three risks – though it naturally retains the right to address more or different risks to overall progress towards business objectives. In coming to a decision, the board may ask itself: do we accept the conclusions put to us? Do we need additional or more objective verification?¹
 - vii. the upshot will be soundly-based, board-led action.
- 2.12 The above is just one possible model for ensuring that the assurance framework is properly maintained and deployed, and it is for individual boards to decide their own procedure. But it will be important that any alternative approach should fully reflect the principles of the above model i.e. it should draw on managerial insight and experience without pre-determining, or limiting the scope of, board decisions on organizational control and direction.

¹ An example of further challenges and prompts based on the Quality Standards themes can be found in Challenges to Board Level Objectives (CSCG Support Team, 2007)
http://www.dhsspsni.gov.uk/board_assurance_challenges.pdf

What assurance means for HSC and other arm's length bodies

- 2.13 Boards can properly fulfil their responsibilities only if they have a sure grasp of the principal risks facing the organization. Boards then need to determine the level of assurance that should be available to them with regard to those risks. The difficulty is that there are many individuals, functions and processes, within and outside an organization, that produce assurances. These range from certification that statutory duties (such as those under health and safety legislation) have been performed, to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes, and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.
- 2.14 All this points to the need for the board to fully debate and map the connections between organizational objectives, risk and the range and effectiveness of existing assurance reporting. In doing so, it will be important to establish the principle of **reasonable** rather than **absolute** assurance, and to reach consensus on what "reasonableness" means for the organization concerned. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost (within the limited resources available) of eliminating, reducing or minimising the risk.
- 2.15 The Assurance Framework will act to define the organization's approach to **reasonable** assurance. Construction of such a Framework will also bring home to individual board members that assurance, from whatever source, will never provide **absolute** certainty. Such a degree of certitude does not exist, and pursuit of it is counter-productive.
- 2.16 For any HSC organization, effective risk management requires the embedding of controls assurance in the key processes that directly support service (business) objectives. And from 2009-10, with the extension of the core controls assurance standards to the RQIA, the NI Fire & Rescue Service, the NI Practice & Education Council for Nursing & Midwifery and the NI Social Care Council, the embedding principle applies to all of the Department's arm's length bodies. The best assurance régime is integral not only to the delivery of safe and high quality health and social care and public safety services; it underpins also effective stewardship of public resources and good performance as regards the delivery of services. It can, moreover, be used to manage change, to involve all levels of the organization, improve or defend the organization's reputation and maximise its opportunities to innovate.
- 2.17 Although these advantages are enough to commend the assurance agenda to all well-ordered organizations, there is also a strong external driver in the form of the SIC. This imposes an important public disclosure obligation on each board of directors. In effect, the SIC requires confirmation that the effectiveness of the system of internal control has been reviewed and that the results of the effectiveness review have been discussed by the Accounting Officer with the board. That responsibility for the system of internal control encompasses:

- adopting appropriate policies on internal control;
- obtaining regular assurance that the system is functioning effectively; and
- ensuring that the system of internal control truly identifies and manages risks, as the board intended.

2.18 Originally, compliance with standards was the governance priority for many HSC boards, with attention focussed on assessing gaps in performance against set criteria within given areas of risk. That compartmentalised process was useful in terms of engaging all HSC organizations in a consistent manner. But the SIC requirement is that each board and its members understand the links in their particular organization's assurance chain, and that the board continuously monitors the effectiveness of its internal control. No set of standards, however rigorously adhered to, replaces the need for an organization-wide bespoke system of risk management.

Summary

To make a balanced, fully informed SIC, boards need to demonstrate that they have been able to identify their objectives and manage the principal risks to achieving them

It is necessary for boards to determine the level of assurance required to manage their principal risks and take stock of the various forms of assurance available to them

In determining reasonable assurance, a balance needs to be struck between the likelihood of a risk occurring and the severity of the consequences should it do so, against the cost of managing it within available resources

The SIC requirement is that each board understands the links in the organization's particular assurance chain and for the board to continuously monitor the effectiveness of its internal control.

SECTION 3 – ACCOUNTABILITY IN CONTEXT

The Policy and Planning hierarchy

- 3.1 Each year the Government sets out, in its **Programme for Government** (PfG) and supporting **Budget and Investment Strategy**, its intentions for improving public services in Northern Ireland. The PfG contains a series of Public Service Agreements committing departments to work towards particular aims and outcomes for the benefit of service users.
- 3.2 In order to produce the outcomes for which the PfG makes DHSSPS ultimately responsible, a strong partnership is required between the Department and those arm's length bodies which have a hand in commissioning, delivering etc the services that lead to those outcomes.
- 3.3 In order to make the partnership effective, it must be expressed in formal and explicit terms. The outcomes and targets specified in the PfG are therefore restated in operationally measurable terms, and are assigned to the appropriate HSC organizations in the Minister's annual **Priorities for Action** (PfA)¹.
- 3.4 The HSC response to PfA is communicated through **commissioning and delivery plans**, which describe how commissioners and Trusts intend to use their resources to, respectively, commission services for their resident populations and deliver health and social care services to service users, carers and families. Action on foot of these plans is subject to Ministerial/Departmental approval.
- 3.5 As approved, commissioning and delivery plans form the basis of the relevant organizations' comprehensive business plans. The latter documents will include other, more local, service objectives as well as those needed to deliver corporate commitments.
- 3.6 For arm's length bodies outside the scope of the PfA process, Departmental approval of their business plans is required.
- 3.7 Since the Assurance Framework is essentially – though not exclusively – a board-level instrument, it will be the objectives contained in the **organization's business plan** that will form the 'spine' of the Framework. But it is important that, within each arm's length body, the organizational objectives should cascade to **director** and **unit/team level**, where more detailed targets and actions will be set in order to support or help meet overall aims and objectives. Individuals should, in turn, be able to translate the unit/team level information into **personal objectives** – thereby establishing the final link between their own jobs, the objectives of their organization, and the Department's objectives as laid down in the PfG.

¹ http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

Accountability: the four domains

- 3.8 Performance of the service-related obligations that flow from the PfG constitutes just one strand of the accountability lines between each arm's length body and the Minister/Department. Looked at in the round, there are four broad domains of accountability.
- 3.9 The first of the four may be classified as **Corporate Control** i.e. the arrangements by which the individual organization directs and controls its functions and relates to stakeholders.
- 3.10 This domain encompasses the policies, procedures, practices and internal structures which are meant to give assurance that the entity is fulfilling its essential obligations as a public body. It follows that most of the requirements reflect those in place across the public sector, but a few have been instituted for reasons peculiar to the field of health and social care – notably the statutory duty of quality created by Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, and the statutory duty to seek views from, and consult with, the recipients of health and social care created by sections 19 and 20 of the HSC (Reform) Act (NI) 2009.
- 3.11 The staple public sector requirements include the existence of appropriate board roles, structures and capacity; compliance with prescribed standards of public administration, with national or regional policy on procurement and pay, operation of a professional internal audit service, and corporate and business planning approvals. The accounting officer letter of appointment will spell out the principles underlying many of these obligations, while the letters appointing chairs and non-executive members of board will also give due emphasis to this aspect of the appointees' duties.
- 3.12 The second domain is **Safety and Quality** – the arrangements for ensuring that health and social care services, and public safety services, are safe and effective and meet people's needs. Self-evidently, this covers a broad field and applies to all programmes of care (including health improvement and health protection) and to infrastructure.
- 3.13 In addition to the numerous operational/professional requirements that concern or touch on safety and quality, there are more general requirements with which compliance is demanded. In the latter category, those issued by the Department include the Quality Standards¹, Care Standards, and most of the Controls Assurance Standards, but the most notable such item has already been mentioned; it is, of course, the statutory duty of quality created under the HPSS (Quality, Improvement and Regulation) (NI) Order 2003.

¹ The Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS (DHSSPS, March 2006)

- 3.14 It is to be expected that any organization's Assurance Framework will attach the highest priority to safety and quality.
- 3.15 **Finance**, i.e. the arrangements for ensuring the financial stability of the Department's arm's length bodies, for securing value for money and for ensuring that resources allocated by the Minister/Department are deployed fully in achievement of agreed outcomes, is the third accountability domain.
- 3.16 Maintaining financial balance is essential. Apart from the accountability and probity problems associated with not living within one's means, concern for service users also points towards the need for strong budgetary control. Failure in financial duties would reduce the Department's claims to an appropriate share of resources. This would damage the longer-term interests of patients, clients, carers, families and others who depend on our services. Through prudent use of resources, the HSC is able to demonstrate delivery of real improvements to service users, not only in productivity (through efficiency and higher levels of activity), but also in terms of quality and modes of delivery.
- 3.17 Boards must therefore be satisfied that the financial information they receive is accurate and that financial controls and systems of risk management are robust and defensible. When considering what it would be justifiable to tolerate by way of risks, boards need to compare the cost (financial or otherwise) of minimising the risk against the cost to be borne should the risk materialise; as in other aspects of risk management, an acceptable balance must be struck. Likewise when considering opportunities, and how much risk can be taken in order to capture their benefits, it is a matter of weighing the value (financial or otherwise) of potential benefits against the losses which the organization might suffer.
- 3.18 As with corporate control matters, the accounting officer's letter of appointment, and those of the chair and other non-executive board members, will stress the probity and related expectations in respect of finance.
- 3.19 The fourth domain covers **Operational Performance and Service Improvement** – fulfilling the Departmental requirements for ensuring achievement of PfG and Ministerial objectives, standards and targets.
- 3.20 Paragraphs 3.1-3.7 above have dealt with the salient issues under this head. But one further consideration should be noted at this stage: while, as in the other three domains, each individual organization's accountability runs ultimately to the Department, the rôles of the Health & Social Care Board (HSCB) and of the Public Health Agency (PHA) will become relevant from 2009-10.
- 3.19 In that connection, the detailed accountability arrangements between the Department and its arm's length bodies will hinge on the terms of the Framework Document to be produced under section 5 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

- 3.20. The Act itself, of course, specifies the essential roles and responsibilities of the Department and the new HSC organizations – the HSCB, the PHA and the Business Services Organization. The equivalent provisions for the Trusts are as set out in the Health and Personal Social Services (Northern Ireland) Order 1991, and each other ALB is subject to its own governing legislation. But the precise inter-relationships, and their detailed application for purposes of accountability, can only be settled once the Framework Document has been approved.
- 3.21. This section of the Assurance Framework guidance will, therefore, have to be amplified in light of those decisions. In the meantime, board members should note that the six principles set out below should underpin the approach to assurance and the performance of corporate responsibilities post-March 2009.
- the Minister and the Department have ultimate accountability for the effective functioning of the HSC across the four domains
 - the Minister and the Department will provide the HSC with a clear direction across each of the four domains, specifying outputs and outcomes that are appropriate, affordable and achievable. This direction will be developed with the involvement of the HSCB, PHA and other HSC organizations, consistent with their stated roles and responsibilities
 - local accountability for organizational performance across the four domains – and for ensuring that appropriate assurance arrangements are in place – rests wholly with each organization’s board of directors. It is the responsibility of these boards to manage local performance and to manage emerging issues in the first instance
 - the assurance arrangements and associated information streams within individual HSC organizations will, as far as possible, be used to meet the assurance requirements of the HSCB and PHA, and those of the Department, subject to such additional independent verification as may be deemed necessary
 - the Department, and in turn the HSCB and PHA, will seek to build a relationship with other HSC organizations based on open communication and ‘no surprises’, adopting an informal, supportive approach to clarify and resolve issues as they arise, minimizing the need for formal intervention
 - there will be a continuing need for the Department to engage with Trusts to ensure sound financial management and for other matters, but the Department will ensure that such engagement is undertaken with proper regard for the roles, responsibilities and effectiveness of the HSCB (and the PHA).

Summary

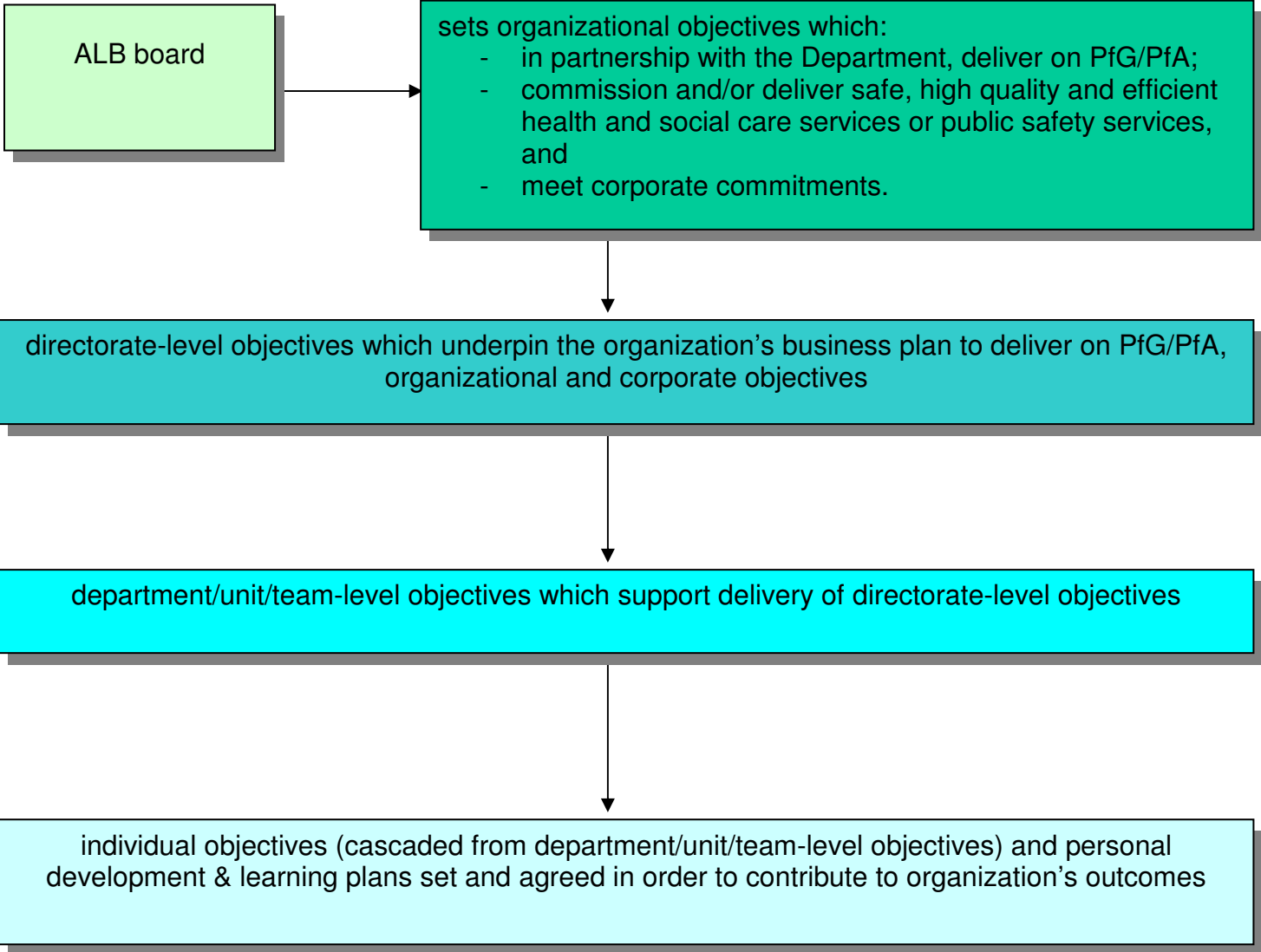
A strong partnership is required between the Department and its arm's length bodies in order to meet the standards and targets set out in the Programme for Government

The Minister's *Priorities for Action* translates the Programme for Government into an action plan for HSC organizations

Organizational objectives should cascade to individual level, establishing a personal link to the strategic agenda

All arm's length bodies remain accountable to the Minister/ Department for their corporate control, safety and quality, financial control and operational performance and service improvement

Figure 1 – Linking Organization Objectives to Individual Objectives

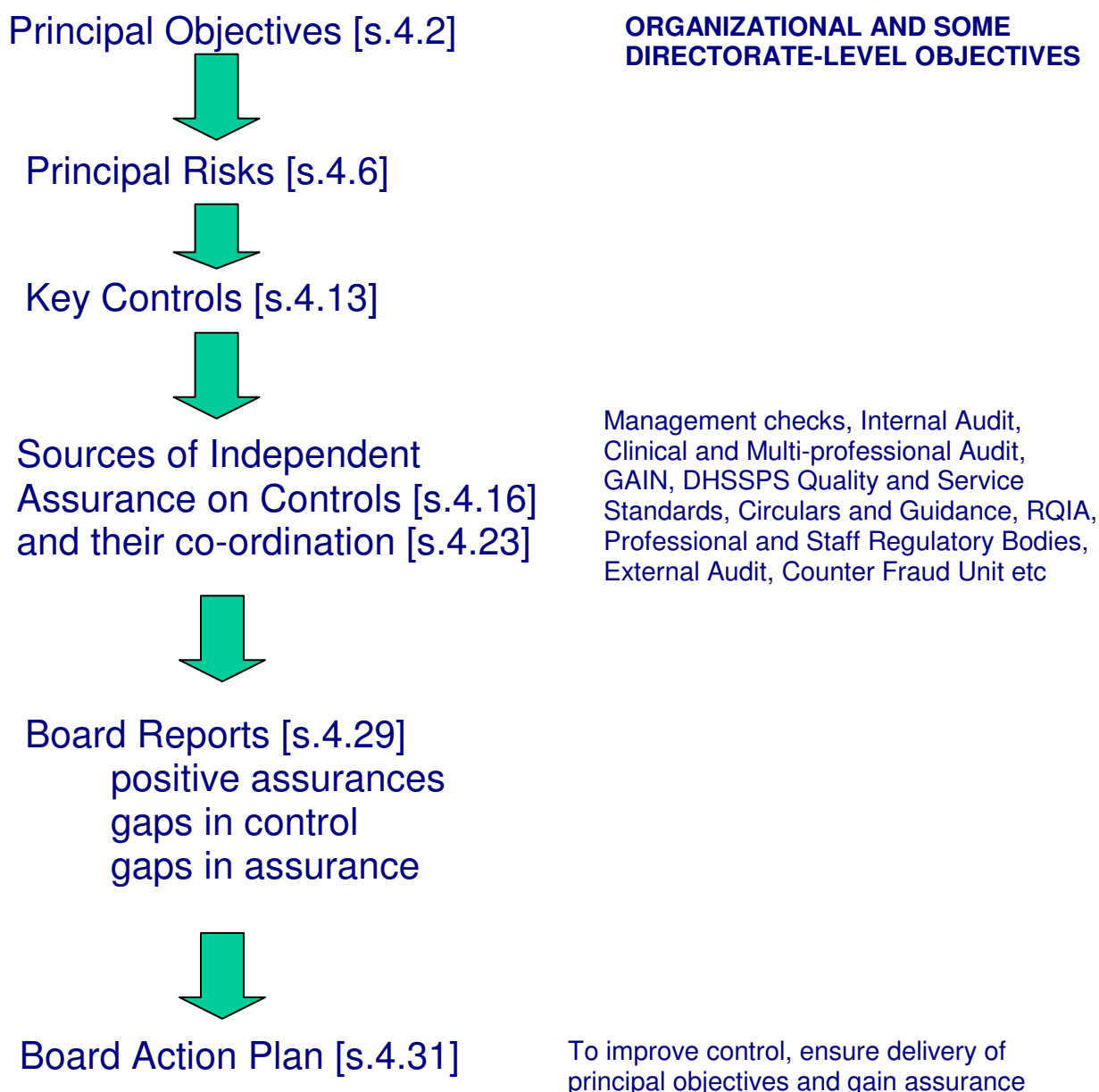


SECTION 4 – AN ASSURANCE FRAMEWORK IN PRACTICE

Building an Assurance Framework

- 4.1 An Assurance Framework provides the organization with a simple but comprehensive method for effectively managing the principal risks to meeting its objectives. It also provides a structure for acquiring and examining the evidence to support the SIC. By contributing to more pertinent board reporting and the prioritisation of action plans, the Framework will, in turn, allow for more effective performance management.

Figure 2 – the Key Stages



Principal objectives

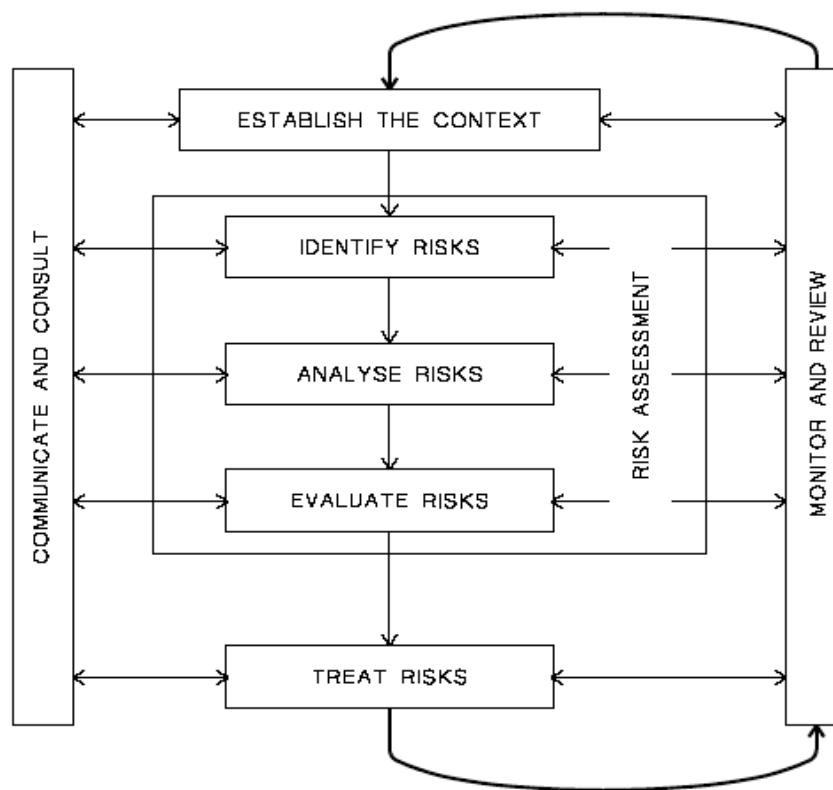
- 4.2 The **first step** in preparing an Assurance Framework is for the board to identify its organization's objectives – whether in clinical and social care, financial management, service improvement or other areas of governance, such as corporate governance, information governance, research governance etc. The board needs to focus on those that are crucial to the achievement of its overall goals - the **principal (ie corporate) objectives**.
- 4.3 It is important that the board should take its principal objectives as the starting point in the assurance process. While it may often be easier to identify risks at directorate rather than the corporate level, for a full appreciation of the risk environment it is essential to take an overall, service-oriented view. The board must, in fact ensure that the linking of risk to objectives is inherent in the way the organization goes about planning and managing its business. The process is intended to be of real operational value and relevance; treating it as a paper or 'tick box' exercise only adds to organizational risk and jeopardises performance.
- 4.4 At the highest level, HSC objectives will include those linked to the Regional Strategy – *A Healthier Future*, Public Service Agreements, *Priorities for Action*, financial responsibilities, compliance with governance and risk management standards, health and wellbeing improvement and developing effective working partnerships. Appendix 2 provides examples of principal (corporate) and directorate level objectives. While drawn from current HSC practice, they are meant to be illustrative and boards will need to consider their relevance in the context of their own priorities.
- 4.5 Directorate objectives are in turn supported by those of constituent departments/units/teams and of individuals. Organizations will wish to record and test the linkages of these "lower level" objectives to their organizational objectives over time. Suitably verified, these will provide assurances that the whole organization is working cohesively and effectively to improve the quality of care and services.

Principal risks

- 4.6 The **second step** involves the identification of **principal (i.e. corporate) risks**, which are defined as those that threaten the achievement of the organization's principal objectives. It is essential that boards understand that they need to actively manage potential principal risks, rather than react to the consequences of risk exposure.
- 4.7 Principal risks should be routinely identified from the risk management arrangements that boards have in place. Many arm's length bodies have made good progress in identifying risks and keeping comprehensive records that support full prioritisation and management of risks across all their main activities.

- 4.8 By focusing on risks to organization and directorate objectives, it should be possible to identify and manage the critical range of principal risks. The relevant assurance committee will then consider, prioritise and facilitate regular reporting on the current top risk issues to the board.
- 4.9 Boards may find it helpful, in mapping arrangements for the management of risk to objectives, to match their principal risks to their organization structure. Examples of such a classification are shown at [Appendix 3](#).
- 4.10 It would be wrong to consider principal risks in isolation from each other. They will have been aggregated from separate sources across the organization, and it is only when they reach the top organizational tier that the opportunity arises to conduct a comparative analysis. A good starting point for the analysis is a structured risk identification, assessment and evaluation exercise involving board members and senior managers, with subsequent wider exercises involving front line staff. The first aim is to define and generate a more detailed understanding of the organization's objectives as well as a consensus about the principal risks. This can then be viewed alongside subsequent analysis of existing and potential control and assurance sources. A sound assessment of the principal risks that the organization actually faces can only be made once the risk management framework described below is fully in place. HSC organizations have adopted the principles set out in AS/NZS 4360:2004 Model ([see](#) Figure 4), which underpins such a framework.

Figure 4 – The AS/NZS 4360:2004 Model¹ – Risk Management Process – An Overview



4.11 The key elements of a risk management system are:

- **board and senior management commitment to risk management.** A clear sense that risk management is integral to planning and achieving objectives and to being accountable – not something that is done “on top of everything else we have to do”;
- **an understanding that risk taking can bring both rewards and penalties, and that certain risks simply have to be accepted.** Numerous individual health and social care and public safety cases attest to that; more broadly, modernisation of services cannot be achieved without risks being taken. The point is to understand more fully the potential consequences, both positive and negative, of taking those risks. Given such understanding risks can be taken with legitimate confidence;
- **a common framework for the analysis of all risks.** For principal risks to be brought meaningfully together for a board, there needs to be a common framework of analysis, whether those risks are strategic or operational, financial or organizational, or related to safety and quality. This calls not only for a common definition of risk and risk identification but also a common means of calibrating likelihood and consequence;

¹ Based on material originally developed by SAI Global

- **a single point of co-ordination for the process.** Once the board has set the framework and the strategy, there needs to be an appropriate infrastructure of committee and individual responsibility to carry through the agenda. An executive committee with responsibility for risk management or governance can be used to co-ordinate and filter the risk assessments that are being conducted operationally throughout the organization. The audit committee, or a separate non-executive assurance committee constituted as a committee of the board, may review the overall operation of these arrangements. In performing this rôle, it may be informed by the internal auditors or by other disinterested experts, as it sees fit.

4.12 Once an understanding of the organization’s objectives has been gained and a consensus on principal risks reached, risks can be assessed in terms of their likelihood and consequence (or impact). Risk assessment is the process of prioritising the “potential risks” to identify those “applicable risks” that will need to be actively managed. Typically, the assessment is assisted by utilisation of the model illustrated in Figure 5. Organizations can adapt the model to suit particular applications (e.g. to represent the scale of ‘untreated’ risk), but the calibration from ‘extreme’/ ‘high’/ ‘medium’/ ‘low’ shown in figure 5 should be used to represent the scale of the ‘residual’ risk as recorded in risk registers.

Figure 5: Likelihood and Consequence/Impact Assessment
(based on the AS/NZS Risk Management Model)

| IMPACT | <i>Risk Quantification Matrix</i> | | | | |
|--------------------------|-----------------------------------|-----------------------------|-----------------------------|---------------------------|---------------------------------------|
| 5 - Catastrophic | High | High | Extreme | Extreme | Extreme |
| 4 – Major | High | High | High | High | Extreme |
| 3 - Moderate | Medium | Medium | Medium | Medium | High |
| 2 – Minor | Low | Low | Low | Medium | Medium |
| 1 – Insignificant | Low | Low | Low | Low | Medium |
| | A Rare | B Unlikely | C Possible | D Likely | E Almost Certain |
| | Likelihood | | | | |

Key controls

4.13 The **third stage** is for arm’s length bodies to ensure that they have **key controls** in place to manage their principal risks.

4.14 Controls must be documented and their design subject to scrutiny by independent reviewers. These would include internal auditors, in conjunction, where necessary, with health and social care professionals and specialists, the RQIA and external audit. The key controls should

be mapped to the principal risks. When assessing the adequacy of controls, consideration must be given not only to their design but also the likelihood of their being effective, given the governance and risk management framework within which they will actually operate; even the best designed controls can fail if staff are not properly trained.

- 4.15 The relationship between a risk and a control is not necessarily straightforward. One specific risk may be mitigated by a number of controls. Some of those controls may only be effective when operating in conjunction with other controls, and one control may relate to more than one risk.

Sources of possible independent assurance

- 4.16 The **fourth stage** in building an assurance framework is for the board to determine what level of **independent assurance** reporting is appropriate, given the risks and controls that have been identified. An adequately resourced internal audit function, operating to agreed (Government Internal Audit Service) standards, should be best placed in terms of objectivity and professional background to support the board on this point. But there are many other individuals, functions and processes that may also produce independent assurance. All these separate activities have been designed for different purposes at different times. They are operating within the HSC and other bodies for their own specialised reasons, not all of which are necessarily connected to the principal risks facing a particular arm's length body. So, before attempting to co-opt these external functions for assurance purposes, it is important to understand what is being done, why it is being done, how that assurance work is performed and the limitations that might apply – in effect, establishing whether there is the necessary overlap between the work of a potential assurer and the organization's own assurance needs.
- 4.17 Appendix 1 provides analysis of the roles and remit of a few of the key assurance functions. The possible sources of assurance listed in this section are by no means exhaustive but, nevertheless, they do illustrate the extent of the inspection and assurance regime. It is recommended that each arm's length body carry out a similar analysis of what is available to it.
- 4.18 One of the conclusions that can be drawn is that the bulk of objective and independent assurance reporting is externally driven; it is not necessarily or primarily conducted to provide assurance to the organization under review. Such reports are often produced as the result of one-off assessment exercises; the extent of the testing, which is often very specific and tightly defined, is limited to the conclusions that need to be reached by that external body; that testing is often quite restricted; and there may be little opportunity for the assessed organization to influence the methodology used.
- 4.19 The board, the audit committee and other relevant assurance (sub-) committee(s) need to understand that different types of auditors and assessors, even when they are examining the same systems, are not

producing the same types of opinion. Clarification needs to be gained on how evidence is collected and evaluated, e.g. if it is through enquiry, observation, desk review, compliance testing, substantive testing or statistical sampling. The auditors and assessors should be asked, if possible, to explain in clear terms how these tests are deployed, the sample sizes used and the value that can be derived from the resulting opinion. Appendix 4 provides additional detail to inform this process.

- 4.20 Internal audit does offer a source of independent ongoing assurance that is within the remit of the arm's length body itself to resource and, to the degree that is proper, direct. This places a particular responsibility on the board and the audit committee to be certain that the audit team has sufficient capacity and competence to conduct the required work. Although the main focus will be on outputs of the audit, information is needed on the depth and range of audit testing that is conducted to arrive at conclusions. Each organization needs to be sure that its internal auditors are not only competent but are undertaking sufficient work to support reliable and worthwhile opinions.
- 4.21 Clarity on the above point is essential, given the crucial part played by internal audit in providing an annual opinion to the board on the effectiveness of the whole system of internal control (and in supporting the mid-year statement). In arriving at its opinion, internal audit will need to work closely with other reviewers and perform a co-ordinating role on assurance issues. The sample templates of an Assurance Framework at Appendices 2 and 3 show the type of documentation needed to fully sustain this process. It links objectives, risk areas, prioritised risks, management assurances and controls, and independent assurance reports. Provided that those essential elements are present, the format can be varied to suit organizational taste or context; additional columns can also be added to capture committee reporting, action-by dates and responsible officers. Sub-sets of this document can be generated at directorate and department level, and assurances on the completion of this activity could be passed up the organization. Internal audit plans will need to be aligned with the Assurance Framework to demonstrate that boards are discharging their responsibilities and that internal audit activity concentrates on the significant risks. Similarly, audit and assurance committees will need to review their own capacity to respond to these assurance challenges.

4.22 Possible sources of independent assurance available to arm's length bodies include*:

- The Customer Service Excellence Standard
- Northern Ireland Environment Agency
- Environmental Health Inspection
- European Foundation for Quality Management (EFQM Model)
- External Audit – professional audit by contract with commercial company
- Northern Ireland Fire and Rescue Service
- General Medical Council, General Dental Council, etc.
- Guidelines and Audit Implementation Network (GAIN)
- Health and Safety Executive for Northern Ireland
- Internal Audit
- ISO Standards
- Investors in People
- Medicines, Inspection & Investigation team (DHSSPS)
- National Patient Safety Agency (incorporating the National Clinical Assessment Service)
- Northern Ireland Social Care Council
- Northern Ireland Audit Office
- Nursing & Midwifery Council
- The Patient and Client Council
- Pharmaceutical Society of Northern Ireland
- Professional accreditation schemes
- Professional advice or inspection from appropriately qualified individuals
- Regulation and Quality Improvement Authority
- Royal Colleges
- Social Services Inspectorate
- Training Accreditation and other regulatory bodies.

* This list is not exhaustive

Some of these sources can be directly commissioned by boards to provide an external or independent assurance of governance processes. Others cannot be so commissioned, although where such bodies produce reviews and reports boards may use them for this purpose.

Assurances and co-ordination

4.23 In implementing a system to gain **assurances** about the effectiveness of the controls they have in place to manage their principal risks, boards will wish to have a system that provides good **co-ordination** and assessment of the work of the auditors, inspectors and reviewers and which will bring increased benefits to both the organization and the review bodies. Such a system will help minimise the burden on the organization by reducing overlap and allow potential gaps in assurance to be identified and closed.

- 4.24 To ensure effective management and provide evidence to support the SIC, there will be a need to review the totality of assurance activity relating to the organization's principal risks. Boards not only need to ensure that they have the right level of assurance; they need to make use, wherever possible, of the work of the many external reviewers and ensure that the whole process is efficient, provides value for money, is proportionate and minimises duplication of work by different reviewers; another reason, in fact, for boards to map their assurance needs and identify the potential sources for providing them.
- 4.25 The process for gaining assurance about the effectiveness of the key controls is fundamentally about gathering all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are those derived from independent reviewers - which will include the RQIA, Departmental special inquiries or reviews, internal audit and external audit. These are supplemented from non-independent sources such as multi-professional audit, internal management representations, performance management, self-assessment reports etc.
- 4.26 In considering such regular reports, boards will need to satisfy themselves as to the adequacy of the assurances on the management of their principal risks, and be proactive in addressing issues that arise. Where the assurer's report is confirmed as relevant, the organization must endeavour to confirm that sufficient work has been undertaken in the review to be able to place reliance on its conclusions.
- 4.27 In summary, the organization will need to assess whether a review of this kind:
- **provides full assurance:** i.e. there are sufficient, relevant, positive assurances to confirm the effectiveness of key controls and that the objectives are met; or
 - **reveals gaps in control:** there is a clear conclusion, based on sufficient and relevant work, that one or more of the key controls on which the organization is relying are not effective; or
 - **reveals gaps in assurance:** there is a lack of assurance, either positive or negative, about the effectiveness of one or more of the key controls. This may be as a result of lack of relevant reviews, or concerns about the scope or depth of reviews that have taken place.
- 4.28 In the last case, the board may wish to consider how other assurances may be used, for example through future RQIA thematic reviews; reports on an organization's compliance with the *Quality Standards* and the development of improvement plans to address shortcomings; inspections and the results of organizational self-assessments to support the SIC. These should be seen as complementary to, rather than in place of, assurances from internal audit or other independent assurers.

Board Reporting

- 4.29 This **fifth stage** of an Assurance Framework provides an explicit framework for **reporting** key information to boards. It identifies which of the organization's objectives are at risk because of inadequacies in the operation of controls or where the organization has insufficient assurance about them. At the same time, it provides structured assurances about where risks are being effectively managed and objectives are being delivered. This allows boards to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.
- 4.30 By focusing on the principal risks, the board's assurance committee and the executive risk management committee can give priority to reporting the current top risk issues to the board. This will help ensure that risk management becomes firmly embedded as a board responsibility.
- 4.31 The assurance committee will also need to prepare a summary report to the board about the effectiveness of the organization's system of internal control, covering all of the principal risks and providing details of:
- positive assurances on principal risks where controls are effective and objectives are being met;
 - where the organization's achievement of its principal objectives is at risk through significant gaps in control;
 - where there are gaps in assurances about the organization's ability to achieve its principal objectives;

LEADING TO

- the **sixth stage** of producing a **Board action plan** to improve its key controls to manage its principal risks to objectives and gain assurances where required.
- 4.32 In addition to improving the effectiveness of board direction and control, this will provide the evidence to support the annual SIC.

Summary

1st step – identifying **principal (corporate) objectives** to achieve outcomes across all relevant business areas – safety and quality, financial, organizational and performance

2nd step – identifying **principal (corporate) risks** which threaten achievement of the principal objectives and these risks are effectively managed

3rd step – documenting the **key controls** in place to manage risk

4th step – determining the **independent assurance** required for the organization to be governed effectively. Consider types of assurance available, co-ordinate these effectively and identify areas where further assurance is required – tailoring assurance to the organization's needs

5th step – **reporting** key information to the board, including positive information on controls and assurance, identification of inadequate controls or where insufficient assurance exists

6th step – **action plan** to be agreed by the board to address gaps in controls and assurance with proposals to take corrective, restorative or remedial steps, as required

SECTION 5 – ASSESSMENT AND REVIEW

Assessing the Assurance Framework

- 5.1 It is important for the quality and robustness of the Assurance Framework itself to be evaluated by the board, which should also have arrangements in place to keep itself updated in the light of evidence from reviews and achievements.
- 5.2 If, for example, the organization's actual or apparent performance in a particular area seems at odds with the assessment from the Assurance Framework reports, the reasons for the discrepancy need to be investigated. Leaving aside the possibility of inaccurate reporting, it may be that:
- the objectives themselves need to be revised;
 - the risks reassessed and evaluated; or
 - the assurance on the effectiveness of the controls reviewed.
- 5.3 The board's action plan should be updated to reflect the remedial or corrective steps to be taken.
- 5.4 A checklist to aid with the completion of an assessment of an Assurance Framework is included in Appendix 5.

SECTION 6 – LINKS BETWEEN AN ASSURANCE FRAMEWORK AND RELATED INTERNAL BUSINESS PROCESSES

Performance reporting

- 6.1 Performance reporting should, among other things, be regarded as a form of assurance (performance and service improvement do, after all, constitute one of the four accountability domains). It can function as an early warning that the delivery of objectives may be at risk and is therefore an important component of the overall system of internal control. It is good practice to integrate the management of risk and organizational performance as part of a coherent approach to corporate governance¹. Performance reports typically cover activity-related performance as well as progress on other work programmes. They provide strong evidence of the effectiveness of control action and will also suggest necessary improvements where controls are lacking. Consequently, performance reports generate valuable information for an Assurance Framework and there is a need for performance reporting and Assurance Framework to be strongly linked.
- 6.2 Performance reports generally record an organization's performance against operational targets, such as those in commissioning plans, delivery plans and business plans. They will also provide a commentary on such other matters as the implementation of projects or programmes. As part of the annual business planning cycle, the board will specify the content of performance reports so that every objective is considered at the appropriate time throughout the year. There will follow regular reports to the board on progress and on difficulties being encountered. Boards may therefore place considerable reliance on performance reports as a method by which to manage principal risks that relate to key objectives.
- 6.3 Conversely, there are limitations to the usefulness of both performance reports and an Assurance Framework if these are left to operate separately. Performance reporting will highlight emerging problems and should describe the action proposed to remedy the situation. Risks which have not yet materialised may not be identified in this process, thus impairing the ability of the performance report to give comprehensive assurance that controls are sufficient to mitigate all material risks relating to an objective. On the other hand, Assurance Frameworks may not take into account performance data, which is an essential element when assessing the effectiveness of control. In order for an Assurance Framework to be more effective:
- performance reporting should be classed as a necessary internal control, with the measurement of outcomes serving as a trigger for necessary internal control improvements. Consequently, many objectives will require performance reporting as a key control requirement;

¹ The Turnbull Report

- secondly, performance reports will detail known performance problems and the planned corrective action. These, in turn, should be reflected in the Assurance Framework within the descriptions of *control gaps* and *planned action*; and
 - thirdly, the Assurance Framework maintenance process should treat the results of performance reporting as a valuable form of internal assurance, and use them to regularly review the effectiveness of internal control.
- 6.4 Such an approach will require those responsible for the Assurance Framework and for performance management to work closely together. Action points stemming from the Framework should be reported regularly to the board alongside, or as part of, performance reports.

Risk registers

- 6.5 Risk registers are a record of all forms of residual risks i.e. those risks which remain after treatment. Action may have reduced the probability of their occurring, but it is unlikely to have eradicated all possibility of the risks occurring. It is axiomatic that, if it is to be accurate and complete, the risk register should be constantly updated to reflect new risks and changes to existing risks. Thus it will be driven from a broad range of information sources. This, in turn, means that the risk register will be linked to risk assessment and inspection programmes and regimes, incident reporting systems and complaints and legal case handling procedures.
- 6.6 The Assurance Framework acts as high-level risk identification in regard to corporate objectives, highlighting gaps in control and/or gaps in assurance process and the details of necessary action. In order to make the most of this information, the principal residual risks identified in the Framework should be incorporated into the risk register to ensure that all forms of risk are shown in one document. By assessing Assurance Framework-derived risks, the risk register can generate prioritised action processes and progress reports.
- 6.7 As the risk register gathers risk details from many other assessment sources, it is very important that the risk identification process determines the relevance and significance of such risks to corporate objectives. Without a strong link between the risk register and the Assurance Framework there is a danger of material risks, and their relevance to the delivery of key objectives, being overlooked.

PART TWO:

PRACTICAL INFORMATION ON,
AND EXAMPLES OF,
AN ASSURANCE FRAMEWORK

APPENDICES

| | |
|--------------------------|--|
| <u>Appendix 1</u> | Some sources of independent assurance, together with their respective rôles and remits. |
| <u>Appendix 2</u> | Illustrative examples of the link between organizational and directorate level objectives, which together form the organization's <i>principal objectives</i> . |
| <u>Appendix 3</u> | How the <i>principal objectives</i> are linked to the <i>principal risks</i> , the key controls, assurances and board reports which together form the <i>assurance framework</i> . These examples are not intended to be comprehensive but to demonstrate the principles to be applied. |
| <u>Appendix 4</u> | Examples of existing HSC Best Practice Assurance Frameworks |
| <u>Appendix 5</u> | Some methodologies for gathering evidence for assurance on systems of internal control. |
| <u>Appendix 6</u> | Assessment of Assurance Frameworks |
| <u>Appendix 7</u> | Board assurance – a quick reference guide |
| <u>Appendix 8</u> | Glossary |

Appendix 1: The Role and Remit of Example Sources of Independent Assurance

Health and Social Care Regulation and Quality Improvement Authority

Role

The Health and Social Care Regulation and Quality Improvement Authority ('RQIA') is an executive Non-Departmental Public Body (NDPB) which was established in April 2005. It has overall responsibility for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

RQIA's main functions are:

- to inspect the quality of health and social care services provided by Health and Social Care bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies; and
- to regulate (register and inspect) a wide range of health and social care services delivered by HSC bodies and by the independent sector. The regulation of services is based on minimum care standards to ensure that service users know what quality of services they can expect to receive, and service providers have a benchmark against which to measure their quality

RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with regulations in The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003. These regulated services include residential care homes, nursing homes, children's homes, independent health care providers, nursing agencies, boarding schools, day care settings, residential family centres, domiciliary care agencies and adult placement agencies.

Any person who carries on or manages an establishment to provide a care service must make an application to RQIA, and once granted, they issue a certificate of registration to the applicant. RQIA maintains a register of all approved establishments.

RQIA inspectors visit nursing and residential care homes and children's homes to examine all aspects of the care provided, to assure the comfort and dignity of those using the facilities, and ensure public confidence in these services. They are also currently responsible for the regulation of independent hospitals and clinics and nursing agencies. RQIA also has a role in assuring the quality of services provided by commissioners, trusts and agencies, to ensure that every aspect of care reaches the standards laid down by the Department of Health, Social Services and Public Safety and expected by the public.

Where serious and/or persistent clinical and social care governance failings come to light, RQIA has a key role, in collaboration with other regulatory and inspectoral bodies, as appropriate, in investigation of such concerns and they work with service providers to encourage quality improvement whilst exercising a monitoring role.

RQIA has a duty to report to the Department on the provision of services, their availability and on the quality of care provided by HSC and other organizations delivering health and social care services. The Department can then consider recommending special measures with a view to improving Health and Social care organizations. For all regulated services, including those provided by the independent sector, the Authority may issue improvement notices or ultimately withhold registration.

Approach

RQIA will:

- promote participation and partnership approaches with public providers and service users;
- formally approve and grant registration to persons, establishments or agencies providing or managing regulated services;

- work in partnership with all stakeholders to promote a culture of continuous improvement and best practice;
- play a key role in the investigation of serious and/or persistent clinical and social care governance failings; and
- have a duty to report to the Department on the provision, availability and quality of care.

Limitations

The choice of methodology, the tools for conducting risk assessment, the balance between self-assessment and inspection frequency and the approach used by RQIA in carrying out its regulatory and improvement functions will also be important factors in securing improvements in safety and effectiveness in HSC organizations in the future.

Scope for coordination

RQIA will use information from a number of sources and will wish to enter into concordats or memoranda of understanding with other regulatory or inspectorial bodies to ensure a sharing of information and avoidance of unnecessary overlap or duplication of function.

The Northern Ireland Social Care Council

Role

The Northern Ireland Social Care Council (NISCC) was established as an executive NDPB in October 2001 under Part 1 of the Health and Personal Social Services (Northern Ireland) Act 2001 (the 2001 Act). It is an integral part of the Department's programme to further promote and develop the quality framework for Health and Social Care in Northern Ireland. People who use social care services are often among the most vulnerable in our community.

It is NISCC's role, through effective regulation of the social care workforce and social work training, to:

- strengthen protection for members of the public who use social care services;
- increase public confidence in those services; and
- promote confidence and competence in the social care workforce.

In particular, NISCC has the duty to promote:

- high standards of conduct and practice among social care workers in Northern Ireland; and
- high standards in their training.

Approach

NISCC is responsible for carrying out the following functions:

- maintaining a register of social workers and social care workers;
- preparing and publishing codes of practice and conduct expected of social care workers and their employers;
- approving courses in relevant social work; and
- undertaking any functions that may be delegated to it by the Department, under Section 14 of the 2001 Act.

Limitations

The Social Care Register opened on 1 April 2003 and NISCC commenced the registration of the priority groups designated by the Department (an estimated 3,500 social workers and staff working in specified settings). NISCC ran the registration in phases according to job role and location:

- Social workers and social work students
- Team leaders in residential child care
- Residential child care staff
- Head of residential homes and day centres
- Domiciliary care managers
- Adult residential care staff

The final phase of registration runs from 2008 to 2010 and includes social care staff in day care, social work assistants and domiciliary care workers. In time, it is intended that, once the registers of social care staff are established, fees from registration will contribute to the cost of the registration function. However, the level of registration fee for the next groups will have to be appropriate to a generally low paid workforce.

Scope for coordination

NISCC will use information from a number of sources and will wish to enter concordats or agreements with other regulatory or inspectorial bodies to ensure an appropriate sharing of information and avoiding unnecessary overlap or duplication. For example, all social care workers registered with NISCC are bound to meet standards set out in its Code of Practice for Social Care Workers. However, RQIA has responsibility for monitoring employers' adherence to the NISCC Codes of Practice for Employers of Social Care Workers.

External Audit

Role

The Comptroller and Auditor General for Northern Ireland (C&AG) is responsible for the external audit of all central government bodies in Northern Ireland and their executive agencies, and a wide range of other public sector bodies, including health and personal social service bodies and executive non-departmental Public Bodies. His responsibility for the audit of health and personal social service organizations was established by the Audit and Accountability (NI) Order 2003. The C&AG, through the Northern Ireland Audit Office (NIAO), undertakes financial audit and value for money audit and the results of his work are reported to the NI Assembly or to Parliament during the suspension of devolution. He is required to give an opinion on the truth and fairness of each organization's financial statements, and on whether the organization's expenditure and income have been applied to the purposes intended by Parliament. He has also agreed, subject to continuing review, to provide a range of assurances to the Departmental Accounting Officer, arising out of his audit work.

Approach

The C&AG conducts his audit in accordance with UK Auditing Standards issued by the Auditing Practices Board. This audit includes an examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of the financial transactions included in the financial statements. It also includes an assessment of the estimates and judgements made by Board members in the preparation of the financial statements, and the appropriateness of the accounting policies used. In planning audits, NIAO has regard for financial and operational risks within the organization. All significant issues arising from the audit are discussed with the organization and reported in a management letter. The C&AG also has the power to report separately to the NI Assembly / Parliament on any issues he considers to merit this course of action.

Limitations

The timing of the NIAO audit is constrained by the accounts timetable established for the HSC, which, in turn, will be increasingly influenced by the reporting arrangements for central government and whole of government accounts. The scope and extent of the C&AG's audit is limited only by the requirements of UK auditing standards, general good practice and the interests of the NI Assembly / Parliament.

Scope for co-ordination

In terms of controls assurance, NIAO will consider the arrangements that the HSC has established. It will consider performance in key standard areas in which the Department has established minimum levels of required compliance. It will take into account the work of independent assessors, including internal audit, accreditation bodies, RQIA etc, and will seek to judge whether the HSC organization's own assessment of compliance with departmental guidance is properly reflected in the Chief Executive's Statement on Internal Control attached to the annual accounts. This approach will, from 2009-10, also be relevant to the Department's four NDPBs (to whom the three core controls assurance standards will be applied).

Internal Audit

Role

Internal audit provides to an organization an independent and objective opinion on risk management, control and governance by measuring and evaluating the effectiveness with which organizational objectives are achieved. All HSC organizations are required to have an internal audit service and each HSC organization is responsible for putting in place a service that meets the Government Internal Audit Standards. This provides for consistency of audit across government bodies, including the HSC. As part of their responsibilities, HSC internal auditors play a key role in the assurance process to the board regarding the effectiveness of controls across all of the organization's activities. Internal auditors may also conduct consultancy and value for money work. They also have counter-fraud investigatory responsibilities. The work of the internal audit departments, in terms of quality and coverage, is assessed annually by the external auditors to determine the degree of reliance that they can place on it.

Approach

The work of internal auditors is agreed annually by the board through the Audit Committee and/or Governance Committee, based on an assessment of risk. The HSC's is a highly complex system and internal auditors will not necessarily possess the full range of skills needed to provide all of the assurances required by the board. To fulfil their function they will therefore review the overall arrangements the board has in place for securing adequate assurances and provide an opinion on those arrangements to support the SIC. Internal auditors will also report on the operation of the governance arrangements mid-year, to facilitate the Accounting Officer's completion of a mid-year Assurance Statement. Internal auditors have rights of access to complete their work and have independent reporting lines. Work is conducted primarily through a systems-based approach that takes account of relative risk. This will entail reviewing the way in which the board itself has identified objectives, risks, controls and sources of assurances on those controls, and has assessed the value of the assurances obtained. Testing is designed to form an opinion on the adequacy and effectiveness of the system under review.

Limitations

There are different structures and funding arrangements of internal audit departments across HSC organizations. These have evolved over time in response to clients' needs and requirements. Proposals to merge all four internal audit departments into a single regional service within the Business Services Organization are at an advanced stage.

Scope for co-ordination

Internal auditors will provide specific assurances about the areas covered in their audit plan, as approved by the Audit and/or Governance Committees. In forming opinions, internal auditors routinely take account of/work alongside other professionals wherever possible, to advise on systems of control and assurance arrangements. This is a distinct role, which is quite different to reviewing and commenting on the reliability of the assurances themselves, which it is the responsibility of the board to assess.

Appendix 2 - Illustration of examples of Principal Objectives showing the link between Organization & Directorate level objectives.

| Area | Organization Objective | Directorate Level (or Equivalent) Objective |
|---|--|--|
| <p><i>This may or may not sit within one directorate. It is recommended that the monitoring of delivery be co-ordinated by the Committee responsible for governance/risk management</i></p> | <p><i>This will relate to an overall goal of the organization</i></p> | <p><i>This will relate to how the organization translates an overall goal into outcomes</i></p> |
| <p>Health and Social Care (including Access)</p> | <p>To ensure that health and social care is developed and maintained to meet the needs of patients, clients and carers effectively, fairly and within appropriate timeframes</p> | <p>To develop and communicate a shared strategic direction which reflects the population it serves currently and in the future</p> <p>To implement recommendations of National, Regional and Local Inquiries/Reviews, etc</p> <p>To review health and social care services and, where necessary, reform and modernise services so that they meet the needs of patients, clients and carers in an effective and timely way (see illustrated example No.2 in Appendix 3)</p> <p>To develop and implement a service user/carer involvement strategy which allows users of health and social services to actively influence the development of those services (* cross-referenced with Governance and Partnership Working)</p> <p>To form health and social care alliances and participate in health and social care networks with other providers to ensure best care for patients, clients and carers and to promote health and wellbeing, reduce inequalities, promote inclusion and provide better opportunities for children and support for families</p> <p>To ensure that health and social care services are developed, commissioned and delivered in accordance with statutory equality duties and any other statutory obligations</p> <p>To ensure that health and social care services are provided in such a way that patients' and clients' dignity and human rights are protected and preserved</p> <p>To raise awareness of elder abuse and strengthen the arrangements for the protection of vulnerable adults</p> <p>To ensure that the organization meets the targets contained within the Programme for Government and the Minister's <i>Priorities for Action</i>, as appropriate to the services delivered by the organization</p> <p>To ensure that prescribing costs and practice are effectively managed (see illustrated example No.4 in Appendix 3)</p> |

| Area | Organization Objective | Directorate Level (or Equivalent) Objective |
|--|---|--|
| | <p>To ensure that patients and clients can receive care at a time that suits them in accordance with assessed clinical and social care need</p> | <p>To ensure that 95% of patients attending any A&E are either treated and discharged home, or are admitted, within four hours of their arrival in the department</p> <p>To ensure that no patient waits longer than nine weeks for a first outpatient appointment, nine weeks for a diagnostic test, and 13 weeks for inpatient or day case treatment</p> <p>To ensure the ambulance service respond to 70% of Category A (life threatening) calls within eight minutes, rising to an average of 72.5% by March 2010</p> <p>To ensure that 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment</p> <p>To ensure that no patient waits longer than 13 weeks from referral to commencement of AHP treatment, reducing to nine weeks by March 2010</p> <p>To ensure that all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks</p> <p>To ensure that 70% receive an appointment within 48 hours with a GP or appropriate practice-based primary care practitioner</p> <p>To promote the expansion of direct payments as a service delivery option</p> <p>To expand flexible and responsive respite services</p> <p>To ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days and all other patients being discharged within six hours of being declared medically fit</p> |
| <p>Governance (including service user safety, clinical & social care and quality improvement)</p> | <p>To establish effective governance arrangements and ensure that the organization is run appropriately and in a way that inspires public confidence (see illustrated example No.5 in Appendix 3)</p> <p>To ensure compliance with the statutory duty of quality and the delivery of as safe as possible, high quality,</p> | <p>To ensure that the organization has in place the systems, resources and training to deliver services that are the safest possible high quality care, transparent and professionally effective, including clear clinical and social care leadership and team accountability arrangements</p> <p>To implement a risk identification, assessment, and treatment strategy & plan that assists in the delivery of the organization's principal objectives</p> <p>To complete, implement and update a plan for maintaining and improving effective clinical and social care governance arrangements, and report on governance on an annual basis</p> <p>To ensure that arrangements are put in place for the purpose of monitoring care and evaluating the outcome of care (see illustrated example No.3 in Appendix 3)</p> <p>To achieve the required levels of compliance with controls assurance standards relevant to the organization.</p> |

| Area | Organization Objective | Directorate Level (or Equivalent) Objective |
|-------------------------------|--|---|
| | effective patient and client care within a reporting and learning culture. | <p>To comply with mandatory and other guidance issued by Health Estates (e.g. MDEAs, clinical waste, firecode compliance, operational estates management guidance) (see illustrated example No.9 in Appendix 3)</p> <p>To promote an open and learning culture where staff identify, report and learn from adverse events and near misses and to ensure that learning is shared across the HSC</p> <p>To meet or exceed minimum care standards for regulated services</p> <p>*To develop & implement a service user involvement strategy which engages service users, carers and the wider community in the assessment of need, planning, development, delivery, evaluation and review of services</p> <p>To implement any action plan agreed in response to a RQIA review or inspection</p> <p>To ensure that the organization responds to all external & internal audit findings as appropriate</p> <p>To ensure the implementation of-</p> <ul style="list-style-type: none"> - best practice guidance, - departmental-endorsed NICE guidance, - RQIA thematic reviews etc, and - Guidance, directives etc issued by the Department <p>To work in partnership with others to improve the patient and client experience of care and to implement agreed service objectives</p> <p>To ensure that health and social care professionals participate in National Confidential Enquiries, and relevant national and local multi-professional audits</p> <p>To develop service improvement programmes that reflect the priority needs of service users, carers and families, which define responsibilities for implementation, describe expected outcomes and indicate ways in which outcomes can be evidenced or measured</p> |
| Mental Health Services | To provide, in line with the Bamford Review, a modern and responsive service to people with mental health needs, developing alternative community services to those offered in hospitals for acute and long-stay patients, progressing resettlement programmes and | <p>To develop community services, such as home treatment or crises resolution services, which provide alternatives to acute admissions</p> <p>To deliver assertive outreach to people with severe mental illness within the community in order to reduce inappropriate hospital admissions, reduce length of stay when hospitalisation is required and increase the stability in their lives and those of their carers</p> <p>To contribute to the development of integrated health and social services responsive to the particular needs of victims of the Conflict</p> <p>To continue to develop Child and Adolescent Mental Health Services (CAMHS) according to agreed local priorities, particularly those services that reduce demand for inpatient services so as to provide for improved life outcomes for additional children and adolescents with mental health problems</p> |

| Area | Organization Objective | Directorate Level (or Equivalent) Objective |
|-------------------------|---|--|
| | <p>modernising hospital services</p> <p>To modernise services having regard to human rights and the UN Convention on the Rights of the Child</p> | <p>To provide integrated forensic mental health services</p> <p>To contribute to the development of an integrated regional and local eating disorder service</p> |
| Child Protection | <p>To ensure that the needs and rights of children are addressed / considered as appropriate and to develop a holistic approach to working with families in the area of child protection (see illustrated example No.8 in Appendix 3)</p> | <p>To ensure that Commissioners and Trusts have agreed regional policies, procedures and thresholds for the management of cases on to and off the Child Protection Register</p> <p>To ensure that all child protection referrals are allocated within 24 hours of receipt; and all child protection and looked after children pathway assessments are allocated immediately following completion of the initial assessment</p> |
| Workforce | <p>To ensure that the organization recruits, retains & develops staff in order to provide high quality patient and client services</p> | <p>To develop and implement a recruitment & retention strategy which reflects available resources and predicts changes in demand</p> <p>To assist the Department in regional workforce planning for specific staff groups</p> <p>To reduce the level of absenteeism in accordance with the department's targets</p> <p>To ensure that the workforce is properly skilled (see illustrated example No.7 in Appendix 3)</p> <p>To achieve the hospital productivity improvements stipulated by the Department</p> <p>To secure improvements in day cases rates for a defined range of procedures, in accordance with Departmental targets</p> <p>To introduce/operate new pay systems in an effective way which maximises service accessibility, is within budget and maximises potential for modernising working practices and providing measurably better services to local community</p> <p>To ensure compliance with relevant employers Codes of Practice (such as NISCC)</p> |

| Area | Organization Objective | Directorate Level (or Equivalent) Objective |
|---|---|--|
| <p>Partnership Working (including service user experience)</p> | <p>To work with partners to improve the way health and social services and other services work together to improve health & social care service provision reduce inequalities, promote inclusion and provide better opportunities for children and support for families</p> <p>To ensure that focus is on service user experience</p> | <p>To work with commissioners and providers of health and social care and the Department to agree areas of responsibility on an individual, joint and multipartite basis</p> |
| | | <p>To develop a communications strategy for both internal & external stakeholders</p> |
| | | <p>*To develop and implement a user involvement strategy which engages service users, carers and the wider community in the assessment of need, planning, development, delivery, evaluation and review of services</p> |
| | | <p>To ensure that skills and competencies in partnership working are developed throughout the whole organization</p> |
| | | <p>To form health and social care alliances and participate in networks with other providers to ensure best care for patients, clients and carers and to reduce inequalities, promote inclusion and provide better opportunities for children and support for families</p> |
| | | <p>To ensure that effective shared service arrangements are in place which provide reliable and accurate management information, and are cost effective (see illustrated example No. 6 in Appendix 3)</p> |
| | | <p>To ensure that there is a regular and systematic approach to obtaining, analysing and responding to local patient/client and public feedback about services</p> |
| | | <p>To ensure the availability of an accessible easy-to-use complaints process, geared to providing patient/client/user satisfaction and enabling learning from complaints received to be shared within and without the organization</p> |
| | | <p>To ensure a community development approach is adopted in policy development and service delivery</p> |
| <p>ICT</p> | <p>To modernise service delivery by exploiting the use of ICT to progress towards more person-centred providing more support for direct care and more support for care professionals.</p> | <p>To plan for and co-operate with the implementation and roll-out of new and enhanced ICT systems</p> |
| | | <p>To review working practices and develop roles and responsibilities taking account of the opportunities offered by new ICT capabilities</p> |
| | | <p>To ensure all care professionals have access to, are trained and routinely use ICT in their daily work by 2010</p> |
| | | <p>To encourage and develop electronic care communications between teams, and organizations, to achieve a better informed and more efficient service</p> |

| Area | Organization Objective | Directorate Level (or Equivalent) Objective |
|-----------------------|--|--|
| | <p>To exploit ICT to the full to realise the potential benefits for patients and staff.</p> <p>To promote multi-disciplinary and cross-organizational working to achieve more efficient services for the public, taking advantage of new ICT services.</p> | <p>To maintain the mandatory element of the HSC Internet web site</p> |
| <p>Finance</p> | <p>To ensure that mandatory financial targets are met</p> | <p>To ensure that statutory financial duties are met</p> |
| | | <p>To ensure the organization achieves financial balance (see illustrated example No.1 in Appendix 3)</p> |
| | | <p>To ensure that the capital programme reflects the strategic direction of the organization and is delivered within timescales and budget</p> |

Appendix 3 - An Assurance Framework – this Appendix demonstrates how the sample principal objectives in Appendix 2 link to the principal risks. These are not intended to be comprehensive but to illustrate the principles to be applied

| Principal Objectives | Principal Risks | | Priority | Key Controls | Assurances on Controls | Board Reports | | |
|---|---|---|--|---|---|--|--|--|
| | Principal Risk | Classification of Principal Risk | Likelihood/ Impact | | | Positive Assurances | Gaps in Control | Gaps in Assurance |
| <i>What the organization aims to deliver</i> | <i>What could prevent this objective being achieved</i> | <i>Which area within our organization this risk primarily relate to</i> | <i>What is the Likelihood of the Risk occurring and its Consequence/ Impact if it occurs</i> | <i>What controls/systems we have in place to assist in securing delivery of our objective</i> | <i>Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective</i> | <i>We have evidence that shows we are reasonably managing our risks and objectives are being delivered</i> | <i>Where are we failing to put controls/ systems in place. / Where are we failing in making them effective</i> | <i>Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective</i> |
| No.1 To ensure the organization achieves financial balance | Unforeseen expenditure due to irrestible demand, new mandatory requirements (e.g. more costly blood products, demand for home care service, increase in child protection referrals, introduction of new drug therapies) etc | Finance | Link to Risk Register | Detailed policy & procedure in place for budget setting. Robust system for budget profiling. System for budget setting involves all relevant parties Process for entry of emerging drugs and therapies | External Audit Internal Audit Internal manager/peer review Etc. | | Insufficient training given to new Budget Holders to support the budget setting process Lack of quality and timeliness of financial data to front line managers | |
| | Income shortfall below what had been agreed e.g. unanticipatable moratorium enforced by the Department | | | | | | | |

| Principal Objectives | Principal Risks | | Priority | Key Controls | Assurances on Controls | Board Reports | | |
|---|---|----------------------------------|-----------------------|---|---|--|--|---|
| | Principal Risk | Classification of Principal Risk | Likelihood/ Impact | | | Positive Assurances | Gaps in Control | Gaps in Assurance |
| | Misforecasting nationally agreed pay awards | | | | | | | |
| No.2 To review Health and Social Care services and, where necessary, reform and modernise services so that they meet the needs of service users in an effective and timely way | Lack of Strategic Direction | Health and Social Care provision | Link to Risk Register | Commissioning/ delivery plans | Planning Review meetings | | No monitoring of patient/ client satisfaction | |
| | Lack of Service User/Carer Involvement | | | Business Plans | Progress Review meetings | | | |
| | Inefficient deployment of available resources | | | Commissioner Involvement | Progress Reports to the Department and Commissioners | | | |
| | | | | Requirements of <i>Priorities for Action</i> | RQIA Reviews and recommendations for quality improvement | | Learning from complaints system needs to be reviewed to ensure learning is across the whole organization | |
| | | | | Systems in place to learn from adverse incidents/ litigation and complaints | External Audit | | | |
| | | | | Active programme to engage with stakeholders | Internal Audit | | | |
| | | | | Benchmarking | Risk assessments | | | |
| | | | | SCIE/NICE guidance | | | | |
| No.3 To ensure that arrangements are put in place for the purpose of monitoring care and evaluating the | Poor investment in IT and inadequate provision/ availability of clinical or professional information to staff and teams | Direct patient and client care | Link to Risk Register | Organization-wide IT strategy | Directorate/team performance reporting and monitoring processes | Performance indicators | No regular review of performance. Poor monitoring of outcome measures. | No assurance of action to address exception reports |
| | | | | Delegated management and team accountability | Board performance/ monitoring reports | Benchmarking | | |
| | | | | | RQIA Review | Progress against clinical and social care governance plans and | | |
| | | | | | Benchmarking | | | |

| Principal Objectives | Principal Risks | | Priority | Key Controls | Assurances on Controls | Board Reports | | |
|---|--|----------------------------------|-----------------------|---|--|--|-----------------|---|
| | Principal Risk | Classification of Principal Risk | Likelihood/ Impact | | | Positive Assurances | Gaps in Control | Gaps in Assurance |
| outcome of care. | Lack of administrative support Lack of effective system to disseminate alerts, standards, guidance, etc Lack of skills to interpret data | | | | Performance indicators Clinical and multi-professional audits and national confidential enquiries SCIE/NICE guidance Effective supervision/appraisal system Effective workforce development strategy | against care standards Clinical and multi-professional audits and National confidential enquiries Maintenance of registration of the workforce Sub-contracting only with registered providers | | |
| No.4 To ensure that prescribing costs and practice are effectively managed | Poor management of funding Inability to implement appropriate guidance Inadequate pharmacy (particularly clinical) resource | Clinical Services | Link to Risk Register | Strategy for cost-effective prescribing. Monitoring arrangements in place for in-year spends and prescribing activity. Capacity Planning undertaken. | Regional Procurement Pharmacist Area Prescribing Fora Trust Drugs and Therapeutic Committee etc. Roll out of integrated medicines management to optimise medicines appropriateness index (MAI) | | | No assurance gained on effectiveness of Capacity Planning |
| No.5 To establish effective governance | Non-identification of the risks to the organization's principal objectives | Organization-wide | Link to Risk Register | Principal objectives set and agreed at board level and communicated to staff | RQIA Review Internal Audit | | | No assurance on the effectiveness |

| Principal Objectives | Principal Risks | | Priority | Key Controls | Assurances on Controls | Board Reports | | |
|--|--|----------------------------------|-----------------------|---|--|--|---|--|
| | Principal Risk | Classification of Principal Risk | Likelihood/ Impact | | | Positive Assurances | Gaps in Control | Gaps in Assurance |
| arrangements and ensure the organization is run appropriately and in a way that inspires public confidence | Inconsistent prioritisation of risks across the organization | | | Policy and Strategy in place regarding the identification and management of risks | Implementation of Medicines Governance Pharmacists | | | of the overall assurance framework |
| | Inability to deliver risk treatment/ action plans | | | Framework in place to gain assurance on the management of risks and the delivery of objectives | Red/Amber management arrangement for complex drugs Etc. | | | |
| No.6 To ensure that effective shared service arrangements are in place which provide reliable and accurate management information, and are cost effective | Poor investment in IT, Finance & HR systems | Partnership Working | Link to Risk Register | SLA in place with shared service provider | External Audit | | No performance monitoring against SLA taken place in current year | |
| | Breakdown in core business systems, controls and processes | | | System in place to monitor performance of shared service provider against SLA | Internal Audit Management reports from shared service host organization Etc. | | | |
| | Business discontinuity | | | Clear lines of accountability set out within provider and user organizations for shared service provision | | | | |
| No.7 To ensure that the workforce is properly skilled | Lack of appropriate training | Workforce | Link to Risk Register | Organization-wide training needs analysis | RQIA Review Royal Colleges | Full Assurance on nursing training Compliance with NISCC Code of Practice | Gaps in linkage to staff appraisal for support staff | No assurance on effectiveness of training strategy |
| | Inability to recruit the right staff | | | Organization-wide training strategy linked to individual staff appraisal | Internal Audit Etc. | | | |
| | Inability to retain key skilled staff | | | System for monitoring the effectiveness of training strategy | | | | |

| Principal Objectives | Principal Risks | | Priority | Key Controls | Assurances on Controls | Board Reports | | |
|---|---|---|-----------------------|--|---|--|---|--|
| | Principal Risk | Classification of Principal Risk | Likelihood/ Impact | | | Positive Assurances | Gaps in Control | Gaps in Assurance |
| No.8 To ensure that the needs and rights of children are addressed / considered as appropriate and to develop a holistic approach to working with families in the area of child protection | Lack of adequate and competently skilled workforce | Workforce Partnership Working Auditing/ monitoring arrangements | Link to Risk Register | Co-operating to Safeguard Children and Regional Policies and Procedures Internal Audit/ monitoring systems Accountability review meetings with commissioners | DHSSPS inspection and follow-up plans RQIA Reviews Chief Social Services Officer holds accountability review meetings | Action plans forwarded to the Department | Inadequate audit arrangements | |
| No.9 To comply with mandatory and other guidance issued by Health Estates (e.g. MDEAs, clinical waste, firecode compliance, operational estates management guidance) | MDEAs: failure to action recommendations in alerts due to internal system failures (e.g. Lack of medical device/ equipment co-ordinators) | All areas | Link to Risk Register | Detailed policy and procedures in place Detailed systems in place for distribution and for assurance that action has been taken | Internal audit External audit RQIA Reviews | Performance indicators. Benchmarking progress against controls assurance standards. | Inappropriate assessment of risk by board Staff training not being updated or undertaken | Identification as a priority for effective clinical and social care governance |
| | Fire code compliance: death or injury to staff or service users due to non-compliance. Prosecution by Regulator. | All areas | Link to Risk Register | Detailed policy and procedures in place Adequate and competently skilled Fire Officers in place Compliance Action | Internal audit External audit Regulatory Inspections | Internal audit reports. Action plans. Investment on compliance measures. | Lack of quality and timeliness of estates performance data to board | Identification as a risk management priority Insufficient competent external inspection of compliance |

| Principal Objectives | Principal Risks | | Priority | Key Controls | Assurances on Controls | Board Reports | | |
|----------------------|--|----------------------------------|-----------------------|--|---|---------------------|-----------------|-------------------|
| | Principal Risk | Classification of Principal Risk | Likelihood/ Impact | | | Positive Assurances | Gaps in Control | Gaps in Assurance |
| | Clinical Waste: failure to manage clinical waste leading to health risk to staff, service users and the public. Failure to comply with statutory legislation leading to prosecution by Regulator | All areas | Link to Risk Register | Plan Detailed policy and procedures in place based on Health Estates guidance Management of the Regional Clinical Waste Contract | Internal audit External audit Regional Clinical Waste contract management reports RQIA Reviews Regulatory inspections | | | |
| | Operational Estates Management Guidance (HTMs etc): Failure to comply with statutory legislation leading to adverse criticism of management and/or prosecution by HSE(NI) | All areas | Link to Risk Register | Detailed policy, procedures and systems in place based on Health Estates guidance Appropriately skilled workforce in place | Internal audit External audit RQIA Reviews Regulatory inspections Peer review inspections | | | |

APPENDIX 4 EXAMPLES OF EXISTING HSC BEST PRACTICE- EXAMPLE 1

| Principal Objectives | Principal Risk P=Potential RR= Risk Register | Existing Controls | Assurances on Controls Internal & External | Strength of Assurance | Action needed/lead Director |
|---|---|--|---|-----------------------------|---|
| <ul style="list-style-type: none"> To deliver the Service and Budget Agreement activity levels agreed with the Commissioners. | <p>Underactivity – lose funding P Bed capacity issues RR Health Visitor shortage RR</p> | <p>Accountability meetings with Directors HR Strategy Acute Medicine Action Plan</p> | <p>Performance Report Bi-annual CE Accountability Meeting with DHSS&PS</p> | <p>Strong</p> | <p>No additional corporate action needed at present.</p> |
| <ul style="list-style-type: none"> To improve services as set out in the Trust Delivery Plan in response to Priorities for Action. | <p>Failing to meet TDP P HCAI RR Difficulty recruiting foster carers RR</p> <p>Failing to meet child care statutory functions P Access to CAMHS RR Timely allocation of childcare cases and Capacity to visit "at risk" children RR</p> | <p>Accountability Review Reduction Plan Outbreak Control Team DH Improvement Team SDU Performance Monitoring Directorate & Service Plans</p> <p>NHSCT Multi Agency Child Protection Panel</p> <p>DMT Sub-group for risk & governance in child care</p> <p>Executive Director Social Work receives weekly report of unallocated cases</p> <p>Monthly review by DHSSPS</p> | <p>Bi-annual CE Accountability Meeting with DHSS&PS Performance Reporting to Trust Board RQIA Outbreak Report Corporate Reduction Plan Statutory Child Care Report Bi annual corporate parenting report to Trust Board and DHSS&PS Annual Report to RQIA</p> <p>RQIA announced & unannounced inspection</p> <p>NED Visits to Children's homes</p> | <p>Strong</p> <p>Medium</p> | <p>Escalate HCAI to corporate register of top risks.</p> <p>Escalate to corporate register of top risks for bi-monthly reporting of progress to</p> |

Example 2

Corporate Objective 1 – To provide safe, high quality and effective care.

| Risk Area and principal risks. | Existing Controls | Assurances - Internal (I) and External (E) | Gaps in controls and Assurances | Action | Progress at August '08 | Reporting Arrangements |
|---|---|---|--|---------------|---|---|
| <p>1.PfA Targets</p> <p>Risk – non achievement of HCAI reduction.</p> | <p>Performance monitoring arrangements.</p> <p>RQIA Action plan monitoring</p> | <p>Performance Management Framework and Performance reporting(I) SDU monitoring trends and performance weekly (E)</p> | | | <p>HCAI Committee established. HCAI Action plan</p> <p>Emergency Plan</p> | <p>Performance Management Reports (Trust Board) Performance reports weekly to SMT</p> |
| <p>2. Statutory Functions</p> <p>Risk – failure to fully discharge Statutory obligations.</p> | <p>Social Care Governance structure, systems, processes and transitional arrangements in place including Social Work and Social Care governance forum and Social work professional forum in each Programme of Care.</p> <p>Baseline review and assessment of discharge of statutory functions.</p> <p>Trust processes for</p> | <p>Corporate parenting report; Delegated statutory functions report; Looked After Children Report; Adoption report; Area Child Protection Committee report; to SMT & Trust Board.</p> <p>Audit Programme (I)</p> <p>RQIA Report of Review of Mental Health and Learning Disability services (E)</p> | | | <p>Permanent appointment of governance officers delayed to autumn.</p> | <p>Corporate Parenting Report (Trust Board)</p> <p>Delegated Statutory Functions report (Trust Board)</p> <p>Looked After Children Report (Trust Board)</p> <p>Adoption Report (Trust Board)</p> <p>Child Protection Panel Report (Trust Board)</p> |

Corporate Objective 1 – To provide safe, high quality and effective care.

| Risk Area and principal risks. | Existing Controls | Assurances - Internal (I) and External (E) | Gaps in controls and Assurances | Action | Progress at August '08 | Reporting Arrangements |
|--------------------------------|---|---|---------------------------------|--------|--|------------------------|
| | harmonisation of policies and procedures. | Case Management Reviews (E) Performance Management Reports (I) *** monitoring of discharge of statutory functions (E) | | | Statutory Functions monitoring meetings with *** established – for children's services and adult services. | |

Example 3 from NHS Strategic Health Authority

| GOVERNANCE: Supporting Trusts and PCTs in developing governance arrangements {1} | | | | | |
|---|--|--|---|--|------------|
| Risk | Controls in place | Gaps in controls | Action Plan to address gaps in controls | Lead Director | Risk Score |
| <p>Weak Board governance arrangements / performance in Trusts and PCTs undermines:</p> <ul style="list-style-type: none"> Trusts achieving FT status PCTs becoming world class commissioners successful delivery of corporate and system-wide objectives | <ul style="list-style-type: none"> *** representation at public Board meetings Feedback to individual organizations through Board to Board and Executive to Executive meetings *** leading on the design and delivery of the NHS *** Non Executive Director training and development programme Survey undertaken of NED training and development needs | <ul style="list-style-type: none"> Sharing good/best practice with NHSSC Trusts and PCTs NED training and development programme yet to be designed/rolled-out | <ul style="list-style-type: none"> Head of Governance and Compliance to produce and distribute a study of NHS *** Boards (including good practice) to all Trusts and PCTs – end of August 2008 Delivery of NED training and development programme – from September 2008 | Director of Communications and Corporate Affairs | 16/16 ● |
| Assurances on controls | Gaps in assurances | Action Plan to address gaps in assurances | | | |
| <ul style="list-style-type: none"> Report on each Board meeting observed presented to Director of Communications and Corporate Affairs (and appropriate officers) Review of NHS *** Boards paper considered by *** Executive Team and Audit Committee Board to Board and Executive to Executive meetings | <ul style="list-style-type: none"> Assessment of PCT Board governance competencies as part of *** assessment yet to take place Second review of NHS *** Boards paper to be produced in Autumn 2008 | <ul style="list-style-type: none"> Report to *** Board on outcomes of *** Board governance competencies assessment (Autumn 2008) Second review of NHS *** Boards paper to be considered by *** Audit Committee (December 2008) | | | |

Appendix 5 - Assurances on Systems on Internal Control

To fulfil their rôle, boards must obtain assurances that the arrangements they have put in place to achieve the organization's objectives and manage risks are effective and operating as intended. This is also a statutory requirement for completion of the Statement on Internal Control. It is important that boards have sufficient understanding of the techniques used by auditors and other reviewers to satisfy themselves that the assurance arrangements they have in place are both comprehensive and efficient.

The assurance process requires a systematic and analytical approach with the level of supporting evidence required carefully matched to the importance of the activity to the organization's objectives and the level of risk. Good systems with effective embedded controls and sound risk assessment arrangements are fundamental to good management and efficient assurance arrangements.

The principles for achieving assurances are the same irrespective of whether clinical and social care, financial or other areas of activity are involved. They all require systems to be evaluated for their ability to prevent or minimise error and then checked to ensure they are actually working as intended, or if not, the effect of weaknesses. This is known as the systems audit approach. It provides an assurance about the whole system and help in reducing ongoing problems. Whilst it is possible to gain some assurance through the examination of individual incidents or transactions, this can be very time-consuming and does not provide an insight into the whole system.

The table below sets out the more common of the different techniques and testing methods that can be used to confirm the effectiveness of the board's arrangements. It should be noted that where systems are inadequate this leads to significant increases in both the numbers and depth of tests required to provide assurances.

| TECHNIQUE | METHOD | STRENGTHS | WEAKNESSES | SOME POSSIBLE APPLICATIONS |
|---|--|---|---|---|
| <i>Systems-based Auditing/Review</i> | | | | |
| Reflects the theory that the achievement of objectives/prevention of error on an ongoing basis is more likely when a sound system has been implemented. | The system is identified and documented, with particular note being taken of the controls and checks that have been built into it. The auditor/reviewer will determine what the objective(s) of the system is and assess whether the system is adequately designed to deliver that objective. The auditor/reviewer will also confirm that there are adequate controls built into the system at key points to ensure that breaches of the system and/or significant errors are identified and flagged up. If the system appears to have significant weaknesses in control, the auditor/reviewer should suggest how this might be rectified. At this point consideration should also be given as to whether to undertake detailed (substantive) testing to ascertain whether the weaknesses have had any serious consequences. | Confirms that there are controls in place to prevent/identify major operational failures. Gives comfort that a system exists to manage the risks. | Is not designed to pick up individual problems, unless accompanied by other testing. Not possible where no system has been in operation, which is the case in some emerging or dissolving organizations | Any area of operation |
| <i>Walk-through Test</i> | | | | |
| Used to confirm that the system described is that used in practice and that the expected controls do exist | A very small number of transactions/cases/incidents etc are followed through the system | Quick confirmation for the reviewer that the system is as understood and so helps prevent erroneous testing | Too small a sample on which to form a judgement on effectiveness of the system or the consistency of its use | Should always be used before any large-scale/detailed testing is undertaken |

| TECHNIQUE | METHOD | STRENGTHS | WEAKNESSES | SOME POSSIBLE APPLICATIONS |
|---|---|--|--|---|
| Compliance Test | | | | |
| Used to provide evidence that internal control/quality procedures are being applied as prescribed | A sample of transactions/ cases/ incidents etc is selected and followed through the system to ensure that the expected controls have been applied. The number of items selected will depend on the level of assurance required. | Enables assurance to be given that the system of internal control is being followed. Testing may reveal breakdowns in the system and consideration of the underlying cause of these can help in refining the system. | Does not enable assurance to be given on the effectiveness of the system. Investigation into breaches of the system can be difficult and time-consuming | All systems |
| Substantive testing | | | | |
| The usual purpose is to enable an opinion to be formed as to the completeness, accuracy and validity of information and records. May be necessary where the organization has poor/no formal systems in place. New and dissolving organizations may be in this position. | There are a number of ways in which this can be done, including <i>analytical review (see below)</i> , however it frequently involves testing on a large scale using scientifically designed, statistical methods. | Correctly done, this can provide a high level of assurance on the effectiveness of the system and its controls. Alternatively can provide a high level of comfort where control systems are poor or absent. | Can be very time-consuming both to set up and to conduct. The cost of obtaining this level of assurance where there is a low tolerance of error can be prohibitive. Needs to be used with care | Systems covering high-risk areas. Clinical and multi-professional audit. Where there are known system weaknesses and information is unreliable. |

| TECHNIQUE | METHOD | STRENGTHS | WEAKNESSES | SOME POSSIBLE APPLICATIONS |
|--|---|---|---|--|
| <i>Analytical review</i> | | | | |
| <p>A textbook definition is 'A form of substantive testing (see above). Often used in conjunction with detailed substantive testing and enables that testing to be more accurately directed.' However it is also a term widely used to describe a review aimed at ascertaining whether there is any glaring evidence that might point to the need for a more thorough and detailed review. Care should be taken to ensure that the extent of the work undertaken is clear when relying on this for assurance purposes.</p> | <p>Uses significant ratios, trends, or other statistics to determine areas for more detailed review. Where the review confirms an expected outcome no further work may be necessary</p> | <p>Low cost. Very efficient in the right circumstances.</p> | <p>Relies upon the accuracy of the data on which it is based, the reviewer's understanding of the organization and knowledge of any operational changes which might have taken place which could have affected the expected outcome. Will only identify major discrepancies unless used in conjunction with more detailed tests. Does not give assurance on the system design</p> | <p>As an indicator of where in depth testing should be undertaken.</p> <p>In place of detailed testing in low risk areas</p> <p>As supplementary evidence on the effectiveness of a system</p> <p>As a means of ensuring that obvious large scale irregularities have not been overlooked.</p> |

APPENDIX 6: ASSESSMENT OF ASSURANCE FRAMEWORKS

Below are the prompts you must consider when assessing the Assurance Frameworks

Please remind yourselves of relevant DHSSPS guidance before completing the assessment.

Please ensure you base the assessment on evidence

| Key Components | Meets reasonable achievement | Does not meet reasonable achievement |
|---|------------------------------|--------------------------------------|
| 1. The components are all present: i.e. objectives; risks; controls; positive assurance; gaps in control and/or assurance and remedial action | | |
| 2. The board has been appropriately engaged in developing and maintaining the assurance framework | | |
| 3. The objectives are sufficiently strategic, well balanced and across all areas of activity | | |
| 4. The objectives are linked to Investing for Health, the Regional Strategy - A healthier future, PSAs and PfA | | |
| 5. The risks are sufficiently strategic/high level and complete (i.e. are potential risks not just residual risks) | | |
| 6. The key controls have been identified and evaluated with regard to their effectiveness to manage the risks | | |
| 7. Potential sources of assurance have been identified | | |
| 8. Results of real assurances have been included in the framework, which include positive assurances, and gaps in control and/or assurance identified where appropriate | | |
| 9. The components of the framework have all been explicitly mapped out against each other so that an assurance can be mapped back to an objective with ease | | |
| 10. The framework is fit for purpose, that is it provides the board with evidence based assurances on the way in which it manages the organization at a strategic level | | |
| 11. Significant issues arising from the assurance framework are being escalated to the board and can be traced through the board agenda | | |
| 12. Arrangements are in place and are being followed to address gaps in control and/or gaps in assurance where the board deems that appropriate | | |
| 13. The framework informs appropriate declarations to be made on the SIC, including significant control issues in line with AASD (DFP) guidance where appropriate | | |

| | | |
|---|---|--|
| <p>SUPPLEMENTARY EVIDENCE</p> <p>Please indicate the evidence/method of assessment you have used from your performance management system in forming conclusions to the questions above (e.g. self assessment, internal auditors, external auditors, RQIA etc)</p> | | |
| <p>OVERALL ASSESSMENT Based on the evidence above</p> | <p>Meets year end requirements</p> <p>Y/N</p> | <p>Needs Further work to meet year end requirements (please specify actions to be taken)</p> |

Notes

- (A) An Assurance Framework has been established which is designed and operating to meet the requirements of the SIC and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organization.
- (B) An Assurance Framework has been established but is not sufficiently complete to meet the requirements of the SIC and provide reasonable assurance that there is an effective system of internal control to manage the principal risks across all the main business activities.
- (C) An Assurance Framework has not been established.

APPENDIX 7: BOARD ASSURANCE – A QUICK REFERENCE GUIDE

This summary enables you to quickly assess which parts of the Assurance Framework you have in place and which you might need to focus on in order to reduce risk.

1. Are your principal objectives defined? Yes No

Principal objectives are the strategic goals set for the organization, and will drive its response to risk.

2. Are your principal risks identified? Yes No

Principal risks will highlight any obstacles to achieving the principal objectives, as well as the associated consequences. They may include, for instance, gaps in staff training or skill mix.

3. Do you have key controls in place to manage risks? Yes No

Are key controls in place to manage the principal risks? Controls should relate directly to the principal risks (though each risk may need more than one control, and each control may address more than one risk) and should be of practical application.

4. Is assurance provided on the effectiveness of controls? Yes No

This element is about gathering the evidence – ideally independent – on the effectiveness of the key controls.

5. Putting it all together

All of the stages of the Assurance Framework should work together as a continuous process of identifying objectives, assessing risks, introducing controls and assessing whether these controls have been effective.

• **Do board papers include all the above elements?** Yes No

Organizations should ensure all the above elements are incorporated into their routine board reports.

• **Assurance Framework assessment tool?** Yes No

A tool to help assess where an organization currently is in terms of compliance against the Assurance Framework and to help identify areas to target improvement.

• **Are effective delivery plans in place?** Yes No

Having assessed the current position, boards should have an action plan which is outcome focused, owned and measurable to improve its key controls to manage its principal risks and gain additional or stronger assurance where required.

APPENDIX 8 : GLOSSARY

| Term | Definition |
|-----------------------------|--|
| Arm's Length Body (ALB) | An Arm's Length Body is a stand-alone organization which is accountable to the Department for aspects (such as commissioning, delivery, regulation etc) of services for which the Department remains fundamentally responsible. |
| Assurance | Confidence, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved |
| Assurance Committee | A board-level committee with overarching responsibility for ensuring that appropriate assurance is gained on the management of all principal risks. This may be an existing committee such as a governance or risk management committee |
| Assurance Framework | A structure within which a board identifies the principal risks to the organization's meeting its principal objectives, and through which they map out both the key controls to manage them and how they have gained sufficient assurance about the effectiveness of those controls |
| Audit Committee | The function of an Audit Committee is to support the accounting officer (or board) by monitoring and reviewing the risk, control and governance processes that have been established in the organization and the associated assurance processes (which are mainly internal and external audit assurances). In some organizations, this role is amalgamated with the relevant assurance committee |
| Board Assurance Action Plan | An action plan approved by the board to improve its key controls to manage its principal risks, and gain assurances where required |
| Board Assurance Reports | Key information reported to the board on the assurance framework, providing details of positive assurances and significant gaps in internal controls and assurances relating to principal risks. In addition to providing information leading to a board assurance action plan, these reports will also supply evidence to support the annual Statement on Internal Control |
| Controls Assurance | A concept resting on best governance practice. Within the HSC, it is a process designed to provide evidence that organizations are doing their 'reasonable best' to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds |

| Term | Definition |
|-----------------------------------|---|
| Core Controls Assurance Standards | The three self-assessment standards which form the essential underpinning of the annual Statement on Internal Control: Governance Standard; Risk Management Standard; Financial Management Standard |
| Corporate Objectives/risks | See ' <i>principal objectives/risks</i> ' below |
| Directorate-level Objective | How the organization translates an overall goal into deliverables at directorate (or equivalent) level |
| Effective Control | A control that is properly designed and is systematically operated to deliver the intended objective |
| External Assurance | Assurances provided by reviewers, auditors and inspectors from outside the organization, such as External Audit, the HSC Regulation and Quality Improvement Authority or Royal Colleges |
| Gap in Assurance | Failure to gain sufficient evidence that policies, procedures, practices or organizational structures on which reliance is placed are operating effectively |
| Gap in Control | Failure to put in place sufficiently effective policies, procedures, practices or organizational structures to manage risks and achieve objectives |
| Head of Internal Audit Opinion | An annual opinion provided to inform the board in completing the Statement on Internal Control. This provides opinion on the effectiveness of that part of the system of internal control reviewed by Internal Audit during the year |
| Independent Assurance | Assurances provided by (a) reviewers external to the organization, such as the HSC Regulation and Quality Improvement Authority, and (b) internal reviewers working to prescribed government standards, such as Internal Audit |
| Internal Assurance | Assurances provided by reviewers, auditors and inspectors who are part of the organization, such as Clinical or Multi-Professional Audit or management peer review |
| Internal Control | The ongoing policies, procedures, practices and organizational structures designed to provide reasonable assurance that objectives will be met and that undesired events will be prevented or detected and corrected |
| Key Control | A control to manage one or more principal risks |
| Mapping of Assurance | A process, providing a clear management and audit trail, that links: <ul style="list-style-type: none"> • principal objectives to principal risks • principal risks to key controls • key controls to assurances |

| Term | Definition |
|---|---|
| Organizational (or Strategic) Objective | An overall goal of the organization |
| Organizational Controls Assurance Standards | Self-assessment standards (excluding the core standards) which provide a framework to improve internal controls across a wide (although not necessarily all-encompassing) range of organizational areas |
| Positive Assurance | Evidence that risks are being reasonably managed and objectives are being achieved |
| Principal Objectives | Objectives set at organization and directorate (or equivalent) level (sometimes referred to as 'corporate objectives') |
| Principal Risk | A risk which threatens the achievement of principal or corporate objectives |
| Prioritisation of Risk | A process by which risks are graded according to the likelihood of their occurrence and the impact of their consequences |
| Reasonable Best | A defensible decision or course of action, agreed by the board, that is based on sufficient evidence |
| Residual Risk | When action is taken to treat risks, this may eradicate the possibility of the risk occurring. The action is, however, more likely to reduce the probability, leaving a residual risk |
| Risk | The possibility of suffering some form of loss or damage and/or the possibility that objectives will not be achieved or that opportunities will not be taken |
| Risk Assessment | The identification and analysis of risks relevant to the achievement of objectives |
| Risk Management | A systematic process by which potential risks are identified, assessed, managed and monitored |
| Risk Register | A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion |
| Sources of Assurance | The various reviewers, auditors and inspectors, internal and external, who carry out work at HSC organizations (see Internal Assurance and External Assurance). Boards determine which sources of assurance are relevant to principal risks and the extent to which they provide sufficient assurance |

| Term | Definition |
|-------------------------------------|---|
| Statement on Internal Control (SIC) | An annual statement, signed by the Accounting Officer on behalf of the board, that forms part of the Annual Financial Statements for the year. The SIC provides public assurances about the effectiveness of the organization's system of internal control |
| System of Internal Control | A system, maintained by the board, that supports the achievement of the organization's objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organization's objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically |