Trust Board paper B

University Hospitals of Leicester NHS
NHS Trust

To:	Trust Board
From:	Chief Executive
Date:	7 June 2012
CQC regulation:	N/A

Title:	**DRAFT ANNUAL GOVERNANCE STATEMENT 2011/12**

Author/Responsible Director:
Director of Corporate and Legal Affairs/Chief Executive

Purpose of the report: To invite the Board to adopt the draft annual governance statement 2011/12

The Report is provided to the Trust Board for:

Decision	√	Discussion	
Assurance		Endorsement	√

Summary:
The Board is invited to adopt the draft annual governance statement 2011/12

Recommendations:
To adopt the draft annual governance statement 2011/12

Strategic Risk Register: N/A	**Performance KPIs year to date:** N/A

Resource implications (e.g. Financial, HR):
N/A

Assurance implications: The draft annual governance statement has been reviewed by the Audit Committee (on 18 April and 29 May 2012) ahead of its eventual submission to the Trust Board for consideration and approval, accompanying the annual accounts 2011/12

Patient and Public Involvement (PPI) implications:
N/A

Equality impact:
N/A

Information exempt from disclosure:
N/A

Requirement for further review:
N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7th JUNE 2012**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **DRAFT ANNUAL GOVERNANCE STATEMENT 2011/12**

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1. INTRODUCTION

1.1 The NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health, requires Strategic Health Authorities, Primary Care Trusts and NHS Trust Accountable Officers to give him assurance about the stewardship of their organisations.

1.2 In previous years, this assurance has flowed primarily from Statements of Internal Control completed by NHS Accountable Officers. For 2011/12, in line with changes to HM Treasury guidance, the Statement is to be replaced by an annual governance statement. The governance statement is to be included in the Trust's annual report and accounts in line with NHS Finance Manual requirements.

1.3 Key extracts from guidance published by the Department of Health on 28th March 2012 on annual governance statements are reproduced below:-

"*The governance statement records the stewardship of the organisation to supplement the accounts. It will give a sense of how successfully it has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be. This statement will draw together position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism.*

The governance statement should be a 'live' document reflecting the organisation's governance procedures and systems. It should not be produced through a process designed solely for the annual report and accounts.

There is no set template for the governance statement as it will be important for each NHS organisation to set reporting in the context of its functions and operating environment. However, in Annex A to this letter I have set out the key elements that must be covered within the governance statement. This is to ensure compliance with Treasury guidance and to ensure that the NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health, is able

to draw the assurance he needs to sign an overarching NHS governance statement.

All elements of the governance statement are important, however, the risk assessment is critical. This is where the Accountable Officer supported by the Board should discuss how the organisation's risk management and internal control mechanism work. Where there are weaknesses, the emphasis should be on how these are being addressed. Where there have been reports published on the organisation during the year, the Accountable Officer should reflect on the assurance these provide in helping to achieve effective operation of controls.

The organisation's external auditor will review your governance statement. They will report on:-

- *inconsistencies between information reported in governance statements and their knowledge of the audited body;*

- *any failure to comply with Department of Health requirements."*

2. UHL'S DRAFT ANNUAL GOVERNANCE STATEMENT 2011/12

2.1 The Trust's draft annual governance statement 2011/12 is attached at Appendix B.

2.2 The draft attached at Appendix B has been updated to take account of feedback provided by the Trust's External Auditor.

2.3 The draft attached at Appendix B has also been the subject of review and comments by the Audit Committee at its meetings on 18 April and 29 May 2012, respectively.

2.4 The External Auditor has advised that the Statement is compliant with NHS guidance and that the Auditor is not aware of any inconsistencies between the information the Trust has recorded in the Statement and their other work.

3. RECOMMENDATION

3.1 The Trust Board is recommended to adopt the draft Annual Governance Statement 2011/12 attached at Appendix B to this report.

Malcolm Lowe-Lauri
Chief Executive

30th May 2012

Appendix A

Governance Statement

Scope of responsibility

Describe the accountable officer responsibilities including, responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding public funds. Acknowledge the accountable officer's responsibilities as set out in the Accountable Officer Memorandum demonstrating an understanding of propriety and accountability issues.

The governance framework of the organisation

This should include:
• information about the board's committee structure, its attendance records and the coverage of its work;
• the board's performance including its assessment of its own effectiveness;
• highlights of board committee reports, notably by the audit committees;
• An account of corporate governance, including the board's assessment of its compliance with the Corporate Governance Code with explanations of any departures.

Risk assessment

Describe how risk is assessed, including the organisation's risk profile, and how it is managed.
Include:
- any newly identified risk i.e. risks identified in the year 2011/12; and
- a summary of any lapses of data security, including any that were reported to the information commissioner.

The risk and control framework

Describe how the risk and control mechanism works. This should cover the key elements and why they were chosen to deliver reasonable assurance for:
- prevention of risks;
- deterrent to risks arising (e.g. fraud deterrents); and
- management of both manifest and potential risks.

Review of the effectiveness of risk management and internal control

Give an assessment of the evidence about the effectiveness in practice of the risk management processes in place. This should include reference to the work of internal audit and executive managers. In doing so you should disclose any revealed deficiencies as risks have materialised – Significant Issues.

Significant Issues

You should, at least, consider these factors when determining whether an issue is significant:
• Might the issue prejudice achievement of the business plan? – Or other priorities?
• Could the issue undermine the integrity or reputation of the organisation?
• What view does the audit committee take on the point?
• What advice or opinions have internal audit and/or external audit given?
• Could delivery of the standards expected of the accountable officer be at risk?
• Might the issue make it harder to resist fraud or other misuse of resources?
• Does the issue put a significant programme or project at risk?
• Could the issue divert resources from another significant aspect of the business?
• Could the issue have a material impact on the accounts?
• Might national security or data integrity be put at risk?

Give full details of any significant issues, including:

- **a description; and**
- **remedial action taken**.

Accountable Officer : Name

Organisation:

Signature

Date

APPENDIX B

DRAFT

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ANNUAL GOVERNANCE STATEMENT 2011/12

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The Governance Framework of the Organisation

Trust Board Composition and Membership

The Trust Board comprises 13 members: a Chairman, seven Non-Executive Directors and five Executive Directors, one of whom is the Chief Executive. The Board is supported in its work by the Director of Communications and External Relations, Director of Corporate and Legal Affairs and Director of Strategy, respectively.

There have been no changes to Board membership during 2011/12.

Performance Management Reporting Framework

To ensure that the Board is aware to a sufficient degree of granularity of what is happening in the hospitals, a comprehensive quality and performance report is reviewed at each monthly public Board meeting.

The monthly report:

- is structured across five domains: patient safety; patient experience; clinical outcomes; staff experience/workforce; and value for money;

- includes a summary section, 'UHL at a Glance', which provides an overview of both in-month and year to date performance, and trends;

- includes performance indicators rated red, amber or green;

- includes data quality indicators, measured against five key data quality components to assist the Board in gaining assurance;

- is complemented by commentaries from the Executive Directors identifying

key issues to the Board and, where necessary, corrective actions to bring performance back on track.

A Clinical Divisional heat map, identifying individual Divisional and Clinical Business Unit performance across all of the domains is also available to the Board.

This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- patient stories, which are presented in public at Board meetings every quarter. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement;

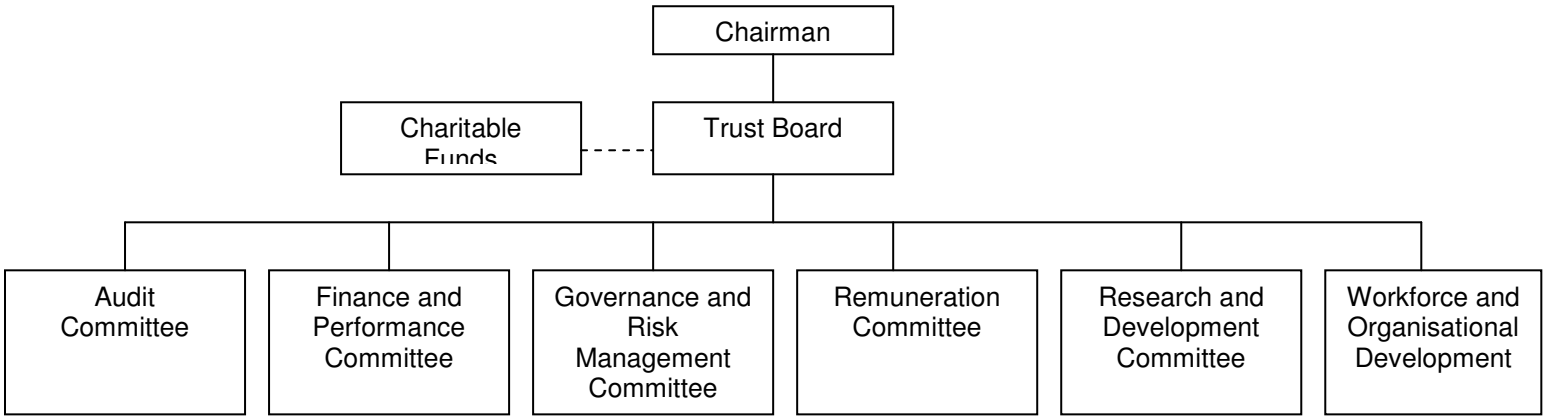
- Board members undertake patient safety walkabouts regularly; and

- four of the Non-Executive Directors are linked to the Clinical Divisions and attend Divisional board meetings.

These arrangements allow Board members to help model the Trust's values through direct engagement, as well as ensuring that Board members take back to the boardroom an enriched understanding of the lived reality for staff, public and patients.

Committee Structure

The Trust has a well-established committee structure to strengthen its focus on finance and performance, governance and risk management and workforce and organisational development. The structure is designed to provide effective governance over, and challenge to, the Trust's patient care and other business activities. The committees therefore carry out detailed work of assurance on behalf of the Board. A diagram illustrating the Board committee structure is set out below.



All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Remuneration Committee, which comprise Non-Executive Directors exclusively.

The Audit Committee is established under powers delegated by the Trust Board with approved terms of reference that are aligned with the NHS Audit Committee Handbook. The Committee consists of four Non-Executive Directors, has met on five occasions throughout the 2011/12 financial year and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

Attendance at Board and committee Meetings

The attendance of the Chairman, individual Non-Executive Directors, Executive Directors and Corporate Directors at Board and committee meetings during 2011/12 is set out below. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attenders as detailed in the terms of reference for each committee.

NAME	TRUST BOARD MAXIMUM - 13	AUDIT COMMITTEE MAXIMUM - 5	FINANCE AND PERFORMANCE COMMITTEE MAXIMUM - 12	GOVERNANCE AND RISK MANAGEMENT COMMITTEE MAXIMUM – 12	RESEARCH AND DEVELOPMENT COMMITTEE MAXIMUM – 10	REMUNERATION COMMITTEE MAXIMUM – 4	WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE MAXIMUM - 4
Martin Hindle	13	N/A	N/A	N/A	10	4	N/A
Kiran Jenkins	12	5	N/A	N/A	N/A	4	N/A
Richard Kilner	13	5	12	N/A	N/A	4	4
Prakash Panchal	12	N/A	N/A	10	8	3	4
Ian Reid	12	3	12	N/A	N/A	4	N/A
David Tracy	13	4	N/A	12	N/A	4	3
Jane Wilson	12	N/A	10	9	N/A	4	4
David Wynford-Thomas	10	N/A	N/A	7	7	3	N/A
Kate Bradley	13	N/A	N/A	N/A	N/A	4	4
Kevin Harris	11	N/A	7	7	8	N/A	3
Suzanne Hinchliffe	13	N/A	10	8	N/A	N/A	3
Malcolm Lowe-Lauri	12	2*	11	11	7	4	3
Andrew Seddon	13	4	12	N/A	N/A	N/A	N/A
Abi Tierney	13	N/A	9	N/A	6	N/A	N/A
Stephen Ward	12	4	N/A	9	N/A	4	N/A
Mark Wightman	13	N/A	N/A	9	4	N/A	2

*NB – Audit Committee Terms of Reference refer to the Chief Executive being invited to attend a meeting annually.

Board Effectiveness

On joining the Board, Non-Executive Directors are given background information describing the Trust and its activities. A full induction programme is arranged.

Board performance depends both upon leadership and the interaction of particular people and personalities. Recognising the importance of getting the right dynamics between Executive and Non-Executive Directors, and to strike the right balance between challenge and support to the Executive Team, each member of the Board has undertaken a 'Myers Briggs' assessment of their personality preferences. This has helped each Board member to become aware of their particular style and to better understand and appreciate the helpful ways that people differ from one another. It has also formed the basis of the development and Board agreement of the Code of Conduct for Directors.

The Board recognises the importance of effectively gauging its own performance so that it can draw conclusions about its strengths and weaknesses, and take steps to improve. The Board therefore undergoes regular assessment using third party external advisers to ensure that it is:

• operating at maximum efficiency and effectiveness;
• adding value; and
• providing a yardstick by which it can both prioritise its activities for the future and measure itself.

Outside of its formal meetings, the Board has held development sessions throughout 2011/12. Amongst the topics considered were risk management; winter planning; market assessment and the forthcoming establishment of Health Watch.

The Chairman of the East Midlands Strategic Health Authority set objectives for the Trust Chairman for 2011/12.

The Trust Chairman set objectives for the Chief Executive and Non-Executive Directors for 2011/12. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2011/12.

Corporate Governance

In managing the affairs of the Trust, the Trust Board is committed to achieving high standards of integrity, ethics and professionalism across all areas of activity. As a fundamental part of this commitment, the Board supports the highest standards of corporate governance within the statutory framework.

The Trust has in place a suite of corporate governance policies which are reviewed and updated annually. These include standing orders, standing

financial instructions, a scheme of delegation, policy on fraud and code of business conduct.

The Trust Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'.

During 2012/13, the Trust Board is to undertake a self-assessment against the Department of Health's Assurance Framework for Aspirant Foundation Trusts. This work is timetabled to be completed by November 2012.

Risk Assessment

The Trust operates a risk management process which enables the identification and control of risks at both a strategic and operational level. Central to this is the Trust's Risk Assessment Policy which sets out details of the risk assessment methodology used across the Trust. This methodology enables a suitable, trained and competent member of staff to identify and quantify risks in their respective area and to decide what action, if any, needs to be taken to reduce or eliminate risks. All risk assessments must be scored and recorded in line with the procedure set out in the Risk Assessment Policy. Completed risk assessments are held at Clinical Division and Corporate Directorate level and when they give rise to a significant residual risk must be linked to the Trust's operational and, if appropriate, strategic risk register.

A common risk-scoring matrix is used by the Trust to quantify and prioritise risks identified through the risk assessment procedure. It is based on the frequency or likelihood of the harm combined with the possible severity or impact of that harm. The arrangement determines at what level in the organisation a risk should be managed and who needs to be assured management arrangements are in place.

The Trust recognises the importance of robust information governance. During 2011/12, the Director of Strategy led on information governance issues as the Trust's Senior Information Risk Owner, supported by an Information Governance Manager. The Medical Director was the Trust's Caldicott Guardian during 2011/12.

The Trust took further actions during 2011/12 to secure improvement in its information governance arrangements. An Information Governance Steering Group monitors and oversees compliance with information governance requirements. The Trust fully supported NHS East Midlands' information governance awareness campaign to promote secure handling of personal data ('NHS Confidential').

All NHS Trusts are required annually to undertaken an information governance self-assessment using the NHS Information Governance Toolkit. This contains 45 standards of good practice. UHL's overall percentage score for 2011/12 was 84%, compared to 75% in 2010/11. This is deemed to be a

'satisfactory – minimum level 2' standard across all of the information governance standards.

There were no serious untoward incidents involving lapses of data security which were required to be reported to the Information Commissioner's Office in 2011/12. In respect of other personal data related incidents experienced during 2011/12, the Trust has undertaken investigations to ensure that the root causes are properly understood and addressed; in addition, patients have been contacted to inform them of the lapses and to provide them with assurance about the actions taken by the Trust to prevent recurrence.

The Risk and Control Framework

The Trust's Risk Management Strategy describes an organisation-wide approach to risk management supported by effective and efficient systems and processes. The Strategy clearly describes the Trust's approach to risk management and the roles and responsibilities of the Trust Board, management and all staff. The Strategy was approved by the Trust Board in May 2011.

Key strategic risks are documented in the Trust's Strategic Risk Register and Board Assurance Framework. Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team and Trust Board review the Register/Framework on a monthly basis to identify and review the Trust's principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed.

The Trust's Annual Plan 2012/13 responds to and, where possible, addresses the strategic risks facing the Trust. The Trust Board will review the current Register and update it to reflect any additional risks in the 2012/13 Plan.

Annual Quality Report

The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to NHS Trusts on the form and content of annual Quality reports which incorporates the above-mentioned legal guidance.

The Director of Clinical Quality, on behalf of the Medical Director co-ordinates the preparation of the Trust's Annual Quality Report. This is reviewed in draft form by the Trust's Governance and Risk Management Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2011/12, the Governance and Risk Management Committee has noted the Trust's internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – which Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 28 June 2012.

APPENDIX B

Review of the Effectiveness of Risk Management and Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Managers and Clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft Quality Account 2011/12 and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance and Performance Committee, Governance and Risk Management Committee and Workforce and Organisational Development Committee. During 2011/12, each of these bodies has been involved in a series of processes that, individually and collectively, has contributed to the review of the effectiveness of the system of internal control.

In the Head of Internal Audit Opinion 2011/12, the Head of Internal Audit notes that, based on the results of the Internal Audit work performed as set out in the 2011/12 Internal Audit Plan (and subsequent amendments) approved by the Audit Committee, at UHL there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. Where individual audits identified high risk issues, action plans have been agreed by management to meet Internal Audit's recommendations and to strengthen internal control.

The Head of Internal Audit's Opinion 2011/12 (which, using the terminology set out in the Department of Health guidance to Head of Internal Audit, equates to "significant assurance") has taken into account the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

2011/12 proved to be a very challenging year for the Trust, particularly in terms of financial delivery, performance of the emergency care system and staff engagement and morale. Given the challenges, the Trust is very aware of the potential impact on clinical quality. Accordingly, in March 2012 the Trust undertook a review of clinical quality indicators over the period winter 2011/12. This demonstrated that, while winter pressures had resulted in a negative impact on patient experience, no measurable effect on patient mortality or clinical outcomes was discernable. Nevertheless, in March 2012 the Care Quality Commission undertook an unannounced inspection at the Acute Medical Unit at the Leicester Royal Infirmary and found, in its judgement, that there were major concerns in relation to the care and welfare of people using the service.

The Care Quality Commission issued a warning notice setting out its findings, to which the Trust responded formally. The Commission subsequently carried out a further inspection and issued a report confirming that the Trust had addressed its concerns and discharged the warning notice.

The Trust Board is not satisfied that the plan in place at present is sufficient to meet the A&E/4 hour standard on a sustainable basis and so it has commissioned two external reviews to examine the Emergency Department and the entire emergency care pathway, respectively. The Board is to receive a revised plan in July 2012 to ensure that the standard is achieved on a sustainable basis. During 2012/13, Internal Audit is to carry out a review of the sustainability and deliverability of the revised plan.

For 2011/12, we set ourselves the target to be in the top 20% of Trust's nationally for positive patient feedback, according to local patient experience survey results and the national patient survey.

Based on the most recent national survey results, although we have not achieved the target we set ourselves, we are in the middle 60% of Trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent.

For 2012/13, we have again identified improving patient experience as one of our top priorities. We want to increase the opportunity for patients, carers and the public to provide feedback on services and care provided through a range of media including establishing the question and baseline 'Net Promoter Score' for 10% of inpatient discharges for any given week at or within 48 hours of discharge.

The first month of reporting will be in April 2012, following which a trajectory for improvement will be agreed to ensure either a 10 point improvement in Net Promoter Score or achievement or maintenance of top quartile performance throughout 2012/13.

The Trust has accepted the need to improve its risk management arrangements and, in response to recommendations made by its Internal Auditor, has agreed a series of actions to improve the effectiveness of risk management at the Trust during 2012/13.

The Trust Board has identified the need to strengthen the capability and experience of the Trust's management team in order to deliver the Annual Plan: this is a key priority for 2012/13 and the Chief Executive, supported by the Chief Operating Officer/Chief Nurse is to report to the Board during quarter 1 2012/13 setting out plans in this regard.

The Trust Board has also identified actions to mitigate other significant risks in 2012/13 in relation to:

(a) the ability to identify sufficient levels of cost reduction and secure the clinical engagement necessary to deliver long-term transformation;

(b) achieving an affordable and sustainable clinical service and site configuration across UHL and the Leicester, Leicestershire and Rutland health economy; and

(c) maintaining the trajectory relating to the Trust's application for NHS Foundation Trust status.

In addition to the issues identified above, further work will be undertaken in 2012/13 to review and strengthen the Trust's governance, risk management and internal control systems, policies and procedures. This work will contribute to the Trust's aim of submitting its application for authorisation as an NHS Foundation Trust.

I am of the opinion that the implementation of the actions described above will strengthen the Trust's system of internal control in 2012/13 and beyond.

My review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed…….

Chief Executive (on behalf of the Trust Board)

Date ……