ANNUAL GOVERNANCE STATEMENT 2015/16

Author: Stephen Ward Sponsor: John Adler Date: Thursday 2 June 2016 Trust Board paper F4

Executive Summary

Context

Attached to this paper is the Annual Governance Statement 2015/16. The Statement has been reviewed by the Trust's External Auditors and is considered by them to be consistent with their knowledge of the Trust.

The Statement was reviewed and approved by the Audit Committee at its meeting on 25th May 2016 and recommended by that Committee to the Trust Board for approval.

Input Sought

The Trust Board is invited to approve the Annual Governance Statement 2015/16.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register
Board Assurance Framework

3. Related Patient and Public Involvement actions taken, or to be taken: N/A

4. Results of any Equality Impact Assessment, relating to this matter: N/A

5. Scheduled date for the next paper on this topic: June 2017 Trust Board

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does not comply]

Annual Governance Statement 2015/16

Executive Summary

The annual governance review confirms that University Hospitals of Leicester NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. We recognise that the internal control environment can always be strengthened and this work will continue in 2016/17, as described below.

We have identified below a number of significant control issues which have impacted on our performance in 2015/16. This Statement gives an account of remedial action which has been, and is being, taken.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports adherence to our policies and achievement of our 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 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.

In undertaking this role I, and my team, have developed strong links with the NHS Trust Development Authority (now NHS Improvement), local Clinical Commissioning Groups and other partner organisations.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide a reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of policies, aims and objectives of the Trust; and
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place at the University Hospitals of Leicester NHS Trust for the financial year ended 31 March 2016 and up to the date of the approval of the annual accounts.

The Governance Framework of the Organisation

Trust Board composition and membership

Our Trust Board comprises 13 members: a Chairman, seven Non-Executive Directors and five Executive Directors. There have been a number of changes in the composition of the Board during 2015/16.

Mr Richard Moore joined the Trust formally as a Non-Executive Director on 1 April 2015 and has served as Chairman of the Audit Committee since that date. Professor Alison Goodall, nominated by the University of Leicester, took up her role as a Non-Executive Director on 1 July 2015. Mr Andrew Johnson took up his position as a Non-Executive Director on 1st November 2015. Ms Jane Wilson stood down as a Non-Executive Director on 31st December 2015.

Having served in the role as Acting Medical Director from 1 April 2015, Mr Andrew Furlong was appointed to the substantive role of Medical Director from 15 January 2016.

Ms Julie Smith and Ms Louise Tibbert took up their roles as Chief Nurse and Director of Workforce and Organisational Development on 1 and 3 August 2015, respectively.

Ms Kate Shields, Director of Strategy left the Trust on 14 February 2016. On an interim basis, the responsibilities of this post have been reallocated to the Chief Financial Officer, Mr Paul Traynor, and Director of Marketing and Communications, Mr Mark Wightman. It is anticipated that a substantive appointment will be made to the post of Director of Strategy during 2016/17.

One post of Non-Executive Director remains vacant and it is anticipated that NHS Improvement will make an appointment to this post in 2016/17.

The Board is supported in its work by the Director of Workforce and Organisational Development, Director of Marketing and Communications and Director of Corporate and Legal Affairs who each have a standing invitation to attend all meetings, but not in a voting capacity.

In summary, although there has been significant turnover at Board level in 2015/16, the process of making substantive appointments is now almost complete, creating a well-balanced Board to provide continuity of leadership going forward.

Performance Management Reporting Framework

The Chief Executive reports on key issues to each public Board meeting and a Quality and Performance Dashboard forms part of this report.

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 meeting of the Board's Integrated Finance, Performance and Investment Committee (IFPIC) and Quality Assurance Committee (QAC). This report is also published as part of our Trust Board papers.

The monthly report:

- is structured across several domains: 'safe'; 'caring'; 'well-led'; 'effective'; 'responsive'; and 'research';
- includes information on our performance against the NHS Trust Development Authority Accountability Framework;
- includes performance indicators rated red, amber or green;
- is complemented by exception reports and commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

Importantly, the quality and performance report includes information on 'never events'. Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.

During 2015/16, two such incidents were reported at the Trust which met the definition of a never event. These related to (a) a patient falling from an inadequately restricted window, and (b) a patient undergoing a skin excision procedure on the incorrect ear. In both cases, the patients and their relatives were informed by the Trust of the errors and the Trust apologised for its failings.

Thorough root cause analysis of both incidents was undertaken to identify key actions to prevent recurrence. Implementation of these actions is tracked by the Quality Assurance Committee on behalf of the Trust Board.

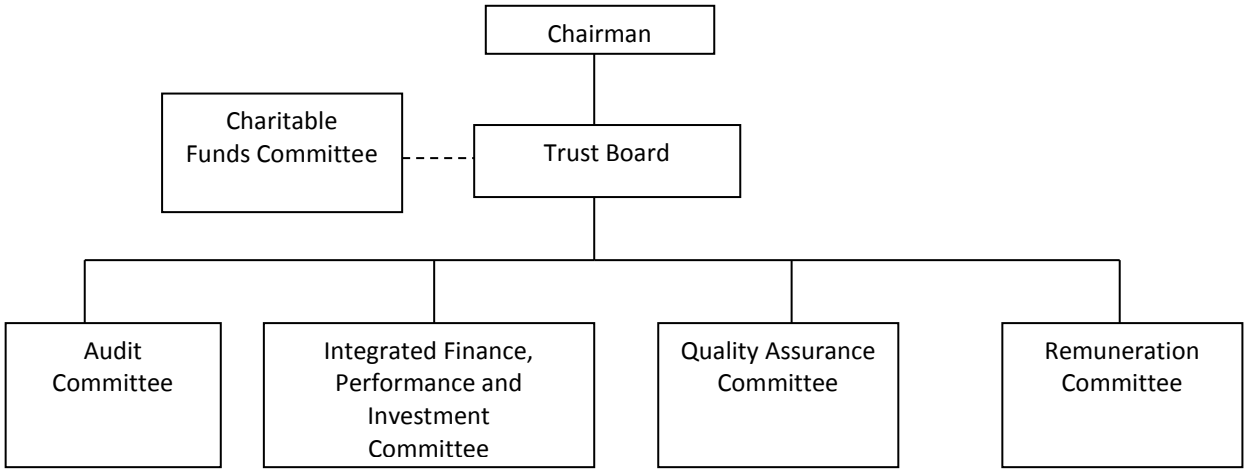
The formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- patient stories, which are presented in public at each Board meeting. These shine a light on individual experiences of care provided by our organisation and act as a catalyst for improvement; and
- Board members carry out regular patient safety walkabouts.

These arrangements allow Board members to help model our 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

We have operated a well-established committee structure to strengthen our focus on quality governance, finance and performance, and risk management. The structure has been designed to provide effective governance over, and challenge to, our patient care and other business activities. The committees carry out detailed work of assurance on behalf of the Trust 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 (in accordance with NHS guidance) comprise Non-Executive Directors exclusively. All Non-Executive Directors are encouraged by our Chairman to attend all Board level committee meetings, even if they are not voting members of those committees.

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 three Non-Executive Directors and has met on five occasions throughout the 2015/16 financial year. It has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of our organisation's business. The Audit Committee receives reports at each of its meetings from the External Auditor, Internal Audit and the Local Counter-Fraud Specialist, the latter providing the Committee with assurance on our work programme to deter fraud.

The Integrated Finance, Performance and Investment Committee meets monthly to oversee the effective management of our financial resources and operational performance across a range of measures. The Quality Assurance Committee also meets monthly and seeks assurances that there

are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients.

The minutes of each meeting of our Board committees are submitted to the next available Trust Board meeting for consideration. Recommendations made by the committees to the Trust Board are clearly identified on a cover sheet accompanying the submission of the minutes to the Board. The Chair of each committee personally presents a summary of the Committee's deliberations and minutes at the Board meeting, highlighting material issues arising from the work of the committee to the Board. In particular, the Chairs provide feedback to the Trust Board on their committees' scrutiny of that month's quality and performance report, thereby complementing the commentaries of the Executive Directors.

Every meeting of the Trust Board and each Board committee meeting was quorate during 2015/16.

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 2015/16 is set out in an appendix to this Statement. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attendees as detailed in the terms of reference for each committee.

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.

Our Board recognises the importance of effectively gauging its own performance so that it can draw conclusions about its strengths and weaknesses, and take necessary steps to improve. The Board is keen to ensure that it is:

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

Building on the findings of a third party external adviser carried out in 2014/15, during the year the Trust Board has implemented a programme of work (supported by external consultants) to improve Board and Board committee reporting. This work has helped us to:

- align the Board agenda to our priorities and the things that matter most;
- stimulate more forward-looking and strategic conversations in the boardroom;
- reduce duplication and size of the Board pack whilst increasing visibility and insight;
- embed the tools, skills and capability to deliver high quality reports and executive summaries that meet the Board's information needs.

Outside of its formal meetings, the Board has held development sessions ('Thinking Days') each month throughout the year. Amongst the topics considered were our reconfiguration programme; risk management; workforce equality and diversity; workforce planning and organisational development; and stakeholder engagement.

Our Chairman set objectives for the Chief Executive and Non-Executive Directors for 2015/16. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2015/16. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively.

Corporate Governance

In managing the affairs of the Trust, the 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.

We have in place a suite of corporate governance policies which are reviewed annually and updated as required, most recently in October 2015. These include standing orders, standing financial instructions, a scheme of delegation, policy on fraud and code of business conduct.

The Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'. We have also adopted the Code of Conduct: "Standards for NHS Board members and members of Clinical Commissioning Group governing bodies in the NHS in England" (Professional Standards Authority: November 2012).

Information Governance

We recognise the importance of robust information governance. During 2015/16, the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Information Governance Toolkit. This contains 45 standards of good practice, spread across the domains of:

- information governance management;
- confidentiality and data protection assurance;
- information security assurance;
- clinical information assurance;
- secondary use assurance; and
- corporate information assurance.

We achieved a minimum level 2 standard across all of the 45 standards, except in the case of:

- training : 89% of staff were trained in information governance in 2015/16 against the toolkit requirement that all staff be trained;
- data quality : the Trust needs to document and implement procedures for using both local and national benchmarking to identify and investigate possible data quality issues;
- corporate information assurance : the Trust needs to carry out an audit of corporate records in at least four corporate areas of the organisation.

An information governance improvement plan for 2016/17 has been prepared for approval by the Executive Team. Implementation will be overseen by the Information Governance Steering Group, chaired by the Senior Information Risk Owner.

During the year we reported to the Information Commissioner's Office one serious untoward incident involving a lapse of data security. Patient care was not put at risk and the data was retrieved.

In respect of other personal data related incidents experienced during the year, we have carried out 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 we have taken to prevent recurrence.

The Risk and Control Framework

Our Board-approved Risk Management Policy describes an organisation-wide approach to risk management, supported by effective and efficient systems and processes. The Policy clearly describes our approach to risk management and the roles and responsibilities of the Trust Board, management and all staff.

All key strategic risks are documented in the Trust's Board Assurance Framework. Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team reviews the Framework on a monthly basis to identify and review our principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, the controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed . The Chief Executive highlights key issues in his monthly report to the public meeting of the Trust Board, appended to which are the Board Assurance Framework Dashboard and Organisational Risk Register Dashboard, respectively. A copy of the full Framework is also published monthly with the Board papers.

During 2015/16, the Trust Board has considered how best to strengthen our risk management arrangements at two development sessions ('Thinking Days').

Agreement has been reached to implement a revised approach in quarter one 2016/17, the principal aims of which are to ensure:

(a) firstly, within the Board itself, that an informed consideration of risk and risk tolerance underpins organisational strategy, decision-making and the allocation of resources; and

(b) secondly, that the organisation has appropriate risk identification and risk management processes in place to deliver the Annual Operational Plan and comply with the registration and licensing requirements of key regulators.

Our Annual Operational Plan 2016/17 responds to and addresses the strategic risks we face. The current Board Assurance Framework is to be updated to reflect risks in the 2016/17 plan and will continue to be reviewed at regular intervals by both the Executive Team and Trust Board.

Following the inspection of our hospitals by the Care Quality Commission in January 2014, the Trust Board approved a formal action plan to address the findings. Progress against this plan has been monitored regularly by the Quality Assurance Committee on behalf of the Trust Board during the year.

I comment below (under 'Significant Control issues') on the findings of an unannounced inspection by the Commission of the Emergency Department at the Leicester Royal Infirmary in November 2015.

The Care Quality Commission is to conduct a full inspection of our Trust in June 2016. As part of the planning for the inspection, we are carrying out self-assessments against the Commission's key lines of enquiry during quarter one 2016/17 and the findings will inform improvements during this financial year. It is anticipated that the Commission's report will be available in Autumn 2016.

Risk Assessment

We operate a risk management process which enables the identification and control of risks at both a strategic and operational level. Central to this is our Risk Assessment Policy which sets out details of the risk assessment methodology used across the Trust. This methodology enables suitable, trained and competent members 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 Management Group and Corporate Directorate level and when they give rise to a significant residual risk must be linked to our risk register.

We use a common risk-scoring matrix 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.

Annual Quality Account

We are 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 Accounts which incorporates the above-mentioned legal guidance.

The Director of Clinical Quality, on behalf of the Chief Nurse, co-ordinates the preparation of our Annual Quality Account. This is reviewed in draft form by our Quality Assurance Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2015/16, the Quality Assurance Committee has noted our internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – the Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 2 June 2016.

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 2015/16 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 note that, in their Annual Audit Letter issued in July 2015, External Audit stated that the Trust has generally sound processes for the production of the financial accounts and in relation to the use of resources.

Arising from their 2014/15 audit of the Trust, External Audit raised one high priority recommendation for the Trust, to strengthen the quality assurance procedures in relation to the valuation of land and assets. We accepted this recommendation and have acted upon it in 2015/16.

I have also 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, Integrated Finance, Performance and Investment Committee and Quality Assurance Committee. During 2015/16, 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 2015/16, the Head of Internal Audit notes that Internal Audit have carried out fourteen reviews during the year which have resulted in one high-risk rated report – Review of compliance with NHS immigration requirements.

The review considered the processes and controls to ensure compliance with Home Office requirements for employing Tier 2 and Tier 5 migrant workers which focus on:

a) right to work checks;

b) recruitment processes for visa requirement checks for Tier 2 and Tier 5 workers;

c) management information, record keeping and reporting; and

d) arrangements for bank staff.

Internal Audit's review identified that senior members of staff in the Recruitment Services Team had a good level of awareness of Home Office requirements and had implemented controls to ensure compliance. However, the review also identified that some of these processes could be strengthened in the following areas:

i. Disclosure and Barring Service (DBS) checks for migrant workers, and risk assessments for the period before the DBS check was obtained;

ii. evidence of robust Right to Work checks;

iii. accuracy of the recording of visa dates;

iv. monitoring of bank staff weekly hours; and

v. record keeping within files.

We are taking action to address the high risk findings of Internal Audit and implementation of the actions in question will be reviewed by the Audit Committee during 2016/17.

The Head of Internal Audit is satisfied that sufficient internal audit work has been carried out in 2015/16 to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, the Head of Internal Audit notes that assurance can never be absolute – the most the Internal Audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

The Head of Internal Audit Opinion for 2015/16 is that governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required to enhance the control framework. I accept this finding and am committed to strengthening the internal control environment, as detailed in this Statement.

Using our Board Assurance Framework, the Trust Board has also identified actions to mitigate other risks in the year in relation to:

a. progress in implementing our Quality Commitment;

b. increasing emergency attendances and admissions;

c. transferring elective activity into community settings, developing patient referral pathways and cancer care;

d. the provision of specialised services;

e. delivering integrated care in partnership with others;

f. attaining Biomedical Research Centre status;

g. delivering consistently high standards of medical education;

h. delivering the Genomic Medicine Centre project;

i. our relationships with partner organisations;

j. staff engagement and workforce recruitment and retention;

k. implementing the major estate transformation programme;

l. limited capital resources to deliver estate reconfiguration;

m. statutory compliance of the estate;

n. delivering clinically sustainable services;

o. delivering the 2015/16 programme of service reviews;

p. delivering our financial control total in 2015/16;

q. approving an updated five-year financial strategy;

r. the Electronic Patient Record programme;

s. delivering information management and technology services.

Any changes in the current or target risk scores are highlighted to the Trust Board, and the Board also reviews and seeks assurances on the management actions in place to mitigate the identified risks.

During quarter one 2016/17, and in response to the Committee's request, the Quality Assurance Committee is to receive a report from the Director of Safety and Risk setting out details of the Trust's compliance with statutory requirements. Appropriate corrective actions will be taken to address any identified gaps in compliance, with progress reported to the Committee.

Significant Control Issues

Key Financial Duties

In respect of performance in 2015/16 against the key financial duties, we have:

a. delivered the planned deficit of £34.1m; this represents a £2m improvement against the original income and expenditure control total which we were asked in year to deliver by the NHS Trust Development Authority;

b. achieved the External Financing Limit (the limit placed on net borrowing) of £49.2m;

c. achieved the Capital Resource Limit (the limit placed on net capital expenditure) of £49.2m.

At its meeting in May 2015, the Audit Committee assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by the preparation of a 2015/16 Working Capital Strategy, authored by the Chief Financial Officer.

The Committee endorsed the Working Capital Strategy, the key objectives of which were to:

i. maintain the cash balance as planned during 2015/16, including drawing down temporary and permanent borrowing and managing our other working capital balances;

ii. improve performance against the 'Better Payment Practice Code';

iii. achieve the External Financing Limit and Capital Resource Limit; and

iv. further develop monitoring and reporting processes to ensure that there were robust linkages between cash balances; revenue income and expenditure; and capital expenditure.

The Trust Board subsequently accepted the 2015/16' going concern' position statement at its meeting in June 2015, on the recommendation of the Audit Committee.

The Board has agreed plans to deliver the agreed 2016/17 control total – a £8.3m deficit (after including Sustainability and Transformation funding of £24.3m), which includes the delivery of a £35m Cost Improvement Programme.

Emergency Care

Unfortunately, we failed to meet the A&E 4-hour standard in 2015/16, achieving a performance of 86.9 per cent (89.1 per cent 2014/15) against a target of 95 per cent.

We have also performed poorly in terms of the time it takes to transfer to our care patients who are brought to our Emergency Department by ambulance. However, since November 2015 and as a result of our work in partnership with the East Midlands Ambulance Service, we have seen a 29 per cent reduction in these delays (total delay time). Nevertheless, despite the improvement, we

acknowledge we still have unacceptable delays in this process and remedying this issue is one of our key priorities for 2016/17.

As a member of the Leicester, Leicestershire and Rutland Urgent Care Board, we are fully committed to working with our partners across the health and social care sectors to improve emergency care performance in 2016/17, and our key priorities are as follows:

a. reduce ambulance handover delays in order to improve patient experience, care and safety;

b. fully utilise ambulatory care to reduce emergency admissions and reduce length of stay;

c. develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps; and

d. diagnose and reduce delays in the inpatient process to increase effective capacity.

Cancer waiting time targets

This year we have seen a significant increase in the number of patients being referred with cancer and, as a consequence, we have struggled to deliver the national cancer standards sustainably. Delivering all of the cancer standards sustainably is one of our priorities for 2016/17 and performance will remain under review on a monthly basis by the Trust Board.

Enforcement action by the Care Quality Commission

On 30 November 2015, the Care Quality Commission (CQC) carried out an unannounced inspection of the Emergency Department at the Royal Infirmary. The CQC identified areas of poor practice and, because of concerns about potential risks to patient safety, issued an urgent Notice of Decision to the Trust on 4 December 2015. This imposed conditions on the Trust's registration as a service provider.

The CQC required the Trust to report weekly and monthly on the actions being taken to address the identified concerns. We have complied with this requirement and co-operated fully with the CQC. Reports submitted to the CQC since their inspections have shown that we have made significant progress and we continue to focus on sustainable improvements. Performance will continue to be overseen on a monthly basis by the Quality Assurance Committee, acting on behalf of the Trust Board.

Waiting list management arrangements

In July 2015, the Executive Team was alerted to the existence of three planned waiting lists (with a total of 347 patients) in the Orthodontics department. These waiting lists had been inappropriately managed with the patients not becoming 'live' when clinically ready for treatment. The incident sparked wider concerns about the use of planned waiting lists across the Trust. In consequence, a thorough review of waiting list management arrangements was undertaken across the Trust. Local processes were strengthened following the review and now each waiting list has a named clinical and managerial lead who provide assurance on the accuracy of the waiting lists.

The 231 orthodontic patients who have waited over 52 weeks continue to be a focus for the local health system. We are committed to providing these patients with suitable treatment either within the NHS or via the independent sector at the earliest opportunity. Our aim is to ensure that, by 31 March 2017, no patients have been waiting longer than one year and the Trust therefore continues to source orthodontic capacity, in collaboration with NHS Improvement and NHS England.

Health and Safety Executive Improvement notice relating to sharps safety

On 21 September 2015, the Health and Safety Executive (HSE) made a planned visit to the Leicester Royal Infirmary. The HSE identified that we were in contravention of the Sharp Instruments in Healthcare Regulations 2013 and served an Improvement Notice on the Trust requiring:

- substitution of unprotected medical sharps with a ‘safer sharp’ where reasonably practicable;
- prevention of recapping of needles;
- effective investigation of needlestick/sharps injuries.

We took action to ensure we met the requirements of the Improvement Notice and following re-inspection on 7 April 2015, the HSE confirmed that we are in compliance with our legal duties.

Conclusion

My review confirms that the University Hospitals of Leicester NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. We recognise that the internal control environment can always be strengthened and this work will continue in 2016/17, as described above.

In addition to the specific issues identified above, further work will also be carried out in 2016/17 to review and strengthen our governance, risk management and internal control systems, policies and procedures as part of our commitment to continuous improvement.

Signed

Chief Executive (on behalf of the Trust Board)

Date:

Trust Board and Committee attendance 2015-16

Name	**Trust Board** maximum – 13	**Audit Committee** maximum – 5	**Integrated Finance, Performance and Investment Committee** maximum – 12	**Quality Assurance Committee** maximum – 12	**Remuneration Committee** maximum – 7	**Charitable Funds Committee** Maximum – 4
Karamjit Singh – Chairman	13/13	N/A	11/12	11/12	7/7	1/1
Ian Crowe – Non-Executive Director	13/13	4/5	12/12	12/12	7/7	3/3
Sarah Dauncey – Non-Executive Director	11/13	5/5	11/12	10/12	5/7	3/4
Alison Goodall – Non-Executive Director **(1)**	10/11	0/5	0/12	0/9	1/5	N/A
Andrew Johnson – Non-Executive Director **(2)**	6/6	3/3	5/5	5/5	3/3	N/A
Richard Moore – Non-Executive Director	13/13	5/5	12/12	12/12	7/7	1/1
Martin Traynor – Non-Executive Director	12/13	5/5	12/12	11/12	6/7	4/4
Jane Wilson – Non-Executive Director **(3)**	10/10	2/3	9/9	9/9	5/5	1/1
John Adler – Chief Executive	13/13	2/2	8/12	8/12	7/7	N/A
Andrew Furlong – Medical Director **(4)**	12/13	N/A	N/A	7/12	N/A	N/A
Richard Mitchell – Chief Operating Officer	13/13	N/A	9/12	N/A	N/A	N/A
Julie Smith – Chief Nurse **(5)**	9/9	N/A	N/A	7/8	N/A	1/3
Emma Stevens Acting Director of Human Resources **(6)**	4/4	N/A	N/A	N/A	2/2	N/A

Name	**Trust Board** maximum – 13	**Audit Committee** maximum – 5	**Integrated Finance, Performance and Investment Committee** maximum – 12	**Quality Assurance Committee** maximum – 12	**Remuneration Committee** maximum – 7	**Charitable Funds Committee** Maximum – 4
Louise Tibbert – Director of Workforce and OD **(7)**	7/9	N/A	N/A	N/A	4/5	N/A
Paul Traynor – Chief Financial Officer	13/13	5/5	11/12	N/A	N/A	3/4
Carole Ribbins – Acting Chief Nurse **(8)**	3/4	N/A	N/A	1/4	N/A	1/1
Helen Seth – Acting Director of Strategy **(9)**	1/1	N/A	1/2	N/A	N/A	N/A
Kate Shields – Director of Strategy **(10)**	8/12	N/A	5/10	N/A	N/A	0/1
Stephen Ward – Director of Corporate and Legal Affairs	13/13	5/5	N/A	N/A	7/7	4/4
Mark Wightman – Director of Marketing and Communications	12/13	N/A	N/A	N/A	N/A	2/4

Notes:-

(1) Non-Executive Director from 1 July 2015
(2) Non-Executive Director from 1 November 2015
(3) Non-Executive Director until 31 December 2015
(4) substantive Medical Director from 15 January 2016 (Acting Medical Director from 1 April 2015)
(5) from 1 August 2015
(6) until 31 July 2015
(7) from 3 August 2015
(8) until 31 July 2015
(9) from 13 February 2016
(10) until 14 February 2016