ANNUAL GOVERNANCE STATEMENT 2016/17

Author: Stephen Ward Sponsor: John Adler Date: Thursday 1 June 2017

Trust Board paper F4

Executive Summary

Context

Attached to this paper is the Annual Governance Statement 2016/17. 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 26th May 2017 and recommended by that Committee to the Trust Board for approval.

Input Sought

The Trust Board is invited to approve the Annual Governance Statement 2016/17.

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 2018 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 2016/17

Executive Summary

The annual governance review confirms that we, the University Hospitals of Leicester NHS Trust, have 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 2017/18, as described below.

We have identified below a number of significant control issues which have impacted on our performance in 2016/17. 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 on-going 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 2017 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 of 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 2016/17.

Professor Alison Goodall, nominated by the University of Leicester, stood down from her role as a Non-Executive Director on 30 June 2016 and was succeeded by Professor Philip Baker, Head of the College of Medicine, Biological Sciences and Psychology. Mr Ballu Patel took up the position of Non-Executive Director on 1st August 2016. Dr Sarah Dauncey resigned from her Non-Executive Director role in July 2016 and Dr Shirley Crawshaw took up the position of Non-Executive Director on 1st January 2017.

On an interim basis, the responsibilities of the post of Director of Strategy have been assigned to the Chief Financial Officer, Mr Paul Traynor, and Director of Communications, Integration and Engagement, Mr Mark Wightman. Consideration will be given to making a substantive appointment to the post of Director of Strategy during 2017/18.

The Board is supported in its work by the Director of Workforce and Organisational Development 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 turnover in Non-Executive Director posts at Board level in 2016/17, the process of making substantive appointments is now 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 Improvement's Single Oversight 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 2016/17, four such incidents were reported at the Trust which met the definition of a never event. These related to a medication incident; an item left in situ following a procedure; and two cases of incorrect tooth extraction.

In each case, we informed the patients and their relatives of the errors and we apologised for our failings.

Thorough root cause analysis of each incident is 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.

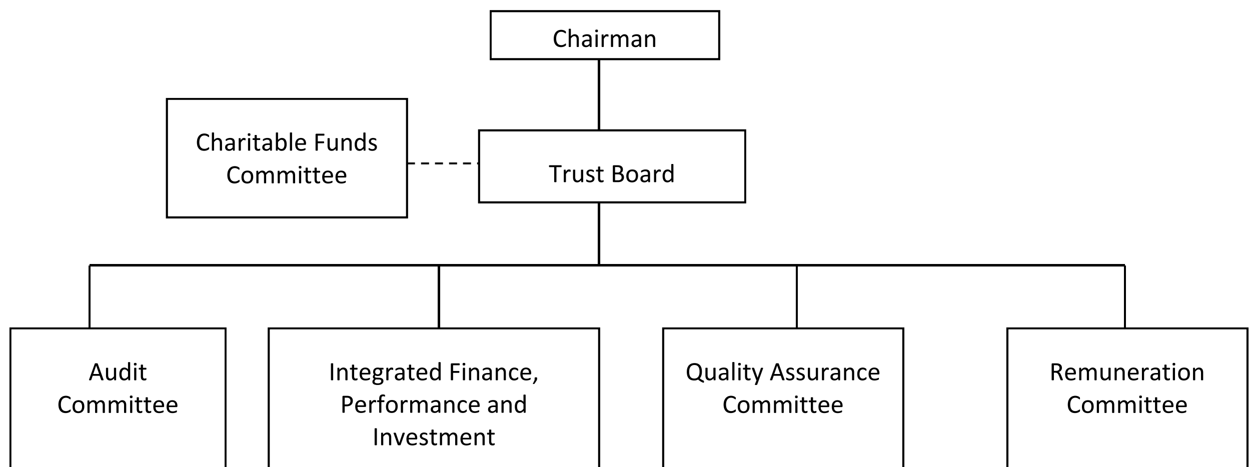
The formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- staff and patient stories, which are presented in public at each Board meeting. These shine a light on staff experiences and individual experiences of patient 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 has met on six occasions throughout the 2016/17 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 Auditor 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 2016/17.

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 2016/17 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 continued to implement a programme of work 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.

Now that its membership is complete, the Trust Board is to embark on an externally facilitated Board development programme, led by NHS Providers and commissioned by NHS Improvement. Workshops will take place in June and July 2017 on (a) developing an effective and compassionate unitary Board and (b), recovering and maintaining performance. Content will be tailored specifically to the Trust, encouraging consistency throughout the organisation and developing team work.

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 2016/17. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2016/17. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively, and the results reported to the Remuneration Committee for consideration.

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. 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).

In line with national guidance issued by NHS England and NHS Improvement in February 2017, we will implement new rules for managing conflicts of interest from 1 June 2017.

Information Governance

We recognise the importance of robust information governance. During 2016/17, 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. Expressed as a score, we achieved 80 per cent, an improvement on our 2015/16 score of 65 per cent.

During the year we reported to the Information Commissioner’s Office two serious untoward incidents involving a lapse of data security. Patient care was not put at risk.

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, where necessary 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 2016/17, 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 2017/18, 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 2017/18 responds to and addresses the strategic risks we face. The current Board Assurance Framework is to be updated to reflect risks in the 2017/18 plan and will continue to be reviewed at regular intervals by both the Executive Team and Trust Board.

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 that appropriate 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 a Quality Account 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 2016/17, 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 1 June 2017.

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 2016/17 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 June 2016, External Audit:

- noted that they had issued an unqualified opinion on the Trust's accounts on 3rd June 2016. This meant that External Audit believed that the accounts gave a true and fair view of our financial affairs and of the income and expenditure received during the year;
- noted that there were no significant matters which they were required to report to those charged with governance;
- noted that we have prepared our accounts on a going concern basis as there was no evidence of a prospect of services ceasing altogether at the Trust, however given our cumulative financial deficit of £114.4 million incurred over the last three financial years, issued a qualified ('except for') conclusion on our Use of Resources conclusions and (as

required) wrote to the Secretary of State for Health confirming this position (referred to as a 'Section 30 letter').

External Audit raised one medium risk recommendation as a result of their 2015/16 audit work relating to valuation assumptions and methodology. We accepted this recommendation and have acted upon it in 2016/17; and have similarly acted upon a recommendation carried forward from the 2014/15 audit to strengthen the quality assurance procedures in relation to the valuation of land and assets.

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 2016/17, 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 2016/17, the Head of Internal Audit notes that Internal Audit have carried out 12 reviews during the year. None of the individual assignment reports had an overall classification of critical or high risk.

We have taken, and are taking action to address the findings of Internal Audit and implementation of the actions in question will be reviewed by the Audit Committee during 2017/18.

The Head of Internal Audit is satisfied that sufficient internal audit work has been carried out in 2016/17 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 2016/17 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 in those areas to enhance the adequacy and effectiveness of 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. implementing our Quality Commitment;
b. providing an appropriate environment for staff/patients;
c. an increase in emergency attendances/admissions without a corresponding improvement in process and /or capacity;
d. delivering the national access standards;
e. tertiary referrals flows from partner organisations;
f. progressing the Better Care Together programme at sufficient pace and scale;
g. delivering an effective learning culture and providing consistently high standards of medical education;
h. delivering the Genomic Medicine Centre project;
i. ensuring the supply and retention of the right staff, at the right time, in the right place and with the right skills that operate across traditional organisational boundaries;
j. system wide consistency and sustainability in the way we manage change and improvement, impacting on the way we deliver the capacity and capability shifts required for new models of care;
k. delivering the recommendations of the national 'freedom to speak up review';
l. estates infrastructure capacity;

m. capital resources to deliver the reconfigured estate which is required to meet our revenue obligations;
n. delivering a clinically sustainable configuration of services;
o. delivering the 2016/17 programme of services reviews, a key component of service-line management;
p. balancing the demand/capacity equation;
q. achieving a revised and approved 5-year financial strategy;
r. progressing the Electronic Patient Record programme;
s. aligning Information Management and Technology priorities to our overall priorities.

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.

Significant Control Issues

Care Quality Commission (CQC) Inspection

In January 2017, the CQC published the findings of their inspection of our hospitals undertaken in June and July 2016. The CQC rated the Trust overall as 'Requires Improvement', and also rated each hospital individually as 'Requires Improvement'. The CQC rated 'Caring' as 'Good' across all three hospital sites.

The Trust Board has approved a formal action plan to address the findings of the CQC and progress against this plan will be monitored by the Quality Assurance Committee on behalf of the Trust Board during 2017/18.

At the time of the CQC inspection, conditions imposed by the CQC in December 2015 on our registration as a service provider (following an unannounced inspection in November 2015 at our adult Emergency Department) remained in place. On 15 November 2016, the CQC lifted the conditions as the CQC was assured that we had satisfactorily addressed areas of poor practice and potential risks to patient safety.

Key Financial Duties

In respect of performance in 2016/17 against the key financial duties, we have:

a. not delivered the planned deficit of £8.3m ;
b. achieved the External Financing Limit (the limit placed on net borrowing) of £87,578k, with a permitted underspend of £5,204k;
c. achieved the Capital Resource Limit (the limit placed on net capital expenditure) of £62,419k, with a permitted underspend of £21,000.

At its meeting in May 2016, the Audit Committee assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by consideration of a 2016/17 going concern statement, prepared by the Chief Financial Officer.

The Committee endorsed the going concern statement, underpinned by a working capital strategy the key objectives of which were to:

a) maintain the cash balance as planned during 2016/17, including drawing down temporary and permanent borrowing and managing our other working capital balances;
b) improve performance against the 'Better Payment Practice Code';
c) achieve the External Financing Limit and Capital Resource Limit; and
d) 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 2016/17 'going concern' position statement at its meeting in June 2016, on the recommendation of the Audit Committee.

Throughout the 2016/17 financial year, we have failed to meet our obligations under the Better Payment Practice Code and have experienced considerable pressures in managing the day to day cash position. This situation has arisen as a result of historic financial deficits; delays in accessing cash within year; and sub-optimal cash management and forecasting processes. In response to these pressures, we commissioned PricewaterhouseCoopers (PwC) to review our approach to cash management, cash forecasting and the associated reporting of the cash position to the Integrated Finance, Performance and Investment Committee. This piece of work has concluded and we have accepted PwC's final report with their recommendations having been adopted and implemented. Performance is reviewed at each meeting of the Integrated Finance, Performance and Investment Committee and scrutinised further on a periodic basis by the Audit Committee.

The Board has agreed plans to deliver the agreed 2017/18 financial plan – a £26.7m deficit - which includes the delivery of a £33m Cost Improvement Programme.

Emergency Care

Unfortunately, we failed to meet the A&E 4-hour standard in 2016/17, achieving a performance of 79.6 per cent (86.9 per cent 2015/16) against a target of 95 per cent.

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 2017/18.

Waiting list management arrangements

We recognise the importance of ensuring that we have in place appropriate arrangements to ensure the effective management and delivery of 'referral to treatment' pathways, and this includes being assured of the quality and accuracy of elective waiting time data. During the course of 2016/17, we have carried out a comprehensive review of the elective pathway from referral through to treatment and discharge of patients. This has included the cancer pathway process and associated diagnostic processes.

The review has identified points at which there is potential for error or failure of our processes. These have then been risk assessed and actions agreed to mitigate the identified risks, with target dates and risk owners. The resulting action plan has been agreed by the Executive Performance Board, and reviewed by the Audit Committee. Implementation of the action plan will be tracked at meetings of both bodies during 2017/18.

We have agreed that External Audit will agree a testing approach with us which will provide assurance that the controls identified are designed and operating effectively. External Audit's work will focus on those areas identified as higher risk. The results of this review, and the response of the Executive Team to those results, will be reported to the Audit Committee in 2017/18.

Alongside these actions, we commissioned Internal Audit during 2016/17 to carry out a review of the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of the data. Internal Audit's review has identified opportunities to make improvements in our processes, and actions have been agreed to implement Internal Audit's recommendations during 2017/18.

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 2017/18, as described above.

In addition to the specific issues identified above, further work will also be carried out in 2017/18 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 2016-17

Name	**Trust Board** maximum – 18	**Audit Committee** maximum – 6	**Integrated Finance, Performance and Investment Committee** maximum – 12	**Quality Assurance Committee** maximum – 12	**Remuneration Committee** maximum – 3	**Charitable Funds Committee** Maximum – 5
Karamjit Singh – Chairman	16/18	N/A	10/12	10/12	3/3	3/4
Professor Philip Baker – Non-Executive Director **(1)**	13/15	N/A	N/A	N/A	1/2	N/A
Dr Shirley Crawshaw – Non-Executive Director **(2)**	4/4	2/2	3/3	3/3	1/1	1/1
Ian Crowe – Non-Executive Director	17/18	5/6	11/12	11/12	2/3	4/5
Dr Sarah Dauncey – Non-Executive Director **(3)**	3/4	0/2	3/3	3/3	1/1	1/1
Alison Goodall – Non-Executive Director **(4)**	2/3	N/A	N/A	N/A	0/1	N/A
Andrew Johnson – Non-Executive Director	18/18	6/6	11/12	11/12	3/3	4/4
Richard Moore – Non-Executive Director	17/18	6/6	9/12	9/12	3/3	4/4
Ballu Patel – Non-Executive Director **(5)**	12/14	4/4	8/9	8/9	2/2	4/4
Martin Traynor – Non-Executive Director	18/18	4/6	11/12	11/12	2/3	5/5
John Adler – Chief Executive	18/18	1/1	10/12	9/12	3/3	N/A
Mr Andrew Furlong – Medical Director	15/18	N/A	N/A	9/12	N/A	N/A
Richard Mitchell – Chief Operating Officer	14/18	N/A	11/12	N/A	N/A	N/A

Name	**Trust Board** maximum – 18	**Audit Committee** maximum – 6	**Integrated Finance, Performance and Investment Committee** maximum – 12	**Quality Assurance Committee** maximum – 12	**Remuneration Committee** maximum – 3	**Charitable Funds Committee** Maximum – 5
Julie Smith – Chief Nurse	17/18	N/A	N/A	8/12	N/A	N/A
Louise Tibbert – Director of Workforce and OD	17/18	N/A	11/12	N/A	2/3	N/A
Paul Traynor – Chief Financial Officer	18/18	6/6	11/12	N/A	N/A	5/5
Stephen Ward – Director of Corporate and Legal Affairs	17/18	6/6	N/A	N/A	3/3	5/5
Mark Wightman – Director of Marketing and Communications	15/18	N/A	N/A	N/A	N/A	4/5

Notes:-

(1) Non-Executive Director from 1 July 2016
(2) Non-Executive Director from 3 January 2017
(3) Non-Executive Director until 14 July 2016
(4) Non-Executive Director until 30 June 2016
(5) Non-Executive Director from 1 August 2016