# ANNUAL GOVERNANCE STATEMENT 2017/18

Author: Stephen Ward Sponsor: John Adler Date: 25th May 2018

# Executive Summary

**Trust Board paper A6**

## Context

This report explains the approach adopted in the preparation of the Annual Governance Statement (AGS) 2017/18.

## Questions

1. Does the Trust Board have any comments on the Annual Governance Statement 2017/18?

## Input Sought

The Trust Board is invited to comment on the Annual Governance Statement 2017/18 and, subject to any amendments agreed by the Audit Committee on the morning of 25th May 2018, approve the Statement for adoption.

# For Reference

Edit as appropriate:

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

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

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:
   The Annual Governance Statement forms part of the Annual Accounts and is a public document.

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

5. Scheduled date for the **next paper** on this topic: Audit Committee – May 2019

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

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

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

**REPORT TO:** **TRUST BOARD**

**DATE:** **25 MAY 2018**

**REPORT BY:** **CHIEF EXECUTIVE**

**SUBJECT:** **ANNUAL GOVERNANCE STATEMENT 2017/18**

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1. At its meeting on 9th March 2018 (Minute 10/18/4 refers), the Audit Committee received and noted the guidance published by NHS Improvement on the completion and submission of Annual Governance Statements for 2017/18.

2. Following receipt of comments from Audit Committee members, the draft Annual Governance Statement (AGS) 2017/18 was submitted to the Trust's External Auditor on 1st May 2018.

3. The draft AGS 2017/18 has been updated to take into account comments received from the External Auditor and the latest version is attached as an appendix to this report.

4. The Audit Committee is charged with the responsibility of reviewing the adequacy of all risk and control related disclosure statements, including the AGS, prior to submission to the Trust Board for consideration and approval.

5. The Committee is invited to review and confirm the AGS 2017/18 attached to this report, ahead of its consideration by the Trust Board on the afternoon of 25th May 2018.

6. Subject to the Committee's comments (if any), the Trust Board will be invited to approve the AGS 2017/18 at its meeting on 25th May 2018.

John Adler
Chief Executive

21st May 2018

# Annual Governance Statement 2017/18

## 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 our policies, aims and objectives. We recognise that our internal control environment can always be improved and strengthened, and this work will continue in 2018/19 as part of our commitment to continuous improvement.

In 2017/18 we identified a number of significant control issues which have impacted on our overall performance. This Statement gives an account of the remedial actions which have been, and are being, taken.

## Scope of Responsibility

As the Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports adherence to our policies and the achievement of our aims and objectives, whilst safeguarding both 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 the 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 31st March 2018 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 thirteen members: a Chairman, seven Non-Executive Directors, and five Executive Directors.

During 2017/18 there have been a number of changes in the composition of the Board. Dr Shirley Crawshaw stood down as a Non-Executive Director in June 2017 and was succeeded by Vicky Bailey, who joined the Trust Board on 1st February 2018.

Richard Mitchell, Chief Operating Officer, left the Trust in June 2017 to become the Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust. Tim Lynch acted as Interim Chief Operating Officer between July and December 2017; Eileen Doyle has fulfilled the Interim Chief Operating

Officer role between January and June 2018. Rebecca Brown will join the Trust as substantive Chief Operating Officer in June 2018.

Julie Smith, Chief Nurse, and Louise Tibbert, Director of Workforce and Organisational Development, left the Trust in April 2018. Carolyn Fox will take up the post of Chief Nurse in October 2018, while Hazel Wyton will join the Trust as Director of People and Organisational Development in August 2018.

During 2017/18, the post of Director of Strategy was abolished, and the responsibilities of the post were reallocated to the Director of Strategy and Communications (held by Mark Wightman) and Chief Financial Officer (held by Paul Traynor).

The Board continues to be supported in its work by the Director of Corporate and Legal Affairs, who has a standing invitation to attend all meetings, but not in a voting capacity.

In summary, although there has been some turnover in Director posts in 2017/18, the process of making substantive appointments to the Trust Board is now complete, creating a well-balanced Board to provide continuity of leadership going forward.

***Performance Management Reporting Framework***

I report 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 monthly at a joint meeting of the Board's People, Process and Performance Committee (PPPC) and Quality and Outcomes Committee (QOC). 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 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.

Our 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:

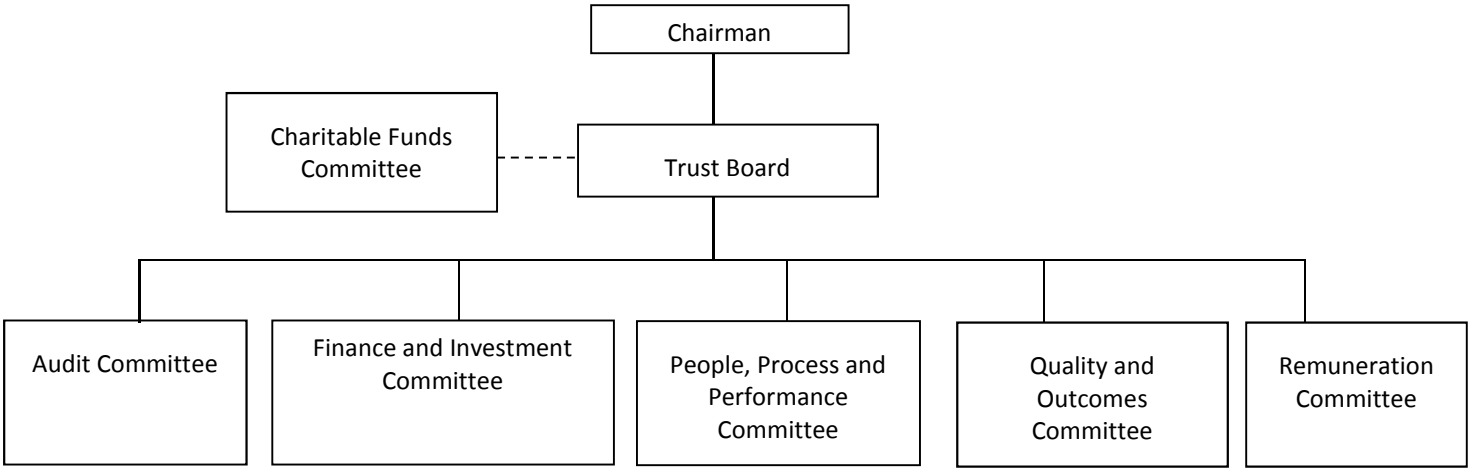
- staff and patient stories, which are presented in public at each Board meeting. These shine a light on staff experiences and individual experiences of patient care provided by our organisation, and act as a catalyst to our commitment to continuous improvement; and
- regular patient safety walkabouts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

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, patients, and public.

***Committee Structure***

We operate a committee structure to strengthen our focus on quality governance, finance, people, process and performance, and risk management. The Board agreed to revise the structure during 2017/18 to strengthen the focus on workforce issues and on organisational systems, processes and performance management. To this end, the People, Process and Performance Committee was established as a new standing Committee of the Board. The Committee meets monthly.

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 our 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.

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 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 Finance and Investment Committee meets monthly to oversee the effective management of our financial resources and financial performance across a range of measures. The Quality and Outcomes 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, highlighting material issues arising from the work of the committee to the Board.

Every meeting of the Trust Board and each Board committee meeting was quorate during 2017/18.

***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 2017/18 is set out in appendix 1 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 body.

***Board Effectiveness***

On joining the Board, Non-Executive Directors participate in a full induction programme and given background information about the Trust and our activities.

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

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

During the year, the Trust Board participated in a formal Board effectiveness programme, facilitated by NHS Providers and sponsored by NHS Improvement. One of the outputs was to implement a programme of work to improve Board and Board committee reporting. This work has helped us to better:

- 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.

Part of the Board effectiveness programme involved a self-assessment by the Board against the NHS Improvement well-led framework.

The findings and resulting actions taken by the Board formed a backdrop to the Care Quality Commission's well-led inspection of the Trust between 10th and 12th January 2018. The Trust retained an overall rating of 'requires improvement', and was again rated 'requires improvement' in relation to the well-led domain. Actions to address the Commission's inspection findings have been agreed and implementation will be monitored by the Quality and Outcomes Committee on behalf of the Board.

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

Our Chairman set objectives for myself and for the Non-Executive Directors for the year. In turn, I set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the 2017/18 Annual Plan. Performance against objectives is reviewed formally on an annual basis by the Chairman and I, 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 and updated as required. These include standing orders, standing financial instructions, a scheme of delegation, and policies to counter fraud, bribery and corruption.

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).

NHS Trusts are subject to oversight by NHS Improvement which uses the Single Oversight Framework for the purpose. The Single Oversight Framework bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions and NHS Improvement has directed that NHS Trusts must self-certify compliance with licence conditions G6 and FT4, respectively.

The Trust Board undertakes a self-assessment of compliance against these conditions annually, having regard to guidance issued by NHS Improvement, and where necessary identifies actions to mitigate risks to compliance.

Following review, the Trust Board declared compliance with conditions G6 and FT4 for the 2017/18 financial year and confirmed that the Trust took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements arising under the NHS Acts and having regard to the NHS Constitution, noting the impact on waiting lists of the Trust's decision to temporarily suspend non-urgent elective procedures during Winter 2017, in line with NHS England guidance.

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

***Information Governance***

We recognise the importance of robust information governance. During 2017/18, the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian. The Chief Information Officer has assumed the role of Senior Information Risk Owner from May 2018.

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 ('satisfactory') across all of the 45 standards.

During the year we reported to the Information Commissioner's Office one serious untoward incident involving a lapse of data security. However, 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.

From April 2018, the new Data Security and Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit and, taking into account the advice of the Chief Information Officer, the Trust Board will self-assess our position against the defined security standards to assure itself that we are meeting our obligations on data protection and data security.

***Review of economy, efficiency and effectiveness of the use of resources***

The Trust's clinical and non-clinical activities are managed under a devolved management structure, governed by a scheme of delegation which is reviewed and updated, where required, on an annual basis.

For clinical activities, we have in place a clinical management structure to support the effective leadership of clinical services and ensure effective care. This management structure consists of 7 Clinical Management Groups (CMG), with each CMG having a leadership team that comprises a senior clinician, senior nurse and senior manager. This core team is supported by the human resources team and information and performance colleagues, with finance support provided through embedded heads of finance and an associated CMG-based finance team.

For non-clinical activities, we have in place a corporate directorate structure to support the organisation and to provide corporate services to the CMGs. This management structure consists of 10 corporate directorates with each directorate being led by a Director, with finance support provided through the corporate finance function.

We maintain a strong focus on performance management, with all CMGs and Directorates bearing responsibility for the delivery of financial and other performance targets. Performance is monitored through a system of performance agreements which are agreed and documented as part of the annual business planning cycle and reviewed through a series of regular performance meetings chaired by a Board-level Executive Director.

The Trust continues to adopt a project-based approach to savings delivery through an established cost improvement programme underpinned by project management office arrangements. Whilst we have enhanced our governance and oversight arrangements in respect of savings delivery during 2017/18, emerging cost pressures and operational challenges have resulted in a programme that has not been able entirely to deliver recurrent savings within the year. Non-recurrent benefits have closed this savings gap in-year, and we are aware that this position creates a further financial challenge heading into the next financial year.

The Finance and Investment Committee provides assurance to the Trust Board as to the achievement of the financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. This Committee interfaces with the other Trust Board Committees and Executive Board meetings, and also reviews the process of business planning, specific business case development, and capital programme management.

The Trust has developed an internal audit programme, based on key business governance themes with Internal Audit providers PWC, designed to enhance focus on business governance and to support improved compliance.

The Trust had a planned deficit in 2017/18 and breached the requirement under section 30 of the Local Audit and Accountability Act 2014 to achieve break-even taking one year against another over a three year rolling period. As such, the Trust's External Auditors have made a referral to the Secretary of State for Health. This referral has been made under Section 30 of the 2014 Act.

The Trust recognises that this position is set within the context of a wider sustainability gap across the local health economy. To address this challenge, work remains on-going through the Trust's longer term reconfiguration programme that is inherently linked to the Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership that includes the local health and social care partners.

## The Risk and Control Framework

### *Capacity to handle risk*

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.

The Medical Director is the lead Director for risk management at the Trust and is supported in this role by the Director of Safety and Risk and Risk and Assurance Manager, respectively. Staff are trained to manage risk in a way appropriate to their authority and duties via the risk management awareness training programme.

The review of risk registers is a standing item on the agenda of each monthly meeting held between the Executive Directors and individual Clinical Management Group senior management teams. Risks which threaten the achievement of the Trust's strategic objectives and which feature on the Board Assurance Framework are reviewed at each Executive Board meeting.

Good risk management encourages organisations to take well-managed risks that allow safe development, growth and change. However, it is impossible to eliminate all risks, and every organisation has to live with a degree of risk. Through its monthly review of the Board Assurance Framework, the Trust Board is able to decide the balance between the cost of mitigating risks, tolerating risks and accepting the risk which is not mitigated – in other words, to determine the Trust's risk appetite.

All key strategic risks are documented in our 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. 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. As Chief Executive, I highlight the key issues in a monthly report to the public meeting of the Trust Board. A copy of the full Framework is also published monthly with the Board papers and scrutinised by the Board.

Our Annual Operational Plan 2018/19 responds to and addresses the strategic risks we face. The current Board Assurance Framework has been updated to reflect risks in the 2018/19 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, they 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.

Control measures are in place to ensure that our organisation complies with all of our obligations under equality, diversity and human rights legislation. Each of the Trust's policies is subject to an equality impact assessment and actions are taken as appropriate when an assessment identifies issues which warrant attention.

The Trust has an open and supportive reporting culture, and staff are actively encouraged to report not only actual incidents but also 'near misses'. Evidence of the Trust's good reporting culture is demonstrated by the fact that the Trust is placed in the top quartile for reporting incidents to the National Reporting Learning System (NRLS).

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure we comply with all employer obligations contained within the scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

We have carried out risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that we comply with our obligations under the Climate Change Act and the Adaptation Reporting requirements.

## 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.

On behalf of our Chief Nurse, the Director of Clinical Quality co-ordinates the preparation of our Annual Quality Account. This is reviewed in draft form by our Quality and Outcomes Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2017/18, the Quality and Outcomes Committee has noted and endorsed our internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – the Statement will be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 7th June 2018.

Our quality governance arrangements are set out in detail in our Governance Framework, the current version of which was approved by the Trust Board in October 2017. Our quality framework includes the following key components:

- an open and participative culture in which education, research and the sharing of good practice are valued and expected;
- a commitment to quality that is shared by staff and managers, and supported by clearly identified local resources, both human and financial;
- a tradition of active working with patients, users, carers and the public;
- an ethos of multi-disciplinary teams working at all levels in the organisation;
- regular Board level discussion of all major quality issues for the organisation and strong leadership from the top;
- good use of information to plan and to assess progress.

### *Data quality, including elective waiting time data*

The following arrangements are in place to assure the quality and accuracy of data (including elective waiting time data):

- the Data Quality Forum meets regularly and oversees the process of assuring the quality of data reported to the Trust Board, and to external agencies to ensure by best endeavours that it is of suitably high quality, timely and accurate. This process uses a locally agreed data quality framework to provide scrutiny and challenge on the quality of data presented. Where such assessments identify shortfalls in data quality, the risks are identified together with recommendations for improvements to ensure that the quality is raised to the required standards;

- there are quarterly reports on the quality of commissioning data and clinical coding which are presented to the Executive Quality Board. These reviews of our position are compared to peer organisations within the NHS Data Quality Maturity Index (produced by NHS Digital) and include the benchmarking of coding completeness;
- an Information Quality Improvement Group establishes and agrees priorities for improving the quality of commissioning and administrative data. Activities include an audit of quality and a review of documentation and training guidance;
- a Corporate Data Quality meeting takes place each week, where inaccurate and incomplete data collections are challenged. The Data Quality Team act on a daily basis to maximise the coverage of NHS Number, accurate GP registration, and ensure singularity of patient records.

In 2017/18 we commissioned Internal Audit to carry out a review of the quality and accuracy of our data quality systems, which included an assessment of the four hour emergency care standard and three of the cancer waiting time standards. Four medium risk actions were identified, and these will be addressed during 2018/19 and implementation will be followed up by Internal Audit and reported to the Audit Committee.

## Review of the Effectiveness of Risk Management and Internal Control

As Accountable Officer, I have the 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 our clinical leads who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft Quality Account 2017/18, along with other performance information made available to me.

During the year I have also been advised on systems of internal control by the Board, the Audit Committee, Finance and Investment Committee, People, Process and Performance Committee and Quality and Outcomes Committee. 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 2017/18, the Head of Internal Audit notes that Internal Audit have carried out twelve reviews during the year. Three of the individual assignment reports had an overall classification of high risk relating to (a) the post project review – emergency floor phase 1; (b) General Data Protection Regulation review; and (c) Electronic Patient Record 'Plan B' review.

***Post project review – emergency floor phase 1:*** This Internal Audit review examined our delivery of phase 1 of the new emergency floor and identified key issues relating to project governance and leadership; team working; change control; and handover of the new building. We have put in place a number of actions to address the findings of Internal Audit and to ensure that lessons learned are carried forward into phase 2 of the emergency floor scheme.

***General Data Protection Regulation (GDPR) review****:* This Internal Audit review examined the approach taken to achieve compliance with the GDPR. Although some elements of good practice were noted, Internal Audit identified some significant gaps that needed to be addressed to enable us to be ready for the implementation of the Regulation in May 2018. A robust action plan to achieve compliance is in place, progress against which is monitored at each meeting of the Audit Committee (reporting to the Trust Board).

***Electronic patient record 'Plan B' review****:* This Internal Audit review examined our plan (known as EPR 'Plan B') to become a paperless hospital at the point of care by 2020, in line with national

requirements. The review identified areas for improvement around the EPR 'Plan B' programme set-up, and the existing IT infrastructure. We accepted the findings and have taken these into account in taking forward our EPR 'Plan B'.

None of the individual assignment reports had an overall classification of critical risk.

We have taken, and are taking action to address the findings of Internal Audit and the implementations of the actions in question will be reviewed by the Audit Committee during 2018/19.

The Head of Internal Audit is satisfied that sufficient internal audit work has been carried out in 2017/18 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 2017/18 is that governance, risk management, and control in relation to business critical areas are generally satisfactory. However, there are some areas of weakness 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 these findings and am committed to strengthening the internal control environment, as detailed in this Statement.

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

a. implementing our Quality Commitment;
b. managing effectively the levels of emergency and elective demand;
c. achieving and maintaining service levels that meet service requirements;
d. maximising our education and research potential;
e. working collaboratively with partners;
f. delivering a clinically sustainable configuration of services;
g. maximising our digital strategy;
h. engaging and empowering our staff effectively;
i. achieving efficiencies in support services;
j. implementing our commercial strategy; and
k. delivering our financial plans.

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

Annually, NHS Improvement issues guidance and model statements for NHS Trusts' Annual Governance Statements. While the guidance issued for 2017/18 differs from that issued in 2016/17, the content of the model statement is largely the same.

NHS Trusts are required to identify in their statements significant control issues and outline the action taken, or proposed, to deal with such issues.

The guidance issued by NHS Improvement offers examples of factors to consider when determining whether an internal control issue is significant, while not prescribing which issues should be considered to be significant.

I can confirm that, annually, we have regard to the guidance issued by NHS Improvement and I apply that guidance in arriving at a consistent view of what constitutes a significant control issue. I am

advised in this task by the Audit Committee whom I consult in identifying the specific issues to be included in the Statement each year.

The following significant control issues have been identified in 2017/18:

***Care Quality Commission (CQC) Inspection***

In January 2018, the CQC published the findings of their inspection of our hospitals carried out between November 2017 and January 2018. The CQC rated the Trust overall as 'Requires Improvement'.

In December 2017, the CQC issued a Section 29A Warning Notice in relation to insulin safety. We were required to make significant improvements by 13th March 2018. Evidence illustrating the improvements made was submitted to the CQC in March 2018 and we expect the CQC to carry out a re-inspection within three months.

We are otherwise compliant with the registration requirements of the CQC.

***Never Events***

Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.

During 2017/18, we reported eight incidents which met the definition of a never event. These related to a misplaced nasogastric tube; retained foreign objects; wrong course of medication; wrong site surgery; and the unintentional connection of a patient requiring oxygen to an air flow meter.

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

A thorough root cause analysis of each incident was carried out to identify key actions to prevent recurrence and to share learning across the organisation. Implementation of these actions was tracked by the Quality and Outcomes Committee on behalf of the Trust Board.

***Key Financial Duties***

In respect of performance in 2017/18, against the key financial duties, we have:

a. not delivered the planned deficit of £26.7m; due to the impact of operational pressures experienced during Winter 2017/18, our actual deficit was £34.5m;
b. achieved the External Financing Limit (the limit placed on net borrowing) of £58.1m,
c. achieved the Capital Resource Limit (the limit placed on net capital expenditure) of £32.5m, with a permitted underspend of £0.2m.

The Trust's financial plan for 2017/18 forecasted the need for £116m of cash to continue to support revenue. This was reduced to £113.4m following receipt of £3.3m winter funding. At year end, the Trust had accessed £58.7m of 'Uncommitted Interim Revenue Support Facility'. Further cash support of £29.9m is projected as part of the 2018/19 financial plans and has been submitted to NHS Improvement as part of the annual planning process. The level of loans the Trust will hold is expected to rise to from £198.4m to £228.3m in 2018/19 representing over 23% of the Trust's projected turnover.

£34.1m of loans are due to mature over the next 12 months and although the mechanism for repaying these through the availability of renewed working capital or longer term loan facilities is yet to be defined, the Trust is planning that these facilities will be made available. The rate of interest of these new facilities is likely to be higher than the rates currently being paid.

The net increase in loans will be £29.9m.

The Trust's net assets have decreased from £230.7m (2016/17) to £215.3m (2017/18). This is a net impact of the increased cash borrowing, offset by the increase in asset valuations.

At its meeting in May 2017, the Audit Committee assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by consideration of a 2017/18 going concern statement, prepared by the Chief Financial Officer.

The Audit 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 2017/18, 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 2017/18 'going concern' position statement at its meeting in June 2017, on the recommendation of the Audit Committee.

Throughout the 2017/18 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, in 2017/18 we commissioned PricewaterhouseCoopers (PwC) to review our approach to cash management, cash forecasting, and the associated reporting of the cash position to the Finance and Investment Committee. We accepted PwC's final report and recommendations. Cash performance continues to be reviewed at each meeting of the Finance and Investment Committee and scrutinised further, on a periodic basis, by the Audit Committee.

The Board has agreed plans to deliver the agreed 2018/19 financial plan – a £29.9m deficit - which includes the delivery of a £51.0m Cost Improvement Programme. Acting on behalf of the Trust Board, the Finance and Investment Committee receives a report at each of its monthly meetings tracking performance against this Cost Improvement Programme.

***Emergency Care***

Unfortunately, we failed to meet the A&E 4-hour standard in 2017/18, achieving a performance of 77.6 per cent (79.6 per cent 2016/17) against a target of 95 per cent.

As a member of the Leicester, Leicestershire and Rutland A&E Delivery Board, we are fully committed to working with our partners across the health and social care sectors to improve emergency care performance in 2018/19. In particular, this will focus on reducing the substantial gap between current demand and capacity, which is the root cause of our on-going poor performance. It is anticipated that this will be achieved by reducing patient flows to us, dealing with (particularly frail) patients more effectively at the front door, expanding medical bed capacity, improving internal processes to reduce avoidable delays and expediting discharges (especially those requiring multi-agency input). Progress will continue to be the subject of monthly reporting to, and monitoring by, the People, Process and Performance Committee, acting on behalf of the Trust Board, as well as at the monthly meeting of the A&E Delivery Board.

***Cancer waiting time standards***

Our performance in 2017/18 against the cancer waiting time targets is set out below:

| Performance Indicator | Target | 2017/18 |
|---|---|---|
| Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers | 93% or above | 94.6% |
| Two week wait for Symptomatic Breast Patients (Cancer Not | 93% or above | 91.9% |

| | | |
|---|---|---|
| Initially Suspected) | | |
| 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers | 96% or above | 95.2% |
| 31-Day Wait For Second Or Subsequent Treatment: Anti-Cancer Drug Treatments | 98% or above | 99.1% |
| 31-Day Wait For Second Or Subsequent Treatment: Surgery | 94% or above | 85.8% |
| 31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments | 94% or above | 95.9% |
| 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers | 85% or above | 78.4% |
| 62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers | 90% or above | 85.8% |
| Cancer waiting 104 days | 0 | 18 |

We are fully committed to improving our performance in this area in 2018/19 and, specifically, to ensure that at least 85 per cent of cancer patients begin their first treatment within 62 days of an urgent GP referral. A comprehensive action plan is in place to achieve this objective, and performance will continue to be the subject of monthly reporting to the People, Process and Performance Committee, acting on behalf of the Trust Board.

## Conclusion

My review confirms that we, the University Hospitals of Leicester NHS Trust, have a generally sound system of internal control that supports the achievement of our policies, aims and objectives. We recognise that the internal control environment can always be improved and strengthened, and this work will continue in 2018/19.

In 2017/18, we identified the following significant control issues which have impacted on our overall performance:

- the safe administration of insulin;
- the incidence of never events;
- non-delivery of the requirement to achieve financial break-even taking one year with another over a three year rolling period;
- non-delivery of the national A&E 4 hour standard; and
- non-delivery of a number of the national cancer waiting time standards.

In addition to the actions taken/to be taken to address the specific significant control issues identified above, further work will also be carried out in the coming year 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 2017-18**

| **Name** | **Trust Board** maximum – 15 | **Audit Committee** maximum – 6 | **IFPIC** maximum – 5 | **FIC** maximum - 7 | **QAC** maximum – 5 | **QOC** maximum - 7 | **PPPC** maximum - 7 | **Remuneration Committee** maximum – 8 | **Charitable Funds Committee** maximum – 6 |
|---|---|---|---|---|---|---|---|---|---|
| Karamjit Singh – Chairman | 15/15 | N/A | 4/5 | 7/7 | 3/5 | 6/7 | 7/7 | 8/8 | 6/6 |
| Vicky Bailey – Non-Executive Director **(1)** | 4/4 | N/A | N/A | N/A | N/A | 1/2 | 2/2 | 1/2 | N/A |
| Professor Philip Baker – Non-Executive Director | 12/15 | N/A | 0/5 | N/A | 0/5 | 4/7 | 5/7 | 3/8 | N/A |
| Dr Shirley Crawshaw – Non-Executive Director **(2)** | 1/3 | 0/1 | 2/2 | N/A | 2/2 | N/A | N/A | 1/2 | 0/2 |
| Ian Crowe – Non-Executive Director | 13/15 | 5/6 | 5/5 | N/A | 4/5 | 7/7 | 6/7 | 6/8 | 3/6 |
| Eileen Doyle – Interim Chief Operating Officer **(3)** | 4/5 | N/A | N/A | 2/3 | N/A | N/A | 3/3 | N/A | N/A |
| Andrew Johnson – Non-Executive Director | 13/15 | 6/6 | 4/5 | 7/7 | 4/5 | N/A | 7/7 | 6/8 | 5/6 |
| Tim Lynch – Interim Chief Operating Officer **(4)** | 7/7 | N/A | 2/2 | 2/4 | N/A | N/A | 3/4 | N/A | N/A |
| Richard Moore – Non-Executive Director | 13/15 | 5/6 | 4/5 | 1/7 | 1/5 | N/A | 1/7 | 4/8 | 1/3 |
| Ballu Patel – Non-Executive Director | 15/15 | 3/3 | 5/3 | N/A | 5/5 | 7/7 | 7/7 | 8/8 | 6/6 |
| Martin Traynor – Non-Executive Director | 15/15 | 6/6 | 4/5 | 7/7 | 4/5 | N/A | 7/7 | 7/8 | 3/3 |

| **Name** | **Trust Board** maximum – 15 | **Audit Committee** maximum – 6 | **IFPIC** maximum – 5 | **FIC** maximum - 7 | **QAC** maximum – 5 | **QOC** maximum - 7 | **PPPC** maximum - 7 | **Remuneration Committee** maximum – 8 | **Charitable Funds Committee** maximum – 6 |
|---|---|---|---|---|---|---|---|---|---|
| John Adler – Chief Executive | 14/15 | 1/1 | 5/5 | 5/7 | 5/5 | 6/7 | 7/7 | 7/8 | N/A |
| Mr Andrew Furlong – Medical Director | 13/15 | N/A | N/A | N/A | 4/5 | 5/7 | 4/7 | N/A | N/A |
| Richard Mitchell – Chief Operating Officer **(5)** | 2/3 | N/A | 2/3 | N/A | N/A | N/A | N/A | N/A | N/A |
| Julie Smith – Chief Nurse | 12/15 | N/A | N/A | N/A | 3/5 | 5/7 | 5/7 | N/A | N/A |
| Louise Tibbert – Director of Workforce and OD (non-voting) | 15/15 | N/A | 5/5 | N/A | 0/5 | N/A | 7/7 | 8/8 | N/A |
| Paul Traynor – Chief Financial Officer | 14/15 | 6/6 | 4/5 | 7/7 | N/A | N/A | 6/7 | N/A | 6/6 |
| Stephen Ward – Director of Corporate and Legal Affairs (non-voting) | 15/15 | 6/6 | N/A | N/A | N/A | N/A | N/A | 8/8 | 6/6 |
| Mark Wightman – Director of Marketing and Communications (non-voting) **(6)** | 14/15 | N/A | N/A | 5/6 | N/A | N/A | N/A | N/A | 4/6 |

**Notes:-**

(1) Non-Executive Director from 1 February 2018
(2) Non-Executive Director until 16 June 2017
(3) Interim Chief Operating Officer from 1 January 2018
(4) Interim Chief Operating Officer from 3 July 2017 – 31 December 2017
(5) Chief Operating Officer until 2 July 2017
(6) FIC attendee as of October 2017