# ANNUAL GOVERNANCE STATEMENT 2018/19

Author: Stephen Ward Sponsor: John Adler Date: 24th May 2019



# Executive Summary

## Context

This report explains the approach adopted in the preparation of the Annual Governance Statement (AGS) 2018/19.

## Questions

1. Does the Committee have any comments on the Annual Governance Statement 2018/19?

## Input Sought

The Committee is invited to comment on the Annual Governance Statement 2018/19 and, subject to any amendments now agreed by the Committee, recommend the Statement for adoption by the Trust Board on the afternoon of 24th May 2019.

# 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: Trust Board – 25 May 2018

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:** **AUDIT COMMITTEE**

**DATE:** **24 MAY 2019**

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

**SUBJECT:** **ANNUAL GOVERNANCE STATEMENT 2018/19**

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1. At its meeting on 8th March 2019 (Minute 25/19/2 refers), the Audit Committee received and noted the guidance published by NHS Improvement on the completion and submission of Annual Governance Statements for 2018/19.

2. Following receipt of comments from Audit Committee members, the draft Annual Governance Statement (AGS) 2018/19 was submitted to NHS Improvement by the deadline of 24 April 2019 and made available to the External Auditor.

3. The draft AGS 2018/19 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 2018/19 attached to this report, ahead of its consideration by the Trust Board on the afternoon of 24th May 2019.

6. Subject to the Committee's comments (if any), the Trust Board will be invited to approve the AGS 2018/19 at its meeting on 24th May 2019.

John Adler
Chief Executive

May 2019

# Annual Governance Statement 2018/19

## 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 2019/20 as part of our commitment to continuous improvement.

In 2018/19 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. In particular, the Trust plays an important role in the Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Partnership, which aims to reshape the provision of health services in LLR by integrating the activities of NHS organisations and local authorities to improve outcomes for patients, and to deliver care more efficiently.

## 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 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 2019 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 thirteen members: a Chairman, seven Non-Executive Directors, and five Executive Directors.

During 2018/19, there have been a number of changes in the composition of the Board. Rebecca Brown joined the Trust as Chief Operating Officer and Deputy Chief Executive in June 2018; Carolyn Fox joined as Chief Nurse in October 2018; and Kiran Jenkins commenced her role as Non-Executive Director (and Chair of the Audit Committee) in December 2018, succeeding Richard Moore.

There were changes, too, amongst those postholders who attend meetings of the Board, but not in a voting capacity. Hazel Wyton joined the Trust as Director of People and Organisational Development in August 2018; and Andy Carruthers, Acting Chief Information Officer and Darryn Kerr, Director of Estates and Facilities were invited by the Board to attend all of its meetings from March 2019 onwards.

In summary, although there has been some turnover in Director posts in 2018/19, 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' and 'responsive';
- 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.

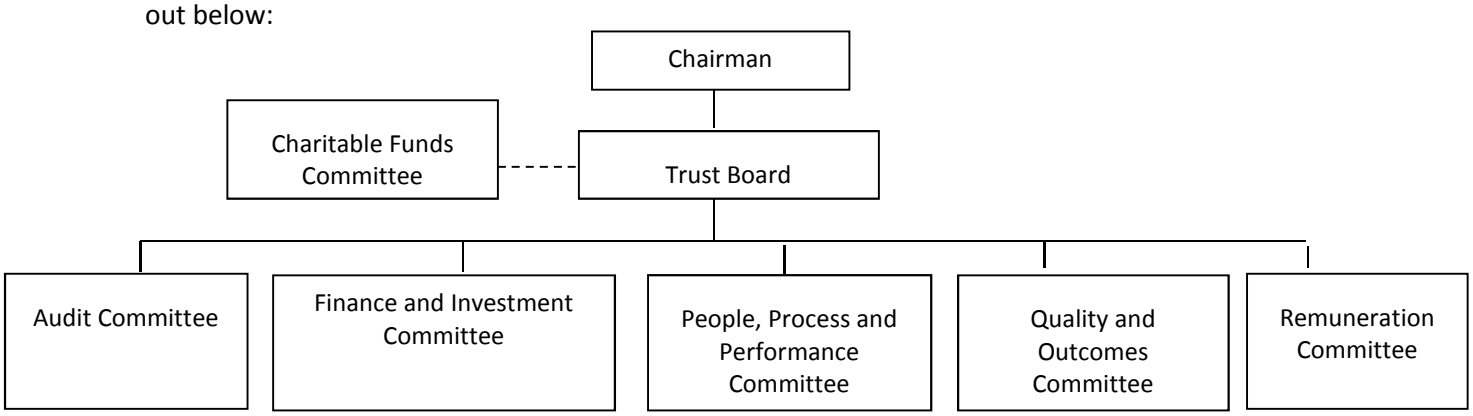
Examples include:

- 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
- 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 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.

To strengthen the focus on workforce issues, and on organisational systems, processes and performance management, the Trust Board has established a People, Process and Performance Committee. This Committee meets monthly, too, and amongst the standing items which feature on its agenda are (a) workforce issues – including regular review of the Workforce Strategy and the Trust's progress against its equality and diversity plan ; (b) urgent and emergency care performance; and (c) performance against the cancer waiting time standards. The Committee has also focussed on a number of specific process issues during 2018/19, including 'Red2Green', Winter planning, and the arrangements in place via the Performance Management and Accountability Framework.

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 2018/19.

***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 2018/19 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 are 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 2018/19, the Trust Board underwent an externally-facilitated developmental review, supported by the NHS East Midlands Leadership Academy. The focus of the review was to illuminate the developmental journey necessary for the Board to exercise effective leadership of quality, set within the context of the Trust's emerging Quality Strategy, and taking into account the Well-Led Framework.

The outcomes of the review are summarised below:

- greater understanding by the Board of what its contribution will be to leading the Trust to an 'outstanding' rating, reflecting the premise that change starts from the top;
- greater understanding of the need to establish more effective relationships with key stakeholders who will implement change activities on the Board's behalf, principal amongst these stakeholders being clinicians;
- enhanced generative conversations at Board level, achieving an appropriate balance between challenge and support, so that Non-Executive Directors carry out the functions of challenge and holding to account effectively, and Executive Directors respond positively to this challenge, leading to effective implementation of Board decisions;
- clarity on the Board's role in implementation of the Trust's Quality Strategy, the way this will be communicated, the expectations that the Board will have of its staff, and the way in which the Board will hold stakeholders to account in achieving quality standards;
- the transfer of knowledge from the external facilitators to the Board, based on their many years of working with Boards and being on Boards themselves.

Outside of its formal meetings, the Board has held development sessions ('Thinking Days') each month throughout the year. Amongst the topics considered were:

- responses to the Francis report : changes in Board leadership and governance in acute hospitals in England since 2013;
- the Leicester, Leicestershire and Rutland Frailty Programme;
- NHS Improvement's Culture and Leadership Programme;
- the development of the Trust's People Strategy;
- the digital agenda : the role of the Board.

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 2018/19 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 2018/19 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.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

***Information Governance***

We recognise the importance of robust information governance. In May 2018, the Chief Information Officer assumed the role of Senior Information Risk Owner; the Medical Director continued as our Caldicott Guardian throughout the year.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Data Security and Protection Toolkit. This contains 10 standards of good practice, spread across the domains of:

1. robust patient confidential data processes
2. staff training around patient confidential data
3. staff training for the General Data Protection Regulation (GDPR)
4. accessing of patient confidential data by appropriate personnel
5. strategy, policy and process review
6. cyber attack prevention
7. continuity planning
8. strategy for unsupported software
9. cyber attack strategy
10. contract management

During the year we reported to the Information Commissioner's Office two serious untoward incidents involving lapses of data security. These incidents remain under consideration by the Commissioner.

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.

***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 quality, 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 monthly performance review meetings, chaired by a Board-level Executive Director, operating under the Trust's Performance Management and Accountability Framework.

The Trust continued to adopt a project-based approach to savings delivery in 2018/19 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 2018/19, 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 provider PWC, designed to enhance focus on business governance and to support improved compliance.

The Trust had a planned deficit in 2018/19 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 ongoing through the Trust's longer term reconfiguration programme that is inherently linked to the Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership that includes local health and social care partners.

**Workforce**

In October 2018, NHS Improvement published 'Developing Workforce Safeguards' to help Trusts manage common workforce problems. From April 2019, NHS Improvement will assess all providers against their compliance with the guidance in order to support a consistent approach to workforce decision-making.

The Trust Board has approved (July 2018) a five year Strategic Workforce Plan which sets out our short, medium and long-term actions to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users.

To complement this plan, in March 2019 the Trust Board approved our People Strategy, 'Becoming the Best through our people', which sets out how we will ensure we have the right people with the right leadership capability, behaviours and skills to deliver 'Caring at its Best'; and how we will prioritise and address our critical workforce gaps. To this end, our Nursing and Midwifery Workforce Plan and Medical Workforce Plan form part of the Strategy.

As part of the Annual Operational Plan 2019/20, approved by the Trust Board in April 2019, we have identified:

- our workforce planning methodology,
- our current workforce challenges and risks,
- our long-term vacancies,
- how our workforce plans align with the Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership Plan, and
- new initiatives to be taken forward in 2019/20 with the benefit of funding provided by Health Education East Midlands.

At Executive level, I chair quarterly meeting of the Executive Workforce Board to oversee the implementation of our workforce plans : in 2019/20, this Board will be replaced by the Executive People and Culture Board and meet bi-monthly.

Acting on behalf of the Trust Board, the People, Process and Performance Committee meets monthly and provides assurance that our staffing processes are safe, sustainable and effective.

The Chief Nurse has assessed the requirements set out in 'Developing Workforce Safeguards' and has concluded that the Trust is compliant with this guidance in respect of the nursing workforce.

Other professional groups do not currently have in place the same level of evidence-based, national benchmarking tools to provide assurance on safe staffing levels, but the Trust uses professional judgement to define and monitor safe staffing levels and risks are managed in line with the Trust's risk management processes and via other mechanisms, eg the deployment of the electronic rostering system, and review of reports prepared quarterly by the Junior Doctors' Guardian of Safe Working (received by the People, Process and Performance Committee and Trust Board).

Having regard to the approach described above, I am satisfied that the Trust has in place appropriate workforce strategies and staffing systems in compliance with the Developing Workforce Safeguards recommendations.

## 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 performance review 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.

The Trust's major risks in 2018/19 (as featured on the Board Assurance Framework) are set out below:

- If the Trust is unable to achieve and maintain the required workforce capacity and capability standards, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, affecting business (finance) and reputation (breach in regulatory duty/adverse publicity);
- If the Trust is unable to achieve and maintain financial sustainability, then it will result in a failure to deliver the financial plan, affecting business (finance) and reputation (breach in regulatory duty/adverse publicity);
- If the Trust is unable to effectively manage the emergency care pathway, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, affecting business (finance) and reputation (breach in regulatory duty/adverse publicity);
- If the Trust does not adequately develop and maintain its estate, then it may result in an increased risk of failure of critical patient, equipment and core critical services leading to compliance issues, risk of regulatory intervention, impact upon business and patient critical infrastructure and adverse publicity.

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 review of the Board Assurance Framework, the aim is that the Trust Board will be able to decide the balance between the cost of mitigating risks, tolerating risks and accepting risk which is not mitigated – in other words, to determine the Trust's risk appetite. The Trust Board accepts that further work is necessary to meet this aim and planned changes to the Framework, to be implemented in 2019/20, will assist in meeting this objective.

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.

Data security risks are managed and controlled under arrangements led by our (Acting) Chief Information Officer. We have employed a Managed Business Partner to support us in our work, and they deploy a number of approaches to monitoring our data security infrastructure to manage cyber risks, including appropriate risk mitigation strategies. An information asset register is in place, and data protection impact assessments are completed in line with our data security and protection policies.

Our Annual Operational Plan 2019/20 responds to and addresses the strategic risks we face. The current Board Assurance Framework has been updated to reflect risks in the 2019/20 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.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UK CP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation reporting requirements are complied with.

## 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 2018/19, 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 6$^{th}$June 2019, Including a statement that the Board is satisfied that the Quality Account presents a balanced picture of the Trust's performance over the period covered.

Our quality governance arrangements are set out in detail in our Governance Framework, approved by the Trust Board. 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.

During 2018/19, each of our Clinical Management Groups undertook a self-assessment against the registration requirements of the Care Quality Commission (expressed via the 'Key Lines of Enquiry'). The results were reported to, and reviewed by, the Executive Quality Board. Internal Audit reviewed the Trust's governance structure for the surgery core services and reviewed the extent to which the CMGs responsible for overseeing surgery were continually assessing compliance with the Care Quality Commission Key Lines of Enquiry. The review identified opportunities to improve our arrangements for undertaking CMG CQC self-assessments of compliance, and actions will be taken in 2019/20 to strengthen the Trust's approach.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

***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 review the Trust's position compared to peer organisations within the NHS Data Quality Maturity Index (produced by NHS Digital) and include the benchmarking of coding completeness;
- a Secondary Uses Service Assurance Group determines the priorities for improving the quality of data used for commissioning and other secondary uses. This includes developing action plans and implementing changes mandated for national data and commissioning standards; acting on external data quality advice and using external benchmarking to improve the quality of commissioning data. Data is analysed over time; trends are monitored and unexpected variation is investigated. We work closely with the local Commissioning Support Unit to ensure that they receive additional data flows to support the commissioning process;
- 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 2018/19 we commissioned Internal Audit to carry out a review of the quality and accuracy of our data quality systems, which included an assessment of two indicators reported monthly in our Quality and Performance report, namely, 18 week wait referral to treatment – patients on incomplete pathways; and long-term follow-up patients. Two medium risk actions were identified, and these will be addressed during 2019/20 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 Quality Account 2018/19, along with other performance information made available to me.

Recognising that clinical audit is a key component of good governance, we are committed to undertaking effective clinical audits across all clinical services and recognise this is a key element of maintaining and developing high quality clinical services. Implementation of the clinical audit programme is reviewed at regular intervals by the Executive Quality Board and Quality and Outcomes Committee; and the Audit Committee also incorporates a review of the clinical audit system within its annual work programme.

My review is also informed by comments made by the External Auditors in their management letter and other reports.

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 2018/19, the Head of Internal Audit notes that Internal Audit have carried out fourteen reviews during the year. None of the individual assignment reports had an overall classification of critical risk.

The Head of Internal Audit is satisfied that sufficient internal audit work has been carried out in 2018/19 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 2018/19 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.

We have taken, and are taking action to address the findings of all of the Internal Audit reviews carried out in 2018/19 and the implementations of the actions in question will be reviewed by the Audit Committee during 2019/20.

High risk findings were identified in the following reviews:

- Post Project Review – Emergency Department Front Door Procurement

  Internal Audit's high risk finding from this review was that many elements of an effective Contract Management Framework were not in place for non-NHS Commissioned services. There were also a number of medium risk findings relating to (a) a number of gaps/ areas for improvement in respect of our Procurement policy; (b) the need to clarify and confirm roles and responsibilities as between the Procurement and Contract Teams, respectively; and in respect of operational teams; and (c) the need for the Trust to improve its contract mobilisation arrangements. We have addressed these findings and subsequently reported to the Audit Committee on a proposed contract management approach for future contracts.

- Fraud Risk Assessment Validation and Financial Systems Review Follow-Up

  The scope of this Internal Audit review was to validate the controls in place for a number of high rated risks arising from the Trust's financial Risk Assessment, and also carry out a follow-up of cash management actions and outstanding purchase to pay actions from previous reviews. Two high risk issues were noted in relation to supplier bank detail changes; and employee leavers. Actions to address these findings have been agreed and they will be followed up in the usual way in conjunction with Internal Audit.

- Business continuity and emergency planning

  Internal Audit's high risk finding from this review was that an IT disaster recovery test programme was not in place. We will develop a programme that seeks to validate the IT disaster recovery plans, and conduct such testing on an annual basis (commencing 2019), with the results being reported to the Audit Committee.

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

a. inadequate clinical practice and/or ineffective clinical governance;
b. employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience); lack of extensive education; training and leadership; and demographic changes;
c. delivery of income, the control of costs and the delivery of cost improvement plans;
d. persistent unprecedented level of demand for services; primary care's ability to provide services; ineffective resources to address patient flow; and fundamental process issues;
e. an inability to secure appropriate resources (including external capital and workforce); a critical infrastructure failure; ineffective system resilience; and preparedness of an external IT supplier or an external shut-down attack;
f. a lack of resources to address the backlog maintenance programme, insufficient clinical decant capacity and the sheer volume of technical work to address ageing buildings;
g. a breakdown of relationships amongst partners and ineffective clinical strategies for the local population.

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

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, whilst 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 2018/19.

***Never Events***

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

During 2018/19, we reported eight incidents which met the definition of a never event. These related to the unintentional connection of a patient requiring oxygen to an air flow meter; a wrong implant/prosthesis; and six instances of wrong site surgery.

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. The actions included the implementation of a comprehensive programme entitled “Stop the Line” which has sought to reinforce the importance of observing the Trust’s Safer Surgery policy and encourage staff to speak up if they feel that patient safety is being, or is about to be, compromised by a failure to follow procedure. In addition, we have taken action to ensure that non-theatre areas which carry out invasive procedures have in place suitable standard operating procedures, ‘Local Safety Standards for Invasive Procedures’ (LocSSIP). Some of the issues involved in never events are cultural and will continue to be addressed through our new comprehensive Quality Strategy.

***Key Financial Duties***

In respect of performance in 2018/19, against the key financial duties, we have:

a. not delivered the planned surplus of £0.7m including £21.9m of Provider Sustainability Funding (PSF) offsetting a deficit of £21.2m. This was due to (i) the cessation of our planned estates and facilities management subsidiary, and (ii) a reduction in Provider Sustainability Fund amounts received. Our actual deficit was £41.7m including PSF of £10.1m;
b. achieved the External Financing Limit (the limit placed on net borrowing) of £50.6m;
c. achieved the Capital Resource Limit (the limit placed on net capital expenditure) of £25.9m.

The Trust's financial plan for 2018/19 forecast the need for £49.5m of cash to continue to support revenue. At year end, the Trust had accessed £49.5m of an ‘Uncommitted Interim Revenue Support Facility’. Further cash support of £10.7m is projected as part of our 2019/20 financial plan and an application has been submitted to NHS Improvement as part of the annual planning process.

The level of loans to support the Trust’s deficit position increased from £198.0m to £245.3m in 2018/19, with this amount expected to rise to £253.8m in 2019/20, representing over 20% 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 has yet to be defined, the Trust is planning that these facilities will be made available. These loans first matured in 2018/19, and their terms were extended to 2019/20 so we can reasonably expect the same thing to happen when the loans mature for a second time.

The net increase in loans will be £8.5m.

The Trust's net assets have decreased from £215.4m (2017/18) to £207.7m (2018/19). This is a net impact of the increased cash borrowing, offset by the increase in asset valuations and receipt of Public Dividend Capital (PDC) funding.
The Board has agreed plans to deliver the agreed 2019/20 financial plan – a £10.7m deficit – which includes the delivery of a £26.6m Efficiency 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 the annual financial plan, as well as the Efficiency Programme.

***Going Concern***
At its meeting in May 2018, the Audit Committee assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by consideration of a 2018/19 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 2018/19, 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 accepted the 2018/19 'going concern' position statement at its meeting in May 2018, on the recommendation of the Audit Committee; adopted the recommendation that the Trust should prepare its financial statements on a going concern basis; and has taken steps to ensure that this has remained the case for at least 12 months from the date of the approval of the Annual Accounts.

Throughout the 2018/19 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. However, the Trust will not be able to meet the Better Payment Practice Code without a significant cash injection.

***Emergency Care***
Unfortunately, we failed to meet the A&E 4-hour standard in 2018/19, achieving a performance of 77.3 per cent (77.6 per cent 2017/18) against a target of 95 per cent. Emergency Department attendances increased by 6.2% in 2018/19, placing considerable pressure on the Trust.

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 2019/20. 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).

In parallel, the Trust will continue to implement its internal action plan with a continued focus on (a) reducing demand; (b) improving ambulance handover performance; (c) improving patient flow through the Emergency Department; and (d) improving patient flow in and out of our hospitals. 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.

Our assessment is that the combined impact of the actions described above will enable us to improve our performance against the 4-hour standard in 2019/20, and we have set out our anticipated performance trajectory in our 2019/20 Annual Operational Plan.

***Cancer waiting time standards***

Our performance in 2018/19 against the cancer waiting time targets is set out below:

| Performance Indicator | Target | 2018/19 |
|---|---|---|
| Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers | 93% or above | 91.9% |
| Two week wait for Symptomatic Breast Patients (Cancer Not Initially Suspected) | 93% or above | 77.1% |
| 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers | 96% or above | 95.71% |
| 31-Day Wait For Second Or Subsequent Treatment: Anti-Cancer Drug Treatments | 98% or above | 99.5% |
| 31-Day Wait For Second Or Subsequent Treatment: Surgery | 94% or above | 85.9% |
| 31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments | 94% or above | 98.1% |
| 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers | 85% or above | 75.8% |
| 62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers | 90% or above | 83.5% |
| Cancer waiting 104 days | 0 | 27 |

We are fully committed to improving our performance in this area in 2019/20 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, with a series of targeted dates, to achieve this objective, with specific actions for each tumour site/cancer specialty. We also continue to work with colleagues in primary care to both reduce demand and reduce late referrals, and in 2019/20 tertiary referral centres will undertake a root cause analysis if any patient is referred to the Trust after day 39. Performance against the cancer waiting time standards 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 a plan to address weaknesses and ensure continuous improvement of the system is in place.

In 2018/19, we identified the following significant control issues which have impacted on our overall performance:

- 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. During 2019/20 we will start to implement our Quality Strategy, "Becoming the Best", which will provide a more comprehensive approach to quality improvement than has hitherto been the case, with a particular focus on consistent methodology and implementation as well as cultural and leadership issues. I am confident that this new approach will help us to continue our journey to become an Outstanding organisation.

Signed:

Chief Executive (on behalf of the Trust Board)

Date:

## Trust Board and Committee attendance 2018-19

| **Name** | **Trust Board** maximum – 18 | **Audit Committee** maximum – 6 | **Finance and Investment Committee** maximum - 12 | **Quality and Outcomes Committee** maximum - 12 | **People, Process and Performance Committee** maximum - 12 | **Remuneration Committee** maximum – 5 | **Charitable Funds Committee** maximum – 6 |
|---|---|---|---|---|---|---|---|
| Karamjit Singh – Chairman | 16/18 | N/A | 10/12 Ex-officio | 9/12 Ex-officio | 10/12 Ex-officio | 4/5 | 5/6 Ex-officio |
| Vicky Bailey – Non-Executive Director | 14/18 | N/A | N/A | 11/12 | 11/12 | 5/5 | N/A |
| Professor Philip Baker – Non-Executive Director | 13/18 | N/A | N/A | 7/12 | 7/12 | 3/5 | N/A |
| Ian Crowe – Non-Executive Director | 17/18 | 6/6 | N/A | 12/12 | 12/12 | 5/5 | 5/6 |
| Kiran Jenkins – Non-Executive Director **(1)** | 4/5 | 2/2 | 4/4 | N/A | 4/4 | 2/3 | N/A |
| Andrew Johnson – Non-Executive Director | 17/18 | 6/6 | 11/12 | N/A | 11/12 | 5/5 | 6/6 |
| Richard Moore – Non-Executive Director **(2)** | 10/13 | 4/4 | 5/8 | N/A | 2/8 | 3/5 | N/A |
| Ballu Patel – Non-Executive Director | 17/18 | N/A | N/A | 11/12 | 11/12 | 5/5 | 5/6 |
| Martin Traynor – Non-Executive Director | 17/18 | 5/6 | 12/12 | N/A | 12/12 | 5/5 | N/A |
| John Adler – Chief Executive | 16/18 | 1/1 | 9/12 | 6/12 | 8/12 | 5/5 | N/A |
| Rebecca Brown – Chief Operating Officer **(3)** | 12/13 | N/A | 9/10 | N/A | 9/10 | N/A | N/A |
| Andy Carruthers – Acting Chief Information Officer **(4)** | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A |
| Eileen Doyle – Interim Chief Operating Officer **(5)** | 5/5 | N/A | 2/2 | N/A | 2/2 | N/A | N/A |

| **Name** | **Trust Board** maximum – 18 | **Audit Committee** maximum – 6 | **Finance and Investment Committee** maximum - 12 | **Quality and Outcomes Committee** maximum - 12 | **People, Process and Performance Committee** maximum - 12 | **Remuneration Committee** maximum – 5 | **Charitable Funds Committee** maximum – 6 |
|---|---|---|---|---|---|---|---|
| Carolyn Fox – Chief Nurse **(6)** | 7/7 | N/A | N/A | 6/6 | 6/6 | N/A | 2/3 |
| Mr Andrew Furlong – Medical Director | 16/18 | N/A | N/A | 9/12 | 9/12 | N/A | N/A |
| Darryn Kerr – Director of Estates and Facilities **(7)** | 1/1 | N/A | 9/12 | N/A | N/A | N/A | N/A |
| Bina Kotecha and Joanne Tyler-Fantom – Joint Acting Directors of Workforce and OD **(8)** | 6/6 | N/A | N/A | N/A | 4/4 | 2/2 | N/A |
| Eleanor Meldrum – Acting Chief Nurse **(9)** | 9/10 | N/A | N/A | 5/6 | 4/6 | N/A | 0/2 |
| Julie Smith – Chief Nurse **(10)** | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A |
| Louise Tibbert – Director of Workforce and OD **(11)** | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A |
| Paul Traynor – Chief Financial Officer | 17/18 | 6/6 | 11/12 | N/A | 10/12 | N/A | 6/6 |
| Stephen Ward – Director of Corporate and Legal Affairs | 17/18 | 6/6 | N/A | N/A | N/A | 5/5 | 6/6 |
| Mark Wightman – Director of Strategy and Communications | 17/18 | N/A | 11/12 | N/A | N/A | N/A | 6/6 |
| Hazel Wyton – Director of People and OD **(12)** | 9/11 | N/A | N/A | N/A | 7/8 | 3/3 | N/A |

**Notes:-**

(1) Non-Executive Director from 1 December 2018
(2) Non-Executive Director until 30 November 2018
(3) Chief Operating Officer from 25 June 2018
(4) Acting Chief Information Officer from 5 March 2019 and invited to attend Trust Board meetings from March 2019

(5) Interim Chief Operating Officer to 24 June 2018
(6) Chief Nurse from 1 October 2018
(7) Invited to attend Trust Board meetings from March 2019
(8) Joint Acting Directors of Workforce and OD from 23 April 2018 to 31 July 2018
(9) Acting Chief Nurse from 23 April 2018 to 30 September 2018
(10) Chief Nurse until 20 April 2018
(11) Director of Workforce and OD until 20 April 2018
(12) Director of People and OD from 1 August 2018

## Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

## Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

.....Date.....Chief Executive

.....Date.....Finance Director