Annual Governance statement

1 April 2013 – 31 March 2014

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation 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 Foundation Trust Accounting Officer Memorandum*.

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 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 Derbyshire Healthcare NHS Foundation Trust, to 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 in Derbyshire Healthcare NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the Annual Report and accounts.

Capacity to handle risk

The Trust has continued to provide high quality care in a uniquely changing and challenging environment which has included system leadership and process changes around commissioning, plus greater expectations on trusts following the Francis Report and the associated recommendations arising from this.

- There is a Board endorsed Integrated Quality Governance Strategy which defines the organisational structures in place for the management and ownership of risk, including the responsibilities of Executive Directors for implementing the strategy. The Executive Director of Nursing and Patient Experience in association with the Medical Director, has the responsibility for risk and quality on behalf of the Board of Directors. This is supported by a range of policies and procedures, including the Risk Assessment and Untoward Incident Procedures.
- There is a governance structure in place to ensure risk is managed effectively throughout the organisation and embedded in all Trust processes. In addition, the Quality Framework sets out the Trust's strategic direction to sustain and improve the quality of care.
- The authority and duties of staff with respect to risk management processes are defined within the Integrated Quality Governance Strategy.
- The Trust provides a range of compulsory and role-specific training which is detailed in the Trust's Training Framework. Training is supported by procedural guidance, direction from specialist staff and all training includes examples of learning from best practice.

The risk and control framework

<u>Key elements of the risk management strategy</u>

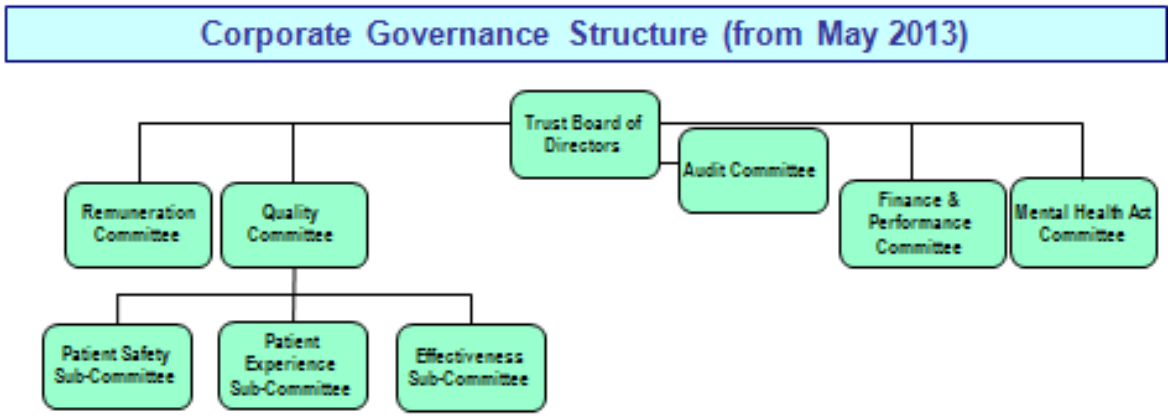
- Risk identification – proactively via risk assessments, project plans and reactively via incident, complaints and claims analysis, internal and external inspection and audit reports.
- Risk evaluation - using a single risk matrix to determine the impact and likelihood of risk realisation and grading of risk by likelihood and severity of impact resulting in a matrix score.

- Risk control and treatment – responsibility and authority for determining the effectiveness of controls, and for developing risk treatment plans, including assigning appropriate resources, is dependent upon the risk grade.
- Risk Register – a single electronic register (held on DATIX) incorporating all operational and strategic risks, with inbuilt ward/team, divisional and corporate level risk register reports
- Board Assurance Framework – detailing key risks to achieving the Trust's strategic objectives, and ways to mitigate those risks. The Board of Directors determines the 'appetite' for risk by obtaining assurance from controls in place and reviewing mitigation plans, relative to the level of risk identified.
- Incident reporting – openly encouraged and supported by an online incident reporting form (DATIX), accessible to all staff.
- Incident investigation – there are robust systems for reporting and investigating incidents to identify areas for organisational learning and good practice. All serious incidents are reported to the Board of Directors on a monthly basis and action plans are reviewed and monitored.
- Communication – the use of a 'Blue Light' system to rapidly communicate information on significant risks that requires immediate action to be taken. 'Practice Matters' and 'Learning the Lessons from Information Governance Incidents' newsletters are used to communicate good practice and actions that have been taken throughout the organisation. 'Policy Bulletin' informs staff of key messages within new or updated policies and procedures.
- The Board of Directors is involved in an ongoing programme of live Equality Impact Assessments across all service areas, and uses this to identify service gaps and improvement opportunities

Effectiveness of governance structures

Reporting line and accountability between the board, its committees and the executive team. Responsibilities of directors and committees:

The revised governance structure shown in the diagram below was agreed by the Board of Directors in May 2013:



All of the following meetings have been reviewed to ensure their work plans are active and they are escalating information and any issues to the Board.

The **Remuneration Committee** decides and reviews the terms and conditions of office of the foundation Trust's executive directors [and senior managers on locally-determined pay] in accordance with all relevant foundation trust policies.

The **Quality Committee** enables the Board to obtain assurance that high standards of care are provided by the Trust and in particular that adequate and appropriate governance structures, processes and controls in are in place throughout the Trust. In May 2013 the Quality Committee became the principal committee concerned with the management of risk, supported by the Patient Experience, Patient Safety and Effectiveness sub committees.

The **Audit Committee** reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), which in turn supports the achievement of the Trust's objectives.

The **Finance and Performance Committee** oversees all aspects of financial management and operational performance on behalf of the Board. This includes: detailed oversight of financial performance, forward projections and assumptions which underpin forward plans; scrutiny of reports on performance; workforce; the cost-improvement programme; and review of the Foundation Trust's capability and capacity to meet the commercial and marketing requirements of potential business opportunities.

The **Mental Health Act Committee** obtains assurances on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; the Committee takes account of the provisions of related statute and guidance, such as the Mental Capacity Act, Deprivation of Liberty Safeguards (D.O.L.S) and Human Rights Act.

In addition the **Executive Leadership Team,** as the most senior executive decision making body in the Trust, is responsible for ensuring that strategies and performance targets, approved by the Board of Directors, are implemented to timescale. The group also shares a fundamental responsibility to provide strategic leadership to the organisation, consistent with its values and principles, whilst ensuring that a culture of empowerment, inclusivity, and devolution of responsibility with accountability is strongly promoted.

The Trust successfully integrates clinical and corporate risk management processes, on which the Executive Director of Nursing and Patient Experience in association with the Medical Director, leads on behalf of the Board of Directors. Responsibilities of individual directors and the governance committees is detailed in the Integrated Governance Strategy.

The scheduled review of the structure coincided with a period of change and transition of positions at Board level. Although the plan was for the Quality Committee to meet monthly from May 2013 onward, the Quality Committee did not convene for two of its planned meetings due to one cancellation due to unforeseen circumstance and one meeting not quorate and so cancelled at short notice. This is recognised as a gap in the Trust's mechanisms of internal control. However, as governance reporting to the Board of Directors and external governance reporting requirements were met during this period, the gap is not identified as significant

A strategic approach to risk-based audit planning, which addresses key financial, control and risk processes is in place to provide assurance under the Board Assurance Framework. During 2013/14, the Quality Committee became responsible for ensuring appropriate assurances are sought for key controls which manage strategic organisational risks. The Board of Directors has reaffirmed that the Audit Committee will be the key committee in terms of oversight of the Board Assurance Framework from April 2014 onwards.

At the year end, the corporate governance structure and its supporting sub-structure is undergoing further review. This will be informed by an independent audit which will take account of Monitor's forthcoming guidance on 'Governance Reviews' which includes the requirement for regular review of Board and Committee structures.

<u>Submission of timely and accurate information to assess risks to compliance with the Trusts licence:</u>
During the year the Board has conducted reviews of the effectiveness of the Trust's systems of internal control, including financial, clinical, operational and compliance controls and risk management systems as part of the ongoing review of its Corporate Governance Structure. Papers outlining the key themes and recommendations were submitted to the Board of Directors in May 2013 and Feb 2014. This requirement is outlined in The Foundation Trust Code of Governance issued by Monitor.

As a result of the controls in place, the Trust has not identified any significant risks to compliance with the NHS foundation trust condition 4 (FT governance).

Ways that the Trust assures the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b):

The Trust has in place a Local Operating Procedure (LOP), the purpose of which is to enable the completion of the template report for the in-year and annual financial and governance combined quarterly returns to Monitor. The LOP describes the data validation processes in place which ensure data quality and gives detailed step by step instruction of how to contribute to the completion of the template report. This process is co-ordinated by the Compliance Team and information is considered by the Audit Committee prior to final sign off by the Board of Directors each quarter.

Degree of rigour and oversight the Board has over the Trust's performance

The Care Quality Commission requirements are underpinned and delivered through the Quality Governance Structure and associated processes. During 2013/14 the Trust took a 'deep dive' approach to integrated performance reports, incorporating quality indicators for specific service lines. Key quality indicators are reported monthly to the Board, with a focus on exceptions. Evidence of compliance with the 16 essential standards of quality and safety is reported through the Quality Committee and complementary committee structure, with each report referencing the essential standards for which it provides evidence of compliance. The work of the Quality Committee and associated groups are active and their outputs are clearly evidenced in the Trusts Quality Account, the accuracy of which is subject to review by internal auditors as well as extensive consultation and feedback internally and externally on the contents of the report.

The Trust has an extensive annual quality visit programme, involving Board members, Governors and stakeholders, which includes announced and unannounced Care Standards assurance visits to wards and teams as a further method of assuring compliance with the CGC requirements. The Trust is an active member of the East Midlands Registration Benchmarking Forum.

The Trust publishes its key performance indicators onto the web daily. This supports the Trust's aim of making sure that transparency of services to the public is maintained.

Data security risks:

The Trust has in place the following arrangements to manage Information Governance risks:

- A Senior Information Risk Owner (Chief Operating Officer) and Caldicott Guardian (Medical Director) at Board Level
- An annually completed Information Governance Toolkit, with reported outcomes to the Audit Committee and Board of Directors
- Risks related to Information Governance are reviewed by the Executive Director Lead and the Information Governance Committee
- A high uptake of information governance compulsory training
- Information governance incidents are reviewed monthly by the Information Governance Group and 'Learning the Lessons' Bulletins are issued to staff.

There has been no internal audit on the Information Governance Toolkit submission carried out this year, however access and security was considered in the 2013/14 Internal Audit EPR Project Review II and the risk was identified as 'green'.

During the year, one incident was reported to the Information Commissioner's Office (ICO). The incident involved an email containing patient sensitive information being sent to a wider mailing list than was intended. No sanction was imposed by the ICO.

Public stakeholders:
The key ways in which public stakeholders are involved in managing risks which impact on them include:

- The Council of Governors at quarterly meetings take the opportunity to hold the Board of Directors to account on its performance, including quality and risk.
- The Trust's commitment to the Strategic Commissioning Group, Quality Assurance Group, Chief Officer and CEO meetings and consultation as required with the Overview and Scrutiny Committees and Healthwatch.
- Consultation for the Quality Account involves key stakeholders, and this is evidenced in our inclusion of their feedback
- Impact assessments for the Transformational Change Programme including a requirement for consultation with key stakeholders.

Major risks:
Identified major risks in year, up to 31 March 2014 were:

Failure to fully implement an electronic Patient Record (EPR).
This risk has been regularly reviewed and updated by the responsible Director throughout the year and updates tracked on the Board Assurance Framework. The risk has been identified due to both the complexity of the implementation and the potential impact of an EPR in allowing the Trust to transform the way services are delivered based upon the new software. The EPR project has twice been audited by PwC: during the development stage (July 2012) resulting in a report classification of Medium Risk; and during the 'go-live' planning stage (March 14) resulting in a report classification of High Risk.

During the second audit the project team was in the process of planning for the 'go-live' of the first team to implement the EPR (the Learning Disability team). A number of the audit findings related to the clarity of the plan which was in the process of being developed. The audit also highlighted that the contract, which is OJEU compliant, had not yet been signed and a closer working relationship was required to ensure successful delivery of the project. Actions taken following the audit include: a supplier executive attending all board meetings, the Civica Project Manager attending all project team meetings and Trust clinicians working collaboratively with Civica on the development of new functionality such as ePrescribing. The audit also recommended that regular updates be provided to the Trust Board on the project's progress. These will be delivered via quarterly updates.

The remaining risks associated with the project relate to outstanding functionality to support batch tracing, ePrecribing and mobile working. These risks are being closely monitored and reviewed by the project team and project board.
The Electronic Patient Record is due to go-live in the first teams between 18 and 21 April 2014. A roll-out to all other mental health wards and teams will follow during 2014/15.

Future risks will be identified through the development of the Board Assurance Framework for 2014/15. Individual risks to the achievement of the Trust's strategic objectives will be detailed together with controls and mitigations as part of the dynamic process of identification and review of risks. During 2014/15 the Board Assurance Framework will be reported to the Audit Committee and then the Board of Directors on a regular basis.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. The planned annual inspection in 2012/13 resulted in two compliance actions. A follow-up review in September 2013 confirmed that the action plan had delivered all the required improvements and the Trust was fully complaint with the terms of its registration.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. 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.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has 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 this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with

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

The Board of Directors carries the final overall corporate accountability for its strategies, policies and actions as set out in the Codes of Conduct and Accountability issued by the Secretary of State for Health.

Internal Audit Services provide the Trust with an independent and objective opinion on the effectiveness of the systems in place for risk management, control and governance. The Audit Committee approve the annual audit plan, informed by risk assessments and the annual clinical audit plan.

All clinical services have carried out viability assessments as part of transformational planning. This includes corporate functions which have participated in the NHS Benchmarking Network exercise.

Under the chairmanship of a Non-Executive Director, the Quality Committee has taken the lead on Trust-wide quality performance, focussing on driving continuous improvement, achievement of clinical standards and dissemination of best practice.

Monitor's Governance Risk Rating has remained 'green' for each quarter during 2013/14.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Trust publishes a Quality Report as part of its Annual Report. The Executive Director of Nursing and Patient Experience is the Director lead for the overall report with individual Directors taking responsibility for signing off their areas of accountability. The report is formulated using the national guidance. Stakeholders receive a draft copy for comment, and feedback is responded to within the final draft. Policies and plans to ensure the quality of care provided are referenced within the document. The Quality Committee has a key role in monitoring the content of the report. The Governor Working Group for Quality and our lead commissioning team are also consulted on the content. Clinical leads responsible for key areas of improvement contribute to the report. The data included is based on the national descriptors in the guidance and is subject to the routine Trust data quality checks. The full Council of Governors selects a further indicator to be reviewed by the auditor. The completed quality report, including two mandatory indicators and comments from our stakeholders, is subject to review by internal and external auditors.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance

information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, and the Risk and Quality Governance committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Monitor's risk rating return and quality declaration, which has been graded green since the Trust became a Foundation Trust
- Registration with the Care Quality Commission from 1 April 2010 – without conditions at year end
- NHS Litigation Authority Risk Management Standards compliance with Level 2 Standards, achieved in June 2010
- Compliance with Monitors Quality Framework
- Reviews of Corporate Governance and associated committees
- Internal Audit reports received during the year following on from the Internal Audit and External Audit Plans agreed by the Trust's Audit Committee
- Clinical Audits
- Outcomes from visits from the CQC**,** including regular visits from the Mental Health Act arm of the CQC.

The following gaps in control are identified:

- Electronic Patient Records (EPR) project
- Meetings of the Quality Committee.

Further description and mitigation to close these gaps in control are detailed earlier in the Annual Governance Statement.

The processes applied in reviewing and maintaining the effectiveness of internal control are described above. In summary:-

The Board of Directors:

- Is responsible for approving and monitoring the systems in place to ensure there are proper and independent assurances given on the soundness and effectiveness of internal control.

The Audit Committee:

- Is responsible for independently overseeing the effectiveness of the Trust's systems for internal control and for reviewing the structures and processes for identifying and managing key risks.
- Is responsible for reviewing the establishment and maintenance of effective systems of internal control.
- Is responsible for reviewing the adequacy of all risk- and control-related statements prior to endorsement by the Board.
- In discharging its responsibilities takes independent advice from the Trust's internal auditor and Grant Thornton (external auditors)

Internal Audit:

- The Internal Audit Annual Report 2013/14 provided by PwC includes the Head of Internal Audit's annual opinion which is as follows:
  Our opinion is based on our assessment of whether the controls in place support the

achievement of management's objectives as set out in our Annual Internal Audit Plan and Risk Assessment. We have completed the program of internal audit work for the year ended 31 March 2014. Our work identified low- and moderate-rated findings and one high-rated finding. Based on the work we have completed, we believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and control.

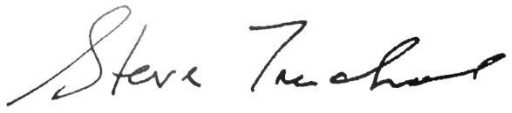
- The most recent Risk Management and Governance Review (February 2013) was carried out in order to understand and evaluate the risk management and governance processes in place in the Trust. The review concluded that overall "the processes in place in the Trust are well designed and are working effectively". The overall report classification of the report was low risk and the single action identified has been completed.

External Audit:

- The Trust's External Auditors, Grant Thornton, provide the Trust with external audit services including the review of the annual accounts and a review of the value for money achieved by the Trust.

Conclusion
No significant internal control issues have been identified and my review confirms that Derbyshire Healthcare NHS Foundation Trust has a generally sound system of internal controls that supports the achievement of its objectives. Control issues have been or are being addressed.

Signed



Chief Executive Date: 28 May 2014