Draft Annual Governance Statement 2012/13

1.0 Scope of Responsibility

1.1 As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Oxford University Hospitals NHS 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.

1.2 I am also responsible for ensuring that the Trust is administered prudently and economically, and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum, including recording the stewardship of the organisation to supplement the annual accounts.

2.0 Accountability

2.1 In the delivery of my responsibilities and objectives, I am accountable to the Board and my performance is reviewed regularly and formally by the Chairman on behalf of the Board. Until 31 March 2013, the organisation routinely reported on financial, operational and strategic matters to the Strategic Health Authority (SHA). Meetings were held with senior officers at the SHA and the PCT cluster in relation to performance and the Trust’s trajectory towards achieving foundation trust status during 2013/14. With effect from 1 April, the Trust reports to the Trust Development Authority under the auspices of the Accountability Framework.

3.0 The purpose of the system of internal control and governance framework of the organisation

3.1 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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS 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.

3.2 The system of internal control has been in place at the Oxford University Hospitals NHS Trust for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Accounts. In July 2012, the Trust Board approved a new Assurance Strategy which established a clear system to enable the Trust Board and senior managers to review the corporate governance, risk management and internal control framework, and address any weaknesses identified. The strategy set out the types, levels and sources of assurance and established how assurance tools, such as the Board Assurance Framework and Internal Audit individually and collectively...
assure the Board of the effectiveness of the system of internal control and what is being done to address any weaknesses.

3.3 The system of internal control is underpinned by the existence of a number of individual controls that are in place: senior management/executive review, policies and procedures covering important activities, the Standing Orders, Standing Financial Instructions and Scheme of Delegation, the checks and balances inherent in internal and external audit reviews and Board oversight.

4.0 The governance framework of the organisation

4.1 The Trust Board has overall responsibility for the activity, integrity and strategy of the Trust and is accountable, through its Chairman, to the SHA and the Secretary of State for Health. Its role is largely supervisory and strategic, and it has six key functions:

- to set strategic direction, define objectives and agree plans for the Trust
- to monitor performance and ensure corrective action
- to ensure financial stewardship
- to ensure high standards of corporate and clinical governance
- to appoint, appraise and remunerate executives
- to ensure dialogue with external bodies and the local community

4.2 The Trust Board operates with the support of four committees: Audit, Finance and Performance, Quality and Remunerations and Appointments. These committees have been established on the basis of the following principles:

- the need for committees to strengthen the Trust’s overall governance arrangements and support the Board in the achievement of the Trust’s strategic aims and objectives,
- the requirement for a committee structure that strengthens the Board’s role in strategic decision making and supports the non-executive directors in scrutiny and challenge of executive management actions,
- maximising the value of the input from non-executive directors, given their limited time, and providing clarity around their role, and
- supporting the Board in fulfilling its role, given the nature and magnitude of the Trust’s wider agenda, to support background development work and to perform scrutiny in more detail than is possible at Board meetings

4.3 In May 2012, the Trust Board approved a proposal to split the functions that had previously been undertaken by the Audit & Finance Committee, leading to the establishment of a dedicated Audit Committee and a new Finance and Performance Committee.

4.4 The Audit Committee exists to oversee the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. The committee reviews the work and findings of External Audit and provides a conduit through which their findings can be considered by the Board. It also reviews the Trust’s annual statutory accounts before they are presented to the Trust Board, ensuring that the
significance of figures, notes and important changes are understood. The committee maintains oversight of the Trust’s Counter Fraud arrangements.

4.5 The Finance and Performance Committee’s main responsibilities are to review the Trust’s financial and operational performance against annual plans and budgets, and to provide overview of the development of the Trust’s medium and long term financial models. It also monitors performance of the Trust’s physical estate and non-clinical services. Other responsibilities include reviewing in-year delivery of annual efficiency savings programmes, and monitoring the effectiveness of the Trust’s financial and operational performance reporting systems.

4.6 The Quality Committee is responsible for providing the Board with assurance on all aspects of the quality of clinical care; on governance systems, including the management of risk, for clinical, corporate, HR, Information Governance, Research & Development issues; and on standards of quality and safety. The committee oversees the Trust’s ongoing compliance with Care Quality Commission Essential Standards of Quality & Safety, and the management of risk through the NHS Litigation Authority’s Risk Management Standards. It works closely with the Audit Committee through joint membership and joint management support provided by the Director of Assurance.

4.7 The Remuneration & Appointments Committee is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for termination of contracts. The committee ensures that appropriate performance management arrangements are in place for Executive Directors and work with the Chief Executive to relate performance judgements to pay. In determining remuneration policy and packages, the committee has regard to the Trust’s overarching reward and benefit strategy for all staff, the arrangements in the wider NHS and any relevant guidance from the Treasury.

Record of attendance at committee meetings

4.8 The table below shows how many of the core members of each of the Board Committees attended meetings during 2012/13

<table>
<thead>
<tr>
<th>Committee</th>
<th>Attendance</th>
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<tbody>
<tr>
<td>Audit Committee</td>
<td>3/3</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>10/11</td>
</tr>
<tr>
<td>Finance &amp; Performance Committee</td>
<td>7/9</td>
</tr>
<tr>
<td>Remuneration and Appointments Committee</td>
<td>6/7</td>
</tr>
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4.9 All meetings were quorate during the year.

4.10 Following the creation of the Finance and Performance Committee, the Trust undertook a review of the Board and its sub-committees. This confirmed changes to the Audit and Quality Committees’ terms of reference.
4.11 The chairs of each of the sub-committees routinely present written and verbal reports to the Board, highlighting key issues and decisions at their meetings. Approved minutes of each sub-committee meeting are also presented at public Board meetings. During the course of the year, the Audit Committee commenced a programme of risk “deep dives”, consisting of an in-depth review of a selection of the Trust’s principal risks, their key controls, and the whether the Board could be assured of the effectiveness of those controls.

4.12 The Board met a total of seven times in public in 2012/13: May, July, September, November 2012, and January, February and March 2013. Attendance was monitored throughout the year, and there was only one authorised absence by a non-executive director during the period.

4.13 As part of its Foundation Trust application, the Trust completed a Board Governance Memorandum for submission to the Strategic Health Authority in July 2012. This assessment highlighted outcomes of an evaluation of the Board’s effectiveness, and referred to the Board’s development programme, which had been informed in the main by these outcomes. In September 2012, a 360 degree assessment process was introduced to enable staff, commissioners and other key stakeholders to participate in evaluations of the Board.

4.14 In September 2012, all Board members signed a declaration of compliance with the NHS Codes of Conduct, Accountability and Openness, and the Trust has not reported any breach of these Codes. The Trust’s Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions were updated in January 2013 to take account of changes to the Trust’s governance arrangements and legislation. The Standing Orders were adhered to over the course of the year and no suspensions were recorded.

4.15 The Board’s Register of Interests was updated throughout the year, and it was formally received at the Trust Board meeting in September 2012. The Register of Gifts, Hospitality, Consultancies, Sponsorship and support for travel education and training covering Board members and Divisional Directors was presented to the Board in November 2012.

4.16 In December 2012, the Trust’s Local Counter Fraud Specialists undertook a Bribery Act Risk Assessment. The Trust was found to be meeting the requirements of the Act, but it was recommended that requirement to declare interests be extended to wider groups of staff. This recommendation has been implemented.

5.0 Capacity to handle risk

5.1 The Trust implemented a revised Risk Management Strategy in September 2012 which sets out the Trust’s philosophy for the management of risk and individual responsibilities and accountabilities in this regard. Operationally, responsibility for the implementation of risk management has been delegated to Executive Directors as follows:
the Director of Assurance has delegated authority for the risk management framework, and is the executive lead for maintaining the Board Assurance Framework and its supporting processes;

the Director of Finance and Procurement has responsibility for financial governance and associated financial risk;

the Medical Director has responsibility for clinical governance and clinical risk, including incident management, and has joint responsibility with the Chief Nurse for quality;

the Chief Nurse has responsibility for patient safety and patient experience, and joint responsibility with the Medical Director for quality;

Executive Directors have responsibility for the management of strategic and operational risks within their individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates.

5.2 A range of risk management training is available to staff based on the nature of their role and position within the organisation. This includes risk awareness training which is provided to all new staff as part of their corporate induction programme. The Risk Management Strategy describes the roles and responsibilities of all staff in relation to the identification, management and control of risk, and encourages the use of risk management processes as a mechanism to highlight areas that they believe require improvement.

6.0 Risk Assessment

6.1 The Risk Management Strategy sets out an integrated approach to the management of risk across the organisation. The aim is to encourage considered risk taking, including experimentation and innovation within authorised limits, but to reduce those risks that impact on patient and staff safety, and have an adverse effect on the Trust's reputation as well as its financial and operational performance.

6.2 The Risk Management Strategy also defines how risks are linked to one or more of the Trust's strategic or operational objectives. Once the risk has been identified, it is then described, and it is assigned an owner. At this stage, key controls that are to be taken to reduce the likelihood of the risk happening, or reducing its impact, are identified. If it has been identified as a severe risk, a contingency action plan would be considered.

6.3 The Trust's risk assessment process covers all of its activities – clinical services, clinical support services and business support functions. Each Division and Directorate is responsible for maintaining its own detailed risk register in accordance with the procedures described in the Risk Management Strategy. These risk registers are reviewed regularly by directorate and divisional forums, and risks are escalated, where their ratings warrant this, for inclusion on the Corporate Risk Register.

6.5 The Board Assurance Framework provides the mechanism for the Board to monitor risks, controls, and the outputs of its assurances processes. It is monitored regularly by the Trust Management Executive, the Audit, Finance and Performance and
Quality Committees and the Trust Board, and it is used as a strategic tool to provide assurance that controls are in place and effective.

6.6 In March 2013, the Trust's Bed and Mattress Task Group identified a number of risks in relation to the replacement, disposal and maintenance of static foam mattresses, the change in regulations to do with bed frames, and the suitability of the Trust's current bed stores and repair sites. The ratings of these risks were such that they were escalated to the Corporate Risk Register, and dedicated projects have been set up to address them.

6.7 As part of its immediate response to the recommendations from the final report of the Mid-Staffordshire NHS Foundation Trust Inquiry, the Trust undertook a series of briefings, providing all staff with an opportunity to comment on what it meant for their practice. A summary of the feedback from these sessions was presented to the Trust Board in March 2013, and a process has been implemented by which concerns about the quality of services can be conveyed directly for discussion at Board meetings.

6.8 Throughout the year, the Trust has monitored its compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 against the 16 Care Quality Commission (CQC) Essential Standards of quality and safety. The Quality and Risk Profile tool, which aggregates a wide range of information on each provider of health and social care registered with the CQC, indicated an overall improvement in the Trust's compliance during the year, and no areas of serious concern. Regular updates on the risk estimates reported within the tool, and the drivers behind any changes, are provided to the Quality Committee.

6.9 In October 2012, the CQC carried out an inspection at the Horton General Hospital as part of its routine schedule of planned reviews. Compliance against 5 of the essential standards was tested and the hospital was found to be meeting all the standards. Identified areas for improvement have been addressed. In February 2013, a further routine inspection was carried out at the John Radcliffe Hospital. This covered 4 of the essential standards including cleanliness and the care and welfare of patients. Again, the Trust was found to be compliant in respect of the requirements of the standards.

6.10 All new staff are provided with Information Governance (IG) training at corporate induction. This includes an outline of the relevant legal position, NHS guidance and the Trust's policies relating to the safe and appropriate processing of data.

6.11 Additionally, in line with the requirements of the IG toolkit, all existing staff are required to undergo IG training on an annual basis. This is carried out mainly via a series of e-learning modules on the Department of Health’s Connecting for Health E-Learning portal. As at March 2013, 76% of staff had completed this training. This was an improvement on 2011/12, but was short of the 95% target set out within the toolkit.

6.12 Data security incidents are reported via the Trust’s incident reporting system. Incidents are reviewed by the Information Governance Group, which is chaired by the Trust's Caldicott Guardian. Where an ongoing information risk is identified, this is
recorded on the Corporate Risk Register, along with a note of actions to be taken to minimise the chances of occurrence and impact.

6.13 In December 2012, a list containing names and limited clinical details of 23 Trust patients was found on a bus and subsequently reported to the BBC by the person who had found it. An internal investigation was conducted and the matter reported to the Information Commissioner’s Office (ICO). The guidance around the use and management of paper based patient lists has been tightened, and revisions made to the Information Protection Policy. A number of other less serious information security related incidents were reported during the year but none of them required referral to the ICO.

6.14 In January 2013, as part of the 2012/13 plan, internal audit conducted a review of the Trust’s IG Toolkit self-assessment. The Trust had determined that it would achieve an overall Level 2 rating by March 2013, but the audit reflected an overall conclusion of limited assurance and therefore did not support the self-assessment. A number of medium and low risk recommendations were made with a view to developing the self-assessment.

7.0 The risk and control framework

7.1 Risk management is embedded within the organisation in a variety of ways. All staff have a duty to report on incidents, hazards, complaints and near misses in accordance with the relevant policies. From 1 June 2012, responsibility for collating and benchmarking the number of incidents reported by all Trusts passed from the National Patient Safety Agency to the NHS Commissioning Board, who provide information on how incident reporting rates at this Trust compare to others. During the course of the year, the Trust introduced the Datix web-based incident reporting system, providing staff with a simpler method for reporting incidents in real time. This has led to a rise in the number of incidents reported, providing all staff with more learning opportunities.

7.2 The Trust has retained its Level 1 accreditation status against the NHS Litigation Authority Risk Management Standards for Trusts. Risk processes are monitored and reviewed by the Clinical Governance Committee, which is a sub-committee of the Trust Management Executive, and the Quality and Audit Committees.

7.3 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.

7.4 Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are met with updated objectives forming part of the Trust’s Equality Delivery Scheme for 2012/16.

7.5 Control measures are in place to ensure that patients, the public and staff with physical and sensory impairments are able to access buildings on all the Trust’s
sites. All new estates schemes, as well as refurbishments or ad hoc improvements, are assessed to ensure that they meet the requirements of the Disability Discrimination Act. Issues identified through patient feedback, complaints or PALS contacts are used to inform priorities for estates improvements.

7.6 The Trust has reviewed and continues to monitor the systems in place to care for people with learning disabilities. One of the requirements of Monitor’s Compliance Framework is that Trusts are compliant with the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All ((DH, 2008). Initially, the Trust had self-assessed itself as amber, but by the end of March 2013, it had taken a number of actions and was able to re-assess itself as fully compliant.

7.7 The Trust has undertaken 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 projections, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

8.1 The Trust has well developed systems and processes for managing its resources. The annual budget setting process for 2012/13 was approved by the Board before the start of the financial year and was communicated to all managers in the organisation. The Director of Finance and Procurement and his team have worked closely with divisional and corporate managers throughout the year to ensure that a robust annual budget was prepared and delivered. In 2013/13, the Trust achieved 90% of its agreed Cost Improvement Programme target, and it generated its planned surplus for the year.

8.2 Monthly financial and operational performance reports are presented to the Finance and Performance Committee, the Trust Management Executive and to the Board. The Trust makes use of both internal and external audit functions to ensure that controls are operating effectively and to advise on areas for improvement. In addition to financially related audits, the internal audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk assessed, such that action plan priorities are agreed with Trust management for implementation. All action plans are monitored and implementation is reviewed regularly and reported to the Audit Committee as appropriate.

8.3 As part of their annual audit, the Trust’s external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this by examining documentary evidence and through discussions with senior managers. The audit working papers in relation to this work are made available to the Trust and presented to the Audit Committee.
9.0 **Annual Quality Report**

9.1 The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare a Quality Account for each financial year. Guidance has been issued to Trusts on the form and content of the annual Quality Account which incorporates the above legal requirements and requisite external assurance arrangements.

9.2 The Medical Director leads on the quality account, and for 2012/13, the decision was made to align the Trust’s Quality Account priorities with four of the Commissioning for Quality and Innovation (CQUIN) schemes. These priorities were agreed between the Trust and its commissioners. For the future, the Trust will work closely with commissioners and other stakeholders to ensure that such priorities are in line with the Quality Strategy. A public engagement event was held in March 2013, during which local people worked with trust staff to agree the organisation’s quality priorities for the coming year. This feedback was combined with guidance contained within the NHS Outcomes Framework as well as nationally and locally mandated CQUINs to arrive at a list of priorities subsequently agreed by the Trust Board. These include reducing preventable harm and providing safer care during surgery.

9.3 In terms of monitoring, regular updates of the Trust’s progress against its Quality Account priorities and the CQUIN payment framework programme are provided both to the Quality Committee and the Trust Board. External assurance of aspects of the Quality Account has been provided by the Trust’s external auditors.

10.0 **Review of effectiveness of risk management and internal control**

10.1 As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the internal auditors, clinical audit and the Executive and Divisional Directors within the Trust that have responsibility for the development and maintenance of the internal control framework. I have also relied on the content of the Quality Account accompanying this Annual Report and other available performance information. This review is also informed by comments made by the external auditors in their management letter; the Head of Internal Audit Opinion and other reports.

10.2 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, the Audit Committee, the Finance and Performance Committee and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

10.3 The effectiveness of the system of internal control has been reviewed by the Trust Board via its sub-committees and individual management responsibilities at Executive and Divisional Director level. I am satisfied that this Annual Governance Statement describes a system and approach which remained robust for the period from 1 April 2012 to 31 March 2013 and supports preparation of the annual accounts on a going concern basis.

10.4 Regular reports have been received from sub-committees or individual senior managers in relation to all of the key risks. Annual reports have been received by the
Board of Directors relating to all important areas of activity, and ad hoc reports in-year wherever these were required.

11.0 Significant issues

11.1 As identified through the Trust’s risk management processes, the significant issues to report and corresponding actions taken to address key risk issues are outlined below:

11.2 The Trust continues to work with colleagues across the local health and social care network to reduce the high number of patients whose discharge from hospital is delayed, and to improve performance against thresholds. Detailed workstreams addressing the various aspects of this issue are being implemented, and the Trust, with its partners, are on track to achieve reductions in the numbers of delays.

11.3 The Trust reported 3 Never Events during 2012/13. All were avoidable incidents of swabs being retained within patients’ bodies following surgery, and although none of the patients involved suffered harm, it was evident that all the cases related to failures to follow established systems and processes. A number of actions were taken following the events, including sessions arranged to remind all surgical staff of the requirements of the WHO Surgical Checklist, and putting in place systems to ensure that these are consistently followed.

11.4 Two surgical site infection deaths were reported in September and October 2012 following cardiac surgery. Both deaths were investigated as Serious Incidents Requiring Investigation (SIRI), and it was concluded that both infections had been hospital acquired. A retrospective audit covering the period from July 2010 to August 2012 was carried out, as a result of which the requirement to undertake surgical site surveillance as recommended by NICE guidance was reiterated, and Trust guidelines for the prevention of such infections were updated.

11.5 In January 2013, as a result of a shortage of sufficiently skilled clinical staff to enable safe delivery of the service, the Trust decided to suspend, with immediate effect, the performance of emergency abdominal surgery at the Horton General Hospital. Revised arrangements for patients to be treated at the John Radcliffe Hospital remain in place.

12.0 Conclusion

12.1 With the exception of the internal control issues that I have outlined in this statement, my review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Signed……………………..

Sir Jonathan Michael

Chief Executive                  Date: xx June 2013