RUH

Royal United Hospital Bath NHS

NHS Trust

Annual Governance Statement

2011/12

Contents

1. Introduction

The NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health, requires the Accountable Officer (AO) for the Royal United Hospital Bath NHS Trust to give him assurance about the stewardship of his organisation.

In previous years, this assurance has primarily been provided in the Statement on Internal Control (SIC). For 2011/12, in line with changes to HM Treasury guidance, the SIC has been replaced by an annual Governance Statement. This Governance Statement will also be included in the Trust's annual report and accounts.

For the Royal United Hospital Bath NHS Trust the Accountable Officer is James Scott, Chief Executive.

2. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

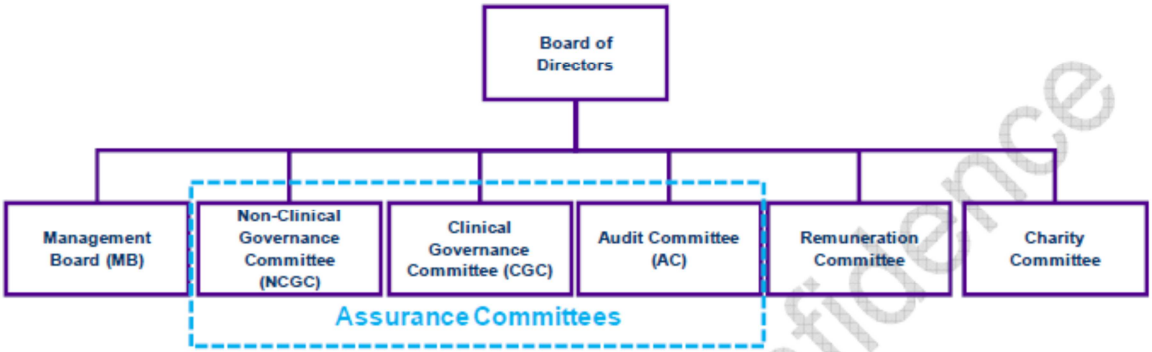
The NHS South West Strategic Health Authority (SHA), commissioning Primary Care Trusts (PCTs) and the Trust have worked closely in 2011/12 and the Trust's performance is reviewed by the SHA and PCTs on a regular basis.

The Bath and Wiltshire Health Community, which consists of the Trust, NHS Bath and North East Somerset (BaNES) and NHS Wiltshire have continued to develop in 2011/12 to improve relationships across the organisations. The PCTs, Overview and Scrutiny Panel, Local Involvement Networks (LINKs) and other partner organisations have worked closely with the Trust and have agreed the areas of work where focus is required. They have been involved in several aspects of the Trust's activities particularly related to patient experiences.

3. The governance framework of the organisation

The Trust has developed its governance structures over a period of time to deliver an integrated governance agenda. Integrated governance is the combination of systems, processes and behaviours which the Trust uses to lead, direct and control its functions in order to achieve its organisational objectives.

The Board of Directors leads on integrated governance and delegates key duties and functions to its six sub-committees. In addition the Board reserves certain decision making powers including decisions on strategy and budgets. The diagram below gives an overview of the integrated governance structure.



The roles and responsibilities of all committees are described more fully below. There are three key committees within the structure that provide assurance to the Board of Directors. These are:

- The Non-Clinical Governance Committee.
- The Clinical Governance Committee.
- The Audit Committee.

There are a range of mechanisms available to these assurance committees to gain assurance that our systems are robust and effective. These include utilising internal and external audit, peer review, management reporting and clinical audit. Where systems and processes cover both clinical and non-clinical areas, for example the process of employing temporary nursing staff, more than one assurance committee will need to assure itself and in turn the Board of Directors that the approach is effective and robust. To do this the Trust has developed a mechanism for cross referring items to seek the other assurance committees' review of relevant systems and processes.

The Board of Directors is accountable for the operations of the Trust. Due to the size and complexity of the operations involved, it delegates responsibility for operational delivery to the Trust's Management Board, which in turn delegates authority to a number of sub groups as appropriate. The expected outcomes, as prescribed by the Board of Directors through the Management Board Terms of Reference, are delivered by the organisation through a series of defined systems and processes

3.1. Committee structure and reporting

Details of the key committees in the Trust's governance structure are given below. Each Committee Chair has information that ensures a consistent approach across all groups, including Terms of Reference, upward reporting and review of effectiveness. Guidelines for the development of agendas and for papers to be presented at the groups are also available. This information has been developed in line with the Productive Leader Toolkit created by the NHS Institute for Innovation and Improvement.

3.2. The Board of Directors

The Board of Directors meets monthly to discuss an agenda based on three key areas of:

- Operational Performance and Use of Resources – This has a primary focus on quality and patient safety outcomes.
- Corporate Governance/Risk/Regulatory – This gives the Board an opportunity to consider key risks, the Board Assurance Framework, legislative changes which may impact on the function of the Trust, other governance issues and regular reports from its sub committees.
- Strategy/Business Planning and Improvement – This covers strategy decision making, approval of business plans and business cases.

The Board of Directors approves annual work plans and annually reviews the Terms of Reference for each of the sub-committees. The Board of Directors receives regular reports from its sub-committees on the business covered, risks identified and actions taken. These reports are delivered by the Non-Executive Chairs of each of these groups, supported by the Executive Director lead.

The Board approves an Annual Cycle of Business in advance of the financial year which identifies the key reports which will be presented in year. Reporting to the Board is based on the principles of exception reporting to ensure that the Board considers the key issues and utilises its time effectively.

The Board conducts the majority of business in public but where this is not possible due to reasons of confidentiality it excludes members of the public pursuant to the Public Bodies (Admission to Meeting) Act 1960.

To ensure adequate flows of information from the Board of Directors to the Management Board, the Chief Executive provides a verbal update to the Management Board on business transacted at the Board of Directors and other issues of importance.

Membership of the Board of Directors is currently made up of the Trust Chairman, five independent Non-Executive Directors and five Executive Directors, including the Chief Executive, and three non-voting Executive Directors. The key roles and responsibilities of the Board are as follows:

- To set and oversee the strategic direction of the Trust.
- Continued appraisal of the financial and operational performance through Director Reports.
- Direct operational decisions as required.
- To discharge their duties of regulation and control.
- To ensure the Trust continues to maintain patient quality and safety as its primary focus, receiving and reviewing data analysis and comment in the form of the Quality and Patient Safety Report.
- To receive reports from the Audit Committee, the annual internal auditor's report and external auditor's report and take action as appropriate.

- To approve the Annual Report and Annual Accounts.

The document which describes how the Trust operates is called the Standing Orders. The Standing Orders are supported by the Standing Financial Instructions and a Scheme of Delegation which shows which decisions the Board has reserved for itself and which it has delegated and to whom it has delegated these.

The Board receives monthly reports on performance which includes an integrated balanced scorecard which shows performance against the identified key performance indictors which contain national, local and internally driven targets. In addition the Board of Directors receives a monthly Quality and Patient Safety Report which outlines progress towards delivering the quality agenda but also provides a mechanism for updating the Board of Directors on key quality issues which may require their attention.

A breakdown of attendance for the Trust Board is presented below:

- Chairman – (Attended 11 of 11)
- Non-Executive Director – Moira Brennan (Attended 9 of 11)
- Non-Executive Director – Joanna Hole (Attended 11 of 11)
- Non-Executive Director – Roger Newton (Attended 11 of 11)
- Non-Executive Director – Michael Earp (Attended 11 of 11)
- Non-Executive Director – Stephen Wheeler (Attended 11 of 11)
- Chief Executive (Attended 11 of 11)
- Director of Strategy* (Board member until November 2011) (Attended 7 of 8)
- Medical Director. (Attended 9 of 11)
- Director of Nursing. (Attended 10 of 11)
- Director of Human Resources*. (Attended 10 of 11)
- Chief Operating Officer (Board member from August 2011) (Attended 7 of 7)
- Director of Operations (Board member until June 2011) (Attended 4 of 4)
- Director of Finance. (Attended 10 of 11)
- Director of Estates and Facilities*. (Attended 11 of 11)

*Indicates non-voting members of the Trust Board.

The key Board sub-committees are described below. The attendance record for each member is indicated in the brackets.

3.3. Management Board

The Management Board is chaired by the Chief Executive and is held monthly. The membership of the Board is as follows:

- Chief Executive (Attended 11 of 12)
- Director of Strategy. (Attended 4 of 6)
- Medical Director. (Attended 9 of 12)
- Director of Nursing. (Attended 10 of 12)
- Director of Human Resources. (Attended 10 of 12)
- Chief Operating Officer (Member from August 2011) (Attended 6 of 8)

- Director of Operations (Member until June 2011) (Attended 2 of 3)
- Director of Finance. (Attended 12 of 12)
- Director of Estates and Facilities. (Attended 9 of 12)
- Head of Medicine Division. (Attended 10 of 12)
- Head of Surgery Division. (Attended 9 of 12)
- Divisional Manager - Medicine. (Attended 10 of 12)
- Divisional Manager – Surgery (Attended 10 of 12)
- Assistant Directors of Nursing – Medicine. (Attended 11 of 12)
- Assistant Directors of Nursing – Surgery. (Attended 9 of 12)
- Associate Medical Director for Quality Improvement. (Attended 5 of 12)*
- Director of Research and Development. (Attended 12 of 12)
- Director of Post Graduate Medical Education. (Attended 2 of 12)**
- Chief Pharmacist (Attended 5 of 6)

* The Associate Medical Director for Quality Improvement was on sick leave for three months and therefore was unable to attend a number of meetings.
**The Director of Post Graduate Medical Education only attends meetings where there is an item of relevance.

The Management Board has delegated powers from the Board of Directors to oversee the day to day management of an effective system of integrated governance, risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives.

3.4. Non-Clinical Governance Committee

The Non-Clinical Governance Committee (NCGC) focuses primarily on providing assurance to the Board that all non-clinical risks are appropriately identified, assessed and managed and to ensure that all non-managed risks are entered onto the Trust-wide risk register and reported to the Board where appropriate. The NCGC is chaired by a Non-Executive Director. The Committee meets bi-monthly.

Membership of this Committee includes:

- Non-Executive Director – Stephen Wheeler (Chair until November 2011). (Attended 5 of 6)
- Non-Executive Director – Joanna Hole (Chair from November 2011) (Attended 5 of 6)
- Director of Human Resources (Lead Executive) (Attended 6 of 6)
- Director of Facilities and Estates (Attended 6 of 6)
- Chief Operating Officer (Attended 3 of 4)
- Director of Strategy (Attended 1 of 2)
- Trust Secretary (Attended 6 of 6)
- Director of Operations (Attended 2 of 2)

The primary objective of the Committee is to provide assurance to the Board that the key critical non-clinical systems and processes are effective and robust.

3.5. Clinical Governance Committee

The purpose of the Clinical Governance Committee is to provide assurance to the Board that all clinical risks are identified, assessed and managed and to ensure that all non-managed risks are entered onto the Trust-wide risk register and reported to the Board where appropriate. The Committee meets bi-monthly and is chaired by a Non-Executive. The membership of the Committee is as follows:

- Non-Executive Director – Michael Earp (Chair) (Attended 5 of 6)
- Non-Executive Director – Roger Newton (Attended 6 of 6)
- Director of Nursing (Lead Executive) (Attended 4 of 6)
- Medical Director (Attended 4 of 6)
- Associate Medical Director for Quality Improvement (Attended 3 of 6)
- Trust Secretary (Attended 5 of 6)

The attendance record for each member is indicated in brackets after the name of the individual.

The primary objective of the Committee is to provide assurance to the Board that the key critical clinical systems and processes are effective and robust

3.6. Audit Committee

The Committee is chaired by a Non-Executive Director and meets no less than four times a year. Membership of this Committee is made up of three Non-Executive Directors (including the Chair).

- Non-Executive Director – Moira Brennan (Chair) (Attended 4 of 4)
- Non-Executive Director – Michael Earp (Attended 4 of 4)
- Non-Executive Director – Stephen Wheeler (Attended 4 of 4)

The attendance record for each member is indicated in brackets after the name of the individual.

At least one of the members of the Audit Committee is required to have recent and relevant financial experience. Moira Brennan provides this experience and also chairs this committee. Further details on the experience and qualifications of the Trust Board can be found on the Trust website at www.ruh.nhs.uk

Additional staff will be invited as required; these could include:

- Chief Executive
- Director of Finance.
- Trust Secretary.
- External Auditor.
- Internal Auditor.
- Local Counter Fraud Specialist.
- Head of Financial Services.

The Committee's key roles and responsibilities are as follows:

Governance
The Committee reviews the establishment and maintenance of an effective system of internal control and probity across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

Internal Audit
The Committee shall ensure that there is an effective internal audit function established by the Trust that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Committee will review the audit function at least annually and agree its plan of work for the forthcoming year.

External Audit
The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management response to their work.

Local Counter Fraud Specialist
The Committee shall ensure that there is an effective counter fraud function established by management that meets NHS Counter Fraud standards and provides independent assurance to the Audit Committee, Chief Executive and Board.

Other assurance functions such as reviews by the Department of Health and / or other regulators / inspectors.

Management
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, probity and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

Financial Reporting
The Audit Committee reviews the Annual Financial statements before submission to the Board. For 2011/12 the Trust Board has delegated authority to the Audit Committee to approve the Annual Financial statements on its behalf to ensure that the deadline for submission is achieved. The Annual Financial statements will then be presented to the Trust Board at its next meeting to ratify the decision of the Audit Committee.

Risk Management
The Audit Committee is responsible for assuring the Board of Directors that the Risk Management system operating within the Trust is robust and effective. To do this the Committee will test the system through Internal Audit Review, as well as corporate and operational review.

3.7. Remuneration Committee

Membership of the Remuneration Committee includes the Chairman of the Board of Directors and all Non-Executive Directors. The Committee meets at least twice annually and its key roles and responsibilities are to determine the appropriate employment and remuneration and terms of employment for the Chief Executive and Executive Directors.

- Chairman – (Attended 4 of 4)
- Non-Executive Director – Moira Brennan (Attended 3 of 4)
- Non-Executive Director – Joanna Hole (Attended 4 of 4)
- Non-Executive Director – Roger Newton (Attended 4 of 4)
- Non-Executive Director – Michael Earp (Attended 4 of 4)
- Non-Executive Director – Stephen Wheeler (Attended 4 of 4)

The attendance record for each member is indicated in brackets after the name of the individual.

3.8. Charities Committee

The Royal United Hospital Charitable Fund was formed under a Deed dated 10 September 1996 as amended by a Supplemental Deed dated 9 December 2009. It is registered with the Charity Commission in England and Wales (Registered number 1058323) ("the Charity").

The Trust is the Corporate Trustee of the Charity, acting through its voting Trust Board members who are collectively referred to as the Trustee's Representatives ("Trustees") and their duties are those of trustees.

The main beneficiary of the Charity is the Trust's patients and staff through the provision of grants to the Trust for purchasing and developing facilities; training and development of staff; and research and development.

The Charity's structure is diverse and reflects the breadth of variety of activities within the Trust. There are in excess of 70 separate funds.

The Charitable Fund has a significant and proactive fundraising operation in the form of The Forever Friends Appeal that is primarily, but not totally, focussed on principal Campaigns agreed with the Charities Committee and the Corporate Trustee.

Whilst the Charities Committee is a formal subcommittee of the Board of Directors, arrangements have been implemented to operate this group and the Full Corporate Trustee of the charity at arm's length from the Trust. These arrangements include: a formal service level agreement between the Trust and the charity outlining the support and associated costs to the charity, reporting to the Full Corporate Trustee of the Charity Annual Report and Accounts and a separate charity strategy.

The Charities Committee is chaired by a Non-Executive Director. Membership of the committee includes a further two Non-Executive Directors, the Director of Nursing and Director of Finance. The committee meets quarterly.

- Non-Executive Director – Roger Newton (Chair from December 2012) (Attended 2 of 2)
- Non-Executive Director – Michael Earp (Chair until December 2012) (Attended 2 of 2)
- Non-Executive Director – Stephen Wheeler (Attended 4 of 4)
- Non-Executive Director – Moira Brennan (Attended 4 of 4)
- Director of Nursing (Attended 1 of 4)
- Director of Finance (Attended 4 of 4)

The attendance record for each member is indicated in brackets after the name of the individual.

3.9. Annual Committee Effectiveness Reviews

Each Committee is required to consider how well it has performed during the year against the objectives as set out in their Terms of Reference and against the delivery of their work plans for the year. This information is collated and then presented to the Trust Board alongside any revisions to the Terms of Reference and the following year's work plan. Any deviation from plan is highlighted to allow the Trust Board to consider whether any further changes to membership or committee constitution are required. The Trust Board also considers the whole of its committee structure to ensure that it is delivering its requirements. During 2011/12 the Trust Board reconsidered the need for a standalone Finance Committee. It was agreed that the Trust Board should retain oversight for the financial management of the Trust and that this function should not be delegated.

4. Key Governance Systems

The Trust has identified the following as key systems which support the delivery of the Trust's objectives:

- Risk Management;
- Performance Management;
- Business Planning and Budget Setting;

Supporting these systems are sub-systems which include, but are not limited to:

- Workforce planning;
- Maintaining clinical and non-clinical competencies;
- Health & Safety;
- Equality & Diversity;

The Trust Board's assurance committees test these systems to ensure they are robust and effective. Where additional assurance is required the Trust's internal auditors are tasked with undertaking a more comprehensive review and actions are taken to address any shortfall against the expected standards.

5. Governance Changes during the Year

There have been no significant changes implemented during the year. There has been work to strengthen current arrangements and embed changes implemented in previous years. This includes reviewing the Trust's governance structure and ensuring that all formal groups have clear Terms of Reference, work plans and reporting arrangements. The revised assurance arrangements, described above, have been embedded within the Trust and the impacts of these changes are now being seen. This has manifested in stronger systems and processes supporting the delivery of the Trust's objectives and Strategy.

Following a review of how successful this embedding has been, an action plan has been developed to ensure that there is greater consistency across the Assurance Committee's in terms of their view of the level of assurance provided to the Trust Board, and also a prioritisation of the systems and processes to be reviewed in 2012/13.

The governance systems will be continually monitored to ensure that the Trust continues to learn from best practice and updates systems so they meet revised guidance throughout the year.

6. Trust Board Review of Effectiveness

The Trust Board is required to consider whether it has been effective in leading the organisation on an annual basis. The Board has undertaken an evaluation for 2011/12 and has determined that the Trust Board is operating at a satisfactorily level. This is supported by the following evidence:

- The Trust has been rated as Performing[1] for 2011/12 for the Acute Trust Performance Framework. This confirms that the Trust has met all of the National Priorities as set out in the NHS Operating Framework.
- The Trust would also be classified as Amber-Green against the Monitor Governance Rating if it was an NHS Foundation Trust;
- The Trust has seen a significant decrease in the number of hospital associated infections, both in relation to MRSA and clostridium difficile;
- The Trust has achieved its planned financial surplus for 2011/12;
- The Trust has developed a 5 year Strategic Plan to support its application to become an NHS Foundation Trust and has supported this by revising its governance arrangements;
- The Trust has developed and implemented a series of supporting Strategies which clearly articulate how major changes within the Trust will be achieved. These include the Estates Strategy, Continuous Improvement Strategy, Quality Improvement Strategy and the Membership Strategy;

[1] The rating of Performing is calculated based on the average score against a series of key performance indicators including those relating of A&E, Referral to Treatment, Cancer and infections. The Trust must achieve an average rating of more than 2.4 to be rated as Performing. More information on the Trust's current performance and weightings for each of the indicators can be found in the Trust's monthly performance report presented to the Trust Board meeting in Public. Copies of papers can be found at http://www.ruh.nhs.uk/about/trustboard/index.asp?menu_id=7

- The Trust has built a membership base which is both representative and inclusive of the local population. The Trust has recruited over 4,000 public members and all members of staff are members;
- The Trust Board has a full complement of Executive and Non-Executive Directors;
- The Trust Board has considered whether it is compliant, where appropriate, with Monitor's Code of Governance. The Trust Board has confirmed that it is compliant.

The Trust Board's assessment has been supported by the following external assessments:

- The Care Quality Commission undertook an unannounced, planned inspection of the Trust in November 2011 and found that the Trust was compliant against all of the Outcomes inspected;
- The Care Quality Commissioning undertook an unannounced inspection of the Trust in March 2012 and found that the Trust was compliant with Outcome 21 – Records. This inspection related to the national inspection of all providers of Termination of Pregnancy services;
- The Trust has employed Deloittes to support its application to become an NHS Foundation Trust. Their work has included an evaluation of the Trust Board which they confirmed was operating at the expected standard;
- The Trust Board was observed by the Strategic Health Authority in April and May 2011 as part of their assessment of the Trust's readiness to progress on its application to become an NHS Foundation Trust. The feedback from the Strategic Health Authority was that the Trust Board was operating at the expected standard;
- The Trust Board has undertaken a self-assessment against the Board Governance Assurance Framework. This has confirmed that in the majority of areas the Trust Board is operating at the expected level. A number of development areas have been identified which are focused on preparing the Trust Board post authorisation as an NHS Foundation Trust. The Trust Board's self-assessment was independently verified by the audit firm, KPMG. Their assessment was broadly similar to the Trust's assessment with only two areas identified where they considered further work was required. These areas related to the accurate forecasting of operational performance, and developing relationships with external stakeholders;
- The Trust is subject to regular inspection by a number of other regulators including the Health & Safety Executive, the Medicines and Healthcare Products Regulatory Agency and the Human Tissue Authority. Whilst a number of improvement actions have been identified through the process of inspection no regulatory actions have been imposed on the Trust.
- The Board has undertaken a self-assessment against the Quality Governance Framework, which has been reviewed by the Strategic Health Authority and by PwC the Trust's internal auditors. This has both confirmed that the Trust Board is aware of its current Quality Governance arrangements and the limitations of those arrangements. An action plan has been developed to address the gaps identified;

- The Care Quality Commission and OFSTED jointly inspected Safeguarding and Looked After Children's Services in Bath & North East Somerset in January 2012. Whilst the overall responsibility for this lies with Bath and North East Somerset Council, the Trust, as a provider of children's healthcare services, plays an important role. The inspection identified a number of actions that the Trust needed to take in order to improve its approach to safeguarding children.

The Trust has identified, through a review of its skills and knowledge mix, that there is a need for a Director of Commercial Development. This Director will be expected to have extensive commercial and communication skills and experience to support the Trust Board in delivering its Strategy. It is expected that the role of Director of Commercial Development will be filled early in 2012/13.

The Trust Board has acknowledged that there is further development work required aligned to the NHS Foundation Trust application. This includes a better understanding of the changes required by the Board to function effectively as an NHS Foundation Trust and how the Board will work together with the Council of Governors to ensure that the Trust delivers the right services for the local population.

Further areas of development have been identified and will be covered by the Trust Board in seminar session. These sessions will include how the Trust will be impacted by changes following the Health and Social Care Bill receiving Royal Assent, the wider changes in the NHS such as those relating to Local Education and Training Boards, the learning from the Trust's participation in the Dr Foster Global Comparators network, and further development of the patient experience systems within the Trust.

7. Trust Board Member Appraisals

Each member of the Trust Board is appraised against their performance during the year, which culminates with an annual appraisal against their objectives for the year. The appraisers for each group of Trust Board members is as follows:

Appraisee	Appraiser
Chairman	Chairman (or Vice Chairman), NHS South of England Senior Independent Director
Non-Executive Directors	Chairman
Chief Executive	Chairman
Executive Directors (as line reports)	Chief Executive
Executive Directors (as Trust Board members)	Chairman

The purpose of the appraisal is to monitor progress against the set objectives and identify any development needs or support required to ensure that by year end the objective is delivered. For the Chief Executive and Executive Directors, delivery against the objectives is taken into consideration when determining if any bonus is to be awarded and the level of the stated bonus. The amount of any bonus awarded to

the Chief Executive and Executive Directors is reported in the Annual Report for the following year.

During 2011/12 the Senior Independent Director, Michael Earp, also undertook an appraisal of the Chairman. In future years, and once authorised as an NHS Foundation Trust, the governors of the Trust will be involved in the Chairman's appraisal.

8. 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 on-going process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; 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 Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

9. Capacity to handle risk

I have overall responsibility for all risks. A nominated lead Director, the Director of Nursing, has been designated as the Director responsible for clinical governance and risk management. I am responsible for corporate governance issues.

The Trust Board is ultimately responsible for managing and directing the Trust's business. However, there are three Assurance sub-committees which provide the Board with assurance. These are the Clinical Governance Committee, Non-Clinical Governance Committee, and the Audit Committee.

The Trust Board has approved the risk management processes and defined the objectives for managing risk. The Trust has a Trust-wide Risk Register. All new significant risks are reviewed by the Management Board and by the Trust Board. The Management Board then takes on oversight of the significant risks until they have been managed to a reduced level of risk. All risks are reviewed by the Trust Board on an annual basis.

The Trust has introduced a six monthly review of the strategic and environmental risks which may affect this Trust. Included within these reviews are the risks related to the changes in the NHS which will introduced following secondary legislation supporting the Health and Social Care Act 2012. Particularly of focus for the Trust Board is the changing commissioner environment with the implementation of Clinical Commissioning Groups, and how best the Trust can work positively with these new organisations.

Assurance Committees have been established as sub-committees of the Trust Board, with membership from Executive and Non-Executive Directors, clinical representatives from the Divisions and other senior clinical and managerial representatives. The Strategic Framework for Risk Management includes a reporting structure to the Trust Board.

Each clinical specialty has a forum for discussing risk management and clinical governance issues. Each clinical specialty has a nominated lead for risk management, clinical effectiveness, research & development, education and training, and patient & public Involvement.

Guidance on risk management is included in the Strategic Framework for Risk Management.

The Clinical Governance Performance Framework includes standards on risk management and the pillars of clinical governance. Key Performance Indicators (KPIs) have been developed for clinical governance and these are monitored through the Trust's performance measures and included in a corporate scorecard on a monthly basis. The evidence used to monitor against the KPIs has been used in a number of areas to provide evidence for the on-going compliance with the Care Quality Commission's "Essential standards of quality and safety".

The Trust seeks to ensure that lessons learned from incident, complaint and other investigations are used to update and improve practice. These issues are regularly communicated to the Operational Governance Committee where Trust wide representatives have the opportunity to discuss themes which may emerge from these investigations and make recommendations for, and implement, policy or procedural change. The Operational Governance Committee reports to the Management Board and escalates issues which require higher level scrutiny.

Incidents are dealt with as per the process identified in the Incident Reporting and Management Policy and Procedure; including the Management of Serious Untoward Incidents.

Lessons learned from complaint investigations are communicated throughout the Trust via the Improvement Forum. This group has representatives from across the Trust and reviews lessons learnt from complaint, incident and other investigations, with a view to identifying and spreading good practice.

10. The Risk and Control Framework

10.1. Context

The Strategic Framework for Risk Management identifies the key risk areas for the Trust as clinical risk, non clinical risk, financial risk, human resource risk and information risk.

The Strategic Framework for Risk Management includes a clear risk management process. If a risk cannot be resolved at a local level the risk can be referred through the operational management structure to the Management Board or ultimately to the Trust Board. The risk is also added to the risk register with a plan detailing ways to minimise the risk. Each risk is assessed for its severity and likelihood of occurrence, and is allocated a risk 'traffic light'. Risks are reviewed to ensure that any inter-dependencies are understood along with the cumulative effect of risks. The level of exposure to risks is also assessed, and an acceptable level of exposure is assigned to each risk. In assessing the Trust's response, due regard is paid to the financial, service delivery and reputational consequences of risks. The Head of Risk and Assurance and the Trust Board Secretary act as gate keepers to the Risk Register to ensure consistency of scoring, as well as the accuracy and currency of the register.

Risks outside the remit of the Trust's local governance groups are entered onto the Risk Register and are reviewed by an appropriate operational management groups, which includes the Management Board and Divisional Boards. The Trust Board reviews each new significant risk and either explores the solutions or accepts the risk. The highest rated risks are reviewed quarterly by the Trust Board. Training in risk management is included as part of the induction programme for new members of staff and is included in the development planner for the Trust Board.

The public and stakeholders are involved in managing risk through representation from the LINKs and the local council led Overview and Scrutiny Committees. In addition, the Trust holds stakeholder events to discuss the issues that should be fed into the Trust strategy. A patient experience strategy has been approved and its progress monitored during 2011/12 by both the Trust Board and the Patient Experience Group (PEG).

10.2. Assurance Framework

The Assurance Framework is a process by which the Trust gains assurance that it has a well-balanced set of objectives for the year and that there are controls and assurances in place to manage the key risks associated with achieving the objectives.

The Assurance Framework was developed using the Trust's Integrated Business Plan and the corporate objectives for 2011/12. The framework is split by the five strategic pillars of Quality Improvement, Demonstrate Performance, Workforce Development, Relationship Management and Improving our buildings and environment. The objectives were assessed, and risks in achieving the objectives identified including any gaps in assurance or control. The Assurance Framework was reviewed by the Trust Board and its Assurance Committees regularly throughout the year. Internal Audit reviewed the issues arising from our prior year review in March

2012, which included a brief overview of current arrangements. The results of this review were that the auditors were satisfied that all recommendations had been implemented or action was on-going to implement them. The auditors were also satisfied that there have been no significant changes in the approach to risk management since we last reviewed this area late in the 2010/11 audit programme and on which we provided a moderate assurance rating.

The term Moderate Assurance reflects that the auditors identified some weaknesses in the design and/or operation of controls; however the likely impact of these weaknesses on the achievement of the key system, function or process objectives was not expected to be significant. Furthermore, these weaknesses are unlikely to impact upon the achievement of organisational objectives.

Control measures are in place to ensure that all the organisation's obligations under the Equalities Act 2010 are complied with. An Equality Analysis is considered and completed for all policies as they are developed or updated.

The Trust has undertaken a climate change risk assessment and developed an Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009, to ensure that the Trust's obligations under the Climate Change Act are met.

The Trust has in place a Major Incident Plan that is fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance.

10.3. Other Risks to Note

The Trust has identified the following as risks which are being highlighted due to their possible impact on the delivery of the Trust's business plan. These are not as significant as the risks which are highlight in Section 10 below.

Non-achievement of the NHS Litigation Authority Risk Management Standards at level 2.

The Trust was assessed in February 2012 against the NHS Litigation Authority Risk Management Standards and was found to have achieved compliance at level 1. It was the Trust's intention to have achieved compliance at level 2. A number of gaps were identified in the monitoring of key policies within the Trust and an action plan has been developed to ensure that the Trust is able to achieve compliance at level 2 at the earliest opportunity. This is expected to be achieved during 2013/14. More information on the NHS Litigation Authority and the risk management standards can be found at www.nhsla.com.

Quality of Medical Records

The quality of the Trust's medical records has been identified as a risk to the Trust for two primary reasons. Firstly there is a risk that the inaccurate or incomplete medical records may impact on the Trust being able to deliver high quality care to all patients. Secondly the medical records are used to capture activity which is

translated into income to the Trust. Without accurate documentation of the activity the Trust may lose income which would impact on the Trust's financial plans.

To address this, the Trust has a Medical Records User Group which works with all staff to ensure that the medical records are of a high quality and meet the minimum standards expected by the Trust. In addition the Data Quality Group of the Trust is working to ensure that activity is accurately recorded and translated into income. The commissioners of the services, from whom the income is received, engage with the Trust's external auditors to undertake an independent audit of how the Trust captures activity and where improvements can be made. Actions arising from these audits are then monitored through the three Assurance Committees.

11. Significant Issues

The Trust has identified two significant issues to report as part of the statement. These are:

Appraisals

During 2011/12 the Trust Board requested an internal audit report on the Trust's approach to staff appraisals. This resulted in a limited assurance judgment being issued. The Trust has developed a robust action plan to address the recommendations which is being implemented and will be completed during 2012/13. The actions being taken include a review of the documentation and guidance issued to staff and managers, and a review of the mechanism to capture information about completed appraisals. This risk was also identified within the Board Assurance Framework for 2011/12. The completion of the action plan is the only gap in control to be reported through this statement.

The Trust's internal auditors will be reviewing the appraisal system again during 2012/13 to review progress being made.

Delivery of Savings

The Trust reported significant variances against its plans to deliver its financial savings during the year. Whilst the Trust has achieved its planned surplus, the Trust has identified that further work is required to ensure that savings plans are robustly identified, described and then enacted during the year. In addition alternative plans need to be identified to be able to respond to changing local healthcare priorities whilst achieving the Trust's own plans.

To better understand the challenges facing the Trust, the Internal Auditors were tasked with assessing the procedures in place for managing and overseeing the Trust's savings delivery programme. This report has been classified as High risk by the Trust's Internal Auditors, PwC, who have identified that further work is required to strengthen the functioning of the Programme Management Office.

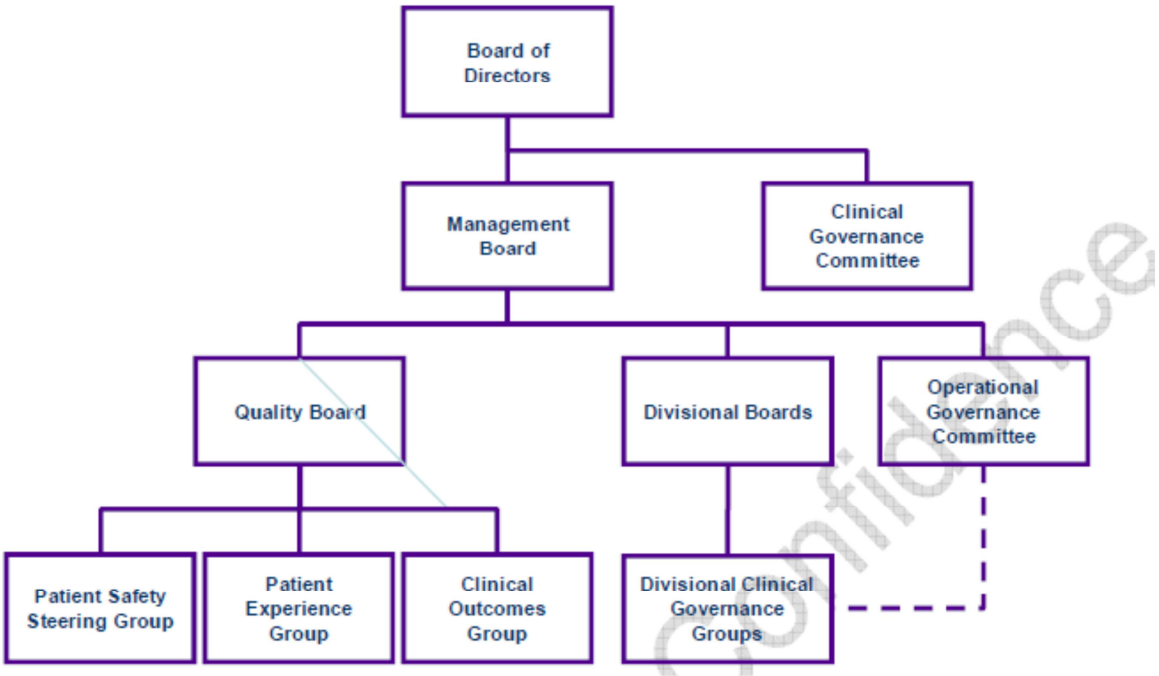
The Trust is addressing the issue of managing variance through the implementation of the Continuous Improvement Strategy, led by the Transformation Board. This Strategy will oversee the implementation of LEAN throughout the Trust, focused on

pathway and service redesign. This is complemented by the work of the Efficiency Board to deliver savings plans.

The Trust is considering how it can strengthen the Programme Management Office and actions will be agreed during Quarter 1 2012/13.

12. Quality Governance

Quality Governance is a key element of the overall governance arrangements of the Trust. Quality is woven into all groups but the key groups involved in delivering the quality agenda are:



Each group as presented above plays a key role in the quality governance of the Trust. Their roles are as follows:

- The Board of Directors approved the Quality Improvement Strategy in November 2010 and has oversight of the delivery of quality through the performance management system and risk management systems.
- The Management Board as the key operational delivery group in the Trust oversees operational performance against quality indicators and receives regular information on quality and patient safety work including the Trust's progress towards achieving the aims of the five year NHS South West Quality and Patient Safety Improvement Programme.
- The Quality Board, which is accountable to the Management Board, has responsibility to formulate the quality improvement strategic direction. This has been achieved through the development of the quality improvement strategy approved by the Board of Directors. The Quality Board oversees the implementation of the strategy. The Quality Board ensures that the Board of Directors, via the Management Board, is aware of risks to the quality of care

being delivered and plans to mitigate these risks, and poorly performing services and the actions being taken to improve them.

- The Operational Governance Committee is the group which delivers quality improvement at an operational level. The Operational Governance Committee works closely with the Quality Board and the Quality Board's sub groups – the Patient Safety Steering Group, the Patient Experience Group and the Clinical Outcomes Group – as well as the Divisional Clinical Governance Groups.

From April 2010 health and adult social care providers had to be registered with the Care Quality Commission (CQC) and this required Trusts to comply with the "Essential standards of quality and safety", as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009. These standards allow Trusts to measure the quality of services they provide and ensure that Trusts are accountable for meeting the regulations. Areas identified from the CQC Quality and Risk Profile and internal reviews as requiring improvement will inform the Quality Work Plan.

The Trust has been registered with the Care Quality Commission without conditions since March 2010.

The CQC undertook an unannounced planned visit to the Trust in November 2011. The CQC inspected compliance against eight of the Essential standards and confirmed compliance against all. Minor concerns were identified against two of the standards and the Trust has taken action to maintain compliance against these standards.

The Trust recognises that the Health Act 2006 introduced a statutory duty on NHS organisations to observe the provisions of the Code of Practice on Healthcare Associated Infections. The Trust Board is aware of its responsibilities in assuring that it has suitable systems and arrangements in place to ensure that the Code is being observed.

13. Board to Ward

The Trust has further developed its key lines of communication between both the Trust Board and Ward level. The main features of this communication are outlined below:

Matron Presentations

The Matrons from the two clinical divisions are invited to present to the Board twice each year. The topics raised are selected by the Matrons and are focused around new initiatives, developments and also quality improvements. This is also an opportunity for the Matrons to interactive with the Board to share ideas, concerns and other issues.

Patient Stories

The Trust Board has introduced a patient story at the beginning of each Trust Board meeting aligned to the Quality & Patient Safety Report. The story takes the form of either a recorded interview with a patient, or is a statement read

out by a member of staff on behalf of the patient. These stories ensure that positive and negative messages about the care being delivered within the Trust, is visible to the Trust Board, and in the words of a patient.

Integrated Balanced Scorecards

The Trust Board has revised the approach it takes to monitoring performance information and has adopted the use of an Integrated Balanced Scorecard. The revised scorecard presents together quality, operational and financial performance, so that an informed view can be taken across the whole without impacting on one area. This approach is being rolled out throughout the Trust to Divisional, Specialty and Ward levels. This consistency in approach will ensure that the Board has oversight of information from Ward to Board.

14. Information Governance

Information Governance within the Trust is managed and controlled through the implementation of the Trust Information Governance strategy which is owned by the Trust Board. The strategy is delivered through an action plan for Information Risk Management and through a commitment to initiate work as early as possible on completing the NHS Information Governance Toolkit and national legislation, policies and directives, thus gaining maximum benefit from introduced improvements.

In 2010/11 the Trust had an overall compliance score of 81% against a new version of the Information Governance Toolkit, Version 8. The Trust achieved the required level 2 in all of the 45 requirements with one exception, the requirement to Pseudonymise data being used for secondary purposes. This had the impact of making the overall assessment of the Trusts Information Governance toolkit return be graded as unsatisfactory.

In July 2011, following a ‘bottom up’ approach to target setting for the 2011/12 Information Governance toolkit, Version 9, by the owners of the various work streams, the target of 91% was agreed by the Information Governance Committee. Work undertaken throughout the year has now assessed the Trust to have achieved a score of 90% and an overall grade of Satisfactory.

A programme of Information Risk Management audits has been completed in both the medicine and surgical divisions with action plans being produced to further ensure risks are reduced and legal compliance with the Data Protection Act maintained.

During the year there has been effective reporting of Information Governance incidents and near misses and follow up on all incidents has ensured corrective actions where necessary. There have been no serious untoward incidents measured at Level 3 reported to the Trust.

15. Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the Internal Audit work. Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The 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:

- Care Quality Commission registration;
- Internal Audit reports;
- External Audit reports;
- Auditors' Value for Money Assessment:
- CQC planned and responsive inspections;
- NHSLA assessments;
- Clinical audits;
- Patient and staff surveys;
- Benchmarking information.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Clinical Governance Committee, Non-Clinical Governance Committee and the Management Board. When issues are identified, plans are put in place to ensure that any learning is embedded in the organisation. This ensures that the system is subject to continuous improvement.

The Trust has an on-going process to assess compliance with the CQC's Essential standards of quality and safety, which includes regular review of the CQC's Quality and Risk Profile and on-going monitoring of the evidence to demonstrate compliance with the standards. No issues have been identified from this process which would affect the Trust's registration. Improvements identified through this process have been incorporated into action plans which are subject to rigorous review. There are no significant control issues to report.

In 2011/12, the Trust's major risks were the achievement of financial savings, associated workforce changes required to deliver the savings, and the appraisal of staff. These risks will be monitored throughout 2012/13.

The Trust Board has a vital role in ensuring that the Trust has an effective system of internal control. 2011/12 has seen further improvements in the system of internal control, building on the work of previous years. The Trust Board and its sub-committees have functioned effectively throughout the year. This effectiveness has been tested and supported by a number of external organisations as part of the NHS Foundation Trust application process. These organisations include NHS South of England, PwC, KPMG and Deloittes, as the Trust's Critical Friend.

My review confirms that the Royal United Hospital Bath NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Accountable Officer: James Scott, Chief Executive

Organisation: Royal United Hospital Bath NHS Trust (RD1)