Annual Governance Statement

1. Scope of responsibility

1.1 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*.

2. The purpose of the system of internal control

2.1 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 HPFT, 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 HPFT for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

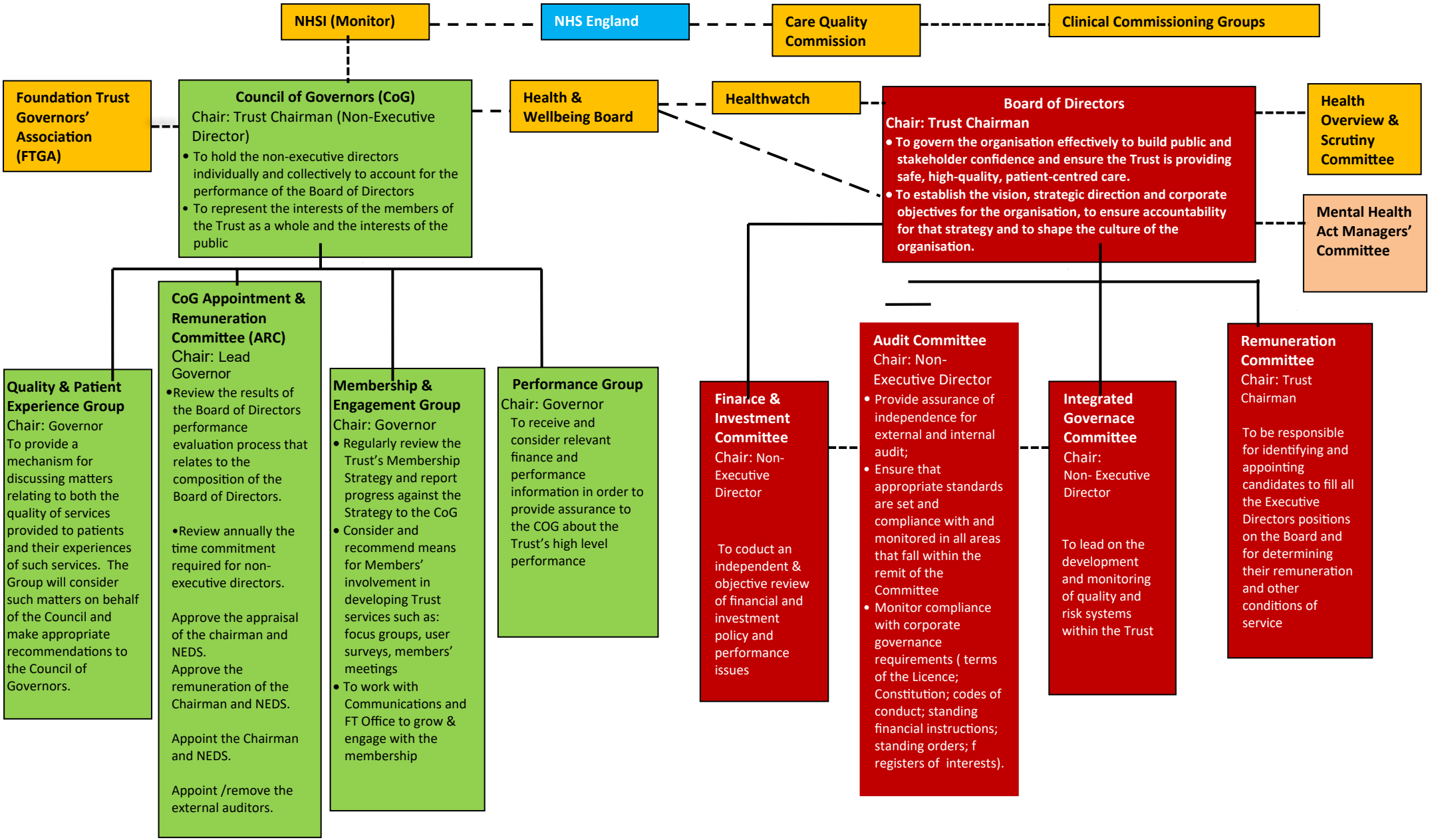
3.1 As Accounting Officer I am accountable for the quality of the services provided by the Trust. I have overall responsibility for risk management within the Trust and this responsibility is incorporated within the risk management strategy. Elements of risk management are delegated to members of my Executive Management Team and designated specialist staff:

Overall Risk Management	Executive Director of Quality & Safety (Caldicott Guardian)
Clinical Governance	Executive Director of Quality & Safety
Clinical Risk & Medical Leadership	Executive Director of Quality & Medical Leadership
Corporate Governance	Company Secretary
Board Assurance & Risk Escalation	Company Secretary
Financial Risk	Executive Director of Finance
Compliance with NHSI Regulatory Framework	Executive Director of Finance & Company Secretary
Compliance with CQC Regulatory Framework	Executive Director of Quality & Safety
Senior Information Risk Owner (SIRO)	Executive Director of Finance)

Our governance structure at **Figure 1** below illustrates the robustness and effectiveness of our risk management and performance processes via our governance structure.

Figure 1

GOVERNANCE STRUCTURE



In addition, the Director of Service Delivery and Customer Experience ,is responsible for the day-to-day management of risk and performance within operational services and there are designated roles of Deputy Director, Safer Care and Standards and Deputy Director of Nursing & Quality providing leadership and support in their respective areas.

Staff members have a responsibility for handling the management of clinical and non-clinical risks according to their roles and duties within the Trust. Mandatory training on key risk areas is undertaken by all staff at induction into the Trust and on a regular refresh basis.

Capacity is developed across the Trust through training events commensurate with staff duties and responsibilities and includes risk management training for all new staff. Awareness raising sessions have also taken place for existing staff teams.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component to maintaining the risk management culture within the Trust. Learning is shared through Clinical Management Teams and Trust wide forums such as the Quality and Risk Management Committee and Health and Safety Committee. Learning is acquired from a variety of sources which include:

- Analysis of incidents, complaints, claims and acting on the findings of investigations.
- External Inspections.
- Internal and external audit reports.
- Clinical audits.
- Outcome of investigations and inspections relating to other organisations.

In accordance with its *Standing Orders* and as required by NHS Improvement's *Code of Governance,* the Trust has an Audit Committee whose role is to review and report upon the adequacy and effective operation of the organisation's overall system of governance and internal control which encompasses risk management – both clinical and non-clinical.

In order to assist both the Board and the Audit Committee, specific risk management is overseen by two other Board Assurance Committees:

- *Integrated Governance Committee* (which receives reports from the Quality & Risk Management Committee and Workforce & Organisational Development Group) and has the specific purpose of delivering assurance to the Board on the management of clinical risk and operational performance against the CQC domains.
- *Finance and Investment Committee*, which provides assurance on management of risks relating to resources – both financial and human; and the strategic direction of the Trust

Please see our Risk Management diagram at **Figure 2** below and our Risk Escalation Model at **Figure 3.**

4. The risk and control framework

4.1 Risk management by the Board is underpinned by four (4) interlocking systems of internal control:

- The Board Assurance Framework
- Trust Corporate Risk Register (informed by Strategic Business Units, Departments and Teams)
- Audit Committee
- Annual Governance Statement

The Risk Management Strategy and Policy which are effective guides on risk management have continued to work effectively during 2016-17. Our Risk Management system, Datix, has continued to be a source of effective risk management across all levels and a source of just-in-time reports when needed. The risk management processes remained the same as defined within the Board Assurance and Escalation Framework. This clearly outlines the leadership, responsibility and accountability arrangements. These responsibilities are then taken forward through the Assurance Framework, the Risk Registers, Business Planning and Performance Management processes enabling the coherent and effective delivery of risk management throughout the organisation.

As **Figure 2** below illustrates, risk management involves the identification, analysis, evaluation and treatment of risks – or more specifically recognising which events (hazards) may lead to harm and therefore minimising the likelihood (how often) and consequences (how badly) of these risks occurring:

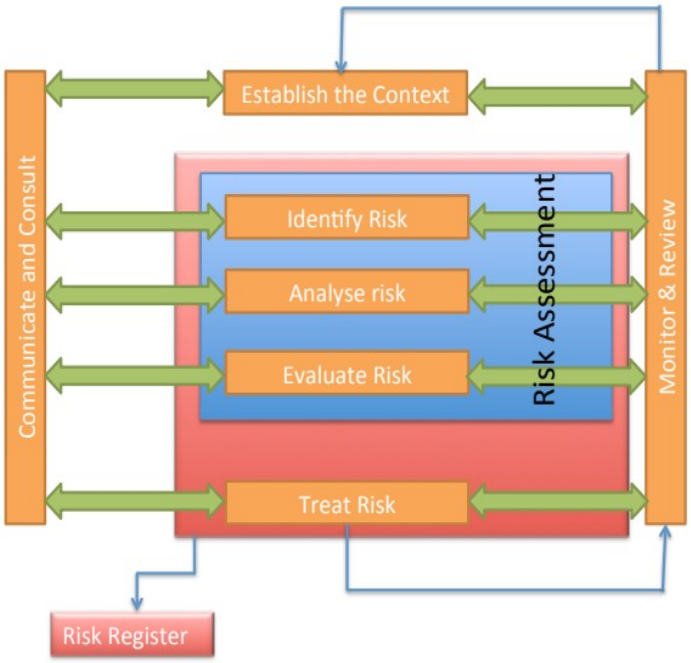


Figure 2 Source: AS/NZS 4360:1999

Risk is managed at all levels, both up and down the organisation and in order to ensure triangulation between the *Annual Plan* and the *Board Assurance Framework (BAF),* the Trust produces a *Performance Report* for the Board on activity within the Trust Risk Register which details the risks that have either come onto the Trust risk register or those that the Executive Team has approved to come off the Risk Register.

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local counter fraud services. The Audit Committee reports to the Board quarterly after every meeting and annually on its work in support of the *Annual Governance Statement*, specifically commenting on the fitness for purpose of the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements.

The Trust recognises the need for a robust focus on the identification and management of risks and therefore risk is an integral part of our overall approach to quality and the management of risk is an explicit process in every activity in which the Trust and its employees take part.

Risk management in the Trust is discharged through clearly focusing executive responsibility for all clinical governance and risks with the respective Executive Directors. The Directors, working closely with the Chief Executive, have responsibility for all Trust care services and supporting corporate functions in this context. The management lead for risk rests with the Director of Quality and Safety who is also the Caldicott Guardian.

The Trust has a strong track record in the identification and mitigation of risks, and when there have been untoward and serious incidents, responding to them quickly and ensuring that the lessons learned from them are implemented swiftly across the organisation. The processes for these are embedded in the culture of the organisation and through robust processes and procedures such as concerns at work and the '*ward to board'* assurance processes.

These are supplemented by the Chief Executive's and Directors' '*Good to Great'* sessions. These have encouraged teams and individuals to openly share any risks and concerns as well as areas of good practice that should be celebrated. It is particularly positive to note the improvement in all areas of the Staff Survey in creating and reinforcing an open culture in which staff feel both motivated and safe to raise any concerns they may have.

4.2 Board Assurance Framework (BAF)

Board assurance is a systematic method of:

- Identifying
- Analysing
- Evaluating, treating, monitoring, reviewing; and
- Communicating all risks-clinical and non-clinical and their integration and management

The requirement to develop a Board Assurance Framework (BAF) was established by the Department of Health (now NHS England), *Assurance: The Board Agenda (July 2002).* The BAF is a tool for the Board to satisfy itself that risks are being managed and strategic objectives are being achieved. The Board has established a robust BAF so that I, as Chief Executive, can confidently sign the *Annual Governance Statement* which deals with statements of internal control.

A Board Assurance Framework has been in place throughout the year which is designed and operating to meet the requirements of the 2016/17 *Annual Governance Statement*. The BAF, which is Board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved.

The BAF is robustly discussed and analysed at the Board. Updates of progress against actions are provided at each meeting of the IGC, Audit Committee and quarterly by the Board.

Risks monitored over the year included:

- Regulatory Compliance
- Financial Resources
- Workforce-recruitment and retention

- Cyber security
- Transformation
- Quality and Safety

The BAF has been reviewed by the Board on a quarterly basis during 2016/17 and provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives and therefore, the operational plan. It maps out the key controls to mitigate the risks and provide a mechanism to inform the Board of the assurances received about the effectiveness of these controls. The Board receives assurances directly or via its statutory and assurance Committees-Audit, Remuneration, Integrated Governance and Finance and Investment.

It is a dynamic tool which supports the Chief Executive to complete the *Annual Governance Statement* at the end of each financial year. It is part of this wider 'Assurance and Escalation Framework' to ensure the Trust's performance across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users.

The formation and maintenance of the BAF is the responsibility of the Company Secretary and is regularly reviewed by each Principal Risk Owner (Executive Directors). This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions.

4.3 Trust's Risk Monitoring Escalation and Assurance Process

The Risk Management Strategy sets out how risk is identified and assimilated into the Risk Registers and reported, monitored and escalated throughout the directorate and corporate governance structures.

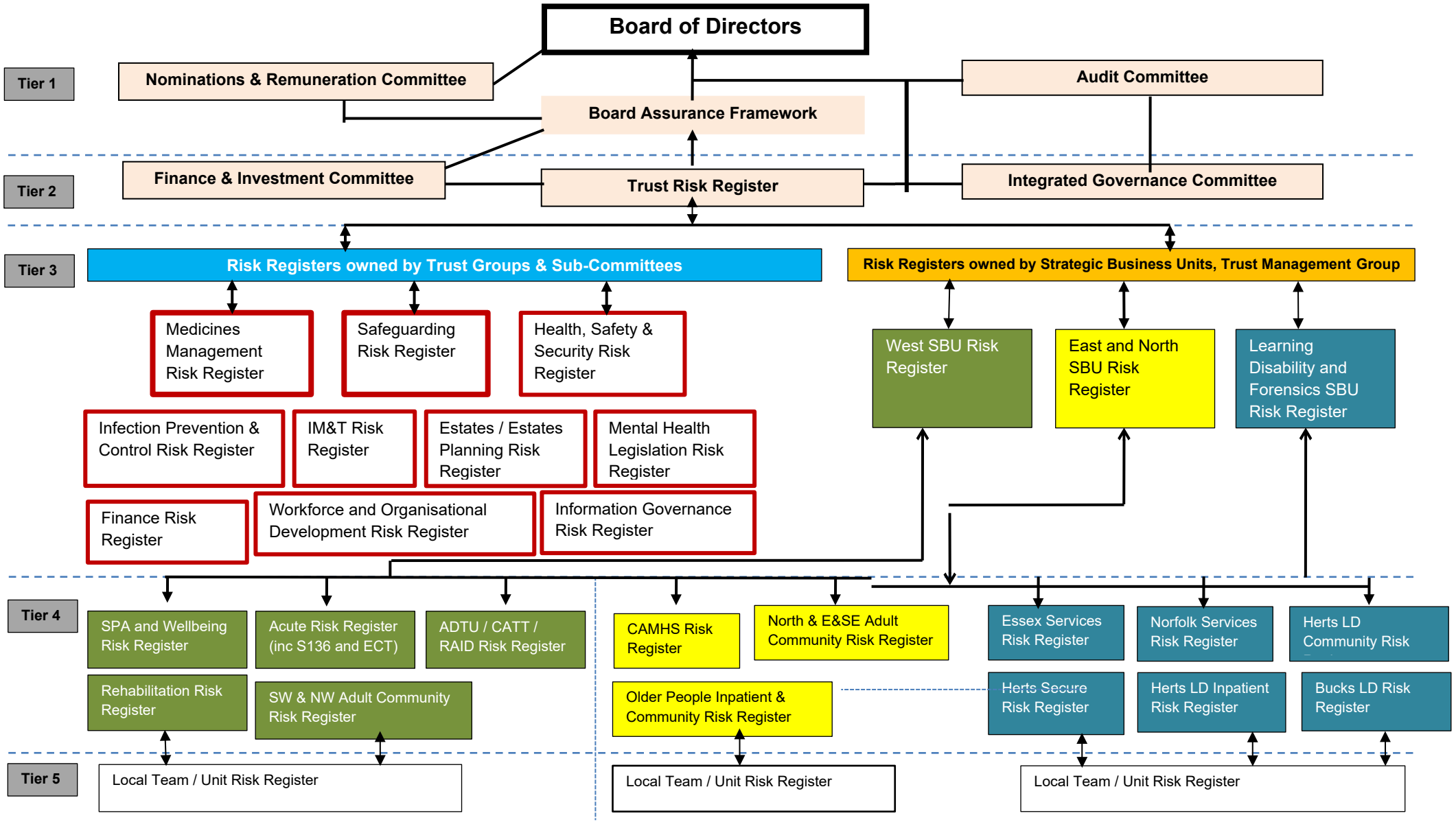
In addition to the Board Assurance Framework (BAF), the Trust operates five tiers of risk management which are all interlinked via an escalation process. The escalation of a risk is dependent upon the level of the risk, or on whether it is felt that the risk needs specialist management at a higher tier, such as the risk requiring a multi-directorate approach to its management.

The registers are recorded using a standardised risk matrix and the severity of each risk is rated according to the Consequence x Likelihood risk assessment matrix within the Risk Management Strategy to establish the risk score which helps guide action at the appropriate level.

There is a clear process for escalating high or significant risks (see **Figure 3** below). The Trust does not have a static risk appetite. The Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. In any event there must be consultation with the Board if there needs to be material altering of significant risk scores by directorates, departments or teams. The statutory and assurance committees and the executive team have regular oversight of all relevant risks from the Trust Risk Register.

Figure 3

Board to Ward Risk Management and Escalation Structure



4.4 Local and Directorate Risk Registers

Each ward team or department produces a local risk register. The register is developed in response to the identification of local risks that may impact on the delivery of their immediate service. Local risk registers are recorded using the Risk module on Datix.

Appropriate steps have been taken to ensure that processes are in place at both clinical service and departmental levels to update and maintain their risk registers. Monthly updates from local and directorate risk registers are provided via the Risk & Compliance Manager for inclusion into the Trust's Risk Register.

All local risks are systematically reviewed within a specified time frame by the local teams to ensure that controls in place are effective, and assess whether the risk changes over time.

Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may also be identified by external factors e.g. national reports and recommendations or regulatory and enforcement notices etc.

4.5 Care Quality Commission essential standards of quality

The Trust registered with the Care Quality Commission (CQC) on 1st April 2010 and was inspected in April 2015 as part of a planned comprehensive inspection. The Trust achieved an overall rating of Good. The Action Plan which emerged from the inspection focused on some 'Must Dos' and 'Should Dos'. The Integrated Governance Committee has received 2-monthly updates on the CQC action plan.

5. Internal and external stakeholders and service user and carer Involvement

Within the Trust we have a Service User Council, Carer Council, Young People's Group and 'Making Services Better' Group for people with Learning Disabilities. Service User and Carer Groups/Councils have been a significant presence in the Trust for over 10 years. They raise and discuss a variety of topics with Trust staff at all levels, and are vital critical friends that the Trust can approach for honest feedback and comment from the perspective of lived experience.

2016/17 has been a particularly productive year for our Service User and Carer Councils. Both councils have been examining and assessing their position within and outside the Trust. They have taken a fresh look at their Terms of Reference, in particular looking at ways of increasing their influence and promoting the voice of service users and carers more generally. One important facet of this has been starting to build more links with service user and carer groups outside the Trust. The regular input of Healthwatch Hertfordshire to our meetings has been hugely valuable and we now have better links with local commissioning. They have also been working more closely with representatives of our Board of Governors.

All groups have also worked fairly intensively with Trust staff on projects which they are aware of being of great importance to many service users and carers. Examples of this have been their contributions to discussions about improving care coordination, use of the 'smoke free' policy and how the Trust's photograph policy will be implemented – as well as representatives becoming involved in new initiatives such as the Hertfordshire Wellbeing College (New Leaf) and the new HPFT Carer Pathway. There have been meetings with both service user and carers councils to discuss HPFT's Quality Account – and they have

been able to contribute to discussion about topics and desired outcomes. The Councils have also enthusiastically contribution to discussion about Quality Improvement.

The Carer Council have developed a clearly structured work plan as a focus for their activities – with priority areas being care coordination, progress following the CQC inspection – the 'good to great' initiative, implementation of HPFT's new Carer Pathway, progress with the Triangle of Care and improving staff understanding of the issues of confidentiality that particularly affect carers. The Carer Council Chair is now part of the Hertfordshire Carer Commissioning Group - so will be able to promote the views of HPFT's carers at that forum also.

The Service User Council has developed much closer links with Trust Governors – and two members of the Board of Governors are regular attendees at council meetings. In addition to the activities above which have occupied both councils, members of the Service User Council have been involved in development of the 'New Leaf' Wellbeing College, working on development of Crisis Cards and discussion about care coordination and 'moving on' plans. One particularly pro-active area of development is the planning of service-user led 'drop ins' to various other Service User Groups and Forums throughout Hertfordshire. Once underway, this will enable the Council to understand and promote the ideas and opinions of a far wider range of people throughout the area.

6. The Energy and Carbon Reduction

The Foundation Trust has undertaken risk assesments 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, together with Hertfordshire County Council, the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

7. Information governance

The Trust takes the management of risks to data security very seriously. In accordance with the 'Health & Social Care Information Centre's Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation' (27 February 2015, V5), there have been four level 2 breaches during the reporting period. These related to:

- one incident involving an unencrypted dictaphone
- three incidents involving inappropriate use of email

All four were reported to the Information Commissioner's Office as potential or actual breaches of confidentiality involving person identifiable data. For each breach, the Trust submitted an action plan outlining the remedial action taken. In each case the Information Commissioner considered the information provided by the Trust, was satisfied with the action taken and closed the incidents with no further action deemed necessary. To further reduce the risk associated with the potential loss of assets the Trust is exploring the potential to replace physical dictaphones with digital dictation.

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

The key financial policies and processes

As Accounting Officer I have responsibility to the Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good governance and systems of internal control designed to ensure that resources are applied efficiently and effectively.

The effective and efficient use of resources is managed by the following key policies:

Standing Orders

The *Standing Orders* are contained within the Trust's Constitution and set out the regulatory processes and proceedings for the Board of Directors and the Council of Governors and their committees and working groups including the Audit Committee, whose role is set out below, thus ensuring the efficient use of resources.

Standing Financial Instructions (SFIs)

The SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

They do this by laying out very clearly who have responsibility for all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to competitive procurement processes, effective and equitable recruitment and payroll
systems and processes. The budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are to be used in conjunction with the Trust's *Standing Orders* and the *Scheme of Delegated Authority* and the individual detailed procedures set by directorates.

Scheme of Delegated Authority

This sets out those matters that are reserved to the Board and the areas of delegated responsibility to committees and individuals. The document sets out who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective resources by ensuring that decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and rigor of the decision making processes are aligned with the strategic priorities of the Trust and it ensures that the Trust puts in place best practice in relation to its decision making.

Anti-fraud and Corruption including the Bribery Act 2010

The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery taking place could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This will help ensure that the taking or receiving of bribes is less likely and improve the integrity and transparency of the Trust's transactions and decisions.

The Trust Board places reliance on the *Audit Committee* to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and the Trust's internal control systems are robust and can be evidenced.

The Audit Committee agrees an annual work programme for the Trust's Internal Auditors and the Counter Fraud Service, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Protect, reports from which are reviewed by the Audit Committee. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the Regulators.

7. Annual Quality Report

The Directors are required under the *Health Act 2009* and the *National Health Service (Quality Accounts) Regulations 2011* to prepare Quality Accounts for each financial year. NHSI 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 has continued with following these steps to assure the Board that the Quality Report presents a balanced view:

- A stakeholder consultation process to agree quality priorities for the reporting and coming year, involving service users, carers, staff, Governors and partner agencies
- A review of all Trust services before the priorities are agreed
- A Quarterly Quality report to the Board leading to scrutiny of whether the focus is right
- Sharing the draft Quality Account/report with partner agencies for comment, with the primary commissioners having the legal right to point out inaccuracies.

The Trust follows these steps to assure the Board that there are appropriate controls ensuring the quality of the data, thus:

- The Provision of appropriate training to all staff, including all new starters, on data inputting.
- An elimination where possible of manual approaches to data gathering and analysis, including investment in new systems
- An audit of supervision to gain assurances that the process is robust in relation to clinical record keeping and data quality
- A separate audit of Clinical Records Management

The accuracy of information for quality reports is assessed via:

- Systematic checks within the Informatics and performance improvement teams themselves
- A scrutiny of the quarterly reports at Board, where any errors and/or corrections are duly noted
- An annual External Audit Assurance as mandated by NHSI

We continue to review our performance reporting framework, considering the increasing size and complexity of the quality measurement and reporting in the Trust. There has been some simplification of reporting processes and some reconsideration of the use of certain metrics. A new business intelligence system was introduced last year with real time capability at local levels where access to performance metrics is more readily available.

The quality metrics which are contained in quarterly Board reports are agreed by the Board after a period of internal and external consultation. The quality metrics – as far as their accuracy and relevance as well as progress made – are each reviewed quarterly at the Board meetings. For a more detailed description of these processes, please refer to the quality report itself. Should an error occur during the year, the errors are corrected at the next Board quarterly report and the occurrence noted.

Processes are established to monitor compliance against Care Quality Commission (CQC) regulations (Health and Social Care Act 2008 Regulated Activities, Regulations 2014) using the updated Quality Visit process which is based on the CQC's key lines of enquiry.

The Intelligence Monitoring Reports are used to check performance against what teams report and to anticipate any potential risks in the future. The Integrated Governance Committee (a Board sub-committee) is then kept informed of the completeness of the data and any areas of concern.

Compliance with the CQC compliance has been monitored in the past year through the following procedures:

- The CQC review and quality improvement plans held locally by the Team Leaders/Managers
- The *CQC Provider Compliance Assessments (PCAs*) completed by the Service Line Leaders recording all evidence of quality improvement within their local service area
- The *Quality and Risk Profile (QRP*) provided by the CQC on a monthly basis is reviewed by the Registration Leads and the risks are then monitored with improvement plans advised to the appropriate sub groups of the IGC
- A revised Trust wide programme of internal quality visits – closely based on the CQC's current standards
- Compliance with each of the above is advised in a bi-annual report to the IGC.

The Trust is currently reviewing the process of the leads and their responsibilities in consideration of the development of the CQC essential standards.

8. 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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report/Account 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, the Audit Committee and the

Integrated Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that had been applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Board and Committees in this process:

- The Board reviews the Board Assurance Framework on a quarterly basis along with the Trust Corporate Risk Register

- A programme of Risk Management training for all staff has been delivered

- The internal audit plan which is risk based, is approved by the Audit Committee at the beginning of each year. Progress reports are then presented to the Audit Committee on a quarterly basis with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly escalate any areas of concern to the Board via a Committee Report and produces an annual report on the work of the Committee and a self-evaluation of its effectiveness.

- The Executive Team meets on a weekly basis and has a process whereby key issues such as performance management, serious incidents, recruitment and retention, safe staffing, action plans arising from external reviews and risk management are considered both on a planned timetable and an ad-hoc basis if there is a need. It also reviews the Trust Risk Register on a monthly basis.

- The Board and its statutory and assurance committees have a clear annual cycle of business and reporting structure to allow issues to be escalated via the *'ward to board'* risk escalation framework.(**see Figure 3**) The work of each committee is outlined in the Governance Structure at **Figure:1**

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 the work of internal and external audit, the external review processes for the clinical negligence scheme along with the National Health Service Litigation Authority (NHSLA) and the Care Quality Commission.

In 2016-17, a Well Led independent Review as set out in the *Monitor's (now NHSI) Risk Assessment Framework* was undertaken by the Foresight Group. The Report identified that the Trust was Green in most domains and Amber/Green in just a few. The Trust's response to the recommendations made has in the main registered our actions as completed.

Head of Internal Audit Opinion

The Head of Internal Audit has provided an overall opinion of positive assurance based on their work during 2016-17, which gives me confidence that we have a solid foundation on which to build our improvement work.

Conclusion

In 2015 the Care Quality Commission assessed the Trust as overall ***Good*** across all its domains and the health regulator, Monitor (later in the year NHSI, gave us a rating of ***Green*** for compliance.

As a result of my review of the system of internal control and despite the positive strides made by the Trust, I identified that further work needs to be carried out to support the on-

going improvement of quality governance and the robustness of assurances received during 2016/17. They are:

- As with other Trusts across the country the challenges around Workforce stability need addressing
- Cyber Security poses a new challenge and needs addressing
- Ensuring that the Trust continues to respond to the changing landscape.

Signed:_____

Name:

Chief Executive

Date: 2017

Author: Audley Charles