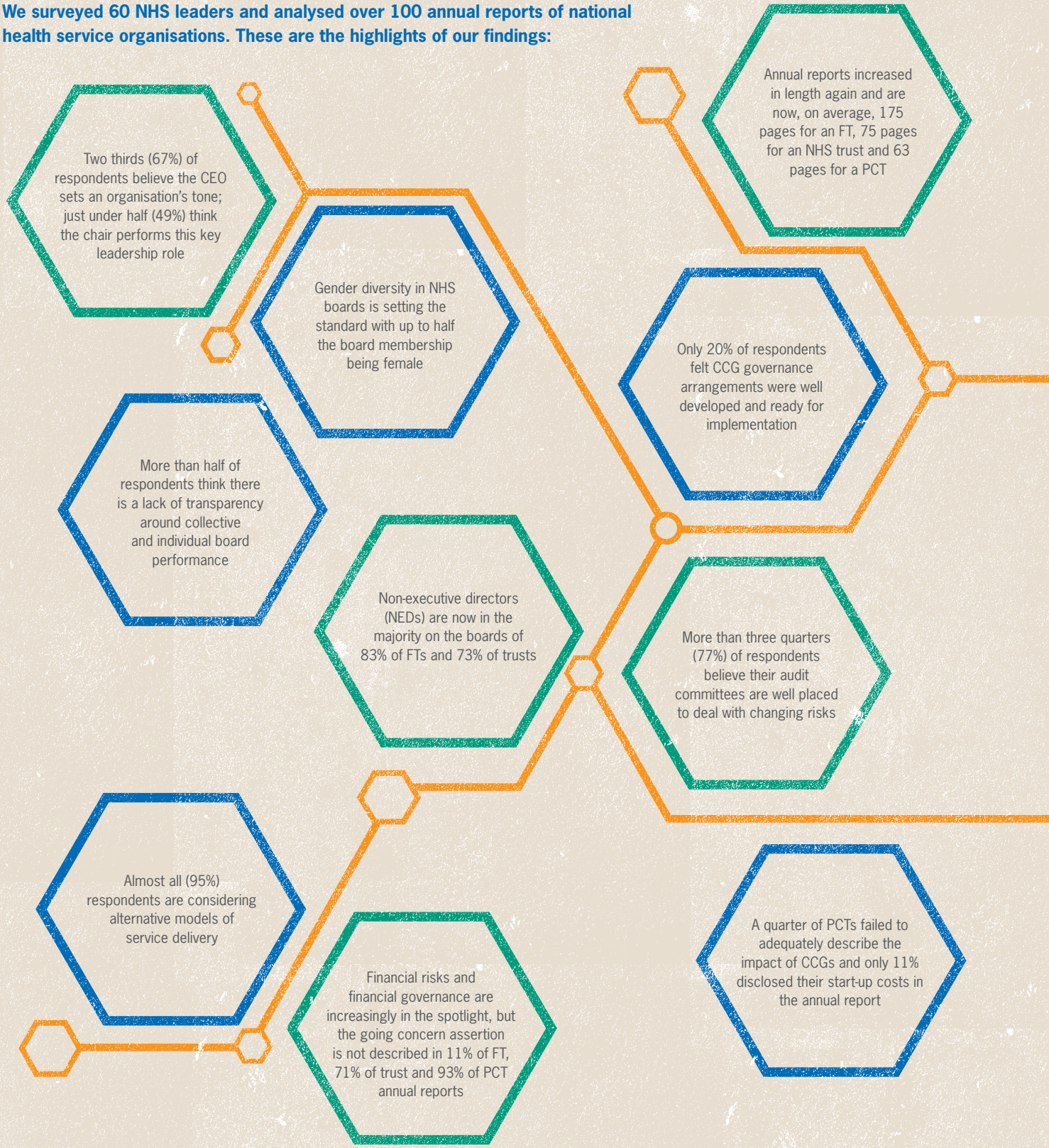
Grant Thornton

NHS GOVERNANCE REVIEW 2013

The formula for clear governance
Finding the equilibrium

2012 highlights

We surveyed 60 NHS leaders and analysed over 100 annual reports of national health service organisations. These are the highlights of our findings:



Contents

Methodology

Our data analysis is based on over 100 2011/12 NHS annual reports and this year we have expanded our review to include primary care trusts (PCTs). We also received more than 60 survey responses from NHS leaders to add comment to our objective data analysis. We set out our findings against each type of NHS body, referred to as PCTs, trusts and FTs throughout this report.

This approach builds on our work from last year, giving us the unique opportunity to review the evolution of NHS corporate governance and provide a comprehensive review of the state of governance across the service.

Executive summary

Welcome to Grant Thornton's annual review of governance in the National Health Service (NHS), part of our cross-sector analysis of UK governance practice.

The NHS is at a significant crossroads. In 2013, its challenges include:

- responding to the 2013 publication of the Francis report on Mid Staffordshire NHS Foundation Trust
- answering issues about the quality of care raised by the Care Quality Commission (CQC), Monitor and other health watchdogs
- adjusting to new commissioning arrangements
- managing mounting financial pressures.

Finding the right formula for effective and embedded governance frameworks will be essential to meeting these challenges and to ensuring NHS organisations progress effectively, with the support of all their stakeholders. Good governance is essential to:

- **patients** – because they depend on the quality of judgements the NHS makes
- **the public** – as it inspires confidence that the best decisions are being taken for the right reasons, that the quality of healthcare is protected and that public money is being wisely spent
- **clinicians** – because it supports them in making the best decisions, reduces the likelihood of things going wrong and protects them when they do.

NHS governance reporting still needs greater transparency, consistency and quality.

Applying useful learnings

This report is part of our wider review of corporate governance and complements our similar reviews on the FTSE 350, local government and charities.

Our ambition for this comprehensive programme is to enable organisations to improve governance by learning from other sectors and their peers, to the benefit of themselves and those they serve. Particularly for 2013, Monitor is introducing a new licence as part of this requirement.

NHS provider licence

Monitor is consulting on the new NHS provider licence[1], brought in through the Health and Social Care Act. It sets out three components of governance in the licence:

1 Board leadership

2 Organisational management

3 Quality governance.

Monitor also requires licencees to provide: "a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks".

[1]The New NHS provider licence: consultation document, issued 31 July 2012

Overall trends in reporting

This year, the quality of NHS governance reporting improved, with foundation trusts (FTs) making particular progress. As primary care trusts (PCTs) work towards new commissioning structures they have not invested in governance reporting and, consequently, demonstrate poorer standards in this area. Their successors, the clinical commissioning groups (CCGs), will need to draw on best practice from elsewhere, rather than relying on past precedent, if they are to launch in 2012/13 with robust reporting arrangements.

NHS governance reporting still needs greater transparency, consistency and quality. There are many examples of NHS organisations with strong governance frameworks across the country, yet on the basis of this year's review, the reporting of these arrangements often does the NHS a disservice.

Leadership

Leadership is a key feature of effective governance. NHS leaders will need to direct their organisations wisely and ethically through tough challenges in the years ahead.

It has been three years since the Healthcare Commission linked poor leadership and NHS failure in its published investigation into Mid Staffordshire NHS Foundation Trust: "We have drawn together the different strands of numerous, wide-ranging and serious findings about the trust which, when brought together, we consider amount to significant failings in the provision of emergency healthcare and in the leadership and management of the trust … We had previously raised concerns with Monitor about the leadership of the trust, and we note that both the chair and chief executive have left the trust in the two weeks leading up to the publication of this report"[2].

Chairs hold a prime leadership responsibility for setting the tone of governance and ensuring the correct values are championed. As NHS organisations face radical change, the chair must support the board and chief executive in establishing and embedding shared values that can guide and support all staff through the transition. However, in our survey, 67% of respondents felt it was the chief executive, not the chair, who sets the tone, with the medical/nursing director and finance director in joint second place (51%). The chair fell into third place with 49%, just 2% ahead of non-executive directors (NEDs).

Accountability

The board of directors of each NHS foundation trust (the board) is accountable for its success or failure and must ensure that the trust operates effectively, efficiently and economically.

Monitor's Compliance Framework 2012/13, Introduction, Paragraph 12

The fact that more than one third of respondents think NHS corporate structures could be improved, suggests that accountability, too, has some way to go.

The number of board meetings per year remained static. However, there was a marked increase in the frequency of key committee meetings, such as those dealing with quality, risk and finance. Disclosures on board meetings and attendance have improved, although PCTs lag behind.

More than half of respondents perceived a lack of transparency on both collective and individual board performance. Despite a small improvement, the transparency of performance management arrangements and links to executive pay remain weak.

In December 2012, the Department of Health published its final report into Winterbourne View Hospital[3]. Included in the lessons learnt is a proposal to strengthen the accountability of the board, and senior managers, against the quality of care provided. The annual report, including transparency on the performance evaluation of the board and its directors, is a crucial tool for boards to be demonstrate accountability.

[2] Source: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 - March 2009, Volume 1

[3] Source: http://www.dh.gov.uk/health/2012/12/final-winterbourne/

NEDs and governors

The ratio of NEDs on NHS boards has increased, providing a more balanced board. Positively, 81% of survey respondents thought NEDs offered an effective challenge. We advise NHS bodies to make good use of NEDs' commercial skills and experience in the new, more commercial healthcare environment.

Women continue to have a strong foothold at board level, holding between 37% and 49% of voting positions.

Councils of governors are becoming increasingly effective. However, to hold boards to account, they will need to keep in step with organisational change – and receive improved performance evaluation data.

Financial governance

Against a background of pressure from exacting savings targets, financial resilience and going concern disclosures have improved. Eighty-four per cent of FTs and 26% of trusts described the rationale for regarding the trust as a going concern, however no PCT made this disclosure, or referred to the going concern of their services into the future.

Almost all (95%) of our survey respondents are considering alternative models of service delivery. More than four out of five (83%) expect to use special purpose vehicles. As public services evolve, accountability must remain a core principle.

Once again, organisations' internal risk reporting systems and their annual reports are not telling the same story.

Quality governance

Quality, similarly, must not be diluted in new partnership arrangements. Almost nine out of 10 (89%) respondents believe their quality governance arrangements have demonstrably improved patient care. We urge bodies to review this assertion to ensure it reflects true conviction that stands up to transparency and scrutiny and can be supported by clear performance data.

FTs are far more likely than trusts to publish their quality reports within the annual report: 89% compared with 11%. Of those organisations that publish the quality report separately, less than half tell readers where copies can be obtained. This is a barrier to accessibility and transparency.

Risks and performance

Robust risk reporting and management are crucial to retaining public confidence and effective management. Our review suggests NHS risk reporting still needs to improve.

Once again, organisations' internal risk reporting systems and their annual reports are not telling the same story.

This year, there were again inconsistencies between the different vehicles, with the annual report often playing down risk.

NHS bodies must present key performance indicators (KPIs) and other measures of success clearly, to hold the board to account. We found FTs and trusts used a broad spread of financial and non-financial indicators; PCTs had a much narrower focus.

Financial risk is, unsurprisingly, the key perceived risk facing the NHS, far above quality (in second place) and operational performance (in third). Most FTs improved their financial risk ratings (FRRs) and governance risk ratings (GRRs), but an increasing number have FRRs of one or two and GRRs of red or amber-to-red. These organisations are in danger of being left behind and of having to find alternative solutions to survive.

Audit and assurance

There was a significant improvement in audit committee disclosures and more than 78% of respondents believe their audit committees are well placed to deal with changing risks.

However, according to the annual report, internal audit is receiving less attention: FT audit committee monitoring of the function's effectiveness fell by 10% to 78%, although our experience at audit committees suggests the true position to be better.

Clinical audit is being overlooked even further: only 43% of FTs and 26% of trusts included disclosures on audit committee oversight of clinical audit.

Health reforms

Outgoing PCTs have not set a comparably high standard for governance reporting for their CCG successors to follow. A quarter (25%) of PCT annual reports failed to adequately describe the impact CCGs would have and only 11% disclosed the set-up costs incurred.

There is concern about the readiness and effectiveness of nascent CCG boards: just 20% of respondents think they are fit to launch. Our analysis shows boards are inconsistent in balance and composition and many still have vacant posts.

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Annual reports

Four out of five (80%) respondents believe the annual report is an important way to communicate key information to stakeholders. Yet, this year, annual reports again increased in length, and are now, on average, 175 pages for an FT (2011: 151) and 75 pages for an NHS trust (2011: 59).

In part, this increase is the result of regulatory requirements. However, we feel annual reports still contain a significant amount of 'clutter' that obscures key messages and detracts from transparent and high quality corporate reporting.

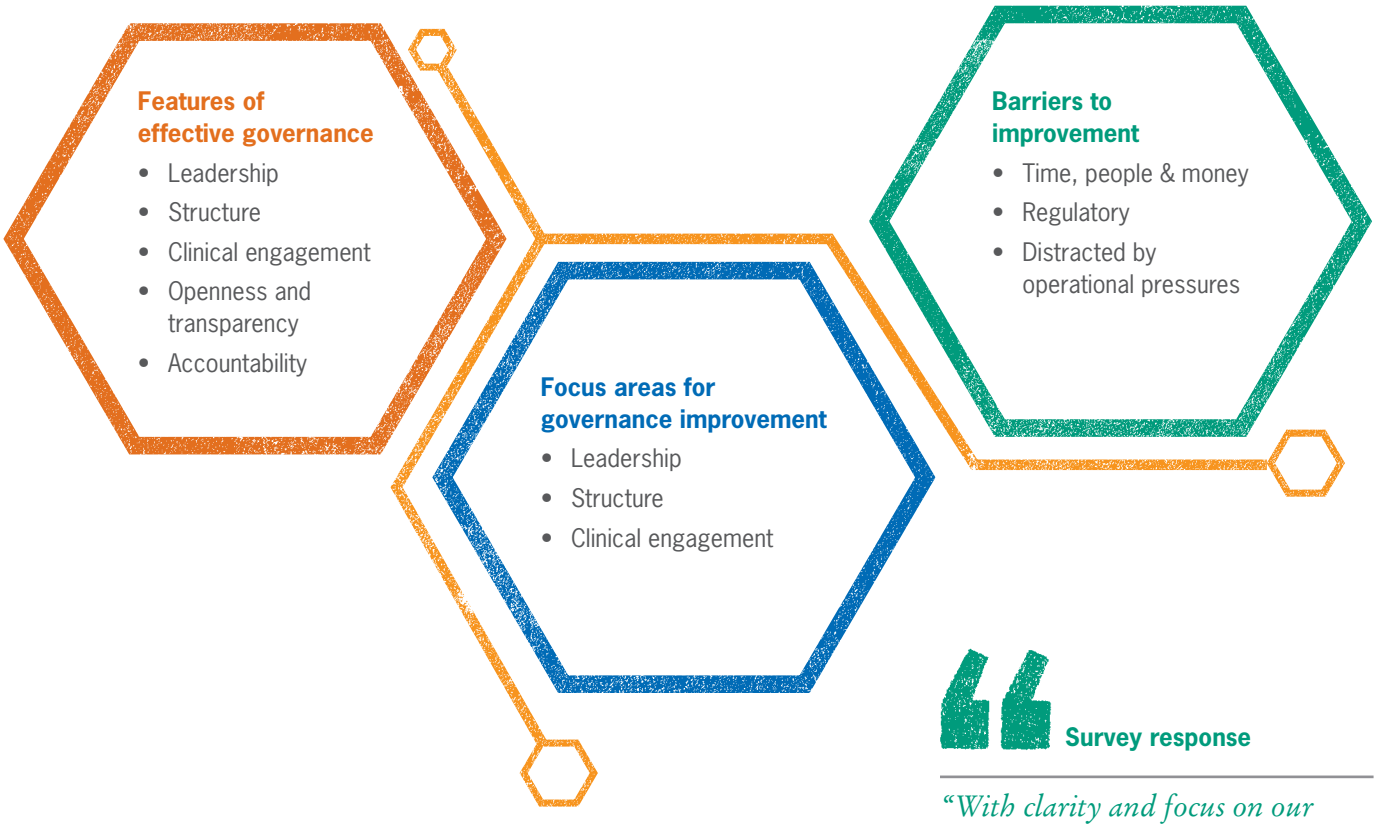
Leadership

Nationwide changes in the NHS require strong and principled leadership from board chairs, but our survey suggests that many have not seized the governance mantle.

Effective governance requires the right organisational culture and principled individual behaviour: it is NHS leaders' responsibility to embed such attributes by setting the right tone. Leaders need to live and breathe their organisation's values and be able to set out, in simple terms, their core strategic principles.

They must also ensure employees can identify with the values and are able to explain how they influence their work. Leadership was recognised by our survey respondents as a fundamental feature of effective governance, but crucially was also identified as a key area in need of improvement.

NHS governance themes and challenges from our survey



Survey response

"With clarity and focus on our underlying purpose – governance is how we make sure we do what we're here to do."

The role of the chair

Chairs have a crucial role in setting the right tone and achieving cultural change.

As the public's primary representative inside the boardroom, the chair must ensure the right thing is always the done thing.

In the face of severe financial challenges and ever-increasing expectations on service availability, NHS organisations are increasingly required to make difficult decisions and continue to face pressure, to put cost savings first. As the public's primary representative inside the boardroom, the chair must ensure the right thing is always the done thing.

That is not to say that the chair can do it alone. No chair – not even the most passionate governance advocate – can embed ethical principles and effective practices without support from other senior figures, particularly the chief executive and trust secretary.

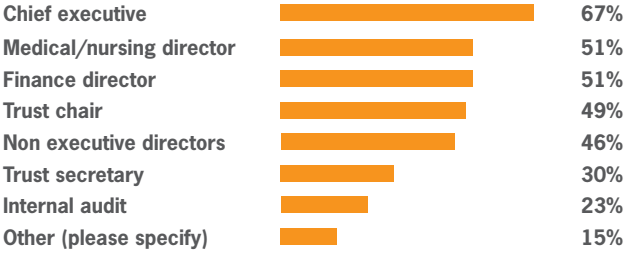
Overall our survey shows that – in the perception of respondents at least – the 'natural order' of leadership is inverted: 67% of respondents felt it was actually the chief executive who was responsible for setting the tone, with the medical/nursing director and finance director in joint second place (51%). The chair fell into third place (49%), only marginally ahead of NEDs (47%).

These perceptions raise the question of whether chairs and trust secretaries/directors of governance are taking sufficiently active governance roles within their boards.

Effective self-governance sits at the heart of the Compliance Framework. The board takes primary responsibility for compliance with the Authorisation. The chair of an NHS foundation trust should ensure that the board monitors the performance of the trust effectively and satisfies itself that appropriate action is taken to remedy problems as they arise.

Monitor's Compliance Framework 2012/13, Introduction, Paragraph 12

IN YOUR ORGANISATION, WHICH INDIVIDUAL(S) SETS THE TONE FOR GOVERNANCE?



Survey response

How does this individual set the tone for governance?

"Takes responsibility at board level and drives the tone through the goals and values of the trust."

"Walking the walk, not just talking the talk."

"Less acceptance of status quo as a sign of all is well."

What do we expect from the chair?

- **Set the tone** – with internal and external stakeholders, supported by tools such as the Department of Health's (DH) Board to Ward guidance, to open honest dialogue with frontline staff
- **Collaborate** – with the chief executive, to embed values and governance
- **Partner** – with clinical leads, to support clinical engagement and engender a sense of shared purpose
- **Support** – the trust secretary/director of governance to implement effective and robust governance structures
- **Publish** – their annual report introduction to outline, honestly, how they set the tone for governance and oversee the embedding of the organisation's values

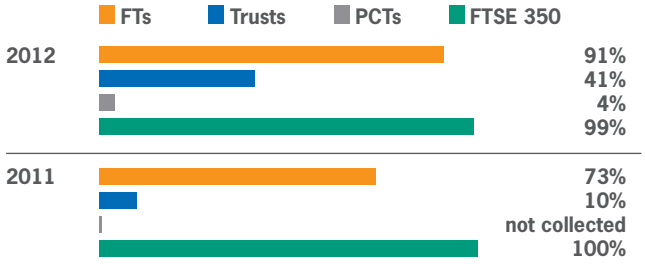
The annual reports of 80% of trusts (up from 45%), 83% of FTs (slightly down from 87%) and 86% of PCTs describe how the board operates and how its duties are discharged. An improvement in transparency is a positive step, but, as more than one third (34%) of those surveyed agreed, there is still a need to strengthen corporate structures.

Disclosures on board meetings and attendance statistics have got better, but quality could improve further. For example, most trusts and PCTs do not indicate the level of attendance at regular meetings – a fundamental of FTSE 350 disclosures.

The number of board meetings remained static, year-on-year, while quality, risk and finance committee activity increased substantially. Quantity does not, however, always equate to quality. As 34% are dissatisfied with the effectiveness of corporate structures, we recommend that boards assess the value of meetings. Boards may also ask whether the increase in sub-committee meetings has led to shorter board meetings that focus on strategy.

IN ENSURING CLEAR LINES OF ACCOUNTABILITY, HOW EFFECTIVE DO YOU THINK YOUR ORGANISATION'S CORPORATE STRUCTURES ARE?

THE PROPORTION OF REPORTS IN WHICH BOTH THE NUMBER OF MEETINGS OF THE BOARD AND COMMITTEES AND OVERALL ATTENDANCE IS DISCLOSED



Average number of meetings		Board meetings	Audit committee	Quality committee (or equivalent)	Risk committee (or equivalent)	Finance & performance committee (or equivalent)
2012	FTs	11.1	5.5	8.3	6.4	7.8
	Trusts	10.6	6.3	8.4	6.4	7.8
	PCTs	10.0	not disclosed	not disclosed	not disclosed	not disclosed
	FTSE350	8.5	4.4	not collected	not collected	not collected
2011	FTs	11.5	5.4	5.8	6.1	6.1
	Trusts	10.4	5.2	4.0	6.5	10.0
	FTSE350	8.7	4.4	not collected	not collected	not collected

Reporting board meetings

Annual reports should include:

- a simple info-graphic on the board and sub-committees, showing the chair of each, to demonstrate the governance framework
- tabular layout of committee meetings and attendance records.

Accountability and transparency are not just characteristics of good leadership, they are vital to maintaining public faith in the quality and sustainability of NHS services.

Questions to consider on board meetings

- Has the increase in sub-committee meetings led to shorter board meetings and allowed the board to focus on strategic issues?
- When was the delegated authority for decision making last reviewed?
- When was the last time the effectiveness of key committees last tested?
- NED time commitment is heavy: the NHS Trust Development Agency estimates the role requires at least 2.5 days per month – are board meetings focused enough to enable the best use of NEDs' time?
- Is the rise in the number of meetings driven by an increase in business?

The effective board

- Clear strategy aligned to capabilities
- Vigorous implementation of strategy
- Key performance drivers monitored
- Effective risk management
- Sharp focus on views of key stakeholders
- Diverse membership
- Healthy, constructive tension
- Regular evaluation of board performance

CCG boards in development

Respondents revealed a high level of concern about emerging CCGs' corporate structures and readiness for implementation. Eighty per cent felt governance arrangements were not sufficiently developed.

Seventy two per cent felt the proposed membership and size of CCG boards would not support effective governance. (Each CCG board requires a chair, an accountable officer, a CFO, two lay members, a nurse, a medical director and a secondary care clinician.)

Our own analysis of CCG boards, which still have many unfilled executive and lay posts, found much variance in practice with board members ranging from six to 25. There was little correlation between board size and population served.

At this important crossroads in the evolution of NHS commissioning, it is important for CCGs to focus on core governance principles to identify the most effective form of governance. A 'reflect and refresh' review during 2013/14, to test whether arrangements are proving fit for purpose, is also recommended.

TO WHAT EXTENT DO YOU AGREE WITH THE FOLLOWING STATEMENT: "GOVERNANCE ARRANGEMENTS FOR OUR CCG ARE WELL DEVELOPED AND READY FOR IMPLEMENTATION"?

TO WHAT EXTENT DO YOU AGREE WITH THE FOLLOWING STATEMENT: "THE PROPOSED MAKE-UP AND SIZE OF CCG BOARDS WILL SUPPORT EFFECTIVE GOVERNANCE"?

Board evaluation and accountability

Accountability

Adjective

1 Required or expected to justify actions or decisions; responsible

2 Able to be explained or understood

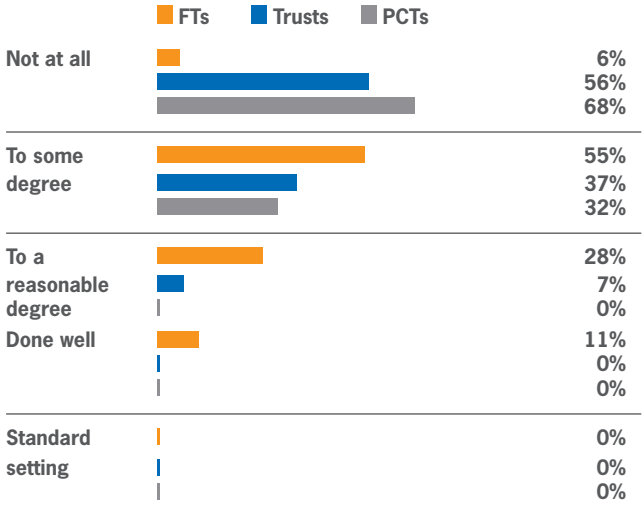
Oxford English Dictionary

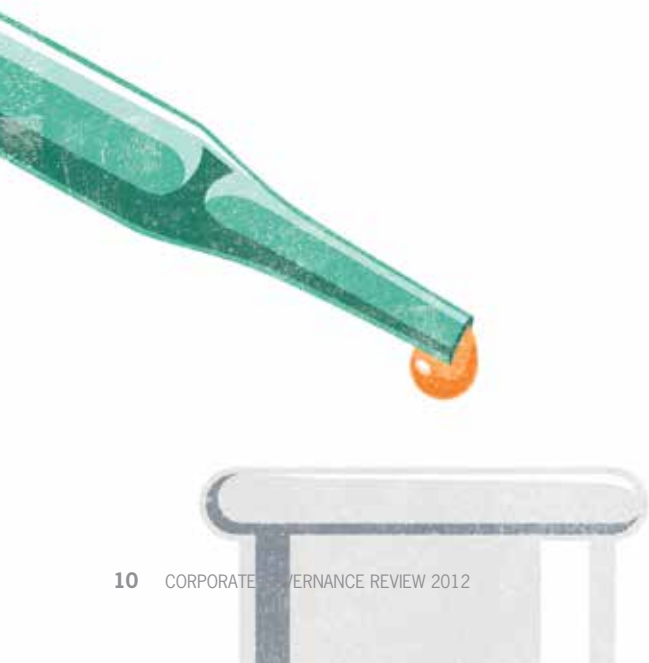
Accountability and transparency are not just characteristics of good leadership, they are vital to maintaining public faith in the quality and sustainability of NHS services.

Explanations that boards, committees and individual directors were evaluated have improved significantly. In 2012, 6% of FTs and 56% of trusts were silent on this, down from 34% and 79%, respectively. This brings FTs closer to the large corporate sector, where only 3% failed to provide any explanation on performance evaluation.

However, few NHS organisations articulated in their annual reports how performance was measured, either for individuals, or the full board: this area needs significant development.

HOW MUCH EXPLANATION IS THERE OF HOW THE BOARD, COMMITTEES AND INDIVIDUAL DIRECTORS ARE ANNUALLY FORMALLY EVALUATED FOR THEIR PERFORMANCE?

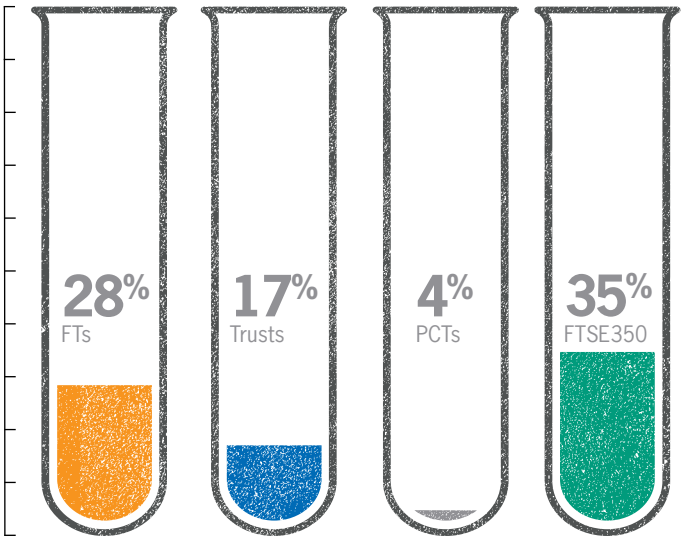




We believe disclosure should cover all board members, not just executives. Such transparency would both instil public confidence in leadership and enable councils of governors to hold boards to account.

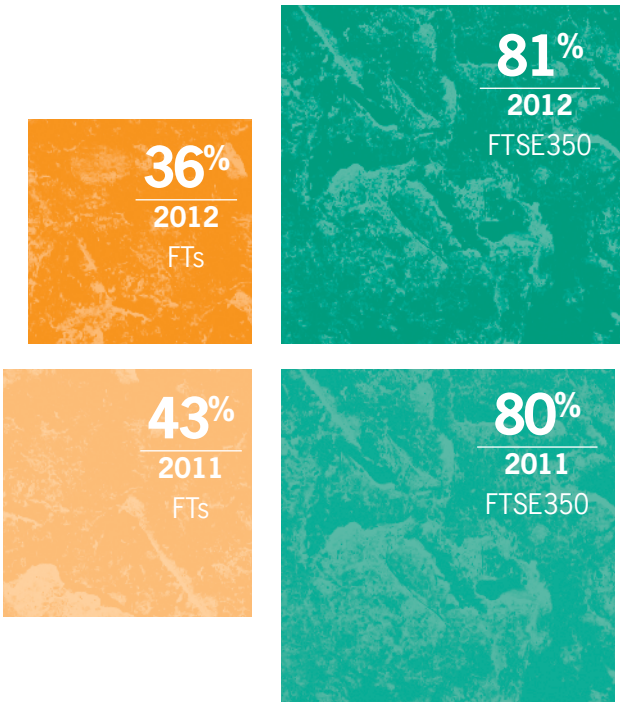
THE ANNUAL REPORT EXPLAINS WHETHER AN EXTERNAL EVALUATION OF BOARD EFFECTIVENESS HAS BEEN CARRIED OUT

2012

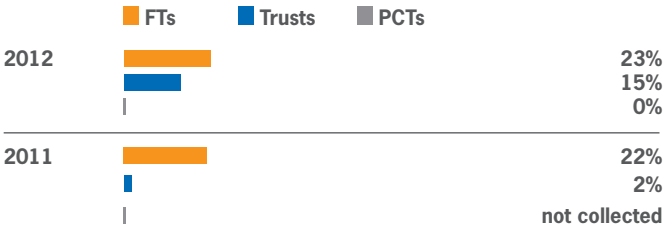


OUR ORGANISATION PROVIDES SUFFICIENT PUBLIC INFORMATION ON HOW THE BOARD AND INDIVIDUAL DIRECTORS ARE ANNUALLY FORMALLY EVALUATED FOR THEIR PERFORMANCE

THE NON-EXECUTIVE DIRECTORS (OR GOVERNORS) MEET WITHOUT THE CHAIR AT LEAST ANNUALLY TO APPRAISE THE CHAIR'S PERFORMANCE



THE NON-EXECUTIVE DIRECTORS (OR GOVERNORS) MEET WITHOUT THE CHIEF EXECUTIVE AT LEAST ANNUALLY TO APPRAISE THE CHIEF EXECUTIVE'S PERFORMANCE



Remuneration and performance appraisal

Effective and transparent disclosure on executive pay and performance is a key ingredient in good corporate governance. The recent furore over the package awarded to the outgoing BBC director general after his 54 days in office, shows the level of public sensitivity about executive reward. If the NHS is not open about board performance and remuneration, and details leak out, there could be a damaging backlash. In 2013, we would expect transparent reporting of executive pay and severance arrangements, particularly in PCTs.

Organisations are becoming more open about the performance evaluation of chairs and chief executives. This year, 80% of FTs disclosed appraisal information on their chairs, more than double the 2011 ratio (40%). And 81% of FTs and 24% of NHS trusts provided basic disclosures about their chief executives' evaluation, up from 31% and 15%.

However, the standard and quality of performance disclosures still leave room for improvement.

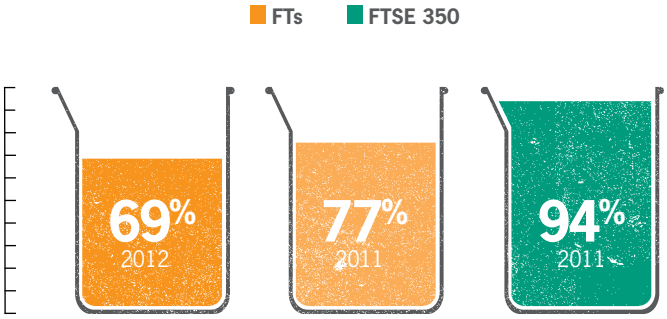
DETAIL PROVIDED ON THE PROCESS OF APPRAISING THE CHAIR

	Not at all	To some degree	To a reasonable degree	Done well	Standard setting
FTs	19%	55%	23%	0%	3%
Trusts	90%	10%	0%	0%	0%
PCTs	100%	0%	0%	0%	0%

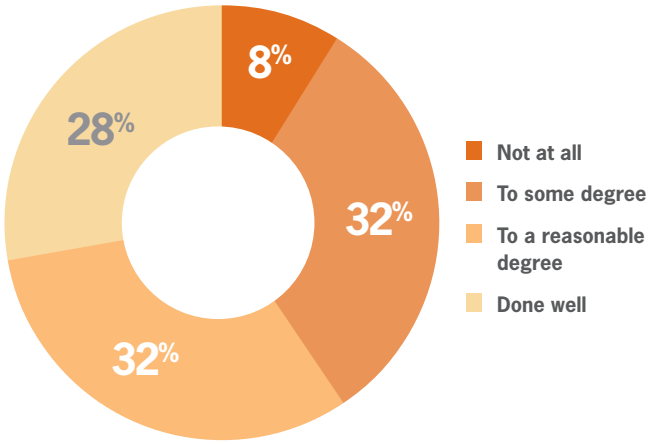
DETAIL PROVIDED ON THE PROCESS OF APPRAISING THE CHIEF EXECUTIVE

	Not at all	To some degree	To a reasonable degree	Done well	Standard setting
FTs	19%	64%	17%	0%	0%
Trusts	76%	24%	0%	0%	0%
PCTs	93%	7%	0%	0%	0%

IT IS STATED THAT THE BOARD (OR GOVERNORS WHERE REQUIRED) SET THE REMUNERATION FOR THE NON-EXECUTIVE DIRECTORS [FT ONLY]



THERE IS A DESCRIPTION OF THE WORK OF THE NOMINATION COMMITTEE, INCLUDING THE PROCESS IT HAS USED IN RELATION TO BOARD APPOINTMENTS [FT ONLY]



CHIEF EXECUTIVE £'000

	FTs	Trusts
Salary and allowances	158	163
Performance related bonus	7	10
Non cash benefits*	28	12

FINANCE DIRECTOR £'000

	FTs	Trusts
Salary and allowances	114	118
Performance related bonus	6	2
Non cash benefits	50	10

MEDICAL DIRECTOR £'000

	FTs	Trusts
Salary and allowances	117	100
Performance related bonus	89	55
Non cash benefits	28	6

NURSING DIRECTOR £'000

	FTs	Trusts
Salary and allowances	97	92
Performance related bonus	2	1
Non cash benefits	16	6

CHIEF OPERATING OFFICER £'000

	FTs	Trusts
Salary and allowances	104	92
Performance related bonus	16	3
Non cash benefits	3	1

OTHER DIRECTORS £'000

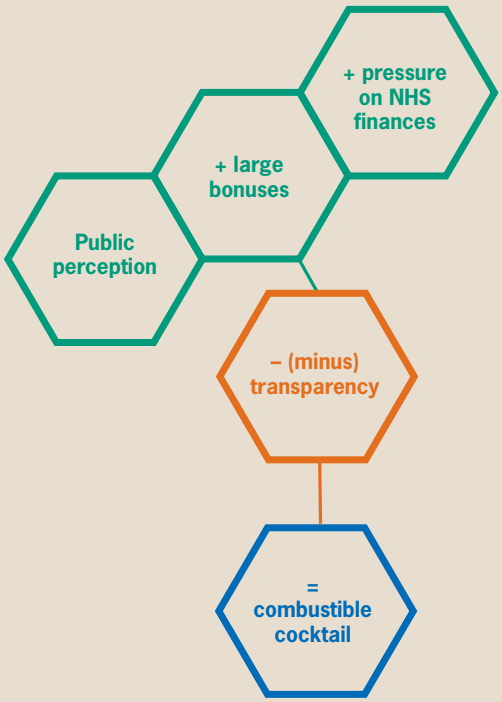
	FTs	Trusts
Salary and allowances	78	69
Performance related bonus	17	11
Non cash benefits	14	10

* Relates throughout to benefits in kind, eg car allowance.

Changes planned for quoted companies

Remuneration reports will be split into two sections: one detailing proposed future policy for executive pay, the other setting out how pay policy was implemented in the preceding year.

Organisations are becoming more open about the performance evaluation of chairs and chief executives.



Non-executive directors and governors

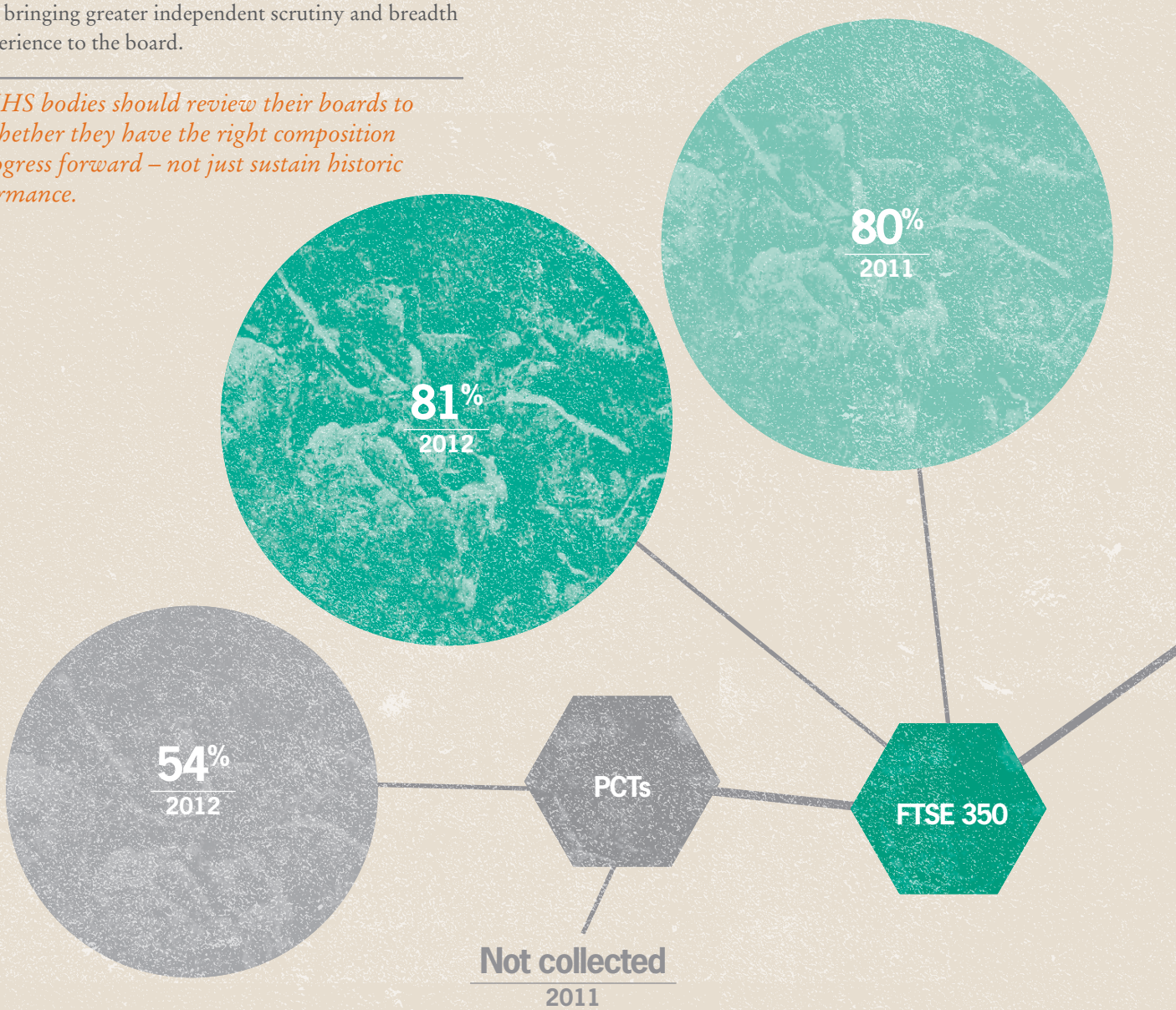
Boards have been strengthened across many organisations, with more non-executive directors and strong female representation. However, PCTs have lagged behind.

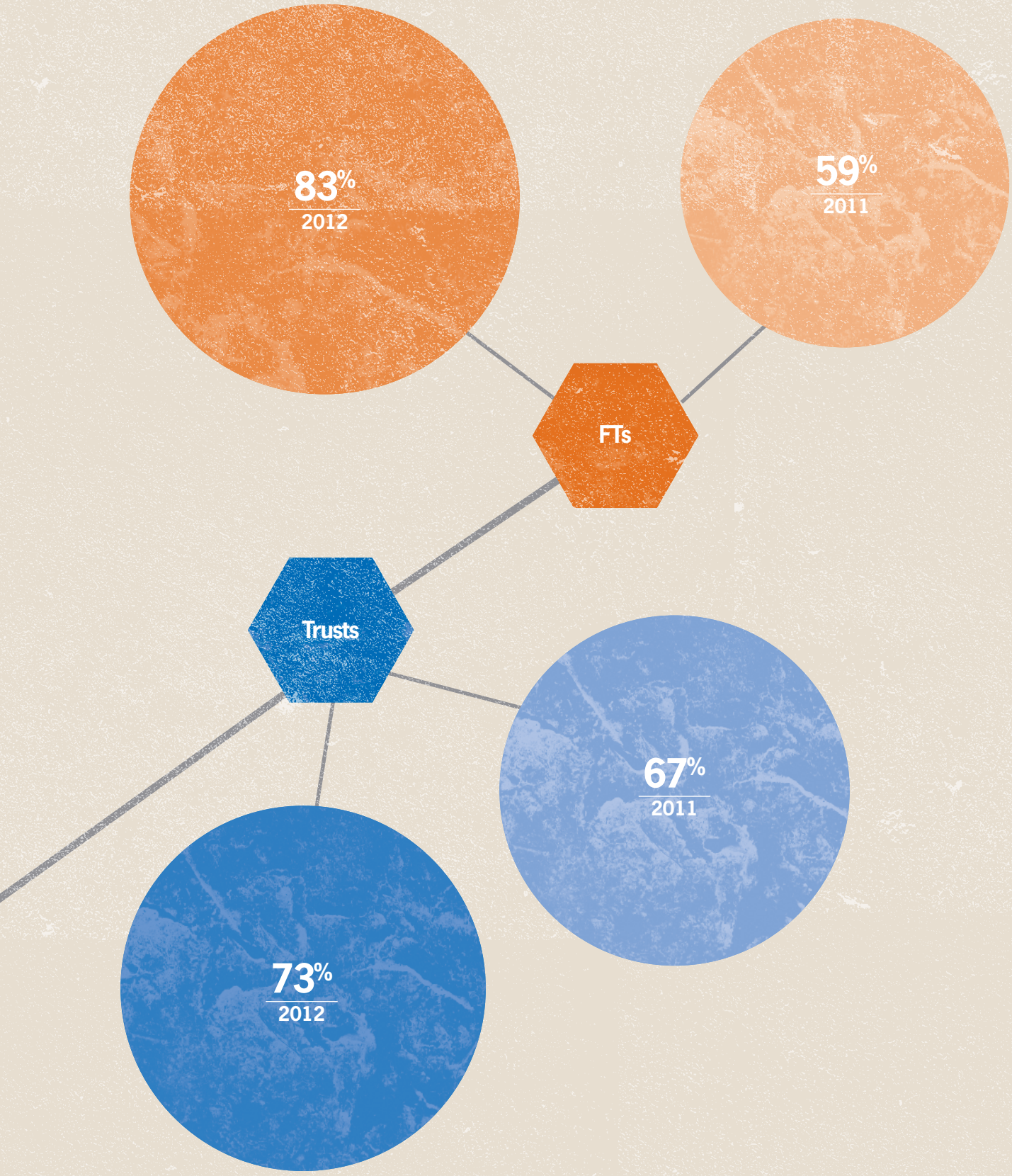
Non-executive directors

NHS boards, like all others, need non-executive balance and diversity to do their jobs effectively. NEDs are now in the majority on the boards of 83% of FTs and 73% of trusts, bringing greater independent scrutiny and breadth of experience to the board.

All NHS bodies should review their boards to see whether they have the right composition to progress forward – not just sustain historic performance.

AT LEAST HALF THE VOTING BOARD (EXCLUDING THE CHAIR) CONSISTS OF INDEPENDENT NON-EXECUTIVE DIRECTORS




83%
2012
59%
2011
FTs
Trusts
67%
2011
73%
2012

Composition

Last year, NEDs were in the minority on 41% of FT boards and 33% of trust boards. This year, the NED imbalance has reduced to 16% at FTs and 27% at trusts. The picture is not so positive for PCTs, where NEDs remain the minority in 46% of cases.

All NHS bodies should review their boards to see whether they have the right composition to progress forward – not just sustain historic performance. This is particularly pressing for CCGs, which need to consider carefully whether the governance models adopted from legacy PCTs offer sufficient independent challenge.

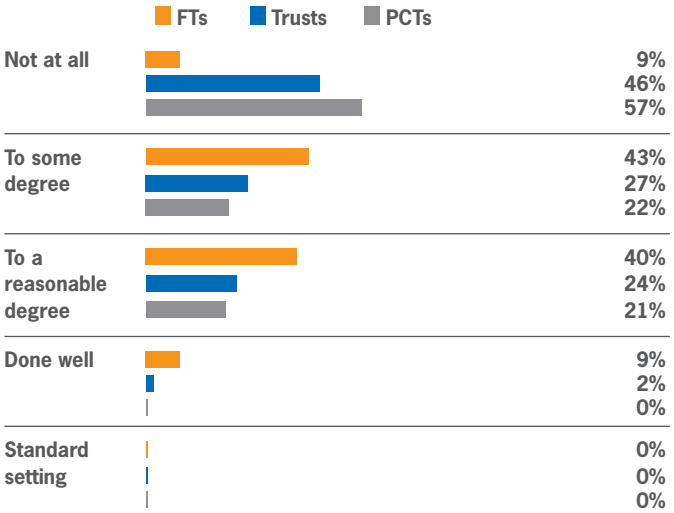
This year, board numbers increased. This expansion makes it even more important to justify and measure the value each member brings.

A slight fall in the number of associate directors was offset by a rise in the number of executive directors: the latter may reflect a desire for additional experience or expertise, or talent retention. There was also a rise in the number of NEDs.

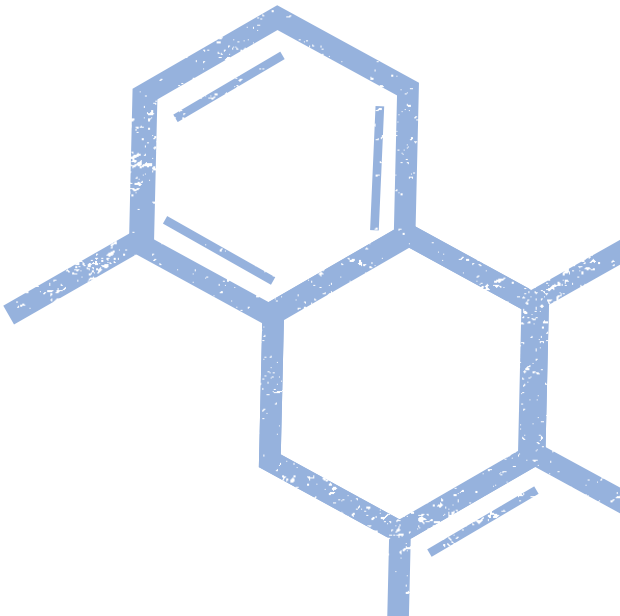
FTs have made considerable improvements in disclosures relating to the independence of their NEDs: only 9% now make no commentary on this, down from 30%. However, we suggest that trusts and PCTs, which trail behind, should review their approach.

Board composition		Average numbers of the Board	Average NEDs	Average voting executive directors	Average non-voting executive directors	Average non-voting NEDs	Chair
2012	FTs	14.6	6.0	6.6	0.7	0.2	1.0
	Trusts	14.2	5.3	6.2	1.5	0.2	1.0
	PCTs	19.4	7.7	9.3	1.0	0.4	1.0
2011	FTs	13.0	5.5	5.3	1.2	n/a	1.0
	Trusts	13.2	5.1	5.3	1.8	n/a	1.0

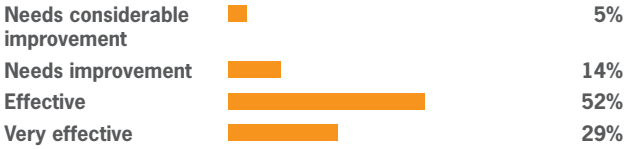
HOW WELL TRUSTS DESCRIBE THE CONSIDERATION OF INDEPENDENCE OF THEIR NEDS



Eighty-one per cent of our respondents thought NEDs offered an effective challenge at board meetings. NHS bodies would be well advised to make good use of this resource.

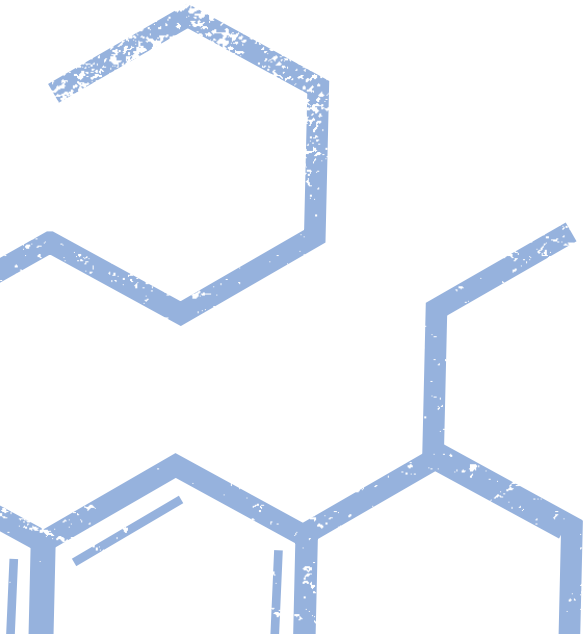


HOW CHALLENGING DO YOU THINK NEDS ARE AT BOARD MEETINGS?



Reporting on NEDs and governors

- Explain the value your NEDs bring rather than just listing their experience
- Describe clearly how NEDs maintain their independence
- If NEDs are in the minority, acknowledge this is a risk and explain how it will be managed
- Explain how NEDs hold the board to account, which committees they attend and how often
- Explain the relationship between the board and council of governors

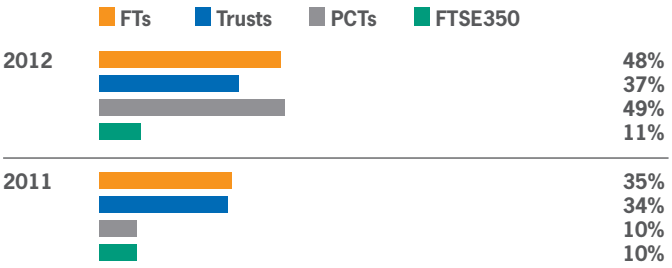


Diversity

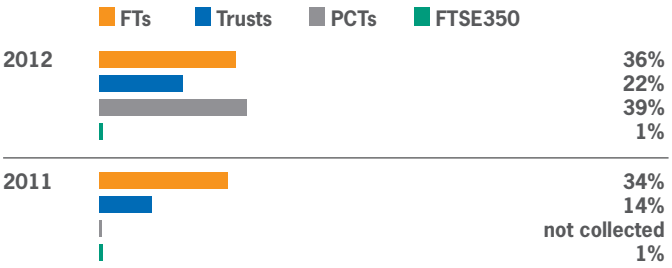
Board diversity is another component of good governance: not just around gender balance, but also in reflecting different skills, experience, ethnicity and mindsets.

The NHS board gender balance continues to outshine the business sector, with between 37% and 49% of voting positions occupied by women, compared to 11% on large corporate boards. The EU has proposed that, by 2020, 40% of NEDs in listed companies should be women: in this, the NHS is leading the way.

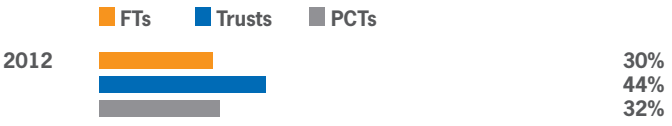
PERCENTAGE OF VOTING BOARD THAT ARE FEMALE



PERCENTAGE OF FEMALE CHAIRS



PERCENTAGE OF FEMALE CHIEF EXECUTIVES

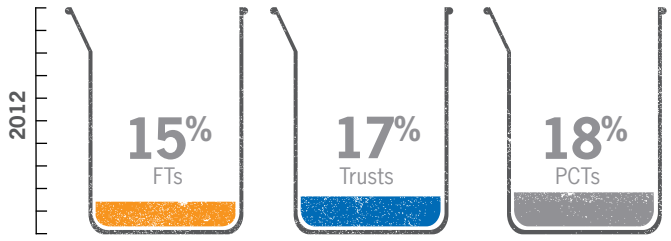


However, further work could be done to reflect overall diversity in the wider workplace, including providing clarity on equal pay, to instil stakeholder confidence in the NHS as a local and national employer.

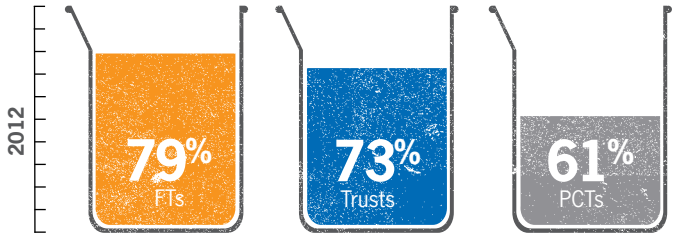
Diversity is not just about women on boards, but gender and other diversity in the workforce.

NHS annual reports include low levels of disclosure on diversity, other than generalist statements, made by less than 20% of NHS bodies. Levels of disclosure were, however, better regarding staff diversity at between 61% to 79%, which is comparable to the large corporate sector at 78%.

THE ANNUAL REPORT INCLUDES A STATEMENT ON BOARD DIVERSITY



THE ANNUAL REPORT INCLUDES A STATEMENT ON STAFF DIVERSITY



Reporting broader diversity

- Draft a statement of employee diversity, including analysis of workforce composition
- Explain the benefits and importance of a diverse board and workforce, for example by age, ethnicity or gender

Changes planned for quoted companies

Following Lord Davies' review of Women on Boards, quoted companies will be required to report on their gender breakdown, both overall and in senior executive positions.

The NHS board gender balance continues to outshine the business sector, with between 37% and 49% of voting positions occupied by women.

Governors

As the FT regime matures, we see general improvements in the way councils of governors understand their role. However, following Health and Social Care Act revisions in role parameters, governors will need to stay attuned to changes in the NHS to properly evaluate the effectiveness of boards. (Our handbook, 'A governor's guide to the Health and Social Care Act', provides further advice to governors on their responsibilities under the new regime.)

AVERAGE NUMBER OF GOVERNORS

	2012	2011
FTs	26	31

NUMBER OF TIMES IN THE YEAR THE COUNCIL OF GOVERNORS MET

	2012	2011
FT average	5.2	5.0
FT highest	13.0	9.0
FT lowest	1.0	3.0

AVERAGE ATTENDANCE LEVELS BY GOVERNORS

	2012	2011
FT average	74%	76%

The Health and Social Care Act gives councils of governors additional rights and powers:

- Councils of governors can call one or more directors to meetings to report on the FT's performance of its functions or directors' performance of their duties. They can propose a vote on the FT's or directors' performance: such votes must be reported in the FT's annual report
- They must approve significant transactions
- Councils of governors must approve FT applications to enter into mergers, acquisitions, separations or dissolutions
- They can judge whether the FT's private patient work significantly interferes with its principal purpose – the provision of goods and services for the health service in England – or the performance of its other functions. They then inform the board of their decision
- Councils must approve proposed increases in private patient income of 5% per year
- They must approve amendments to FT constitutions (Amendments no longer need to be approved by Monitor)

The above approvals must be passed by more than half of voting governors.

Governors must be engaged, informed and active. Reflecting the basic principles of board effectiveness, meetings need to be focused, well attended and frequent enough to be both proactive and reactive to issues.

Questions governors may wish to ask:

- Has the definition of a significant transaction been included within the FT's constitution?
- Has the council of governors received sufficient information before considering applications by the FT to enter into a merger, acquisition, separation or dissolution?
- What arrangements are in place to consider the level of the FT's private patient work?
- Have the risks of delivering non-NHS work been considered?
- Is the council of governors aware of the process for considering amendments to the FT's constitution?

Questions FTs, and aspiring FTs, may wish to ask:

- Is the cost of servicing the council of governors, including any sub-committees, commensurate with the contribution it makes?
- Are we clear about the role of governors and does this match the governors' perception of their role?
- Are we doing enough to attract and retain governors who could add real value to the trust?
- What can we do with the existing council to maximise quality and expertise?

Financial governance

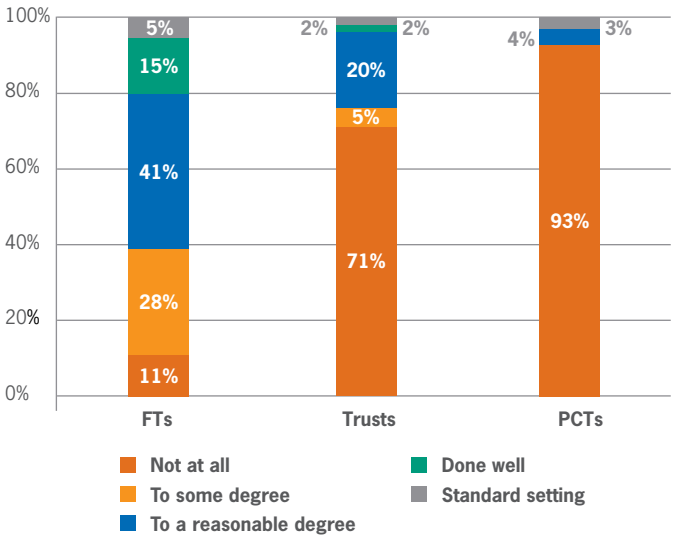
The NHS was embraced as a national treasure at the 2012 Olympics opening ceremony but, while opinion on the visual spectacle varies, there is no denying that public expectations of the service have risen. Deferential acceptance has been replaced by demand for a modern, well-governed and sophisticated patient-focused service. Yet traditional cost improvement programmes (CIPs) will be hard-pressed to address the demographic changes that are threatening the sustainability of NHS services.

This summer, in conjunction with the Healthcare Financial Management Association (HFMA), we surveyed NHS directors of finance about their experience of CIPs and how they expect their programmes to progress over the next three years. The survey showed that trusts are feeling the pressure. The Government's ambitious £20 billion savings challenge is requiring huge effort from all healthcare organisations – and delivering the savings and efficiencies required will only become harder in the years ahead.

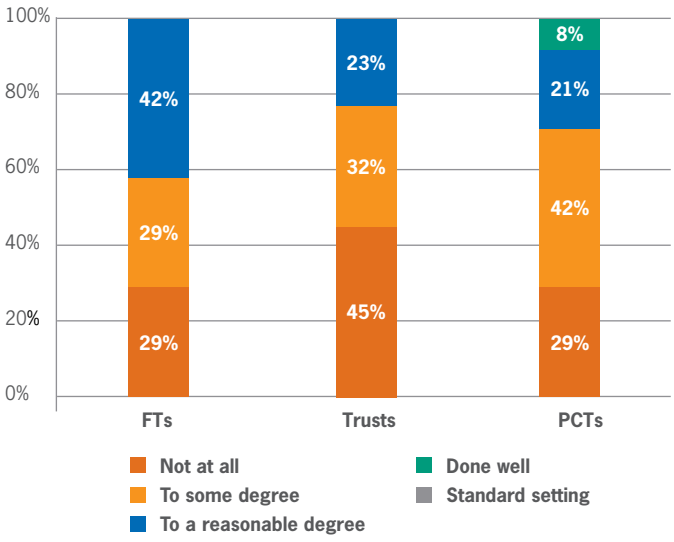
While some organisations have previously delivered more than 5% savings, estimates suggest the whole service will need to match this performance. For some areas the challenge will be even greater. To succeed, finance professionals will need to work alongside clinical colleagues and other support services. But as different localities rise to their own challenges, it will be vital to understand different approaches to CIP delivery and, where appropriate, to share good practice. If this does not take place, an increasing number of NHS bodies will face financial difficulty, even administration.

It is surprising that – given the financial challenge facing the NHS and the whole public sector – so few trusts provide information about their financial health.

HOW WELL THE TRUST DESCRIBES ITS ASSERTION AS A GOING CONCERN



WHERE NO REFERENCE TO GOING CONCERN IS MADE, THE ANNUAL REPORT INCLUDES COMMENTARY ON THE TRUST'S FINANCIAL RESILIENCE



It is surprising that – given the financial challenge facing the NHS and the whole public sector – so few trusts provide information about their financial health.

Many of our governance survey respondents supported this analysis: 26% felt the annual report did not outline the financial position of the trust. In such cases, one could query whether the annual report, in its current format, is fit for purpose, and whether integrated reporting is the route forward (see page 45). Regardless, we believe directors should make clear reference to the trust's financial position.

The challenging economy and NHS proposals for dealing with financially failing bodies mean no NHS organisation can automatically be considered viable: directors may, therefore, need to make careful judgements and clear disclosures on going concern and financial health.

I FIND THE ANNUAL REPORT AND ACCOUNTS HELPFUL IN UNDERSTANDING THE FINANCIAL POSITION OF THE ORGANISATION

Directors' assessment of going concern

Directors should plan going concern assessments as early as possible – deciding on the processes, procedures, information, analyses and board papers required. They should establish what evidence is needed, including identifying remedial actions that may need addressing before financial statements can be approved.

The board should request that going concern assessments outline clearly the basis for the management's conclusion.

The directors should be invited to review and approve the documented assessment at the board meeting that approves the financial statements.

Financial risk rating

We analysed the financial performance of all FTs, using 2011/12 audited accounts, to identify sector trends and enable individual FTs to compare their performance.

Our findings revealed the significant pressures facing the NHS:

- The underlying financial performance of all FTs continues to deteriorate. The earnings before interest, taxes, depreciation and amortisation (EBITDA) margin, which measures the surpluses generated in the year, fell from 6.7% in 2010/11 to 6.1%, a drop of 8.5%. When compared to the performance in 2009/10, the reduction is even more pronounced, at 12%
- The number of FTs recording a negative EBITDA in 2011/12 increased, up to 2% of all FTs
- There is continued downward pressure on staff and non-staff costs. These have fallen year-on-year, by 2.0% and 4% respectively
- Foundation trusts are taking longer to pay non-NHS creditors: only 81% now meet the better payment practice code of 30 days, down from 88%

Year-on-year comparison as at 30 June		Financial risk rating				
		FRR 1	FRR 2	FRR 3	FRR 4	FRR 5
Monitor governance risk rating	Red Amber – red	2012 11%	2011 9%	2012 14%	2011 32%	
	Amber – Green Green	2012 1%	2011 2%	2012 74%	2011 56%	

Alternative models of delivery

Innovation and evolution are central to the future of public healthcare and would be so even without sector reform. Partnerships and joined-up working will become a necessity of health and social care but, as public services adapt to create more efficient and effective healthcare commissioners and providers, accountability must remain a core principle.

Our survey shows that most organisations intend to share frontline services with other NHS or public sector bodies. It indicates that, in the next two to five years, there will be an increasing number of alternative service delivery models, possibly including commercial structures.

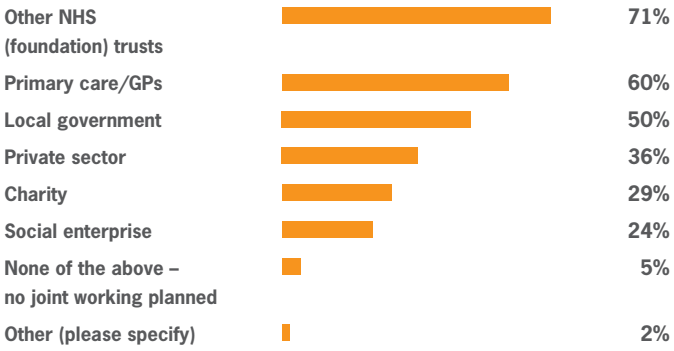
As the NHS continues to embrace local autonomy and accountability, boards need to focus on minimising risk to ensure their policies and processes deliver overarching strategic objectives. As organisations move towards partnerships and other frontline service delivery models there is a risk that strong governance arrangements will become diluted: boards need to retain responsibility and control. Last year, the number of complaints to the Health Service Ombudsman against independent providers rose by 61%: NHS organisations must ensure that new partnerships do not cause service standards to fall.

The Department of Health (DH) Assurance Framework is a valuable tool in maintaining standards, providing a simple but comprehensive method for managing principal risks while delivering core/strategic objectives. It simplifies board reporting and the prioritisation of action plans, in turn enabling more effective performance management.

It will be the effective extension and use of the assurance framework into these new ventures that will help to determine their success.

FTs need to make full use of their powers. Many took on responsibility for community services in 2011/12, but the handover is not the end of the transaction. FTs should seek to capitalise on the extension of services into the community, moving beyond healthcare pathways into full care packages. They should, as standard, be looking at closer working with local authorities, primary care organisations and other NHS bodies. In undertaking such ventures, NHS organisations must develop effective governance models, using the right mix of non-executives for effective oversight.

WHICH OF THE FOLLOWING ORGANISATIONS ARE YOU MOST LIKELY TO ENTER INTO SOME FORM OF JOINT WORKING WITH TO DELIVER FRONT-LINE SERVICES (TICK ALL THAT APPLY)?



DOES YOUR NHS TRUST USE ANY SPECIAL PURPOSE VEHICLES FOR SERVICE DELIVERY (EG A SUBSIDIARY, LIMITED COMPANY, PARTNERSHIP ETC)?

Survey response

"The trust is at a crossroads in terms of its ability to deliver required services and service levels using current delivery methods. In order to deliver the Quality, Innovation, Productivity and Prevention (QIPP) changes required within local health economies it must find new ways of working across traditional organisational boundaries."

"It is the only way we will grow and survive."

Brave new world

There is a risk that, while NHS organisations focus on intra-NHS and public sector alliances, they will fall behind commercial and not-for-profit bodies that have already begun to expand. Care homes, respite care centres, private facilities, A&E intervention services, hospitals and pharmacies are just some of the commercial organisations now providing NHS services. FTs, in particular, should bring a commercial edge to strategic and operational development. In this, NEDs, who often have a commercial background, should take a lead role.

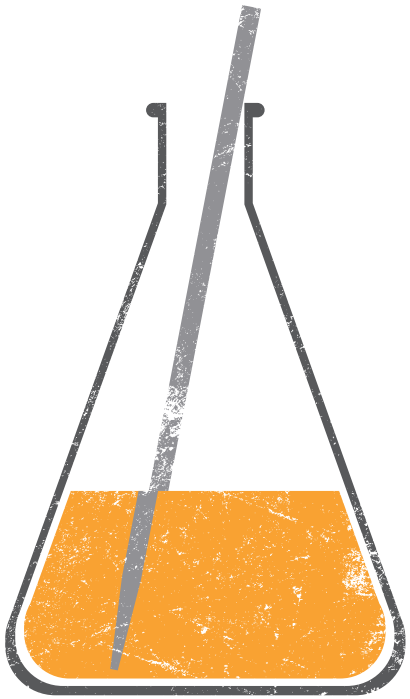
Making partnerships work

There is renewed interest in promoting formal arrangements between public sector bodies and third parties via structured collaboration.

Collaboration – as set out in the first national standards on collaboration, BS 11000 – represents an evolution in managing partnerships. The standard advocates sharing visions and resources and outlines mechanisms that can create efficient and effective delivery.

Structured collaboration is relatively new in the UK, with early adopters including the defence, aerospace and rail industries. Applying the standard's concepts and tools to the public sector could deliver considerable benefits.

At a time of increasing partnership working, it is essential to understand the costs, benefits and outcomes of collaboration. We believe structured collaboration provides the focus on value and outcomes that NHS organisations and their partners need.



Benefits of structured collaboration

- Changing behaviours and improving trust, to make collaboration more efficient within and between organisations
- Introducing a common language, to improve communication between organisations
- Aligning aspirations and capabilities between partners and playing to organisations' strengths, to improve productivity
- Providing greater continuity and flexibility of resource across organisations
- Enhancing governance across organisations by, for instance, sharing approaches to risk management
- Promoting innovation and continuous improvement

Quality and quality governance

To maintain the NHS's high level of care, in the face of mounting pressures and changing working practices, boards must keep their focus on quality and seek out best practice.

Public confidence in the quality of health and social care has been rocked by high-profile scandals, such as Winterbourne View Hospital and Mid Staffordshire NHS Foundation Trust.

Such cases should not detract from the generally high standards of care provided by the NHS. However, they serve as a warning that, no matter what the level of financial challenge, quality should remain at the forefront of every NHS professional's mind.

High standards in quality go hand in hand with good financial management and the better performing bodies are usually those with both strong financial and quality governance arrangements.

As NHS organisations enter into more partnerships and look for alternative models of service delivery, the provision of high quality care must be among the board's paramount concerns.

Indicated in the quote from our survey respondent, fragmented care makes it harder to maintain standards in an increasingly competitive and challenging environment. In such situations, providers of healthcare typically turn to reviewing care pathways to improve efficiency, whereas a more coordinated response might ask whether the quality of care would improve if more time was spent on preventative measures or allow care to be delivered by different organisations.

There is a perception that 'quality' is used by clinicians to hold boards hostage. Furthermore, when quality governance becomes obtrusive, it can take the focus away from patient care and break clinical engagement. However, when quality and quality governance become genuinely embedded in values and behaviour, they can become a catalyst for innovation and improvement.

OUR QUALITY GOVERNANCE ARRANGEMENTS HAVE MADE A DEMONSTRABLE IMPACT ON IMPROVING THE QUALITY OF PATIENT CARE (CLINICAL EFFECTIVENESS, PATIENT SAFETY, PATIENT EXPERIENCE)

While structures are an important and necessary part of governance, what is really important is that they deliver the desired outcome, namely safe and good quality care. There is evidence that setting up systems predominated over improving actual outcomes for patients: for example, the introduction of a new governance structure did not appreciably improve care for patients.

Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 – March 2009, Volume I

Survey response

"Care delivery has never been so fragmented. Quality of care improvements are down to individual enthusiasm and commitment of clinicians. Trust governance is more about box ticking and makes no difference whatever to quality of care."

"Fragmented care makes it harder to maintain standards in an increasingly competitive and challenging environment."

Quality governance board-level considerations

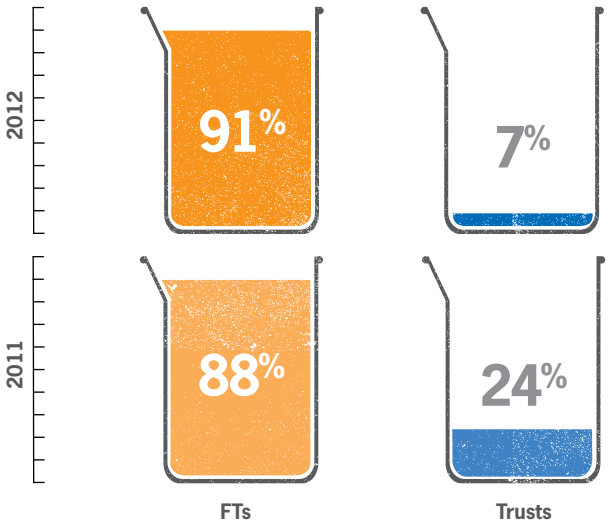
- Be aware of the regulatory changes and the impact they will have on the organisation – and communicate this to all staff
- Communicate clearly, both internally and externally, how quality governance arrangements have made, and will continue to make, a difference
- Give staff a voice
- Take a fresh perspective on services: consider delivery models, purpose and viability
- Formally evaluate the efficiency and effectiveness of governance arrangements (both financial and quality) using a 360-degree perspective
- Be wary of fragmenting structures too far: sometimes the board needs to retain oversight

Effective care is the primary output of quality governance. To bring quality standards to the fore, we believe key messages from the quality report and financial statements, properly cross-referenced, should feature in the main body of the annual report. In 2012, 91% of FTs published their quality reports in their annual reports, up 3%. However, just 7% of trusts published theirs together – down from 24%.

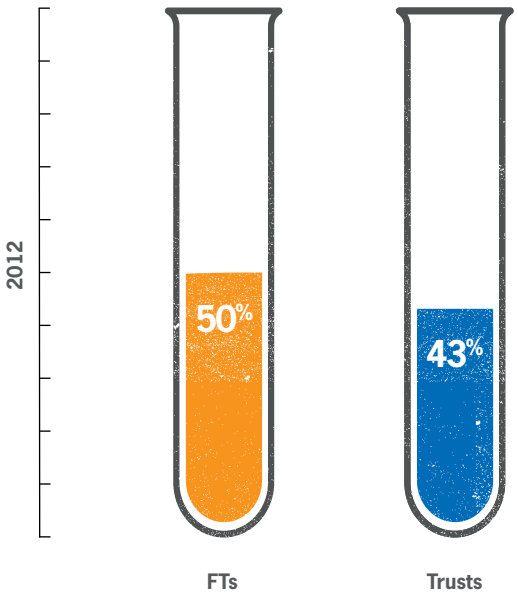
Fewer than half the organisations that publish separate quality reports tell readers where copies can be obtained. This means readers need to search or contact the body for the report – a barrier to accessibility and transparency.

When quality and quality governance become genuinely embedded in values and behaviour, they can become a catalyst for innovation and improvement.

QUALITY ACCOUNTS WERE PUBLISHED WITHIN THE ANNUAL REPORT



WHERE THE QUALITY ACCOUNT IS PUBLISHED SEPARATELY, THE ANNUAL REPORT SIGNPOSTS WHERE THE QUALITY REPORT CAN BE OBTAINED



Annual Governance Statement

Our survey showed that national tools had a positive effect on governance arrangements: notably, the DH's annual governance statement (AGS) which this year replaced the Statement on Internal Control (SIC). More than three-quarters (77%) believed the AGS enabled all stakeholders to understand their governance arrangements. Yet, 68% of PCTs, 34% of trusts and 2% of FTs did not publish the AGS within the annual report.

Our review of the AGS found that, in many cases, the AGS was derived from the example text, with some additions or amendments for specific circumstances. This is not too dissimilar from our experience of the SIC, where the current year reporting date was added to the prior year SIC and regulatory guidance checked for any changes to mandated text.

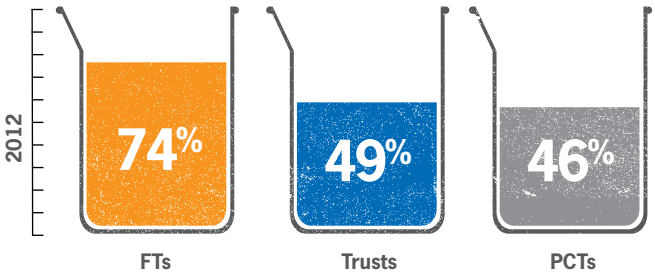
We are pleased to see that around three-quarters (75.6%) of respondents believed senior management shared ownership of the AGS. Commitment to this key statement must not wane.

With the enthusiasm for the AGS still relatively high in the NHS, there is a clear opportunity to ensure that NHS bodies benefit from local government's experience with the AGS. Our local government governance survey found that the helpfulness and understandability of the AGS had reduced, although the results remain very positive.

2012 average report length	FTs	Trusts	PCTs	Local government
Quality report	58.1	44	n/a	n/a
AGS	9.5	8.3	5.9	11.3

NATIONAL TOOLS (EG QUALITY OUTCOMES FRAMEWORK, BOARD GOVERNANCE ASSURANCE FRAMEWORK) HAVE DEMONSTRABLY IMPROVED THE EFFECTIVENESS OF OUR GOVERNANCE ARRANGEMENTS

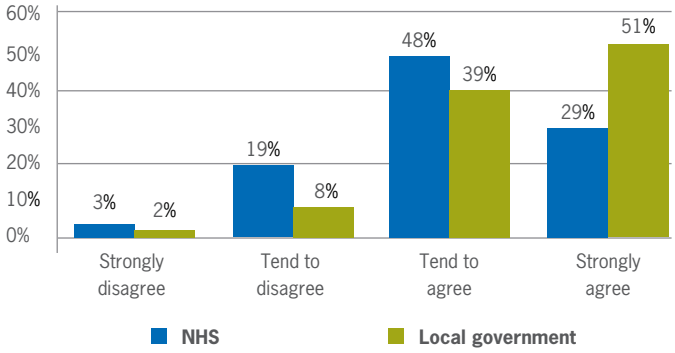
THE BODY OF THE ANNUAL REPORT SIGNPOSTS THE READER TO AREAS WHERE QUALITY GOVERNANCE (EG AGS OR QUALITY REPORT) IS EXPLAINED IN MORE DETAIL



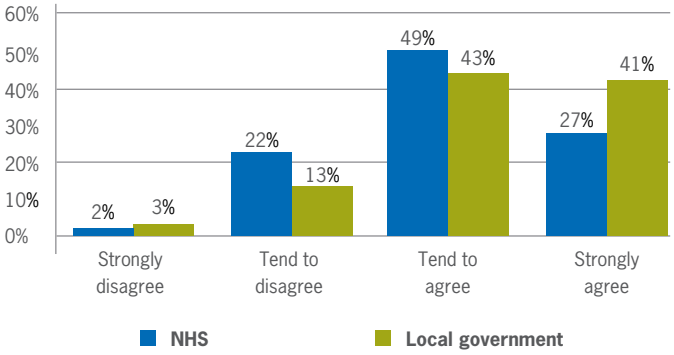
Survey responses

"National tools improve governance arrangements by giving a framework and platform to move the organisation onwards but most of the work needs to be locally driven and locally responsive."

OUR ANNUAL GOVERNANCE STATEMENT ENABLES ALL STAKEHOLDERS, INCLUDING THE PUBLIC, TO UNDERSTAND CLEARLY THE GOVERNANCE ARRANGEMENTS THE TRUST HAS IN PLACE, INCLUDING WHAT IS BEING DONE TO ADDRESS ANY AREAS OF SIGNIFICANT WEAKNESS



SENIOR MANAGEMENT SHARES OWNERSHIP OF THE AGS



Lessons from local government

- **Content and style of document** – less process and repetition of what is already in code of governance, more focus on key governance mechanisms and description of what assurances were received on these in the year, more user friendly in language and layout, focus on significant governance or control issues that flow from the earlier sections of the document
- **Ownership** – leaning towards performance involvement in the production of the AGS to help emphasise that the AGS is about assurances received over risks to the achievement of strategic objectives, desire to retain internal audit involvement so as not to lose the specialist assurance knowledge, small corporate governance group (including audit and performance) seemed to be regarded as a good forum for owning and producing the AGS and (along with having a more user-friendly document) it was felt that this would help with senior management ownership
- **Linking the document with year round assurance processes** – AGS used as end point to shape the Audit Committee workplan, building up assurances for AGS during the year, regular monitoring by officer governance group, clarity to the Audit Committee of assurances being received against plan
- **Education** – underpinning but also facilitated by all of the above, ensuring a wider and better understanding of the governance framework and the AGS

Risks and performance

Clear, consistent risk reporting can enhance an organisation's reputation, but NHS bodies must be wary of concentrating so hard on financial risk that they overlook other challenges and opportunities.

The current debate about NHS reform, service reconfigurations and new regulatory powers, has left some people thinking the service is at risk: this may have a negative impact on NHS bodies' reputation. Trusts can offset this by ensuring relevant material risks, and their mitigation and management, are explained clearly in the annual report and stakeholders are kept up to date as developments occur.

We asked respondents to name the top three risks facing their organisation, from which we extrapolated the eight most significant risks facing the NHS.

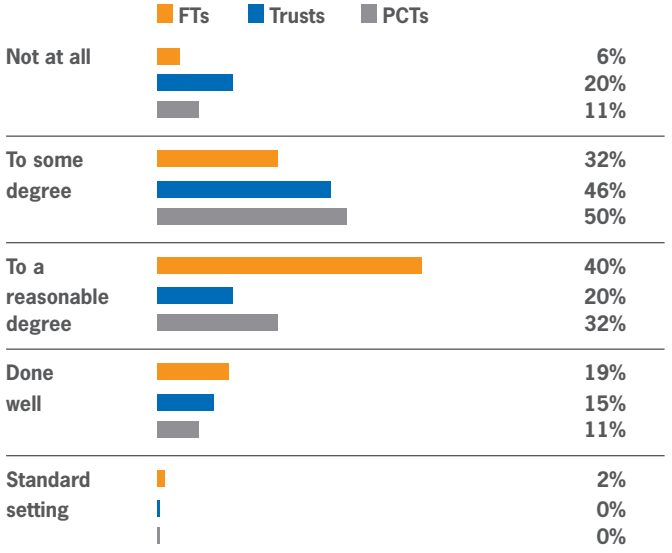
Risk priority	Financial	Quality	Operational performance	Health reforms	People	Service reconfiguration	Estate	FT pipeline	Other
1	38%	19%	10%	5%	5%	10%	5%	5%	5%
2	43%	19%	14%	10%	14%	0%	0%	0%	0%
3	14%	14%	10%	19%	10%	10%	5%	5%	14%

Financial risk is the top priority for 38% of respondents, way ahead of quality with 19% and operational performance with 10%. This is perhaps not surprising when Monitor has shown an increase in FTs facing red/amber-to-red governance risk ratings (GRR) or level one or two financial risk ratings (FRR), up 2% to 11%.

In the context of the '£20 billion challenge' this focus on financial issues is understandable. However, we caution that, if bodies focus solely on operational and financial challenges, the opportunities and threats facing the post-2015 NHS may be overlooked.

We have seen significant improvement in risk reporting. Only 6% of FTs (13% in 2011) and 20% of trusts (45% in 2011) failed to provide any information on their principal risks – it will be important to ensure that this trend continues into 2013.

TO WHAT EXTENT DO TRUSTS DESCRIBE THEIR PRINCIPAL BUSINESS RISKS AND UNCERTAINTIES?



Financial risk is the top priority for 38% of respondents, way ahead of quality with 19% and operational performance with 10%.

RISK CATEGORISATION

Average number of risks reported		Financial	Operational	Macro-economic/ political	Clinical	Other	Total
2012	FT	1.3	1.9	0.4	0.9	0.4	4.9
	Trusts	1.3	1.9	0.2	1.4	0.3	4.5
	PCTs	0.3	1.0	0.0	0.1	0.1	1.5
	FTSE 350	2.6	2.1	1.8	n/a	4.5	11.0
	FTSE 350 Healthcare	3.6	3.1	1.6	n/a	8.2	16.2
2011	FT	2.4	1.8	0.3	0.6	0.7	5.8
	Trusts	0.9	3.2	0.2	1.1	1.6	6.9
	PCTs	-	-	-	-	-	-
	FTSE 350	2.9	2.3	1.6	n/a	4.5	11.3
	FTSE 350 Healthcare	2.6	3.4	1.9	n/a	6.7	14.6

Tips for risk reporting

Describe not identify

The annual report should describe the principal risks and uncertainties facing the organisation. Simply providing a list, no matter how comprehensive, is insufficient.

Explain what is being done to manage risks

The description should:

- identify the risk and convey a basic understanding
- indicate to a reasonably informed reader how the risk could harm the organisation
- explain the actions taken or processes adopted to mitigate the likelihood and impact of the risk or uncertainty.

Alignment of reported risks

Organisations need to be consistent in the way they describe themselves – particularly about risk. Again this year, in comparing the risks presented in annual reports to the strategic (or corporate) risk registers for a sample of trusts, we found a disconnect between the two. This undermines transparency and hinders the ability of governors and stakeholders to hold trusts to account.

Furthermore, while our survey respondents clearly prioritised financial risks, the annual report showed a slightly different picture. Annual reports include a higher proportion of operational risks to financial risks, which makes it important for organisations to triangulate risk reporting with board reporting.

The average number of reported risks has fallen and these are now more evenly spread across broader range of categories. Large corporates continue to report more than twice the number of risks as the FTs and trusts, and more than seven times the number of principal risks reported by PCTs.

With margins falling, CIPs rising, an increasing number of FTs having a financial risk rating of level one or two, and proposals for dealing with financially failing NHS bodies due to be introduced, financial risk reporting clearly has room to improve.

KPIs

The business review should include analysis of KPIs, to help readers understand the development, performance or position of the organisation. Our survey shows there is still an inconsistent approach to KPI reporting, with a tendency to confuse KPIs with the indicators used in quality reports.

The average number of KPIs presented fell slightly, with FTs averaging 2.1 financial indicators (2.6 in 2011) and 11.4 non-financial ones (14.3 in 2011), and trusts using one financial KPI (2.0 in 2011) and 9.7 non-financial measures (14.3 in 2011).

FTs disclose a broad spread of KPIs as do, to a lesser extent, trusts. PCTs present a much narrower focus, for example making no reference to environmental or reputational risk.

Average number of financial KPIs	FTs	Trusts	PCTs	FTSE 350
Cost control	0.4	0.4	0.7	2.2
Revenue/income maximisation	0.7	0.2	0.2	1.6
Interest/debt	0.3	0.0	0.0	0.2
Working capital/treasury	0.3	0.1	0.2	0.6
Capital expenditure	0.1	0.2	0.4	0.5
Other	0.2	0.2	0.0	1.0

Average number of non-financial KPIs	FTs	Trusts	PCTs	FTSE 350
Employees	3.8	0.9	0.1	0.6
Patients	2.5	3.3	1.6	n/a
Regulators (eg CQC, Monitor, DH)	0.7	1.2	0.3	0.2
Environmental	1.7	0.3	0.0	0.7
Reputational	0.7	0.0	0.0	0.6
Clinical	1.6	3.3	3.1	n/a
Other	0.5	0.5	0.5	1.5

Some trusts just give bullet point lists of KPIs: this can cause confusion. In giving KPIs, trusts should explain their significance and/or refer to them in the discussion of the organisation's performance. For example, if an FT uses financial statistics, such as EBITDA, in the business review, their relationship to amounts presented in the financial statements needs to be explained. If there is no clear linkage, readers are unlikely to understand the KPI's significance.

FTs disclose a broad spread of KPIs as do, to a lesser extent, trusts. PCTs present a much narrower focus.

Key questions to consider on performance reporting:

- Do the KPIs accurately reflect those used by the board to measure the successful delivery of our the organisation's strategy?
- Do we explain the purpose and meaning of each KPI?
- Do financial KPIs agree to the primary financial statements?
- When placed alongside risk reporting, does performance reporting present a consistent and collaborative view of the organisation, as seen by the board?

Audit and assurance

Audit committees are widely applauded as effective, but could do more to monitor and report the impact of internal, external and clinical audit.

Audit committees

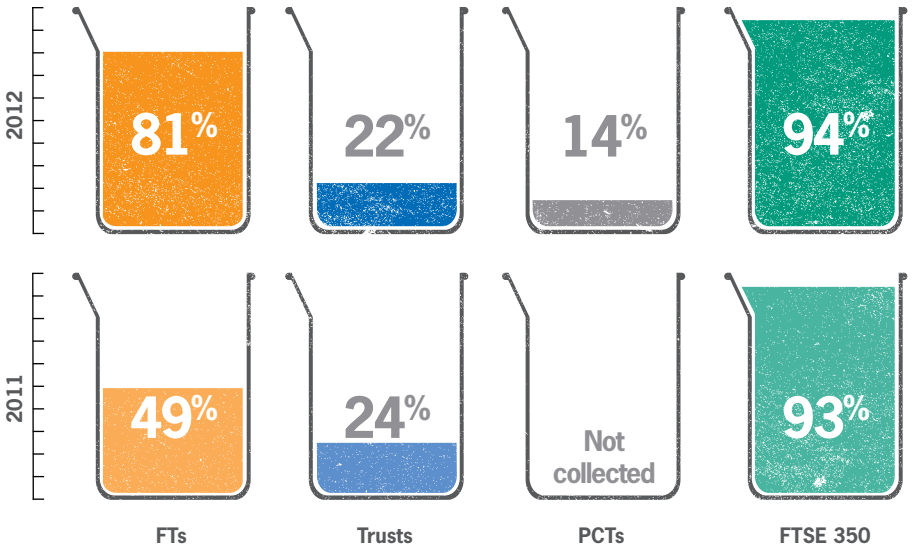
Audit committee disclosures improved significantly, although, as elsewhere, PCTs performed less well than FTs and trusts.

More than three quarters (78%) of respondents felt audit committees dealt effectively with changing risks and even more (87%) believed they demonstrated their value annually: a strong vote of confidence. Underlining this perception of worth, more reports had dedicated audit committee sections: up 5% to 100% for FTs, and up 34% to 71% for trusts.

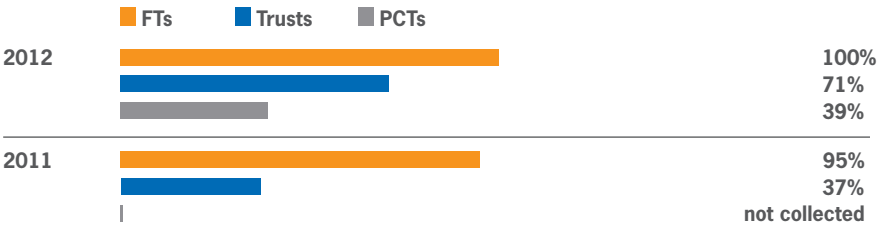
The pace, rate and extent of change in the NHS, both to individual bodies and the wider sector, will continue to increase. Audit committees and their NED members must have the capacity and capability to understand the impact of such change on organisations' risk profiles. Those 22% that 'tend to disagree' that their audit committee is managing risks effectively should take action now.

More than three quarters of respondents felt audit committees dealt effectively with changing risks.

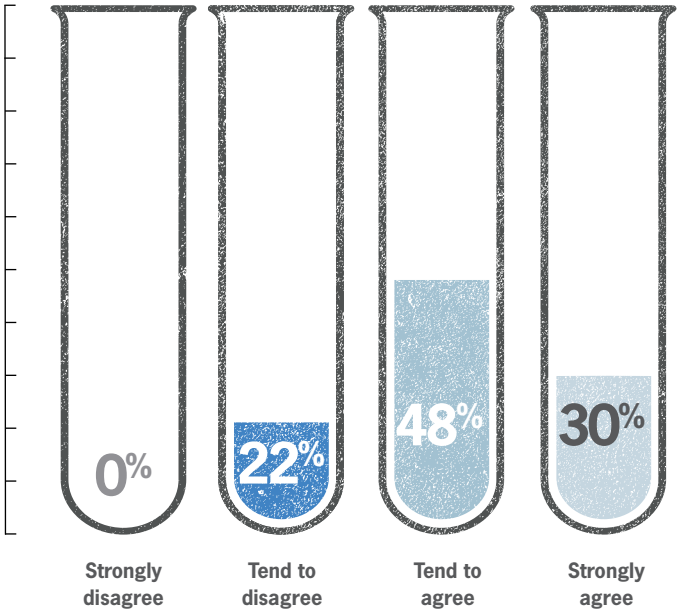
THE AUDIT COMMITTEE INCLUDES A MEMBER WITH RECENT AND RELEVANT FINANCE EXPERIENCE



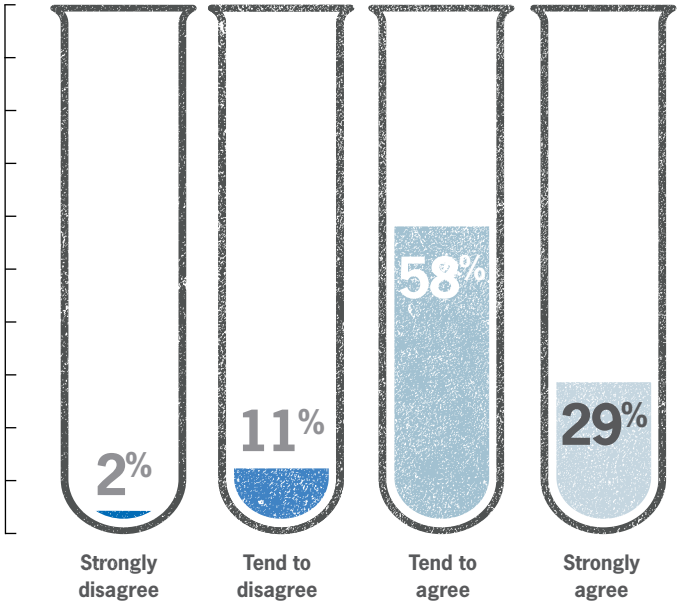
THERE IS A SEPARATE SECTION OF THE ANNUAL REPORT WHICH DESCRIBES THE WORK OF THE AUDIT COMMITTEE



OUR AUDIT COMMITTEE EFFECTIVELY DEALS WITH THE CHANGING RISKS FACING THE ORGANISATION (ALL BODIES)



OUR AUDIT COMMITTEE CAN ANNUALLY DEMONSTRATE THE VALUE IT ADDS (ALL BODIES)

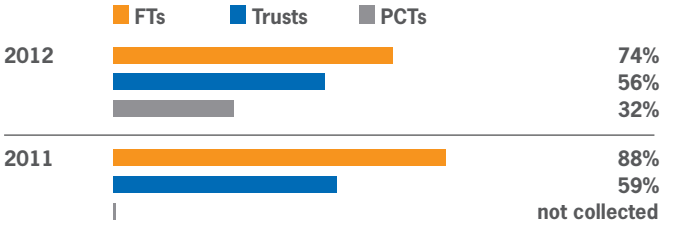


Internal audit

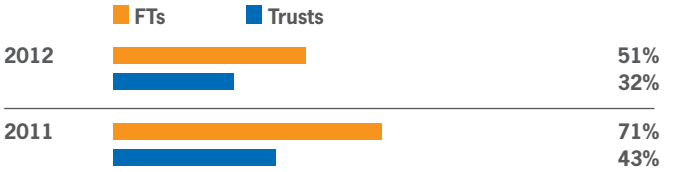
Internal audit's role is to provide the audit committee and senior management with independent assurance that an organisation's controls are effective in mitigating principal risks.

In the current economic climate, it is essential that different assurance providers understand their respective roles and ensure there is no duplication in their work. We were disappointed, therefore, to identify reduced content in annual reports relating to FT audit committee monitoring and review of internal audit effectiveness and in the disclosures of such reviews: down by 14% and 20% respectively.

THE AUDIT COMMITTEE MONITORS AND REVIEWS THE EFFECTIVENESS OF INTERNAL AUDIT ACTIVITIES



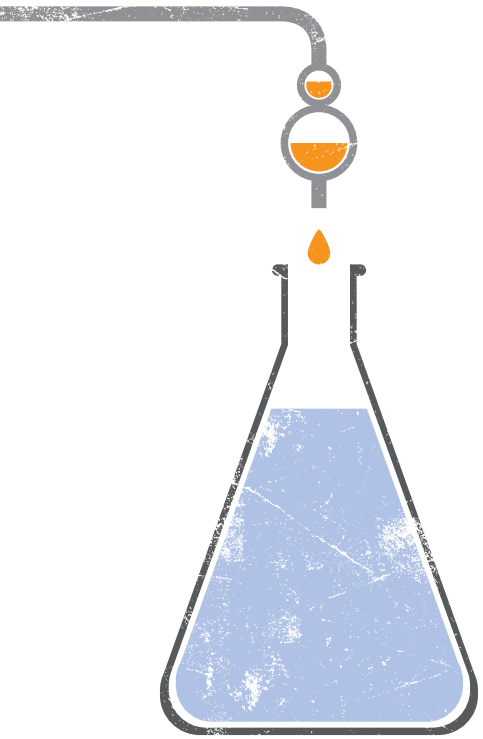
THE TRUST MAKES REFERENCE TO AN INTERNAL AUDIT EFFECTIVENESS REVIEW BEING PERFORMED



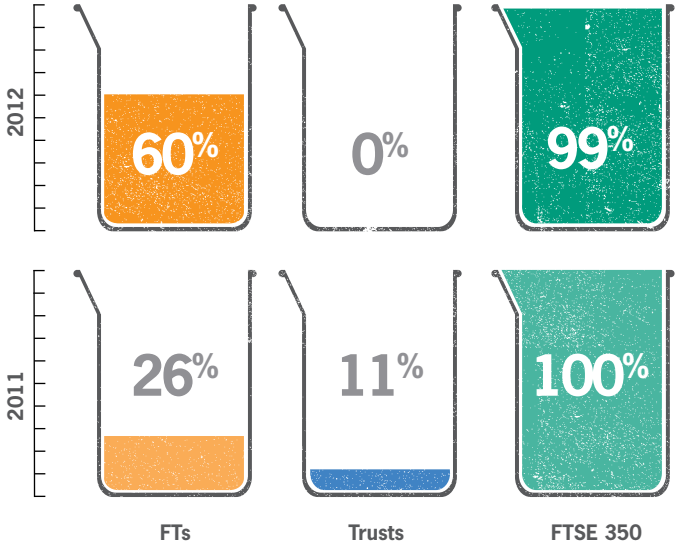
External audit

The broad remit of external audit – encompassing the financial statements, quality report, annual report and annual governance statements – makes it an important source of assurance to the audit committee.

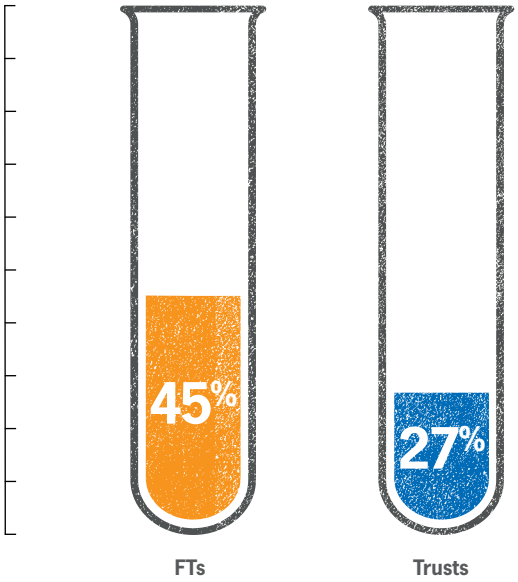
FTs are improving their performance on considering the objectivity of their external auditor, with the number of those providing an auditor objectivity statement rising by 34% to 60%. Where the external auditor had provided non-audit services, no trust annual report confirmed the external auditor's objectivity and independence had been safeguarded, a fall of 11%. However, we feel that disclosures still need to improve, particularly when the value of non-audit fees is around 56% (2011: 51%) of an FT's audit fee, 18% of a PCT's and 5% (2011: 13%) of a trust's. We would point out that 63% of trusts provided no information on audit and non-audit fees, meaning that key information was not transparently available.



IF THE AUDITOR PROVIDES NON-AUDIT SERVICES, THERE IS A STATEMENT AS TO HOW THE AUDITOR'S OBJECTIVITY AND INDEPENDENCE IS SAFEGUARDED



THE TRUST PROVIDES A BREAKDOWN OF AUDIT AND NON-AUDIT FEES



Clinical audit

Audit committees should consider clinical audit as part of their holistic consideration of governance and control. It needs to be employed in a systematic way that adds value to the organisation.

There has been an overall improvement in the understanding and use of clinical audit. However, with fewer than half of FT audit committees and barely a quarter of those at trusts reporting that they are reviewing clinical audit activities, this valuable resource needs to be better utilised in the context of the wider governance agenda.

THE AUDIT COMMITTEE MONITORS AND REVIEWS THE EFFECTIVENESS OF CLINICAL AUDIT ACTIVITIES

CLINICAL AUDIT IS PROPERLY UNDERSTOOD AND POSITIONED WITHIN OUR GOVERNANCE FRAMEWORK

Survey response

"Our annual clinical audit report highlights areas of demonstrable improvement in clinical practice as a consequence of audit activity."

Evaluation of audit performance

Annual evaluations of internal and external audit effectiveness are a regular feature of an audit committee's annual work plan, but should be expanded to cover clinical audit.

Key performance measures covering quality, service delivery, impact and responsiveness can be equally applied to all three strands of audit provider and will help the audit committee ensure value for money is being achieved.

Where the auditor has been appointed through a tender process, the annual evaluation should also consider whether the auditor has delivered against all the promises made as part of the bidding process.

Examples of audit key performance measures

Quality

- Results of quality assurance reviews
- Level of involvement of senior members of the team
- Specialists used where appropriate
- Proper balance between team rotation and consistency

Delivery

- Turnaround time to requests, queries
- Flexibility
- Timeliness of work and conclusions

Customer focus

- [Independent] client service reviews
- Regularity of meetings
- Professionalism and conduct of audit teams

Impact

- Clarity of reporting
- Value adding activities, such as market insight

Changes in the private sector

In April 2012, the Financial Reporting Council (FRC) issued limited changes to the UK Corporate Governance Code and Stewardship Code, to increase accountability and engagement. Both codes continue to apply on a 'comply or explain' basis, with companies still needing to explain how they applied the main principles in their corporate governance report.

Key changes	
UK Corporate Governance Code New code provisions:	**Potential impact for the NHS**
• FTSE 350 companies need to re-tender their external audit contract every 10 years (or explain why not) with the aim of ensuring a high quality and effective audit	• Monitor already requires FTs to tender every five years • NHS auditors are appointed independently through the Audit Commission
• Audit committees need to indicate how they have carried out their responsibilities, including how they assessed the effectiveness of the external audit process	• Our analysis of annual reports shows external audit-related governance disclosures could further improve, particularly in relation to independence considerations arising from non-audit services • There is also potential for greater transparency of reporting on external audit quality
• Boards must confirm that the annual report and accounts are fair, balanced and understandable, to ensure the narrative sections are consistent with the financial statements and accurately reflect performance	• Many NHS boards do review the annual report pre-publication. However, we support a more rigorous assessment to increase board accountability for the report
• Companies should explain, and report progress against, their policies on boardroom diversity	• Board diversity is a strength in the NHS, yet annual reports make little reference to this
• Companies must provide fuller explanations as to why they choose not to follow a provision of the code (see separate section on 'comply or explain')	• We urge greater compliance with the required content of NHS annual reports, rather than better 'explanations' • Our analysis of 2012 reports shows a significant number of trusts and FTs do not comply with all reporting standards. The code's requirement for fuller explanations could help NHS annual reports become more like governance reports than, as is now often the case, marketing brochures

With less than half of FT audit committees and barely a quarter of those at trusts reviewing clinical audit activities, this valuable resource needs to be better exploited.

Commissioner reforms

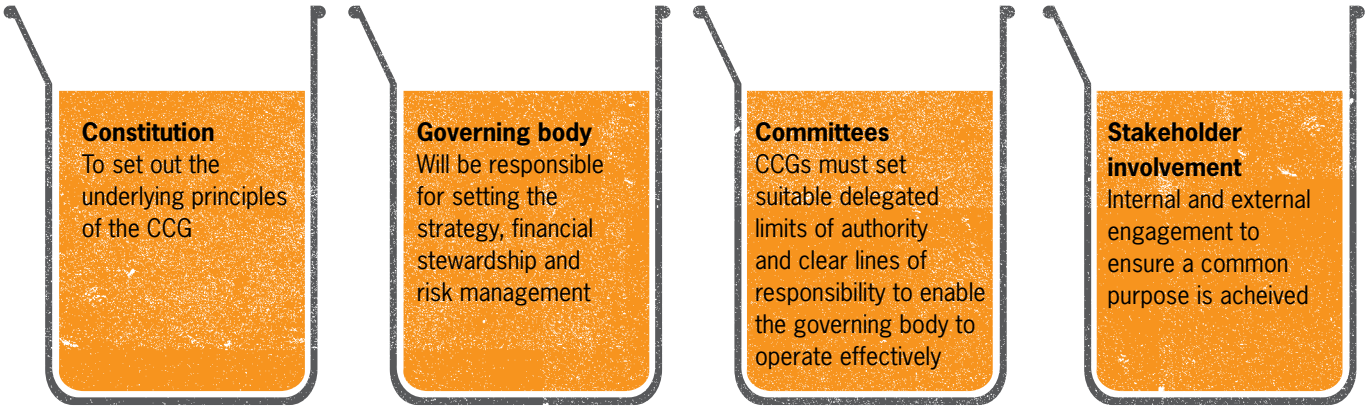
The new CCG boards will need robust governance systems to navigate coming challenges, not least in avoiding conflict of interest claims. Unfortunately, the annual reports of their PCT predecessors are not the best examples to base future annual reports on.

PCTs will be dissolved on 31 March 2013, with their functions transferred to new or existing public sector entities, notably CCGs and the NHS Commissioning Board (NHSCB), which will, in the short-term at least, also comprise the Local Commissioning Support Units.

The accountability and governance frameworks of the new CCGs need to be imbued with transparency, sustainability and probity. However, this year's PCT annual reports do not provide a good launch pad: giving little, if any, information on the impact of CCGs in their locality. While three quarters (75%) explain how CCGs will be created, only 11% disclose their set-up costs.

The accountability and governance frameworks of the new CCGs need to be imbued with transparency, sustainability and probity.

Governance arrangements for CCGs



CCG accountability framework

PCTs' failure to fully consider the impact and cost of CCGs should be addressed by the new bodies.

Our research focuses on a need to improve corporate governance reporting, which shows room for improvement, but as seen through our survey, many wider governance issues still need to be addressed.

When commenting on 'other' challenges facing CCGs, remarks included:

- variability in the commitment of local GPs to the process
- confusion and lack of clarity about roles and responsibilities
- lack of focus on key delivery issues
- delays in appointments to key posts.

WHAT DO YOU THINK ARE THE MAIN CHALLENGES OF THE TRANSITION PROCESS TO CCGS?

Survey response

"Strategic oversight of health economy vis-à-vis local practice/primary care issues."

"My concern is that too much time will be spent setting up the management structures and not enough time on the hard infrastructure, such as business systems and the ability to ensure cash flows to where it is needed while maintaining adequate control."

Conflicts of interest

Annual report – good practice

Create a link in the annual report to where directors' interests are disclosed on the trust's website. This should cover business interests, gifts and hospitality.

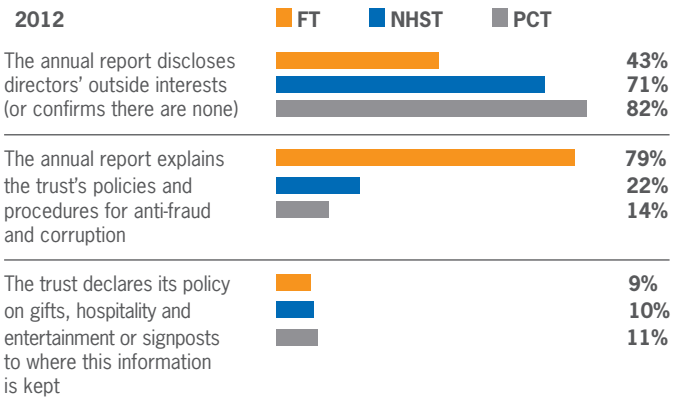
Now the Bribery Act has been in place for more than a year, our main verdict on evaluation and accountability disclosures is that, despite improvements, they are inconsistent and hard to navigate. To use FTs as an example:

- fifty-seven per cent fail to disclose directors' interests, but 79% explain their policies for anti-fraud and corruption
- only 9% direct readers to where directors' interests can be found, and just 11% provide a value for them.

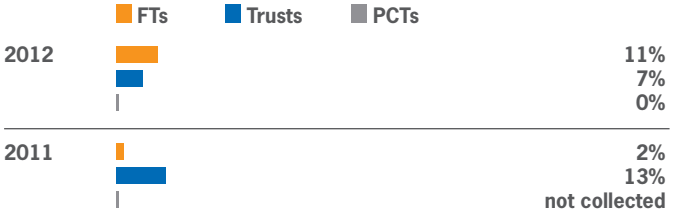
Readers, therefore, need to research extensively to grasp the full extent of a director's interests – and potential conflicts of interest.

The issue of CCG conflicts of interest received significant media attention during recent health reform discussions. The Health and Social Care Act requires CCGs to publish their process for managing conflicts of interest, alongside other requirements, such as their response to the Bribery Act. Regulators and auditors will be keen to see appropriate arrangements in place early on, that will enable CCGs to demonstrate proper stewardship of public money.

To maintain both confidence in the integrity of CCGs and trust between patients and GPs, it is essential that conflicts of interest are handled well. It is particularly important that CCGs appear transparent and fair in managing conflicts of interest around decisions that involve GP practices as potential providers of CCG-commissioned services.



THE TRUST DISCLOSES THE VALUE OF GIFTS, HOSPITALITY AND ENTERTAINMENT RECEIVED BY ITS STAFF/SENIOR MANAGEMENT



Principles for managing conflicts of interest:

- Good business practices
- Being proactive not reactive
- Being ethical and professional
- Being balanced and proportionate

Systems and procedures:

- Code of conduct
- Declarations of interest:
  - on appointment
  - annually
  - at meetings
  - on changing roles or responsibilities
  - on changing circumstances
  - publically available and easily accessible.

Existing rules and guidance:

- The Health and Social Care Act – must make provision for dealing with conflicts of interest of members of committees or sub-committees
- CCG governing bodies must include at least two lay members, one with a lead role in overseeing key elements of governance
- Requirements on commissioners follow best practice procurement arrangements, avoid anti-competitive behaviour and promote the rights of patients

Commissioning support

The NHSCB takes on full responsibilities as an independent statutory authority from April 2013. It will need to have regard to the mandate from the Secretary of State as it aims to improve health outcomes for people in England through:

- authorising, allocating budgets to, and holding to account CCGs, assessing their performance and intervening where necessary
- commissioning primary care and specialised health services, as well as some other services
- hosting clinical networks and senates, to empower and support clinical leadership
- issuing commissioning guidance and overseeing the overall commissioning revenue resource limit.

Local area teams (LATs) will be the regional presence of the NHSCB and will both commission and manage performance locally. Their governance arrangements will need to ensure:

- accurate and reliable information to:
  - support local commissioning responsibilities
  - monitor and assess CCG performance
  - monitor and support the development of sustainable CSUs
  - ensure effective emergency planning, resilience and response.
- effective working relationships with other key stakeholders, such as Health and Well Being Boards, CCGs and the local healthwatch.

LATs will need strong risk and performance management to exercise system oversight and identify and share good practices, as well as any need to intervene. LATs will also need to support clinical leadership locally and be alert to any perceived conflicts of interest in the commissioning system.

In the very short term, both the LATs and the Commissioning Support Units (CSUs) will need to manage effective transition and ensure their respective workforces function from the start as cohesive units. They will need effective communication, training and development and workforce planning to both anticipate and respond to system needs.

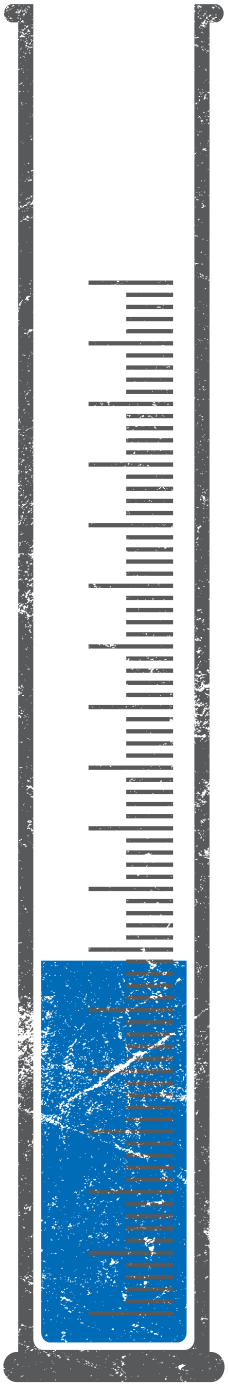
CSUs will play a vital role in supporting CCGs in the new NHS environment and they will have their own governance challenges. They will not legally be boards, as they are not yet independent organisations. Instead they will be part of the NHSCB, and therefore sit under its umbrella governance arrangements. However, they will need to have their own robust governance arrangements as if they were an independent entity and are expected to have individuals who will act in a 'non-executive' role.

At the outset, CSUs are likely to be given varying amounts of freedoms and delegated powers depending on their assessed risk. This will be set out in their licence to operate, which will effectively define the relationship between the NHSCB and CSUs. However, all CSUs will need to move quickly to act in an increasingly autonomous and self-supporting way so that they are fit to act independently in a commercial and customer focused environment. Their governance arrangements will need to develop quickly to reflect this.

This increasingly independent status will help the NHSCB manage any perceived conflicts of interest that may arise from its role in performance-managing CCGs but also, at the same time, providing them with the vital services to perform their duties.

CSUs will need to build credibility quickly with CCGs, and demonstrate they have the capacity, range of skills, and the necessary risk and performance management arrangements to meet demanding workloads and timescales. They will need to have in place effective governance arrangements to:

- ensure integrity and security of data
- monitor and manage contracts
- develop and execute future business plans
- ensure sound and sustainable finances
- embed quality assurance to ensure consistent high quality of operations
- manage and develop the workforce.



Communicating effectively

Annual reports are valued by respondents as valuable communication tools but many are still too long, cluttered and overdue.

The Health Service Ombudsman issued its annual report: 'Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011-12' in November 2012. A key message that chimes perfectly with our review is that poor communication damages trust and reputations.

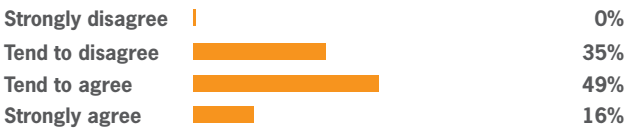
Eighty per cent of our respondents believe the annual report is an important way of communicating key information to stakeholders. However, only 65% think their organisation's annual report is actually helpful in explaining its challenges, risks, performance and forward plans.

AN ANNUAL REPORT (COVERING FINANCIAL, GOVERNANCE, RISK AND PERFORMANCE INFORMATION) IS AN IMPORTANT WAY OF COMMUNICATING KEY INFORMATION TO STAKEHOLDERS

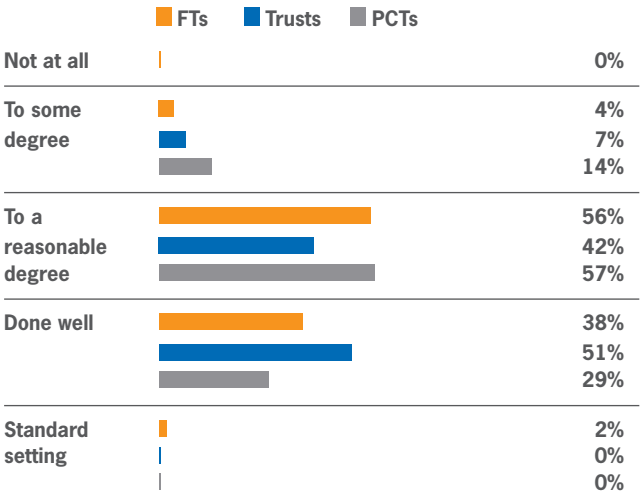
Only 65% think their organisation's annual report is actually helpful in explaining its challenges, risks, performance and forward plans.

Overall, the annual reports of NHS providers are more accessible than those of PCTs: with 43% of FT reports and 51% of trusts' self-assessed as having done well or better in being 'readily understandable', but just 29% of PCTs'. While there is always room for organisations to improve, we believe it is particularly important that PCTs set a strong quality marker to get CCG governance reporting off to a good start.

I FIND THE ANNUAL REPORT HELPFUL IN UNDERSTANDING THE CHALLENGES, RISKS, PERFORMANCE AND FORWARD PLANS OF OUR ORGANISATION



THE REPORT IS READILY UNDERSTANDABLE TO READERS WHO MAY NOT HAVE HAD PREVIOUS NHS EXPERIENCE



Accessibility and transparency

Most respondents (80%) believe their annual reports, accounts and quality reports are published in a timely and accessible way. This is broadly consistent with our review of annual reports, as explored below.

However, there is still potential for development. For 67% of trusts, 58% of FTs, and 57% of PCTs in our sample, we needed to use either internal or external search engines to find the annual report on the organisation's website. At the other end of the scale, a promising 10% of trust, 3% of FT and 6% of PCT annual reports were on the home page. Timeliness of information is one area of weakness: some NHS organisations did not publish their annual report until August or September, meaning that up to six months of the new financial year had elapsed before they reported on the previous year.

Ease of access is another issue: trusts often publish their accounts and quality account/report separately. In some cases, we were advised to request copies from the chief executive or director of finance. Such barriers to transparency are inconsistent with accountability and good governance.

THE ANNUAL REPORT, ACCOUNTS AND QUALITY ACCOUNT ARE MADE AVAILABLE TO THE PUBLIC IN A TIMELY AND EASILY ACCESSIBLE WAY

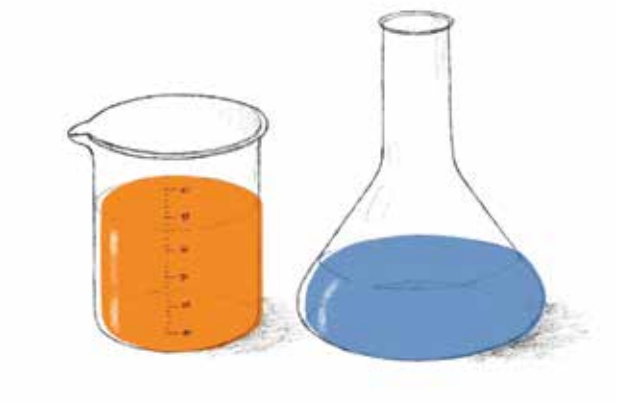
Cutting clutter

Much annual report content is determined by statute or other regulatory requirements. However, organisations should still see the report as a communication tool, not a compliance exercise. The front-end narrative should 'tell the story' in a compelling and succinct way. Immaterial detail should be avoided: it can overwhelm key messages and deter readers.

Last year, we set trusts and FTs the challenge of 'cutting the clutter', to produce quality reports with purpose and value. Unfortunately, the average length of annual reports again increased: the average FT publication grew by 24 pages to 175 pages, with trust reports expanding by 16 pages to 75.

As CCGs are created and we slowly move to an all-FT marketplace, it may be a good time to rethink the narrative section of the annual report (incorporating the discussion of risks and mitigations). Crucially, writers should start each year afresh: currently, it can appear as if the previous year's narrative has just been updated.

The average length of annual reports again increased: the average FT publication grew by 24 pages to 175 pages, with NHS trust reports expanding by 16 pages to 75.



	2012			2011	
	FTs	Trusts	PCTs	FTs	Trusts
Average number of pages	175	75	63	151	59
Longest	266	259	122	240	123
Shortest	49	34	19	60	21
Annual reports that include the full accounts	95%	28%	30%	92%	14%
Annual reports that include summary accounts	5%	72%	70%	8%	86%
Annual reports that include the quality report	89%	7%	n/a	88%	24%
Annual reports that include the annual governance statement	98%	66%	32%	n/a	n/a

In a positive step towards transparency, this year more annual reports presented a full governance picture by including the full financial statements, quality report and annual governance statement. This need not add to the overall length of the annual report; these documents are all part of the same story and should not duplicate content – they should complement each other to reduce clutter.

Integrated reporting

OUR ANNUAL REPORT IS MORE THAN A DOCUMENT CONTAINING REGULATORY DISCLOSURES; IT CAPTURES THE TANGIBLE AND INTANGIBLE VALUE OF OUR ORGANISATION

NHS reports score highly in their presentation of the holistic value of their operations – not just those requirements measured by the compliance yardsticks referred to throughout this report. Almost 73.9% of respondents believe they capture the 'tangible and intangible value of our organisation'. In this, they chime with the International Integrated Reporting Council (IIRC)'s vision of integrated reporting, which aims to capture all-round value: not just that tied up in financial and physical assets, but also that found in such things as brand reputation, people, intellectual property, software and customer retention.

Integrated reporting is a natural evolution for the NHS: involving clear, transparent and relevant reporting on the sustainability of quality services and the strength of governance. The IIRC is currently working with more than 80 companies and 25 investors on an integrated reporting pilot programme, with the aim of launching this framework in late 2013. It will be interesting to see how NHS reports evolve in response to integrated reporting.

Good corporate reporting

In its 2012 annual report, the Financial Reporting Review Panel (FRRP) once again set out the characteristics of good corporate reporting. The following principles are based on the FRRP characteristics: we advise boards to consider the adjacent questions when comparing their annual report against the principles.

	Principles	Key questions for the board
1	A company's annual report and accounts must comply with relevant laws and accounting standards and give complete and accurate accounting information.	• Do the annual report and accounts comply with relevant laws and accounting standards? • Is the information complete and accurate? • Are the accounting policies clear, relevant and complete?
2	The front-end narrative should be consistent with the accounts. It should explain significant points in the accounts: there should be no surprises hidden in the accounts.	• Do the annual report and accounts present a single story? • Is the description of the organisation's service and how it is managed in the narrative report consistent with disclosures in the financial statements?
3	The business review should give a clear and balanced story including an explanation of the company's business model and the salient features of the company's position and performance, good or bad.	• Does the business review explain how the body has performed financially and the public benefit it has created?
4	The business review should describe the principal risks and uncertainties faced. The risks and uncertainties described should genuinely be the principal ones that concern the board. The reader should be able to understand why they are important and the links to accounting judgements and estimates should be clear.	• Does the business review address adequately what worries the board? • Are the narrative disclosures consistent with the accounting risks and uncertainties, where appropriate?
5	If the organisation refers to adjusted figures or key performance indicators in the business review, these need to be reconciled clearly to main heading figures in the accounts. Any adjustments need to be explained clearly, with the reasons why they were made.	• Are we consistent in our reporting? • Are all financial KPIs properly explained with reference to key financial statements?
6	Important messages should be highlighted and supported with relevant contextual information – not obscured by immaterial detail. Effective cross-referencing should be provided and repetition avoided.	• Is the reporting of material transactions clear and transparent and have appropriate accounting policies been developed? • Have accounting policies for irrelevant and immaterial items been removed? • Has the clutter been cut?
7	Language should be precise. Complex issues need to be explained clearly. Jargon and boilerplate should be avoided.	• Is the language clear? • Are disclosures specific to the business' operations and risks?
8	Items in the annual report and accounts should be reported at an appropriate level of aggregation to convey the essential messages and avoid unnecessary detail. Tables of reconciliations should be supported by, and consistent with, the accompanying narrative.	• Have we summarised appropriately?
9	Significant changes from the previous period in policy or presentation should be explained properly.	• Have we explained changes and, where appropriate, are the revised accounting policies clear?
10	The spirit as well as the letter of accounting standards should be followed, and appropriate disclosures provided, to give a true and fair view.	• Do the accounts give a true and fair view?

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We are Grant Thornton UK LLP

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Through empowered client service teams, approachable partners and shorter decision-making chains, we provide a wider point of view and operate in a way that's as fast and agile as our clients. The real benefit for dynamic organisations is more meaningful and forward-looking advice that can help unlock their potential for growth.

This means we're assisting our clients to get strong governance and financial arrangements in place that ensure operational effectiveness and sustainable financial health, and help them to move towards foundation trust status. We also advise on how to deploy innovative methods of financing capital infrastructure and assess new business structures and potential opportunities for outsourcing, as well as considering how local needs can be met through new models of service delivery and collaboration.

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Governance matters

Corporate Governance Review 2012

NHS Governance Review 2013

Local Government Governance Review 2013

Charities Governance Review 2013

For further information, visit:
www.grant-thornton.co.uk/governancematters

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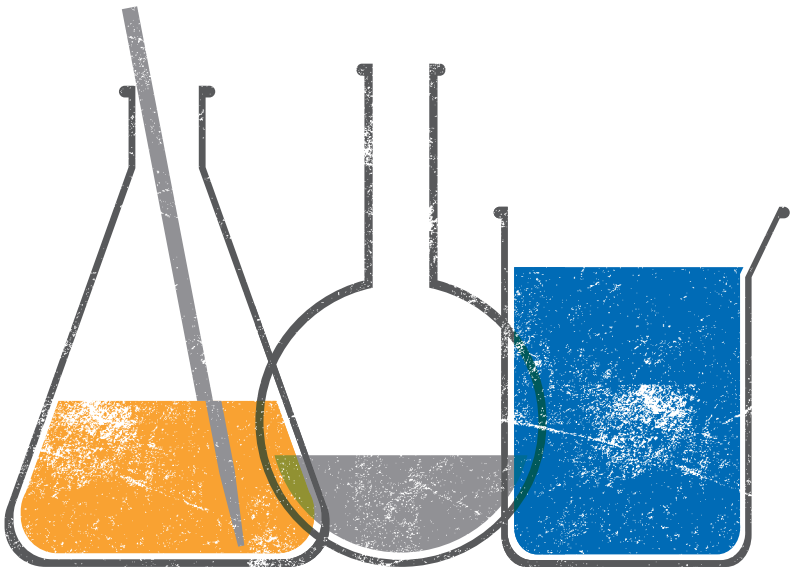

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