SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting: 26 May 2015

Subject	Annual Governance Statement 2014/15 – FINAL DRAFT
Prepared by	Ruth James
Approved by	
Presented by	Ruth James
Name of meeting considered/approved by	Quality Assurance Committee, May 13th 2015 Audit Committee, May 20th 2015

Purpose: To describe the system of internal control in place during 2014/15		
	Decision	
	Approval	●
	Information	
	Assurance	

Executive Summary

The report describes the risk and control framework in place in the Trust.

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The Annual Governance Statement identifies the key risks in 2014/15 and going forward into 2015/16 as the financial position and Clostridium Difficile.

The statement concludes that the Trust has not identified any significant control issues for the financial year ending 31 March, 2015, and that there is a generally sound system of internal controls that supports the achievement of the Trust's policies, aims and objectives. This conclusion is supported by the Head of Internal Audit draft opinion.

The statement has been reviewed and supported by the Quality Assurance Committee and the Audit Committee

Next Steps

The Board is requested to approve the statement for submission with the annual reports to Monitor.

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care		improved cost control		improved patient flow		improved information	
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety		enhanced services				strong partnerships & engagement	

If a key risk(s) has been identified, please describe below

The key risks identified for 2015/16 are:

- **The delivery of the CIPs in the 2015/16 element of the recovery plan**
- **The achievement of the Clostridium Difficile improvement target**
- **The achievement of the A&E target in quarter 1 2015/16.**

Annual Governance Statement 2014/5

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South Tees Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South Tees Hospitals NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accountable Officer and Chief Executive I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the Trust for meeting all statutory requirements and adhering to guidance issued by Monitor in respect of governance and risk management.

Some aspects of risk are delegated to the Trust's Executive Directors:

- The Director of Quality was appointed on the 23rd of February 2015 and is accountable for the assessment and improvement of quality and patient safety and ensuring effective risk management. The Director of Quality works closely with the other executives to maintain the system of internal control.

- The Medical Director is the responsible officer and is accountable for the local clinical governance processes in the Trust, focusing on the conduct and performance of doctors. The Medical Director is also the Caldicott Guardian, responsible for information governance risks and is the accountable officer for controlled drugs.

- The Director of Nursing is responsible for infection prevention and control and is the Senior Information Risk Owner. The Director of Nursing was overall lead for risk management and patient safety until the 23rd of February 2015 when the board responsibility for risk management transferred to the Director of Quality.

- The Director of Nursing is also responsible for business continuity planning and emergency planning. This responsibility previously rested with the Chief Operating Officer who left the organisation in December 2014.

- The Director of Finance provides the strategic lead for financial risk and the effective co-ordination of financial controls throughout the Trust. The Director of Finance is also the executive lead for workforce, performance management and information technology.

- The Transformation Director took up post on the 1st of May 2015 and is responsible for the development and delivery of the Trust's transformation programmes to ensure achievement of the organisation's strategic aims.

- The executive directors are supported in the management of risk by the assistant director of quality assurance, the Trust incident and risk manager, the head of information governance and the Trust solicitor.

The delivery of clinical activities is managed within a structure of seven clinical centres supported by the corporate directorates. Each clinical centre is led by a triumvirate consisting of Chiefs of Service, Managing Director and Head of Nursing. All Chiefs of Service, clinical directors and managers have delegated responsibility for the management of risk and patient safety in their areas. Recognising and managing risk is integral to their day-to-day management responsibilities.

All members of staff have responsibility for participation in the risk/patient safety management system through:

- awareness of risk assessments which have been carried out in their place of work and to comply with any control measures introduced by these risk assessments;

- compliance with all legislation relevant to their role;

- following all Trust policies and procedures particularly risk management and incident reporting policies which are available to all staff electronically through the intranet;

- reporting all adverse incidents and near-misses via the Trust Incident Reporting System;

- attending regular training as required ensuring safe working practices;

- awareness of the Trust Risk Management Policy and their own Clinical Centre risk management and escalation process, and

- knowing their limitations and seeking advice and assistance in a timely manner when relevant.

The Trust recognises the importance of supporting staff. All employees, including members of the Board, clinicians, managers, and permanent, temporary and locum staff are provided risk management training appropriate to their role. Training includes:

- corporate induction training when staff join the Trust;

- mandatory update training for all staff every two years; and

- targeted training on specific areas including risk assessment, incident reporting and incident investigation including root cause analysis.

The Trust seeks to learn from good practice through Trust communication media and education sessions. Managers produce and distribute lessons learned reports following investigations of incidents.

The risk and control framework

The risk management strategy outlines how quality governance works in practice across the organisation, including how the Trust's performance management systems contribute to an effective system of internal control, ensuring delivery of key objectives and management of risk across all areas in the organisation.

The organisation's risk appetite was recently reviewed and updated at the Board of Directors meeting in April 2015. The risk management policy specifies that risks which score 15 or higher, using the National Patient Safety Agency five by five risk matrix, will be escalated for review by the Quality Assurance Committee. The risk management strategy will be updated to include the revised risk appetite statement below:

- The Trust accepts that there is a degree of risk in every activity that it undertakes and it's appetite for risk will depend upon the impact of the risk on the organisations strategic direction and sustainability, the likelihood of it materialising and the effect on the organisations reputation and image. The Board has considered the level of risk that it is prepared to tolerate in relation to the delivery of our objectives and agreed the following approach for different types of risk exposure:

  Regulatory Compliance
  We have a moderate appetite for risk where actions may result in challenge to regulatory compliance.

  Finance
  The Trust has a moderate appetite for financial risk and is prepared to accept the possibility of some limited financial loss if the overall benefit justifies the risk. The Trust is prepared to support investment for return and minimise the possibility of financial loss by managing associated risks to a tolerable level.

  Innovation, quality improvement.
  The Trust will pursue innovation and challenge existing practice to drive transformation in care and improvement in quality. In this aspect of our strategic decision-making the Trust has a higher appetite for risk.

  Reputation
  The Trust has a moderate risk appetite for actions and decisions that may affect the reputation of the organisation and its' employees. Such actions and decisions will be subject to a rigorous risk assessment and will be signed off by the Board.

The strategy is supported by a range of detailed Trust policies and accompanying guidance. The risk management policy was updated during 2014/15 to reflect the revised clinical centre structure and to clarify the framework for monitoring and escalation of risk. The policy describes:

- A clear framework of accountability and delegated responsibility for risk;

- Detailed, defined processes for identifying and evaluating risks. Tools available include a standard process for scoring the consequence and likelihood of risks;

- An electronic risk register providing a comprehensive, standardised record of risks at clinical centre and corporate level. This allows risks to be managed consistently;

- The use of risk register movement charts to show how risk ratings have changed as risks are managed;

- A dedicated risk management team supporting the risk management process;

- Training processes to support staff to deliver their risk management objectives; and

- A clearly defined committee structure that supports the risk management process.

The committee structure comprises of:

- The Audit Committee which supports the Board by critically reviewing the governance and assurance processes on which the Board places reliance.

- The Finance and Investment Committee was established during 2014/15 as a Sub Committee of the Board. Its role is to maintain robust financial management by monitoring financial performance and making recommendations to the Trust Board as appropriate.

- The Quality Assurance Committee, the role of this Committee and its sub groups is to assist the Board and organisation in ensuring it fully discharges its duties in relation to the delivery of high quality services and patient outcomes, having regard to patient safety, clinical effectiveness and patient experience. The Quality Assurance Committee is also responsible for assuring the Board on the effective management of risk and play a key role in the risk escalation process.

- The Patient Safety Sub-group reports to the Quality Assurance Committee, its role is to monitor the delivery of patient safety improvement initiatives which support the delivery of the Trust's objectives in relation to safety and quality and to review themes and trends from incidents to identify patient safety concerns and ensure actions are taken to address any issues identified.

- The role of the Patient Experience Sub-group is to review patient experience feedback, complaints and PALs. This group reports to the Quality Assurance Committee.

- The Workforce Sub-Group has responsibility for assuring workforce development, workforce planning and staff health & wellbeing.

- The Clinical Standards Subgroup ensures agreement and delivery of the highest clinical standards throughout the Trust.

Quality of care and patient safety is the core transformational theme which underpins the development of the Trust's values and objectives. Each Board meeting starts with a patient story. The Board receives a range of quality information and assurance both through the committee structure and directly at Board meetings. The data used to report the Trust's quality performance is taken from national data submissions, clinical audit, national benchmarking systems, quality observatories and patient and staff surveys. The indicators and measures used to track the Trust's quality and safety objectives are reported through the patient safety and quality dashboards. The dashboards are produced at Trust, clinical centre, directorate and ward level. The quality indicators are formally reported in the quarterly quality report which includes qualitative and quantitative information, statistical analysis of trends and benchmarking. All serious incidents are reported to the Board. Quality improvement targets are determined by the Trust's strategies, triangulation of incidents, complaints and claims, audits and CQUIN contracts.

During 2015/16 the Trust established a transformation team to provide support to the delivery of the transformation programme which underpins the achievement of cost improvement initiatives. Risks to quality arising from cost improvement initiatives are assessed using a standard quality impact assessment process which is defined in a standard operating procedure. Quality impact assessments are signed off by the Director of Nursing, Director of Quality and the Medical Director and are monitored by the Quality Assurance Committee.

The performance against Monitor's continuity of service risk rating and applicable national standards is reported monthly to the Board. The performance data used by the Trust is split into two categories:

- Clinical data items, related to the accuracy of clinically coded data; and
- Administrative data items, related to the patient's care pathway.

The Trust undertakes a number of processes to validate and provide assurance of the quality of the data used within the Trust:

- Internal programme of specialty level clinical coding audits;
- Live validation of clinically coded data;
- Weekly validation of NHS numbers;
- Weekly validation of Patient's GP details; and
- Internal audits to review accuracy of data used for specific performance reports, i.e. cancer targets, 18 week targets etc.

To assist in the above the Trust uses a number of sources external to the Trust to facilitate this including:

- Internal Audit data validation and data quality reviews, in 2014/15 these were:

  - Emergency readmissions within 28 days of discharge from hospital (May 2014);
  - Community 18 Week RTT (Feb 2015);
  - Community End of Life (Feb 2015); and
  - End to End Income Lifecycle (April 2014).
- HSCIC – SUS Data quality dashboards.
- CHKS – Signpost – Data Quality Indicators.

The data quality team review information on the Health and Social Care Information Centre and CHKS websites routinely to highlight any issues which require further investigation.

The management of risk is monitored at all levels within the organisation. There is a rolling programme of presentations from clinical centres and corporate directorates to the Quality Assurance Committee to review local risk management arrangements and to receive a report on risks managed on clinical centre and corporate directorate risk registers. Minutes of these meetings are reported through the committee structure to the Board.

Each month, the executive directors review strategic risks to the corporate objectives which are identified on the assurance framework, this is then presented to the Board of Directors. To address recommendations from an internal audit review of the risk management process all new red risks are now reviewed by the Quality Assurance Committee and the risk management policy has been revised during 2014/15 to include a clear framework for accountability to manage and escalate risk. The Committee identifies any risks for escalation to Board for consideration as a corporate risk. An audit trail of these decisions is recorded in the minutes and in the electronic risk register system.

The Information Governance Steering Group ensures that the Trust complies with legislation and standards relating to information risks and is chaired by the Trust Senior Information Risk Owner (SIRO). The Board of Directors has agreed the Information Risk Management (IRM) framework for the Trust.

The Trust has a continuous work programme to further embed the IRM framework within the organisation, ensuring that any data security risks are highlighted by the Information Asset Administrators (IAA) at ward and centre level, reported to the Managing Director who are the Information Asset Owners (IAO) and then discussed with the SIRO.

All data security incidents are investigated and reported in accordance with the Trusts incident and serious incident policies and are escalated via the IG Toolkit as mandated nationally. No Level 2 incidents occurred during 2014/15; therefore none were reported via IG Toolkit Reporting Tool.

The Trust has successfully achieved a minimum of level 2 on the 45 standards of the Information Governance (IG) Toolkit. The Trust overall IG compliance score for 2014/15 was submitted as 80% Green – Satisfactory.

- Public stakeholders are also involved in managing risks which impact upon the organisation;

- Patients are involved in planning their own treatment at every level;

- The Trust consults with patients and the public when developing services; and

- The Trust maintains close links with social services, working together on the handling of issues such as delayed discharges.

The processes set out above, in particular the standardised approaches, the on-going training, reporting and monitoring mechanisms, have allowed the Trust to embed risk management in the activity of the Trust.

- The Trust's assurance framework sets out the following:

- What the organisation aims to deliver (corporate/strategic objectives);

- Factors which could prevent those objectives been achieved (principle risks);

- Processes in place to manage those risks (controls);

- The extent to which the controls will reduce the likelihood of a risk occurring (likelihood); and

- The evidence that appropriate controls are in place and operating effectively (assurance).

In October 2013, Monitor informed the Trust of its decision to open a formal investigation into the Trust's compliance with its licence. This investigation was opened due to governance concerns arising primarily out of the Trust's failure to meet the Referral to Treatment Target for three consecutive quarters and Monitor also identified concerns about 'never events' and the Trust's performance against the Clostridium Difficile target. The Trust responded to these concerns in November 2013 and has subsequently delivered and sustained throughout 2014/15, compliance with the 18 week referral to treatment target and has reported 1 never event in 2014/15. Monitor confirmed that it was satisfied with the actions taken in respect of these issues. With regards to Clostridium Difficile the Trust did not achieve the required improvement and failed to meet the 2014/15 threshold ending the year with 76 cases against a target of no more than 49 cases.

The two year financial plan for 2014 - 2016 submitted in June 2014 forecast a worsening position from a forecast £5.2 million deficit (excluding impairments) at the year-end in 2013/14 to a projected £29.4 million deficit in 2014/15. The plan set out that £29.4 million was a worst case figure and that action was being taken to reduce the deficit through recovery plans.

In May 2014, working with McKinsey, the Trust commenced an intensive process to develop a financial recovery programme, under the banner of "Continuing the Journey". The initial plan submitted in June 2014 included efficiencies amounting to £11.4 million and a further £10.4 million was then identified to take the planned total efficiency savings to £21.8m for 2014/15.

In July 2014 Monitor notified the Trust that it considered the Trust to be in breach of its licence and was to take enforcement action in respect of;

- The breach of the Clostridium Difficile annual objective; and
- The continuity of services risk rating.

In response the Trust agreed the following undertakings:

- To develop and implement a Clostridium Difficile action plan which had been subject to external assurance;
- To develop and submit a financial recovery plan which returns the Trust to an acceptable continuity of services risk rating of 3 within three years; and
- Commission a board governance review.

The Trust's financial position and reducing Clostridium Difficile have been the major risks faced by the Trust in 2014/15.

A detailed three year recovery plan describing how the Trust planned to return to a continuity of services risk rating of 3 was submitted to Monitor in September 2014. The risks associated with the delivery of the plan for 2014/15 were mitigated through rigorous budgetary control and management of cost improvement plans through the transformation office with regular reports to the management group and the Board of Directors. The Recovery Plan included a planned deficit of £18.4 million for 2014/15, the Trust ended the year £11.4 million ahead of plan. In addition, the Trust delivered £26.0 million of efficiencies against the target £21.8 million set in the Recovery Plan, of which £22.5 million were recurring savings. Although this was a significant improvement, the Trust is looking to deliver £36.0 million of efficiencies in 2015/16 and the organisation must continue to maintain the current momentum in order to deliver these challenging financial targets.

On the basis of the improved performance in 2014/15 and the programme of service transformation planned for 2015/16 the Trust is forecasting that it will achieve the 2015/16 element of the recovery plan.

The position with Clostridium Difficile remains challenging. The Clostridium Difficile action plan has been revised and updated during the year and the Trust commissioned further external reviews to advise on the content of the plan and to review the governance of the infection prevention and control processes. The Trust is also working with its PFI partner to review and improve cleaning standards following an independent review by Pierce Management Services that demonstrated that there was room for improvement. The Board have been updated every month on progress with the financial plan and Clostridium Difficile through individual reports and review of the corporate risk register.

Monitor has recently issues draft variations to the terms of the enforcement undertakings accepted from the Trust in July 2014. The variation is to clarify the requirements relating to the delivery and assurance of a revised Clostridium Difficile action plan. Specifically Monitor requires:

- A revised Clostridium Difficile action plan setting out details of actions to be taken, milestones and the intended outcomes. The revised action plan will include metrics and key performance indicators (KPIs) as are necessary to provide assurance on the implementation of the revised plan;
- The Trust is to obtain external assurance of the revised plan by an expert in infection control. The identity of that expert is to be agreed with Monitor;
- By a date to be agreed with Monitor, obtain from the expert a further report on the Trust's implementation of the revised plan. The scope of this report is to be agreed with Monitor; and
- To provide monthly reports to Monitor on the implementation of the revised plan until the Trust returns to compliance with the agreed Clostridium Difficile trajectory.

Actions to respond to these requirements are in progress and will be reviewed at monthly meetings with Monitor.

The winter of 2014/15 saw significant increases in demand for A&E services nationally, this increase resulted in the Trust failing to achieve the A&E waiting time target for quarter 3 and quarter 4, this was a position that was replicated across the country. A&E waiting time continues to be a concern for quarter 1 of 2015/16. The Trust has commissioned external support for the redesign of the Emergency Care Pathway which will reduce avoidable admissions, streamline flow of patients through the front of house, reduce length of stay and improve discharge. These improvements, together with work the Trust is doing in collaboration with local CCGs to redesign community services will support achievement of the A&E waiting times in the remainder of 2015/16.

During 2014/15 the Trust commissioned an independent review of its governance arrangements using Monitor's Well Led Framework for governance reviews. The findings of the review identified a number of areas of good practice including the focus by the Board and the wider organisation on provision of high quality care, the focus on organisational development and the openness and responsiveness to feedback and learning. There were also a number of areas of significant concern where improvement was required, these were:

- Clarification of the portfolios of the executive team following the changes to the structure of this team;

- It was recognised that a number of improvements had been made to the performance management arrangements but that there needed to be consistency in the governance arrangements in each clinical centre;

- Board scrutiny and debate should be strengthened to ensure all directors fully participate as corporate directors.

- Improvement in Board reporting to provide integrated performance and financial reporting and ensuring that actions are robustly tracked and actioned;

- Improvement in accountability and engagement of staff to support the success of the programme of transformation; and

A number of processes which underpin financial governance had been strengthened prior to the review including the development of the finance system, restructure of the finance team and a review of business case prioritisation. These were recognised in the findings of the review with a recommendation for further focus on increased financial scrutiny and debate, strengthening budget management processes, increasing financial support to the clinical centres and progressing service line reporting.

An action plan to address the recommendations of the review has been submitted to Monitor, a number of actions have been completed including the establishment of the Finance and Investment Committee, the restructure of the finance and transformation teams to provide improved support to clinical centres and the introduction of an integrated quality, finance and performance report. Progress with the action plan is monitored quarterly by the Board of Directors and through the monthly PRM meetings with Monitor.

The assurance framework and risk register did not describe any significant gaps in control/assurance during 2014/15. The position with the risks described above was closely monitored during the year and the controls applied were reviewed and revised as the factors influencing the risks changed.

The Trust was inspected by the Care Quality Commission in December 2014, no urgent compliance actions were identified during the course of the inspection.

Insert a summary of the findings from the final report available w/c 25th May

The CQC guidance published in the appendices to the provider handbook states that for trusts where Monitor is taking regulatory action, the overall trust rating will normally be limited to 'requires improvement' at best.

A quality summit for the Trust, CQC, Monitor and local commissioners to review the findings of the reports and agree an action plan is scheduled for June. The action plan will be monitored and reported to the Board through the Quality Assurance Committee.

The CQC intelligent monitoring report is reviewed when published and reported by exception to the Quality Assurance Committee. The Trust has introduced bi-annual CQC-style in-house inspections which have been very well received by staff and are a good source of on-going assurance of compliance, this is in addition to the ward accreditation system which was introduced in 2014/15 and uses a set of standards based on the CQC requirements against which the wards are assessed and assigned a quality rating, there is rolling programme of assessments across the year.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has a comprehensive system that sets strategic and annual objectives and has appointed the Transformation Director to lead the further development of the organisations strategy. The Board of Directors sets the organisations objectives with regard to the economic, efficient and effective use of resources. The objectives set reflect national and local performance targets for standards of patient care and financial targets to deliver this care within available resources. Within these targets, the Trust includes specific cost improvement programmes which will be delivered through rigorous budgetary control and the transformation of services..

The Trust has a robust monitoring system to ensure that it delivers the objectives it identifies. Ultimate responsibility lies with the Board who monitor performance through reports to its monthly meetings. Underpinning this is a system of monthly reports on financial and operational information to the Trust's executive management group, clinical centres and other management units. Reporting at all levels includes detail on the achievement against cost improvement targets.

The Trust operates within a governance framework of Standing Orders, Standing Financial Instructions and other processes. This framework includes explicit arrangements for:

- setting and monitoring financial budgets;
- delegation of authority;
- performance management; and
- achieving value for money in procurement.

The governance framework is subject to scrutiny by the Trust's Audit Committee and internal and external audit.

Annual Quality Report

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

For the development of the 2014/15 Quality Report the Trust has used a range of sources of feedback from staff, patients, governors and external stakeholders to identify the priorities for quality improvement. This information was presented to the Board who approved the following quality improvement priorities for 2014/15:

Sign up to safety (Patient Safety); Reducing avoidable harm by 50% over 3 years with a specific focus on:

- Reducing pressure ulcers;
- Reducing harm from falls';
- Reducing HCAI; and
- Reducing incidents of missed and delayed diagnosis.

Right Care, Right Place, Right Time (Clinical Effectiveness):

- Identification and management of deterioration in condition; and
- Improve the experience of services users with dementia.

At the heart of the matter (Patient Experience):

- Listening and learning, improving how we respond to complaints and patient feedback including a focus on improving communication.

Board responsibility for the Quality Report rests with the Director of Quality, the production of the Quality Report is overseen by the directorate of quality assurance. Each quality priority has a clinical lead identified who is responsible for identifying the initiatives which will drive

improvements and the measurements which will be used to gauge progress. A mid-year progress report on the quality priorities is presented to the Quality Assurance Committee and the Council of Governors. The data used in the Quality Report is taken from the regular quality and performance reports presented to Board. The quality initiatives described in the Quality Report demonstrate progress across a range of measures but also those where there is scope for further improvement. The mechanisms for assuring the accuracy of the data used in quality monitoring reports is described in the 'Risk and Control Framework Section' above. The Trust is assured of the quality and accuracy of elective waiting time data through the application of national definitions and guidance for the extraction of raw data from the trust's patient administration system (PAS) which is then used to create a patient target list (PTL); this is used to manage the patients on the elective pathway. The technical processes to produce the PTL have validation checks built in to them and a further manual validation check is undertaken before the report is distributed. The information services team have full procedural documentation that the team follow to run the processes that produce the PTL and waiting list reports.

A central tracking team receives the PTL and waiting list reports and, working closely with identified personnel in every specialty across the organisation, validate the data on a daily basis.

The risks to the accuracy of the data arise from the potential for error in the manual data entry. These risks are mitigated by the regular checks that are built in and the daily validation by the central tracking team. Any errors with data input are fed back to the appropriate teams with further guidance, training and education. The Trust has an access policy which is reviewed every 2 years so that the processes for the management of waiting lists is standardised. The internal audit programme includes reviews of waiting lists; the most recent of these was the community referral to treatment data which was completed in February 2015.

Further assurance that the quality report is accurate and representative was gained by sharing the Quality Report with Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees, as required by national regulation.

The external auditors will provide a signed limited assurance report on the content of the Quality Report and mandated indicators in the annual report. The signed limited assurance report will be submitted to Monitor by the 29th May 2015.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on controls reviewed as of Internal Audit's work. However, as part of my review I am also required to review the findings

of all internal audit work in order to satisfy myself that any significant control issues have been disclosed within the Statement on Internal Control.

For the 2014/15 internal audit plan management asked internal audit to undertake a number of audits in areas where there were known to be risks so that the findings could inform the strengthening of control processes. The plan included a number of core systems and processes which internal audit has commented on positively. These being:

- key financial systems;
- information governance toolkit; and
- IT infrastructure controls.

Internal audit found that some progress had been made in respect of the actions arising from the limited assurance reports issues in 2013/14 albeit further work is required. The majority of the other audits conducted during the year resulted in limited assurance, this reflects the risk based nature of the internal audit plan and in forming his opinion the head of internal audit considered the relative materiality of the systems where limited assurance opinions have been assigned. Executive directors have also reviewed the limited assurance reports issued during the year and have not identified any significant gaps in the adequacy of the controls relevant to the audits.

I am pleased to report that the head of internal audit draft opinion is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk.

As part of the Head of Audit's opinion he has informed me that there are no significant controls issues which he would wish to bring to my attention for potential disclosure.

The following groups and committees are involved in maintaining and reviewing the effectiveness of the system of internal control:

- The Board of Directors has overall accountability for delivery of patient care, statutory functions and Department of Health requirements;
- Audit Committee oversees the maintenance of an effective system of internal control and reviews the Annual Governance Statement; and
- Quality Assurance Committee ensures that a fully integrated approach is taken when considering whether the Trust has in place systems and processes to support individuals, teams and corporate accountability for the delivery of safe patient centred, high quality care. The committee considers the assurance framework and corporate risk register and identifies new corporate risks for escalation to the Board of Directors.

Review and assurance mechanisms are in place and the Trust continues to develop arrangements to ensure that:

- Management, including the Board, regularly reviews the risks and controls for which it is responsible;

- Reviews are monitored and reported to the next level of management;

- Changes to priorities or controls are recorded and appropriately referred or actioned;

- Lessons which can be learned, from both successes and failures, are identified and promulgated to those who can gain from them; and

- Appropriate level of independent assurance is provided on the whole process of risk identification, evaluation and control.

Conclusion

The Trust has not identified any significant control issues for the financial year ending 31 March, 2015, which require reporting within this statement.

My review confirms that South Tees Hospitals NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed……..

Chief Executive Date: …… May 2015