NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date: 29 April 2015

Title and Author of Paper:
Draft Annual Governance Statement 2014/15
John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Debate / Decision

Key Points to Note:

The Annual Governance Statement is a mandatory requirement. It provides assurance that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives, and provides details of any significant internal control issues. See the attached draft Statement (note blue writing indicates mandatory wording).

The Statement must be signed off by the Chief Executive, as the accounting officer, on behalf of the Board of Directors. It is part of the annual report and accounts and subject to external audit scrutiny. The external auditor will report on inconsistencies between information in the Statement and their knowledge of the Trust and any failure to comply with Monitor's requirements. Detailed guidance on the format and contents of the Statement is available in Monitor's NHS Foundation Trust Annual Reporting Manual.

The Head of Internal Audit provides an annual opinion to the accounting officer and the Audit Committee on the adequacy and effectiveness of the risk management, control and governance processes to support the Statement.

The Audit Committee provides an annual report of its work which provides assurance relating to the signing of the Annual Governance Statement, i.e. to demonstrate that the Committee had performed sufficient review and debate during the year to be able to issue its recommendations to the Board on the Annual Governance Statement and financial statements.

Once the draft Statement has been prepared, it is subject to the following process:

- 20 April – CDT for consideration and comments.
- 22 April – Audit Committee review along with the draft Head of Internal Audit Opinion. The Audit Committee reviews the Statement to consider whether it is consistent with the Committee's view on the organisation's system of internal control with a view to recommending the draft Statement to the Board of Directors.
- 29 April – Board of Directors comments and adoption of the draft Statement.
- 20 May – Audit Committee review of the now audited Statement and final Head of Internal Audit Opinion with a view to recommending approval of the final Statement to the Board of Directors.
- 27 May – Board of Directors approval of the final Statement.

Outcome required:
The Board of Directors to adopt the draft Annual Governance Statement.

DRAFT ANNUAL GOVERNANCE STATEMENT 2014/15

1 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.*

2 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 Northumberland, Tyne and Wear 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 Northumberland, Tyne and Wear NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

The Executive Director of Performance and Assurance has overall lead responsibility for performance risk management within the Foundation Trust. While the Executive Director of Performance and Assurance has a lead role in terms of reporting arrangements, all directors have responsibility for the effective management of risk within their own area of direct management responsibility, and corporate and joint responsibility for the management of risk across the organisation.

Structures and systems are in place to support the delivery of integrated risk management, across the organisation. A wide range of risk management training has continued to be provided throughout the Foundation Trust during the year. This includes providing training for all new staff as well as training specific to roles in areas of clinical and corporate risk. Delivery of training against planned targets is monitored by the Board of Directors, and managed through the Trust Corporate Decisions Team and devolved management structures. The Foundation Trust has a Board of Directors approved Risk Management Strategy in place.

Committees of the Board of Directors are in place both to ensure effective governance for the major operational and strategic processes and systems of

the Foundation Trust, and also to provide assurance that risk is effectively managed. Operations for the Foundation Trust are managed through an organisational structure, with operations divided into three groups, and each has governance committees in place for quality and performance and operational management. Risk registers are maintained and reviewed by each Group and reviewed through the Foundation Trust-wide governance structures. The Quality and Performance Committee consider group top risks and the Assurance Framework and Corporate Risk Register every two months. The Corporate Decisions Team also undertake this review from an operational perspective to ensure that risks are recorded effectively and consistently and that controls in place are appropriate to the level of risk. The Audit Committee considers the systems and processes in place to maintain and update the Assurance Framework, and considers the effectiveness and completeness of assurances that documented controls are in place and functioning effectively. The Mental Health Legislation Committee has delegated powers to ensure that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and to ensure compliance with associated codes of practice and recognised best practice.

4 The risk and control framework

The Foundation Trust continually reviews its risk and control framework through its governance and operational structures. It has identified its major strategic risks, and these are monitored and maintained and managed through the Board of Directors Assurance Framework and Corporate Risk Register, supported by Group and directorate risk registers. The Foundation Trust's principal risks and mechanisms to control them are identified through the Assurance Framework, which is reviewed by the Board of Directors every two months. These risks are reviewed and updated through the Foundation Trust's governance structure. Outcomes are reviewed through consideration of the Assurance Framework to assess for completeness of actions, review of the control mechanisms and on-going assessment and reviews of risk scores.

The principal risks are considered as those rated over 15 at a corporate level on the standard 5 by 5 risk assessment measure. The table below summarises those risks and the key controls as reported in the Board Assurance Framework and Corporate Risk Register. All risks identified below are considered as in year and future risks

Reference	Risk	Key Controls
SO1.1	That we do not develop and correctly implement service model changes.	Evidence base developed through Service Model Review Governance arrangements, including programme management structure under Business Case Process.
SO1.2	That we do not effectively engage commissioners and other key stakeholders leading to opposition or significant delay in implementing service model review changes and other major planned service changes.	Partnership arrangements, including Customer Relationship Management. Engagement with Clinical Commissioning Groups. Membership of Health and Well-being Boards for 5 out of 6 localities. Staff Side Engagement and Partnership Agreement. Service User and Carer Network Groups Community Strategy.
SO2.2	That we do not manage our financial resources effectively to ensure long term financial stability (including differential between income and inflation, impact of QIPP and the cost improvement programme).	Annual Plan/IBP/Long term financial model/ Updated Financial Strategy. Transforming Services Programme – aligning long term strategy / service redesign with funding. Annual Delivery Plan (including. Cost Improvement Plan) – management by FIBD Committee.
SO2.7	That we do not meet compliance and performance standards and/or misreport on these through data quality errors.	Financial and Performance Management reporting systems; other business critical systems Trust Essential Standards Working Group. Group Governance – Q&P Committees / Essential Standards sub groups Quality Accounts Data Quality Policy
SO3.1	That we do not effectively manage significant workforce and organisational changes, including increasing staff productivity.	Workforce Strategy. Workforce Programme Board. Workforce KPIs monitored through Q&P Committee. Group/Directorate Workforce Plans. Time and Attendance and e-rostering system. Transitional Employment & Development Approach (TED). Revalidation process.
SO5.1	That there are risks to the safety of service users and others if the key components to support good patient safety governance are not embedded across the Trust.	Monitoring of Quality Account Goal 1 (reducing harm to patients). Complaints, Litigation, Incidents, PALS and Point of You (CLIPP) reporting system in place across Clinical Services. Patient Safety Incidents reporting system, including Serious and Untoward Incidents (SUIs). Incidents Policy Infection Prevention and Control Policy and Practice Guidance Notes (PGNs). Medicines Management Policy and PGNs Safety Alerts Policy.
SO5.2	That there are risks to the safety of service users and others if we do not have safe and supportive clinical	Care Quality Commission inspections and action plans. Clinical Environment Risk Assessment

	environments.	(CERA) process. Capital programme to improve facilities.
SO5.3	That there are risks to the safety of service users and others if the key components to support good care co-ordination are not embedded across the Trust.	Care Co-ordination and Care Programme Approach Policy and Practice Guidance Notes. Care Co-ordination training.
SO5.4	That there are risks to the safety of service users and others if the key components to support good Safeguarding and MAPPA arrangements are not embedded across the Trust.	Safeguarding Children and Safeguarding Adults Policies, Trust Action Plan. Local Safeguarding Boards. Trust-wide structure for Safeguarding in place. Trust Safeguarding – Public Protection Meeting.
SO5.6	The risk that high quality, evidence-based and safe services will not be provided if there are difficulties in accessing services in a timely manner and that services are not sufficiently responsive to demands.	Reconfiguration of team and working practices across Sunderland and South Tyneside Crisis Teams have a prescriptive service framework
SO5.10	That we do not ensure that we have effective governance arrangements in place to maintain safe services whilst implementing the Transforming Services Programme.	Governance Arrangements. Programme Management arrangements. Decision Making Framework. Board Assurance Framework.
SO6.3	That we do not further develop integrated information systems across partner organisations.	Local partnerships to support integrated Information across organisational boundaries. Trust Information Sharing Policy. Information Protocols.
From Corporate Risk Register	Risk of injury or death of an inpatient from ligature use, including compliance with the Trust's Observation Policy.	Observation Policy and training arrangements. SUI review process Anti –ligature programme. Clinical Environmental Risk Assessment process and programme.
From Corporate Risk Register	That uncertainties during the transition to embedding new NHS structures and systems affect the ability of the Trust to progress its strategic objectives.	Contractual arrangements. Customer Relationship Management. Engagement with Clinical Commissioning Groups.

The governance structures supporting and underpinning this are the Quality and Performance Committee, Finance, Infrastructure and Business Development Committee, and Mental Health Legislation Committee. There is also a Trust Programmes Board, which provides the Board with assurance regarding the Trusts programmes, which deliver on the Trust's transformation and development agenda. These structures were reviewed by the Trust Board in May 2012.

Each of the committees is chaired by a Non-Executive Director and has Executive Director membership. The Quality and Performance Committee acts as the core risk management committee of the Foundation Trust Board of Directors, ensuring that there is a fully integrated approach to performance and risk management. This committee provides oversight to the performance and assurance framework, Foundation Trust risk management arrangements for both clinical and non-clinical risk, and has full responsibility for overseeing the Foundation Trust's performance against essential standards for quality and safety as part of this role. The Quality and Performance Committee reviews the top risks for each group, and the Assurance Framework and Corporate Risk Register every two months. The committee also considers all aspects of quality and performance, in terms of delivery of internal and external standards of care and performance. The Finance, Infrastructure and Business Development Committee provides assurance that all matters relating to Finance, Estates, Information Management and Technology and Business and Commercial Development are effectively managed and governed.

Quality Governance arrangements are through the governance structures outlined above, ensuring there are arrangements in place from ward to board. Review, monitoring and oversight of these arrangements takes place through the following among others:

1. Trust Board
2. Quality and Performance Committee
3. Group Quality and Performance committees
4. Corporate Decisions Team meetings

In 2010 the Trust supported Monitor in the development of a Quality Governance Framework. The Trust now reviews it's performance against Monitor's published Quality Governance Framework on a quarterly basis through the Quality and Performance Committee.

The Trust has a data quality improvement plan in place to ensure continuous improvement in performance information and has made continued advances in this area through 2014-15 with continued development of dashboard reporting from patient and staff level to Trust position. The Trust audit plan includes a rolling programme of audit against all performance and quality indicators.

Registration compliance is managed through the above quality governance structures and is supplemented by a Group Director being responsible for the oversight of all compliance assessments and management of on-going compliance through the Trust Fundamental Standards Group. This Group reports into the Corporate Decisions Team. There is a central log of all evidence supporting registration requirements and a process in place through the governance arrangements highlighted above to learn from external assessments and improve our compliance. The Fundamental Standards Group undertakes regular reviews of compliance against the CQC Fundamental Standards including undertaking mock visits and identifying Improvement requirements.

This formal governance framework is supplemented by an on-going programme of Board visits, which are reported through the Corporate Decisions Team, and an ongoing programme of observational shifts with wards and teams for Corporate Decisions Team members.

The Foundation Trust is registered with the CQC and has maintained full registration, with no non-routine conditions, from 1st April 2010. The CQC has inspected all of the Trust registered locations. The Foundation Trust is fully compliant with the requirements of registration with the CQC.

The Trust recognises the significant organisational change that is required to meet the challenges of the external environment, the changing NHS and the requirement to improve the quality of our services with reducing resources. In response to this the Trust has developed its Transforming Services Programme. This programme is focussed on developing a new service model for the Trust, having implemented a new business model, which included seeking to put clinicians at the heart of the Foundation Trust decision making process. The service model review, which was clinically led has developed a blueprint for the future development of the Foundation Trust services to meet our future challenges, and was presented to our Board of Directors in July 2011. The Board of Directors receives an update on Trust Programmes every two months.

As described above the Trust has robust arrangements for governance across the Trust. Risks to compliance with the requirements of NHS Foundation Trust condition 4 (FT governance) are set out where appropriate within the Trust Assurance Framework and Corporate Risk Register. The Board has reviewed its governance structures and the Board and its committees undertake an annual self-assessment of effectiveness and annual review their terms of reference. The Trust Board reviewed its Corporate Governance Statement at its April meetings, where it considered evidence of assurance against each of the statements required. This evidence documented where the Board had considered appropriate information in its public and private meetings, where internal and external assurances had been gained, mapped across to the Assurance Framework, how the Board had received further evidence and assurance through Board visits and development sessions with the wider Trust management team, and how the board and governance structures monitored and assured compliance with the requirements as set out in the statement. The management of future risks was comprehensively mapped against the past evidence of delivery.

The Corporate Decisions Team is responsible for the co-ordination and operational management of the system of internal control and for the management of the achievement of the Foundation Trust's objectives agreed by the Board of Directors. Operational management, through the Foundation Trust's directors, is responsible for the delivery of Foundation Trust objectives and national standards and for managing the risks associated with the delivery of these objectives through the implementation of the Foundation Trust's risk and control framework. Governance groups have been in place across all areas throughout this accounting period, with each directorate, and then Group having in place an Operational Management Group, and a Quality and Performance Group. To fulfil this function the Corporate Decisions Team reviews the Foundation Trust Assurance Framework and Corporate Risk Register, as well as reviewing Group top risks. It also receives and considers detailed reports on performance and risk management across the Foundation Trust. Summary reports on the work of internal audit and the counter fraud team are also presented to the Corporate Decisions Team on a regular basis, with the emphasis on lessons learned and follow up actions required.

The Risk Management Strategy, the associated Risk Management Policy and the governance structure identified above have been developed in line with nationally identified good practice and assurance of this have previously been received through independent assessment of performance against standards assessed through the National Health Service Litigation Authority scheme, where the Foundation Trust had Level 1 compliance, with 100% delivery against all standards. The Assurance Framework and arrangements for governance were subjected to external review through the Foundation Trust application process, including review by Monitor, the Department of Health and independent auditors during 2009, and are subject to on-going review through Internal Audit. The Trust will undertake an external assessment of its governance arrangements through 2015-16. This has been delayed from 2014-15 as the Trust has undertaken a self-assessment of its governance arrangements, and put in place a range of improvement actions which will be completed before external review.

The Foundation Trust involves public stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Working with partners in health and social services in considering business and service change. The Foundation Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners across the North East. The Foundation Trust also has good relationships with Overview and Scrutiny Committees, with an excellent record of obtaining agreement to significant service change.

- Active relationships with Healthwatch and user and carer groups, and works with these groups on the management of service risks.

- A Deputy Director of Partnerships Role reporting directly into the Chief Executive for sustaining effective relationships with the key public stakeholders.

- Active engagement with governors on strategic, service, and quality risks, including active engagement in the preparation of the Annual Plan, Quality Accounts and the setting of Quality priorities.

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 in to 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 the organisation's obligations under equality, diversity and human rights are complied with. All policies implemented across the organisation have been subject to equality impact assessments.

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 Adaption Reporting requirements are complied with.

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

The Foundation Trust has a financial strategy, which is approved by the Board of Directors, and which was reviewed and approved by the Board of Directors in March 2013, updated in May 2013, and approved again as part of the annual plan in March 2014. The Financial Strategy has been considered by the Finance Infrastructure and Business Development Committee, and adopted by the Trust Board. The financial strategy as adopted in March 2013 supported the updated five year Integrated Business Plan, which was formally approved by the Board in September 2012, and identified clear plans for the longer term use of resources to meet the organisational objectives and the financial demands generated by the prevailing economic climate. This strategy has been updated as part of the preparation for submission of the 2015-16 Annual Plan, and now includes detailed plans for delivery of service and financial objectives to March 2017. The financial position is reviewed on a monthly basis through the Finance Infrastructure and Business Development Committee, through the Corporate Decisions Team and through the Board of Directors. The Financial Delivery Plan is reviewed on a monthly basis by the Finance Infrastructure and Business Development Committee, for both the deliverability and impact of the overall plan and individual schemes. The Trust Board receives an update on the financial delivery plan at each meeting. On-going plans for financial delivery have been developed through the Transforming Services Programme, and reviewed through the Corporate Decisions Team and the Trust Board. An integrated approach has been taken to financial delivery with resources

allocated in line with the Trust Service Development Strategy. Financial and Service Delivery Plans are integrally linked with Workforce Development Plans, which are in place for each Group. Each Group reviews its own performance on its contribution to the Trust Financial Delivery Plan at its monthly Operational Management Group. The Foundation Trust actively benchmarks its performance, through a range of local, consortium based and national groups.

Internal Audit provides regular review of financial procedures on a risk based approach, and the outcomes of these reviews are reported through the Audit Committee. The internal audit plan for the year is approved on an annual basis by the Audit Committee, and the plan is derived through the consideration of key controls and required assurances as laid out in the Trust Assurance Framework. The Audit Committee have received significant assurance on all key financial systems through this process.

6 Information Governance

The Foundation Trust also has effective arrangements in place for Information Governance with performance against the Information Governance Toolkit reported through the Health Informatics Group, Finance, Infrastructure and Business Development Committee and the Corporate Decisions Team. The Foundation Trust put in place a range of measures to manage risks to data security and has met the required standard of level 2 across all key standards in the Information Governance Toolkit

The Trust has had one incident during the current year classified at level 2 in the Governance Incident Reporting Tool. In this incident two raw HES data files containing 62,148 and 54,860 admission/discharge events were uploaded on to the North East Quality Observatory Service website in December 2013 and removed May 2014. This was reported to the Information Commissioner but no action was taken. In response to a wider review of a further 6 incidents reported to the IC in previous years, the Trust has requested support from the IC to assist the Trust in reviewing its information governance arrangements and to identify areas for improvement.

7 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.*

2015/16 is the 5th year of developing of Quality Accounts/Report for Northumberland, Tyne and Wear NHS Foundation Trust. The Trust has built on the extensive work undertaken to develop the Trust Integrated Business Plan and has drawn on the various guidance published in relation to Quality Accounts.

The Trust has drawn upon service user and carer feedback as well as the Council of Governors to inform the Quality Account/Report. We have also listened to partner feedback on areas for improvement and our response to these are incorporated in the 2014-15 Quality Account.

Whilst the national requirement is to set annual priorities the Trust has established 3 overarching Quality Goals which span the life of the Integrated Business Plan, ensuring our annual priorities enable us to continually improve upon the three elements of quality: Patient Safety, Clinical Effectiveness and Patient Experience as shown in the table below.

Goal	**Description**
Safety	Reduce incidents of harm to patients
Experience	Improve the way we relate to patients and carers
Effectiveness	Ensure the right services are in the right place at the right time for the right person

Our Quality Governance arrangements are set out in section 4 of the Annual Governance Statement. The Executive Director of Performance and Assurance has overall responsibility to lead the production and development of the Quality Account/Report. A formal review process was established, the Quality Account/Report drafts were formally reviewed through the Trust governance arrangements (Corporate Decisions Team, Quality and Performance Committee, Audit Committee, Council of Governors and Board of Directors) as well as being shared with partners.

The Trust has put controls in place to ensure the accuracy of the data used in the Quality Account/Report. These controls include:

- Trust policies on quality reporting, key policies include:
    - NTW (O) 05 Incident Policy (including the management of Serious Untoward Incidents)
    - NTW (O) 07 Comments, Compliments and Complaints Policy
    - NTW(O)09 - Management of Records Policy
    - NTW(O)26 - Data Quality Policy
    - NTW(O)28 – Information Governance Policy
    - NTW(O)34 - 7 Day Follow Up
    - NTW(O)62 - Information Sharing Policy

- Systems and processes have been further improved across the Trust during 2014-15 with the continued expansion of the near real-time dashboard reporting system, reporting quality indicators at every level in the Trust from patient/staff member to Trust level.

- The Trust has training programmes in place to ensure staff have the appropriate skills to record and report quality indicators. Key training includes:
    - Electronic Patient Record (RiO)
    - Trust Induction
    - Information Governance

- The Trust audit plan includes a rolling programme of audits on quality reporting systems and metrics.

- The internal audit plan is fully aligned to the Trust's Corporate Risk Register and Assurance Framework, and integrates with the work of clinical audit where this can provide more appropriate assurance.

- In 2010 the Trust supported Monitor in the development of a Quality Governance Framework. The Trust Board now reviews it's performance against Monitor's published Quality Governance Framework on an annual basis.

- The Foundation Trust has a near real-time reporting system which connects all our business critical systems. The system presents information at varying levels enabling board to patient drill down. It is accessible by all Trust staff.

Through the engagement and governance arrangements outlined above the Trust has been able to ensure the Quality Account/Report provides a balanced view of the Organisation and appropriate controls are in place to ensure the accuracy of data.

8 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, the counter fraud team, 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 Trust Board, the Audit Committee, and the Foundation Trust governance committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Performance and Assurance Framework provide me with evidence that the effectiveness of controls in place to manage the risks associated with achieving key organisational objectives have been systematically reviewed. Internally I receive assurance through the operation of a governance framework as described above, including the Trustwide Governance Structure, Group level governance structures, internal audit reviews and the Audit Committee.

My review is also informed by (i) On-going registration inspections and Mental Health Act reviews by the Care Quality Commission (ii) the National Health Service Litigation Authority, having achieved 100% at Level I for the Risk Management Standards for Mental Health and Learning Disability, (iii) External Audit, (iv) NHS England (v) Monitor's ongoing assessment of the Foundation Trust's performance, and (vi) on-going review of performance and quality by our commissioners

Throughout the year the Audit Committee has operated as the key standing committee of the Trust Board with the responsibility for assuring the Board of Directors that effective processes and systems are in place across the organisation to ensure effective internal control, governance and risk management. The Audit Committee is made up of three Non-Executive Directors, and reports directly to the Board of Directors. The Committee achieves its duties through:

- Review of the Assurance Framework in place across the organisation and detailed review of the Foundation Trust's self-assessment against essential standards.

- Scrutiny of the corporate governance documentation for the Foundation Trust.

- The agreement of external audit, internal audit and counter fraud plans and detailed scrutiny of progress reports. The Audit Committee pays particular attention to any aspects of limited assurance, any individual areas within reports where particular issues of risk have been highlighted by internal audit, and on follow up actions undertaken. Discussions take place with both sets of auditors and management as the basis for obtaining explanations and clarification.

- Receipt and detailed scrutiny of reports from the Foundation Trust's management concerning the governance and performance management of the organisation, where this is considered appropriate.

- Review of its own effectiveness against national best practice on an annual basis. The terms of reference for the committee were adopted in line with the requirements of the Audit Committee Handbook and Monitor's Code of Governance.

The Trust Board itself has a comprehensive system of performance reporting, which includes analysis against the full range of performance and compliance standards, review of the Assurance Framework and Corporate Risk Register every two months, ongoing assessment of clinical risk through review of complaints, SUIs, incidents, and lessons learned. The Quality and Performance Committee receives a regular update on the performance of clinical audit. The Board of Directors also considers on a quarterly basis an epidemiological review of suicides, presented by our Trust lead for Public Health.

There are a number of processes and assurances that contribute towards the system of internal control as described above. These are subject to continuous review and assessment. The Assurance Framework encapsulates the work that has been undertaken throughout the year in ensuring that the Board of Directors has an appropriate and effective control environment. This has identified no significant gaps in control and where gaps in assurance have been identified, actions are in place to ensure that these gaps are addressed.

9 Conclusion

My review confirms that Northumberland Tyne and Wear NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. No significant internal control issues have been identified.

…….. Chief Executive Officer
(on behalf of the board)

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