

Annual Governance Statement

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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Clatterbridge Cancer Centre NHS Foundation Trust (CCC), 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 The Clatterbridge Cancer Centre NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust is committed to providing high quality services in a safe and secure environment. As Interim Chief Executive I have overall responsibility and accountability for all aspects of risk management within the Trust, making sure that the organisational structure and resources are in place to ensure this occurs. Senior leadership is delegated through the directors and operationally through directorates, departments and committee structures. This covers all aspects of governance relating to our service delivery, including: quality governance, infection control, clinical care, radiation protection, Care Quality Commission (CQC) Regulatory Requirements, NHSI Single Oversight Framework, finance, contracts, information technology, health and safety, cancer standards peer review, research, and employment practices.

The Audit Committee's role is to scrutinise and seek assurance that risk is managed effectively within the organisation. This role is supported by Board committees that oversee specific aspects of the risk portfolio and which also ensure that the Trust continually learns from good practice.

The system provides a central steer whilst supporting local ownership in managing and controlling risks to which the Trust may be exposed.

These systems are further supported by the evaluation of the effectiveness of risk management and control systems and implementation of recommendations from external assessments to promote both organisational and individual learning and the dissemination of good practice within the Trust. Bespoke learning and development is provided according to individual role requirements such as Trust Board members, senior managers and all staff. Risk Management training is mandatory for all staff including senior managers and Board members. Clear delegated authority is defined within the Corporate Governance Manual and the Trust's Risk Management Strategy.

The Risk Management Strategy is underpinned by a number of risk related policies and procedures which provide further information and guidance to staff in the management of risk. The Trust is committed to continually reviewing its risk management process and endeavors to ensure that it learns from best practice.

The risk and control framework

The key elements of the Trust's Risk Management Strategy are to manage and control identified risks, whether clinical, non-clinical or financial, appropriately. This is achieved through a sound organisational framework which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources. It ensures that staff are aware of their roles and responsibilities and outlines the structures and processes through which risk is assessed, controlled and managed. The Strategy was updated and approved in December 2017. The Trust Board determines the risk appetite of the Trust. Levels of acceptable risk are determined by working within agreed Trust policies and procedures; an acceptable risk is one which has been accepted after proper evaluation, with all the possible controls in place.

Risks are identified through feedback from many sources such as, formal risk assessment, the assurance framework, incident reporting, audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assessment.

The Trust Board has endorsed the Quality Strategy, the Business Plan and the Risk Management Strategy. In addition, a range of Trust-wide policies and procedures further supports the risk management processes.

The risk and control framework continues to be reviewed and developed. In 2017/18 this included a review of the Trust Board governance arrangements.

The 'Well Led' review conducted by Deloitte in March 2016, whilst identifying no significant issues, made recommendations to review the Trust's governance arrangements to ensure that they remain fit for purpose for a changing operating environment.

The Board undertook an externally facilitated in-depth review to test existing structures and to plan for potential future scenarios through a range of diagnostic, mapping and workshop activities. The findings of the review have been largely

consistent with the Deloitte report but the more detailed review has highlighted a number of areas where improvements to existing systems and ways of working could enhance the flow of information in the organisation and to the Board.

The Board approved and implemented new governance arrangements aimed at improving governance practice and oversight, and ensuring that future reporting adapts and is sustainable in a dynamic governance environment.

A revised risk escalation process was also implemented in 2017/18.

The Trust Board continues to review compliance with the NHSI Single Oversight Framework including performance against all best practice areas. The requirements of the Framework are embedded into the Trust's Performance Management Framework. An in depth review of the Trusts performance reporting arrangements was completed with revised streamlined performance reporting embedded within the new governance structure supporting 'board to ward' reporting.

The Trust Board receives a regular quality report detailing performance against the delivery of its stated quality objectives and performance information on a range of quality metrics. The quality of performance information is assessed and assured through data quality audits and reviews by our internal and external auditors.

The Quality Board Committee has responsibility for the ongoing monitoring of compliance with the CQC registration requirements. It does this through the review of the individual regulations and associated outcome measures such as patient survey results and audits against each of the required outcomes. Additional information is provided following CQC inspections and reviews and from planned internal audits as part of the Trust's audit schedule. In addition the Trust has in place a programme of 'mock inspections' against each of the outcomes which are reported to the Quality Committee.

The Trust had a CQC inspection in June 2016. In February 2017 we were notified that we had received a rating of 'Outstanding'. All mandated actions were completed in 2017/18.

The Trust has appointed an Executive Director as the Senior Information Risk Officer. Risks relating to data security are assessed through the completion of the Department of Health's Information Governance Toolkit. The Trust has assessed itself as securing a score of 83% (a "Green" rating) against the Department of Health's Information Governance Toolkit in 2017/18; The Trust achieved a minimum of Level 2 against the requirements of the Information Governance Statement of Compliance, where relevant information risks identified in the course of the Trust's incident reporting processes are investigated and lessons learned.

The Trust has embedded a Board Assurance Framework which is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board. The Board Assurance Framework identifies those risks deemed as strategically significant to the Trust's objectives, the controls in place to manage / mitigate those risks and the assurances received by the Trust. All Board members have been involved in the development, identification, quantification and prioritisation of the risks and the subsequent action planning to address areas for

improvement. Significant risks are escalated to the Trust Board as they arise through the Board Assurance Framework.

Each high scoring risk has an individual risk mitigation plan developed by the responsible Executive Director. The Trust Board development plan will continue to develop and strengthen the Board's risk appetite and assessment.

The current major risks both in year and for the future are:

- Ensuring the delivery of high quality patient services (safety, experience and outcomes).
- Ensuring the Trust has the appropriate, motivated and engaged workforce in place to deliver its strategy.
- Ensuring financial sustainability and delivery of the financial plan
- Ensuring regulatory compliance with, CQC, NHSI, and other relevant legislation.
- Ensuring strong leadership within the Trust and external to the Trust
- Ensuring capability and capacity to deliver major strategic change
- Ensuring adequate infrastructure e.g. estates and IT
- Ensuring robust external relationships and responding to changes in the external environment
- Ensuring responsiveness to technical challenges and development to deliver cancer treatments.

The Trust Board recognises and has considered a number of strategic challenges as part of its ambition to contribute fully to the Cheshire & Merseyside system leadership and clinical strategy and also the Trust's continual journey to deliver best practice and learning culture. These will be set out in the operational plan priorities for 18/19 and include:

- **Governance implications relating to in year changes to the Chair, Chief Executive, Executive and Senior Management:** A strategic risk assessment was undertaken by the Board members in early March and the purpose was to ensure the a high degree of stability for the organisational governance and material decisions, the capability and capacity gaps to achieve this and ensure appropriate steps were taken rapidly as appropriate. The BAF was amended to take this matter and the outcome of the Board meeting into account. At the end of March and during April the measures planned have been put in place and these are deemed to be effective as noted at the Trust Board in April. The interim Chief Executive recommended further measures e.g. enhanced assurance and risk determination at the Trust Board in April and these were approved and are being implemented. These measures will be carefully reviewed by the Board.
- **Establishment and ongoing delivery of services within the requirements of the Provider Licence, Single Oversight Framework and compliance with the NHSI Code of Governance:** The Trust is required to submit reports to the NHSI within the defined timeframes

outlined in the Single Oversight Framework. This information is then triangulated to provide the Trust with an overall segment rating (Segment 1 – 4, 1 being lowest risk), see 'review of effectiveness' for 2017/18 rating. A gaps analysis process is completed at least every three years to ensure the Trust is compliant with all elements of the Provider Licence and NHSI Code of Governance and reported via the Governance & Compliance Committee.

- **Regulatory compliance, including CQC ratings and feedback from inspections in year:** The Trust achieved Outstanding in 2016 and retaining the rating is a strategic goal. In doing so, it is to be recognised that there are enhanced requirements each year by the broad range of regulatory bodies and an area of development for the Trust during 2018/19 is to strengthen the broad understanding of the significance of the changes and prepare robustly. The most significant regulatory change is the approach to the Well Led reviews by the CQC. An independent governance review was completed during 2017 and progress on implementing the key recommendations has taken place, there remains work in progress particularly concerning embedding an enhanced culture of risk management and escalation. A work programme for the Well-led review has been established as a priority and will report to the Board.
- **Challenges in organisational performance and developments in the local health economy to drive forward the Cancer Plan:** The Trust operational performance for the new national cancer strategy targets has improved substantially during 2017/18 and is resilient going forward. The Trust is a major contributor to the success of the Cancer Alliance and recognises the enhanced leadership role in the future delivery of the Cancer Alliance strategy. The new Chief Executive role sets out this ambition and measures are in place by the Cheshire & Merseyside System-Wide Board to recommend a mandate for the Cancer Alliance to take on this role for 18/19 and beyond. The Trust Board recognises that its longer term strategy needs to take this into account during 2018 and measures will be put in place. This wider working with leading partners such as Liverpool Health Partners and Liverpool Integrated Care Partnership and C&M Acute Trust Sustainability are examples of how the Trust is stepping up its system-wide leadership role.
- **Relationship and management of 3rd party providers upon which the Trust places reliance, and the provision of assurances from these:** The Trust receives services supplied by a number of third party providers, which include clinical support services (for example, Pathology), equipment maintenance, facilities management, and payroll. Where services are provided by a third party, the Trust has contracts in place that specify the services to be provided and appropriate standards. It is the responsibility for each senior manager to ensure appropriate oversight and performance management of any provider contracts in their span of control.
- **Cyber security, information governance risks and any associated reportable incidents to the Information Commissioner:** The Trust has a robust action plan in place for Cyber Security improvements which will be

reported through our governance processes with any exceptions reported at Trust Board level. Any Cyber and Information Governance risks are reported through our risk processes. Risks are visible and will be reported and discussed at Board Level. Through our newly acquired Global Digital Exemplar (GDE) Fast Follower status we have, as a Trust, committed to Cyber Security as a key priority. We are working with Mersey Internal Audit Agency and with the Cyber Digital workstream within the STP footprint to share learning, good practice and collaborate where possible. We have retained for the 5th year running, significant assurance in our Information Governance toolkit submission. We have robust processes in place for reporting any reportable incidents to the Information Commissioner and have had no reportable incidents in the last year.

All areas of delivery are risk assessed and any identified risks are included within the Trust's Board Assurance Framework and Trust-wide Risk Register, it is recognised that these require further strengthening. The Trust's major risks all have risk mitigation plans and are reviewed at each Board meeting including actions identified to mitigate these risks.

The Trust has reviewed its compliance with the NHS foundation trust condition 4 (FT governance). This recognises the areas for improvement to strengthen the Board Assurance Framework, which have been approved by the Audit Committee.

The responsibilities of Directors are reviewed through individual performance review and through the review and refresh of the Policy for the Appointment for Non-Executive Directors. During 2017/18 the portfolios of the executive directors were reviewed and changed to ensure that the executive team is fit for purpose for the opportunities and challenges faced by the Trust.

The Board has processes in place to ensure timely and accurate information is received to enable the review of risks to compliance with its licence, as described above.

The Board receives and reviews a monthly integrated performance report and a separate finance performance report ensuring the Board is appraised of the Trusts performance and is able to challenge and scrutinise this performance. This report will be enhanced during 2018 to reflect the ambition to provide the best health care (top 10%) within our available resources.

The Board has in place clear systems and processes to ensure that it is able assure itself of the validity of its Corporate Governance Statement. In addition areas already referred to these include:

- Review and implementation of all NHSI guidance
- Regular review of the Board and its committee structures and their terms of reference to ensure they are effective
- Regular review of the Trusts management structures and reporting lines including annual review of the Trust's Corporate Governance Manual
- Review of third party assurance on the Trusts compliance with the Licence
- Effective scrutiny and oversight of all operations and compliance with healthcare standards and statutory regulation

- Monthly Board review of all high risks within the Trust's risk register
- Regular review of the Trust's delivery of its operational and strategic plans

Risk management is embedded throughout the Trust. This is demonstrated by the incident reporting arrangements within the Trust where this is openly encouraged. The Trust operates a 'fair blame' culture with a clear approach to identifying the causes of incidents, learning lessons from them and providing feedback and support to staff involved in incidents. The aim is to support staff and encourage participation rather than to expose them to recrimination or blame. It should be noted that in exceptional circumstances further action may be taken if appropriate, e.g. evidence of breach in the law, professional misconduct or repetitious incidents. Assurance of this process was previously gained by the achievement of NHSLA level 3 (since November 2007) and the ISO 9001:2008 quality management system accreditation in Radiotherapy, Imaging, Chemotherapy and Nursing services, 6 months ahead of the planned schedule. Since the NHSLA changed its assessment process from April 2014 the Trust has developed its own Quality and Risk Management Standards and monitoring methodology to provide internal assurance which is subject to an annual audit programme.

Engagement with public stakeholders in managing risks which may impact on them is undertaken in a number of ways, principally through:

- The Trust Board working closely with the Council of Governors
- Communication and engagement with our members
- Communication and engagement with patient and public stakeholders
- Provision of accurate patient information (accredited with the Information Standard Quality Mark)
- Engagement with Healthwatch and Overview and Scrutiny Committees

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. During the course of the year the Trust was issued with a section 64 notice and the Trust has fully complied with the request.

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

As the Accounting Officer, I am responsible for ensuring that the organisation has arrangements in place to secure value for money in the use of resources. The Trust achieves this through the following systems:

- Setting and monitoring the delivery of strategic and operational objectives
- Monitoring and review of organisational performance
- Delivery of efficiency savings
- Workforce review

Annually the Trust produces an operational plan which incorporates a supporting financial plan for approval by the Board of Directors. The plan, approved by the Board of Directors, informs the detailed annual financial and performance plans and forecasts for years two and three. The Board monitors performance monthly through the corporate Finance Balanced Scorecard Report, which provides information on current and forecast financial performance, achievement of savings targets, capital investment, contract activity and performance against key targets.

The role of internal audit is to provide independent assurance that the Trust's risk management, governance and internal control processes are operating effectively.

External audit provide an independent opinion on the Trusts financial statements and may review, and report on, aspects of the arrangements put in place to ensure the proper conduct of the Trusts financial affairs and to manage its performance and use of resources.

Reports on specific issues relating to economy, efficiency and effectiveness are commissioned by the Audit Committee from the Trust's Internal Auditors and it also receives reports from the External Auditors as required. The Audit Committee monitors closely the implementation of Audit recommendations.

Effective performance has been demonstrated through:

- The achievement of all the key NHS targets:
- Allocation of segment 1 (NHSI)

Information Governance

There has been no Serious Incident Requiring Investigation (SIRI) during 2017/18.

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. NHS Improvement (in exercise of the powers conferred on 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*.

In preparing the Quality Report, directors are required to take steps to satisfy

themselves that:

- the quality report presents a balanced picture of the foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with NHSI's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The following steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data.

1. Governance and leadership

The Director of Nursing and Quality is responsible for the Quality Strategy and the Quality Accounts. The Board receives a quality report which is built on the structure of the annual Quality Report to ensure that progress against priorities and monitoring of performance measures are reviewed throughout the year and to ensure that the Quality Report is balanced.

The Director of Nursing and Quality is responsible for Information Governance. The Deputy CEO / Finance Director has overall strategic responsibility for data quality, and this responsibility is not delegated. During the interim arrangements this is covered by the SIRO.

The Trust has in place a Data Quality Policy which ensures that the Trust holds good data quality processes and procedures in place to provide assurances to themselves as well as external users of their information. This Policy covers all patient data collected by the Trust. The Data Quality Policy states that all staff responsible for entering data in the Trust's Electronic Patient Record (EPR) system are required to attend annual refresher training as per the Information Governance toolkit standards. Data quality is regularly reviewed and reviews are reported through the Information Governance Committee.

The Trust has in place an Information Governance Strategy. This strategy includes the responsibility to monitor risks and ensure the correct operation of security and Information Governance policies including compliance with the Data Protection and Freedom of Information Acts.

Information governance in relation to assessment of risk is clearly identified within the Risk Management Strategy. All risks are fed into the organisational risk register. Risks associated with data quality audit reports are included in the organisational risk register.

The Quality Report includes information on both good performance and areas for improvements which provides a balanced picture of the Trust's performance. The majority of indicators relate to performance of the whole Trust.

As part of the Board approval process, the two clinicians on the Trust Board (Medical Director and Director of Nursing and Quality) explicitly approve the data included in the Quality Report.

2. The Role of Policies and Plans in Ensuring the Quality of Care Provided

The Trust has in place policies, plans (strategies) and standards to ensure the provision of high quality care. These documents are subject to regular review and audit to ensure compliance with the standards set.

The policies and procedures that relate to the quality of the data in the quality accounts are:

- Quality Strategy
- Risk Management Strategy
- Quality and Risk Management Standards
- Data quality policy (including the Quality Accounts data quality SOP)
- Incident reporting policy
- Clinical coding policy and procedure
- Clinical systems training policy
- Records management policy
- Information risk policy
- Data protection policy

All Trust policies and procedures are reviewed periodically and updated when needed in accordance with the Trusts Document Management Policy.

Staff are informed of all policy changes via the monthly clinical governance report at Team Brief. Where significant policy changes are made formal launches may be delivered.

3. Systems and processes

There are systems and processes in place for the collection, recording, analysis and reporting of data which are focused on securing data which are accurate, valid, reliable, timely, relevant and complete.

The Trust has in place a Business Continuity Plan and Disaster recovery arrangements. Both of these were tested in 2017/18.

4. People and skills

Staff training is identified within the Data Quality Policy.

Roles and responsibilities in relation to data quality are clearly defined and documented, and incorporated where appropriate into job descriptions and are reflected in the Knowledge and Skills framework.

The Trust has put in place and trained the necessary staff, ensuring they have the capacity and skills for the effective collection, recording, analysis and reporting of data.

Staff collecting, recording, analysing and reporting data are assessed on their adherence to the data quality standards set by the Trust through the data quality audit programme.

5. Data use and reporting

Clinical data is reported at Board level primarily within the monthly Integrated Performance Report, with evidence of Board challenge in response. Detailed quality information is reviewed by the Board Quality Committee.

The Trust has arrangements in place to ensure that data supporting reported quality information is actively used in decision making processes, and is subject to a system of internal control and validation.

The Information Governance Sub-Committee reviews data quality audits on a quarterly basis and a Data Quality Group meets monthly to analyse detailed quality reports.

Operational and performance reports are produced on a monthly basis and key quality indicators are included in a corporate balanced scorecard which is reviewed by the Trust Board and Executive Team. Detailed reports are produced on a weekly basis and reviewed by the Trust's Management Group.

Internal and external reporting requirements are regularly reviewed and data provision is aligned to management and operational needs. Data used for reporting to those charged with governance are also used for day-to-day management of the Trust's business, via a combination of reports.

Data quality and performance reports are routinely provided to staff groups who create the data using various clinical and business systems, to reinforce understanding of their wider role and importance.

Data which are used for external reporting are subject to rigorous verification reviewing both data collection and reporting. A range of reports are used to monitor the quality of data reported externally and a variety of audit processes are used routinely. All data returns are prepared and submitted on a timely basis, and are supported by a clear and complete audit trail. Where appropriate data is triangulated

against other sources of information such as patient feedback and is included within scorecard reports.

Waiting times data accuracy

The Trust assures the quality and accuracy of elective waiting times data by completing regular Data Quality Audit reports in line with the National Information Governance toolkit requirements.

Probity on waiting times data is also supported through the organisational separation of responsibility for delivery of targets and management of data and performance. Delivery of targets is managed through the operational Clinical Directorates and performance management reporting is the responsibility of the Performance Management and Information departments. The separation of the functions is in line with good practice and ensures that there is no potential conflict of interest for the managers accountable for the target in reporting on performance and information on waiting times.

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

The Board of Directors reviews performance across a range of indicators, which include both corporate and national objectives and those measures of performance included in the Quality Accounts:

Achievement of both local and national objectives and measures of performance is an important function of the Trust Board; in ensuring our effectiveness in doing this a number of measures are in place across the Trust:

- Individual departments have a series of key performance indicators which are monitored on a monthly basis. In addition to this there is also a trust wide set of key performance indicators that are reviewed each month at Trust Board, these cover waiting times, infection control as well as finance.
- Four times a year the executive directors meet with each clinical directorate to formally review performance against objectives, management of clinical governance & risk, financial management and delivery against national waiting time targets.

- The Trust has been assessed against five themes of the Single Oversight Framework: Quality of Care, Finance and use of resources, Operational performance, Strategic change and Leadership and improvement capability (well-led). Trusts will be scored and allocated to a Segment 1 – 4, 1 being lowest risk.
- The Trust has been allocated Segment 1 (March 2018)
- Regular Audit Committee review to ensure up to date and relevant financial policies and procedures are maintained.
- The Trust has been granted full registration without conditions as a service provider from the Care Quality Commission in March 2010 for the treatment of disease, disorder or injury and for diagnostic and screening procedures. In July this was extended to cover the new haemato-oncology service with a new location at the Royal Liverpool Hospital being registered with the CQC.
- The Trust Board receives a Quality Report on a quarterly basis which is built on the structure of the annual Quality Accounts to ensure that progress against priorities and monitoring of performance measures is reviewed throughout the year.

The Quality Committee provides a core function of monitoring any clinical risks and ensuring appropriate mitigations are in place. This is achieved through :

- Approval of the clinical audit plans and receiving regular clinical audit reports
- Receiving and reviewing reports on all incidents reported including Serious Untoward Incidents (SUIs)
- Receiving external assurance reports and monitoring action plans where deficiencies are identified
- Providing assurance to the Board on risk identification and mitigation.

As Interim Chief Executive I have invited an independent clinical review of the serious untoward event registered in April 2018, however the original serious incident took place in late 2016. This review will recommend areas for improvement. Immediate appropriate measures are in progress following an extraordinary risk escalation meeting attended by the senior clinical leaders to learn and embed a better open culture to risk determination and escalation. The newly appointed Medical Director and Director of Nursing & Quality will ensure the recommendations are implemented and audited for compliance and improvement through the Quality and Safety Sub Committee, Quality Committee (Committee to the Board) and the Board of Directors.

The Audit Committee provides a central means by which the Trust Board ensures effective internal control mechanisms are in place. This includes receiving and reviewing reports from both Internal Audit and our External Auditors.

Internal Audit concluded that the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Governing Body and clearly reflects the risks discussed by the Governing Body.

In addition the new Interim Chief Executive has commissioned experienced external support to implement the proposals identified in the Assurance Framework Review 2017/18.

Internal Audit have also provided significant assurance overall across a range of individual opinions arising from risk based audit assignments reported throughout the year.

The purpose of the Director of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

For 2017/18 the opinion received by the Trust was one of Substantial Assurance. This 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.

During 2017/18 thirteen reviews were undertaken with an opinion given. No review received 'high assurance', seven received 'significant assurance' and six 'limited assurance'. None of the reviews had 'no assurance'.

I have received limited assurance opinions in respect of:

- Quality Spot Checks (Mersey, Sulby and Conway Ward)
- Quality Spot Checks (Haemato-oncology)
- Service Review Haemato-oncology
- IT Service Continuity
- Data Warehouse
- Research Funding & Governance.

Actions identified as part of these reviews have been signed off by the Governance & Compliance Committee and assigned to Executive Team leads to address the issues raised in the limited opinion reports. Improvement will be demonstrated and monitored through the audit tracker and reported to the Governance and Compliance Committee. Thereafter progress against the actions will be presented to the Audit Committee to ensure satisfactory resolution and followed up in-year by the Internal Audit team.

The Trust Board has received external assurance of its systems of internal control by:

- Maintaining a quality management accreditation (ISO9001:2015) across Radiotherapy, Imaging, Chemotherapy and Nursing services from the British Standards Institute (BSI), 6 months ahead of the planned schedule.

Conclusion

In conclusion there are no significant internal control issues which have been identified and appropriate reasonable assurance has been received by the Board via the sub-committees of the Trust Board.

Signed

Ann Farrar
Interim Chief Executive

Date: xxth May 2018