Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

4th June 2014

Title:	**Annual Governance Statement 2013/14**		
Agenda item:	**14/106**	**Paper**	**10**
Action requested:	For adoption		
Executive Summary:	The Governance Statement is a record of the stewardship of the organisation. It outlines who in the organisation has overall accountability for performance (the Accountable Officer), how the organisation is organised to support decision-making, performance is managed and risks are controlled.		
Summary of recommendations:	Recommended for adoption.		
Fit with WH strategy:	N/A		
Reference to related / other documents:	Annual Governance Statement is a mandatory return in support of statutory accounts.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A		
Date paper completed:	28th May 2014		

Author name and title:		**Simon Wombwell, Interim Chief Finance Officer**		**Director name and title:**		**Simon Pleydell, Chief Executive Officer**	
Date paper seen by EC	**27/5/14**	**Equality Impact Assessment complete?**	N/A	**Quality Impact Assessment complete?**	N/A	**Financial Impact Assessment complete?**	N/A

The Whittington Hospital NHS Trust ("Whittington Health")

Annual Governance Statement 2013/14

1. Introduction

The Governance Statement is a record of the stewardship of the organisation. It outlines who in the organisation has overall accountability for performance (the Accountable Officer), how the organisation is organised to support decision-making, performance is managed and risks are controlled.

For Whittington Health, the Accountable Officer is Simon Pleydell, Chief Executive.

2. Scope of responsibility

As Accountable Officer, and Chief Executive of the Whittington Health Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of Whittington Health's aims and objectives, and supports the delivery of the organisation's policies, the NHS Operating Framework and relevant stakeholder aims and objectives. I also have responsibility for safeguarding the public funds, the organisation's assets for which I am personally responsible, while also safeguarding safety and quality standards, as set out in the Accountable Officer Memorandum.

As Accountable Officer, I have overall responsibility for risk management but day-to-day management is delegated to Executive directors. The Chief Finance Officer is the lead for financial risk and the Director of Nursing has overall responsibility for ensuring an effective clinical risk management system is in place, with the Director of Nursing and Medical Director being jointly responsible for clinical quality and safety risk. The Chief Operating Officer has responsibility for ensuring the risk management system is working securely across the three clinical divisions of the Trust, emergency planning and operational resilience.

3. Governance framework

The Trust has a well-established system of integrated governance and a structure that supports the running of the organisation.

3.1 Trust Board and committee structure

The Trust Board holds corporate responsibility for the development and execution of the Trust's strategies, its actions and finances. For the resulting outcomes in each of these areas, the Board remains publically accountable. The makeup of the Board intends to create a diversity and range of capabilities to support the successful delivery of Board business and leadership.

The Board has an assurance framework system in which significant risks to the Trust's strategic objectives are monitored and managed. The board assurance framework informs the Board's agenda and focus.

Reporting to the Board are sub-committees responsible for audit and risk, quality (of patient services), resources and planning (replaced by finance and business development with effect from 1 April 2014) and remuneration.

The Board met a total of ten times in public in 2013/14, every month except August and December. Attendance is monitored. The average overall attendance was 90 per cent with no individual's attendance falling below 80 per cent. During the year, there were seven changes to the membership of the Board including a new Chair Steve Hitchins, who started in January 2014.

3.2 Board performance and areas of focus

In addition to formal board meetings, the Trust Board has undertaken seminars to review strategy and performance in more detail. Board meetings include a 'patient story', often delivered by patients themselves, giving the Board feedback on their direct patient experience at the Trust.

The Board's work programme has supported a system of internal control through monthly reporting against plans and forecasts for:

- Measures of service quality;
- Performance against key targets and
- Review against financial performance and standing.

Performance reports provided assurance to the Board on the delivery against in-year plans and, where appropriate, the areas for corrective action; and, subsequently, the monitoring of corrective actions.

The Board maintained up-to-date knowledge on matters of strategic importance, risks and controls relating to the local health economy and national agendas.

All risks relating to patient safety and service quality were reviewed using the organisations risk register. The risk register content is informed through multiple sources, including serious incidents, clusters of incidents following thematic reviews, feedback from patient experience, complaints, claims and outcomes from services reviews and audits.

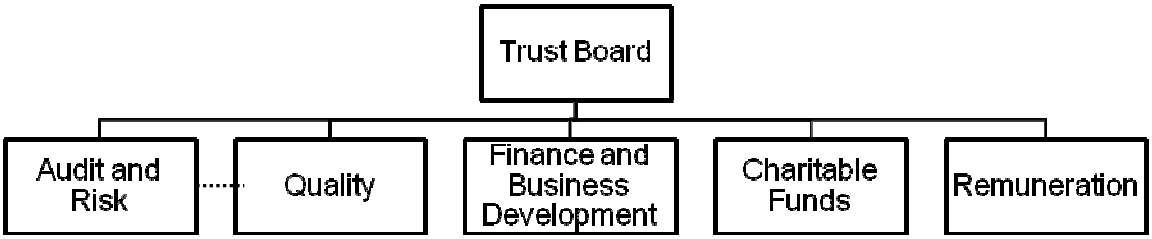
Key performance against indicators reported in the quality accounts are reviewed monthly, demonstrating progress in a number of priority areas: mortality rates, MRSA infection control, harm-free care and reductions in serious incidents (as defined by the national framework).

The Board recognises the importance of a capable and content workforce and received regular updates on workforce performance including sickness rates, staff turnover, staff appraisal and mandatory training requirements. The Board received national workforce survey results and conducted a full staff survey of its own. The results will be used to develop the workforce strategy and focus improvements through employee engagement.

During the year the Board has also discussed its response to the Francis Report, the policy agenda around foundation trust status, its own strategy to develop integrated models of care linking acute and community services. The Board has conducted a review of its estates strategy, including engaging with our local population, and approved an outline business case for the redevelopment of the maternity and neo-natal service accommodation.

3.3 Supporting committee structure – performance and areas of focus

The Trust Board undertakes a proportion of its work through sub committees:



Each sub-committee has its own terms of reference, formally adopted by the Trust Board. The chair of each committee presents a summary of every meeting to the Trust Board.

3.3.1 Audit and Risk Committee

The Audit and Risk Committee is responsible for monitoring and reviewing the risk management, control and governance processes of the organisation, and the associated assurance processes. It retains an oversight role of the Quality Committee to enable the Audit and Risk Committee to have full review of the Board Assurance Framework including the controls relating to clinical governance. The committee also reviews the corporate risk register.

The Audit and Risk Committee met seven times in 2013/14. All meetings were quorate and in accordance with its terms of reference. The Chair of the Committee, Peter Freedman, left the Trust in December 2013. The new Chair is Rob Whiteman, Non-Executive Director.

The Audit and Risk Committee approved the internal audit programme based on risks identified through the board assurance framework, risk register and results of previous audit activities. The Head of Internal Audit opinion for 2013/14 was “significant assurance” 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 were identified, particularly in relation to risk management. These are expected to be addressed by the complete implementation of the risk management system (“Datix”) described in Section 4 below. In addition, the internal audit programme highlighted the need for developments in the way the Trust handles complaints and financial reporting of service lines. Both these areas are the subject of improvement plans in 2014/15.

The committee received regular reports from external audit, internal audit and counter fraud specialists on progress and updates relating to their activities. The committee scrutinises reports on bad debt written off, the record of tender waivers and approves any changes to the Trust’s Standing Orders, Scheme of Delegation and Standing Financial Instructions (these latter areas were discussed at the September and October 2013 meetings with a report to the Trust Board in November 2013). In 2013/14, the committee sought assurance against the delivery of the targets set out in the Information Governance Toolkit, the electronic patient record (EPR) project and risk management processes in one operational area.

3.3.2 Quality Committee

The Quality Committee meets six times a year and provides assurance to Trust Board that high standards of care are provided in the Trust. The Committee met six times during 2013/14 and were quorate on five occasions. The chair of the committee, Sue Rubenstein, left the Trust in March 2014. A new Non-Executive Chair of the Committee, Miss Anu Singh, has been appointed and took up her role in April 2014.

The Director of Nursing and Patient Experience and Medical Director have joint delegated responsibility for quality. The Quality Strategy 2012 – 2017 was approved by the Trust Board in 2012 and provides a continuous improvement framework. The performance of quality has been

monitored closely by the Board with detailed reviews part of the function of the Quality Committee. The Committee received regular integrated dashboard reports from each of the divisions focussing on areas for improvement and from the sub-committees of the Quality Committee on progress and key issues relating to their activities. The Quality Committee is assured there is a quality focussed culture within the Trust and robust processes are in place to identify and monitor quality priorities.

The Quality Governance Framework, in conjunction with the risk management framework, assesses the combination of structures and processes in place, both at and below board level, which enables the Trust Board to assure the quality of care it provides. These processes are currently under review.

3.3.3 Resource and Planning Committee (replaced by *Finance and Business Development*)
The Resources and Planning Committee provided review and scrutiny over in-year performance against plans and targets and planning for future periods. The committee also reviewed major business cases and activities of the procurement function.

The Committee focused on tight scrutiny of savings delivery and the major initiatives that sat within this programme. The Committee was also concerned with the development of plans to support better delivery of plans in future; the development of workforce planning in particular, and analysing service line reporting and reference costs to assess how this data can inform future plans. The Committee reviewed the development of the contracting and tendering processes to seek improvement in the organisation's capability and capacity in this area and address the increasing demands on contracting in the NHS.

3.3.4 Charitable Funds Committee
The Charitable Funds Committee manages the receipt and spending of the Trust's charitable donations, ensuring that donated funds are invested and spent in line with Trust policies and legal requirements. The Charitable Funds Annual Report and Account is reported to the Charities Commission each year.

3.3.5 Remuneration Committee
The Remuneration Committee determines the appointment, remuneration, terms of service and performance of the executive directors. The committee met four times during 2013/14 – April, July and September 2013 and March 2014.

3.4 Corporate Governance Code

3.4.1 Code of Conduct and Code of Accountability
All Board members have signed the NHS Code of Conduct and Code of Accountability.

3.4.2 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions
The Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions were subjected to full compliance with no suspensions recorded. Cost controls and delegated spending limits were reviewed and ratified by the Audit Committee in September and October 2013. The Trust operates NHS Standards of Business Conduct policies on declaration of interests and receipt of gifts and hospitality, which are monitored during the year.

3.4.3 Bribery Act 2010
Following the introduction of the Bribery Act 2010, the Trust has incorporated its requirements within counter fraud, bribery and corruption policies. As Accountable Officer, I operate a policy of zero tolerance over any forms of bribery and fraudulent activities by Trust staff, those contracted to undertake work for it, or anyone acting on its behalf.

3.5 Quality governance

The directors of the Trust are required under the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year, adopted by the Trust Board in June 2014 for 2013/14. The Quality Account is developed by clinicians and senior managers within the Trust, in conjunction with stakeholders and partner organisations. The Medical Director has overall responsibility to lead and advise on all matters relating to the preparation of the Trust's annual Quality Accounts. In order to ensure the accuracy of the Quality Accounts, improving the quality and reliability of information has been a key aspect of the quality agenda. Within the Trust, there are systems and processes in place for the collection, recording, analysis and reporting of data which are focused on securing data which is valid, reliable, relevant and complete. This area is the subject of ongoing work to improve upon our current systems.

3.6 Discharge of statutory functions

Arrangements are in place to ensure effective discharge of statutory duties, examples are child safeguarding, radiation protection, medicines management, anti-discrimination laws and data protection.

4. Risk assessment

4.1 How risk is assessed?

The key aim of the Trust's risk management approach is to ensure that all risks to the achievement of the Trust's objectives (whether clinical or non-clinical) are identified, evaluated, monitored, and managed appropriately. The system of risk management is described in the Trust's Risk Management Strategy which is reviewed annually by the Board and is accessible to all staff via the Trust's intranet. The Risk Management Strategy includes a clear management process. If a risk cannot be resolved at a local level, the risk can be referred through the operational management structure to the Audit and Risk Committee or ultimately to the Trust Board. Risks are reviewed to ensure that any interdependencies are understood.

Risk assessment is a key feature of all normal management processes. All areas of the Trust have an ongoing programme of risk assessments. Risks are evaluated using the Trust risk matrix which is a five-by-five scoring system, the nationally recognised risk assessment tool developed by the National Patient Safety Agency (NPSA). This risk scoring system feeds into the decision making process about whether a risk is considered acceptable. Unacceptable risks require control measures and action plans to reduce them to an acceptable level. Each risk has an identified owner who is responsible for monitoring and reporting on the risk to the appropriate committee(s). Each action has a named action owner responsible for implementing the changes to reduce the risk to an acceptable level in a specified timeframe.

At the highest level, the Board Assurance Framework (BAF) enables the focused management of the principal risks to achievement of the organisation's objectives. The BAF is developed annually by the Board to review known and potential risks to our strategic objectives, the existing control measures and evidence to support assurance around mitigation. It identifies any gaps in control or assurance. There is a schedule of associated action plans for each key risk which identifies the date and Committee of last presentation. Progress against mitigating these principal risks is proactively monitored and reported to Trust Board. The BAF was formally presented to the Board three times during the year with updates to four meetings of the Audit and Risk Committee in year.

Underpinning the BAF, the Trust has a system which holds a structured set of risk registers for each area, including strategic and Trust-wide risks.

The risk management process is supported by the use of an electronic, integrated risk management system ("Datix"). The system has been in development since in April 2012, with the final (risk register) module going live in September 2013. The system captures information about activity in the following areas: incidents, complaints, claims, inquests, patient liaison services and the organisation's risk register. The risk register component supports a process of *dynamic* risk management i.e. staff highlight and record risks in real time and ensure records and responses are kept up-to-date. The system supports the organisation to map risks back to their source and provide thematic analyses of risks including the correlation of risk management across the quality domains of safety, clinical effectiveness and patient experience. This information is then used to undertake aggregated reviews of risks with the emphasis to focus on proactive risk management, through reviews of systems and processes and related corrective activities.

4.2 Clinical care and Regulatory risk - Care Quality Commission (CQC)

The Trust is registered with CQC at the following sites 'without conditions':

- Whittington Hospital NHS Trust trading as Whittington Health ('headquarters'), including community based services.
- HMP Pentonville (until the 30th April 2014 then services transfer to Care UK)
- Simmons House (child and adolescent mental health facility).

Reporting to September 2014, the CQC published a *Quality Risk Profile* for each Trust. This risk rated organisations against each of the sixteen *Essential Clinical Outcomes*, informed by over 600 quantitative and qualitative data items from a variety of external sources including Dr Foster, hospital episode statistics, the National Reporting and Learning System (NRLS), National Patient Surveys. This profile was issued ten times a year, and while scores changed marginally, the Trust never reported an adverse rating. In October 2013 this scheme was replaced with the new *Intelligent Monitoring Report*, which resulted in the Whittington Hospital moving from band four in October 2013 to band six (the lowest risk category) in March 2014.

4.3 Financial risk

The current fiscal climate coupled with a fixed income position and a material cost reduction target, as well as a clear mandate from the Board to continue to improve patient safety and quality, means the management of financial risk is a key issue for the organisation. The Trust has used the Monitor approach to financial risk rating and is making further plans to link quality measurement to ensure no adverse impact of planned savings on patient care. The Trust Board receives a monthly financial report covering each aspect of financial performance, including performance against plan, delivery of statutory financial targets and any subsequent corrective actions. The Trust is working to strengthen its monitoring, reporting and performance management of cost improvement plans and measurement to avoid any adverse impact upon our service quality.

5. The risk and control framework

5.1 Risk Management Framework

The system of internal control is designed to develop a risk aware culture; to generate an organisation that is continuously learning and improving. The Trust is unable to remove risk completely, but through process risks can be mitigated and lessons learnt. Our aim is to create a safer and sustainable organisation engaged in proactive activity rather than reactive. The system aims to manage risk to a reasonable level rather than attempt to eliminate all risk of failure to achieve policies, aims and objectives. The system of internal control is designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being crystallised, the impact should they happen, and to manage them efficiently, effectively and economically.

5.2 Prevention of risks

5.2.1 Committee Structures

The Board agenda is informed by the key risks. The Trust's Audit and Risk and Quality Committees, through integrated risk management arrangements, oversees the development and continuous improvement of risk management across the Trust.

5.2.2 Board Assurance Framework

The Board Assurance Framework (BAF) provides direct assurance that a risk management system is in place, through a system of escalation and de-escalation, of performance against the Trusts strategic objectives. The executive team is responsible for implementing the controls approved by the Board (e.g. strategies, policies, plans). The Board will receive assurance that these controls are working effectively through a variety of management reports.

5.2.3 Mandatory training

Mandatory training comprises corporate, local induction and role-related induction plus 'refresher' training. The key performance indicator (KPI) compliance target set by the executive team is 90 per cent (95 per cent for information governance). The mandatory training KPI includes a number of subjects considered core subjects covered through the 'streamlining movement' designed and led by Skills for Health and NHS Employers. The latest report dated 28th March 2014 shows a compliance rate of 75 per cent, well within NHS Litigation Authority's level one requirement. The Board and Quality Committee closely monitor mandatory training levels within the Trust. There has been a call for additional subjects such as fraud, dementia, and health promotion to be included in mandatory training and consideration is being given to this.

5.2.4 Risk and performance management

Whittington Health implemented an organisational wide Datix Risk Management System from April 2012. Since then the organisation has reported routinely to the National Patient Safety Agency, National Reporting and Learning System (NRLS) and prior to April 2012 this was reported via the organisations three legacy Datix risk management systems.

We use the Datix Risk Management system to manage incidents across the organisation, these are then reported via governance committees and through divisional boards.

- The Datix Risk Management system is web-based to support both hospital and community staff in the active reporting of incidents.
- The Datix Risk Management system has the ability to provide localised dashboards to support managers and clinicians in monitoring trends concerning reported incidents to enable discussions and feedback at local team, service or divisional level.

The following information depicts how lessons learnt are reviewed, themes identified and shared across the organisation.

- Aggregated reports are provided at divisional level and at corporate level pooling information from incidents, complaints, claims and PALS; reports focus on themes, actions and associated learning.
- Learning is shared through a combination of presentations and discussions within governance committees and at operational team level. Maternity, for example, has message of the week which shares outcomes and learning from reported serious incidents, whereas other services such as district nursing share learning through practice development and training sessions.
- Case studies from serious incidents are used to inform training for Root Cause Analysis within the organisation.

The current processes for managing Serious Incidents are detailed below. We are conducting a review to strengthen this process.

- Serious Incidents (SIs)are reported via the centralised Governance and Risk Team, all SIs are reported within national policy frameworks.
- SIs are reported both on Datix for internal monitoring and the Strategic Executive Information System (STEIS) nationally for monitoring by commissioners at a local sector level.
- Divisional boards take responsibility for quality assuring their serious incident investigation reports prior to executive level approval.
- The monitoring for the implementation of action plans is divisionally led as per organisational policy with assurance exercises completed by the Central Governance team for grade two SIs in conjunction with commissioners.
- Reporting, is managed through governance committees and at a divisional board level, with routine divisional clinical risk reports to the Quality Committee, and reporting to the Executive Team.
- Investigations are conducted utilising Root Cause Analysis (RCA) methodology, dependent on the complexity of the serious incident. The central governance and risk team will provide additional support to the investigation.
- For grade one serious incidents, action plans are monitored through divisional level patient safety committees with independent scrutiny for progress on actions being monitored via the Trust's Patient Safety Committee, this includes evidence of compliance with related action plans prior to sign off and closure of action plans.

We have a rolling programme of Patient Safety Walkabouts using the *15-Step methodology* developed by the NHS Institute for Innovation and Improvement. The walkabout program is centrally monitored and attended by a combination of Executives, Non Executives, Lay Representatives from Haringey and Islington Boroughs, Commissioners and Assistant/Deputy Directors.

There are plans to include, junior doctors in training and students nurses to participate in the 2014/15 programme:

- Regular performance management meetings for divisions and directorates are being introduced across the Integrated Care Organisation and are chaired by Divisional Clinical Directors, providing wide coverage of corporate and clinical governance areas.
- During the year, divisions have been performance managed on a variety of risk related issues including completion of risk scores for incident reporting and updating of local risk registers.

- The performance management, progress monitoring and internal controls are developing within the Trust to ensure that corrective actions required to deliver objectives are applied consistently across the breadth of the Integrated Care Organisation.

5.3 Deterrents to risks

5.3.1Fraud deterrents

The Trust employs a local counter fraud specialist (CFS) who is responsible for fraud awareness across the Trust and the investigation of any suspected or reported fraud activity. This work is supported by regular risk assessment and fraud and bribery prevention techniques. A zero tolerance attitude to fraud and bribery operates within the Trust. The CFS undertook a compliance exercise to assure the Trust Board of compliance against national standards for countering fraud and bribery.

5.4. Management and mitigation of risks

Following proactive risk assessment outlined in section four, the Trust assigns operational and executive leads to deliver agreed action plans to mitigate risk based on severity of risk, and monitors residual risk levels until they are as low as reasonably possible through local, corporate management forums and up to Board level.

6. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways covered previously in this report. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal auditor's work.

6.1 Head of Internal Audit Opinion

'Substantial assurance' - generally sound system of internal control designed and operating in a way that gives a reasonable likelihood that the system's objectives will be met.

6.2 My review of effectiveness is also informed by the following evidence:

- Care Quality Commission registration without conditions
- NHSLA Risk Management Standards (general and maternity)
- Achievement of performance targets
- Financial performance reports
- External audit reports
- Internal audit progress reports
- Counter fraud annual report
- Audit and risk committee reports
- Quality committee reports
- Risk and patient safety reports
- Clinical audit reports and participation in national audits
- Infection control reports to the board and root cause analyses
- Specific service accreditations e.g. pathology
- Benchmarked Hospital Standardised Mortality Rates(HSMR) and Standardised Hospital Mortality Indicator (SHMI) reports

- Whistle blowing policy
- Business continuity plans and emergency planning
- Feedback from key stakeholders
- The contribution of all staff in maintaining risk management practices as set out in their job descriptions and professional codes.

7. Issues to highlight 2013/14

7.1 Waiting list management

In March 2013, the Trust invited the National Intensive Support Team (IST) to review processes for managing Referral To Treatment (RTT) and Cancer pathways i.e. patient waiting times for treatment. As a result of these reviews, and in anticipation of the introduction of a new electronic patient record system, the Trust initiated (in April) a major six month programme to audit and improve data quality for waiting lists for non-urgent treatment. This has involved a full waiting list validation exercise, as well as a redesign programme to improve how we report internally and externally.

During 2013/14 issues emerged with regard to the management of endoscopy, RTT and Cancer waiting lists. A series of actions were established with the support of the NHS Intensive Support Team. A clinical review panel was established to review any potential harm to patients who may have waited over 18 weeks for treatment. The clinical review was completed with no known adverse impacts to patient care.

7.2 Information Governance toolkit

The Trust fell marginally short of its requirements under the Information Governance Toolkit. This is a framework to ensure the Trust manages the sensitive data its holds safely and within statutory requirements. The Trust is required to achieve 66 per cent against the Level 2 assessment of the Toolkit – it achieved 60 per cent.

The Trust takes its requirements to protect confidential data seriously and has made improvements in information security (access controls, information security systems) and corporate information assurance (corporate records audit).The trust is committed to improve its assurance over clinical information, particularly the transfer of data between care agencies. In 2014/15 the Trust will continue to work towards meeting full compliance to have 95 per cent completion of information governance training by Trust employees and the completion of a coding classification audit. In addition the Trust will work to improve the management of patient records to ensure better tracing, tracking and destruction at the appropriate time.

7.3 Electronic Patient Record management information reporting

The Trust went live with the first phase of its new electronic patient records system in 2013/14. This system upgrade included a module to deliver contract and management information. Despite a relatively smooth implementation of the wider system, the reporting module was not implemented successfully. As a consequence the Trust has not reported performance against its contracts since September 2013. Additional measures were taken to ensure no impact on patient care. The system was successfully upgraded in May 2014.

8. Issues to highlight 2014/15

8.1 Leadership team

The Trust appointed a new chair in January 2014 and three new non-executive post holders, completing the new appointments in April 2014. The Trust's objective is to recruit to the posts of Chief Executive, Medical Director, Director of Nursing and Chief Finance Officer in 2014/15.

8.2 Cost Improvement Programme

The Trust has a significant savings programme of £15m (5% of turnover) set for 2014/15. The Trust has put in place additional arrangements to improve its planning and delivery of savings plans, as well as assessing and monitoring for any adverse impacts these schemes may have on quality of services.

8.3 Seven Day Working

The Trust is committed to the recommendations by Sir Bruce Keogh and the implementation of safe services across the whole week. A detailed assessment of current performance is underway to assess any additional requirements across the key staff groups and the cost of implementation. Evidence produced at a national level indicates a significant financial impact upon the NHS which is not included in 2014/15 funding levels. The implementation of this important initiative may therefore put additional financial pressure on our financial plans.

My review confirms that the Whittington Health in 2013/14 had a generally sound system of internal controls that supports the achievement of its policies, aims and objectives. Action plans are in place to strengthen areas identified by both internal and external reviews reported in this statement.

Simon Pleydell
Chief Executive