- The ability to deliver the Trusts CIP of £7m was hindered by the significantly above-plan emergency activity
- Medical staff agency costs of £5m
- £3.5m of non funding emergency activity due the emergency threshold adjustment
- Escalation costs (related to emergency activity) of £700k

Within the 2009/10 Annual Audit Report the Trust's external auditors reported concerns around two key themes;

(i)   Sustainability of the in year financial position given the significant levels of SHA support and the poor performance against the delivery of cost improvement programmes. In addition highlighting the effect this performance had against the cumulative breakeven duty;

(ii)   cash management and the significant negative effects this had on the Trust's performance against the better payment practice code.

These themes were repeated within the 2010/11 Interim Audit Report and the Trust is undertaking specific actions to address these points including; closer working across the heath economy to ensure financially sustainable short, medium and long term plans are in place; the use of external support to create a Project Management Office (PMO) to ensure the formulation and delivery of robust cost improvement programmes; improvements within cash flow management to ensure greater visibility around short, medium and long term cash forecasting.

It is important to remember that an organisation's assets include information as well as more tangible parts of the estate. Information may have limited financial value on the balance sheet but it must be managed appropriately and securely. All information used for operational purposes and financial reporting purposes needs to be encompassed and evidence maintained of effective information governance processes and procedures with risk based and proportionate safeguards. The Trust has a process for managing and controlling risks to information. It has undertaken the assessment using the Information Governance (IG) Action Planning Toolkit and reports to the Information Governance Forum - assurance was provided by the 31 March 2011. This included progress on key IG initiatives:

o   Implemented an Information Governance e-learning training plan for all trust staff;
o   Developed a comprehensive Asset Register;
o   Identified information asset owners (IAOs) and information asset administrators (IAAs);
o   Organised external professional training for the IAOs and IAAs;
o   Continued to identify and map the trust's data flows;
o   Have developed project initiation documents and plans for the auditing and monitoring of corporate records;
o   Taken a decision that no Trust computer equipment will allow unencrypted mobile media to be used.

The Information Governance Toolkit Assessment was completed and submitted by the Trust by the 31 March 2011. The overall result for SaTH was 72% (Not satisfactory). The score in October 2010 was 50%. The Information Governance Framework processes were audited by internal auditors following the October 2010 submission as recommended by DH.

The Trust attained at least level 2 in the 22 key requirements and achieved level 2 in 43/45 requirements overall. However, the mandatory requirement is for all NHS organisations to achieve level 2 compliance in all 45 requirements otherwise a 'not satisfactory' score is awarded. The two requirements scored at level one were:

8-324 - Pseudonymised and/or anonymised data is used for all secondary purposes. Currently this is not technically possible throughout most of the NHS.

8-505 - This requirement is scored by using the results from a 'clinical coding audit'.   This   was carried out in early March and the results of accuracy did not meet the requirement to achieve a level 2.

The Trust Director of Compliance and Risk Management is the Senior Information Risk Officer, with the Medical Director as the Caldicott Guardian.

The risk management strategy requires an ongoing programme of risk assessment and review using the guidance, tools, and matrices in the Risk Management Strategy, the guidance for ongoing risk assessment, and the risk register procedure.   Risk assessment is covered on induction and in sessions held by the integrated risk and safety team throughout the year. Sources of specialist advice and assistance available for managing risk include Chief Compliance Officer, Patient Safety Team, Health and Safety Team, Security Manager, Investigations Team, Vulnerable Adults Lead, Safeguarding Nurse, Head of Patient and Corporate Services, Information Governance Manager and Patient & Public Engagement manager, who oversees the use of Equality Impact Assessments and is working closely with the Service Development team to further embed this work across the Trust.

During the year the Trust has continued with the development of its Assurance Framework to assess the potential risks that threaten the achievement of the organisational objectives, the existing control measures and where assurances are gained. The framework has been used to identify where there are gaps in control and assurance with action plans drawn up to address these where appropriate. The Assurance Framework also mapped back to the Care Quality Commission Essential Standards of Quality and Safety.   The Framework identifies any gaps in control or assurance and there is an associated action plan to address these.   The gap action plan and progress is reported to each session of the Audit Committee and regularly to the Trust Board with the Assurance Framework. Gaps in control and assurance were identified in the following areas:

- Catering: ordering and receipt of provisions
- Charitable funds
- Network security
- Backup and recovery follow up
- Data Quality (Cancer waiting times and thrombolysis)

Actions are in place to address these limited assurance items.

Internal Audit's review of the Trust's Assurance Framework which found that "Taking account of the issues identified, the Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective."

The Trust is fully compliant with CQC essential standards of quality and safety.

The Trust was registered with the CQC without conditions on 1 April 2010.   A responsive review was undertaken in 2010 and the CQC noted two minor concerns which the Trust was addressing. In addition, the CQC carried out a review of privacy (outcome 1) and nutrition (outcome 5). This was part of a national programme of reviews of 100 organisations which were chosen at random. The review highlighted a minor concern in relation to treatment of vulnerable adults.

Internal Audit reviewed the process for monitoring compliance with the standards and gave substantial assurance on the process in place in the Trust.

The Trust has worked closely with key partner organisations to address risks in the community and for disaster planning. These organisations include Police, Ambulance Service, Fire, Health and Safety Executive and Local Authorities.

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

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.

There is a Carbon Reduction Strategy and action plan approved by the Board which is monitored through the trust's Good Corporate Citizen Forum. The 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 UK Climate Impact Programmes (UKCIP) 2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and the adaptation Reporting requirements are complied with.

The Trust works with the West Mercia Resilience Forum to study and exercise/test arrangements for localised fluvial and run off flooding. The Trust has been a part of a number of exercises in recent years looking at the specific issues within the West Mercia Area (including Shropshire.)

Risk assessments are undertaken on behalf of the whole Local Resilience Forum by the Environment Agency.

The Trust will continue to work with its partners to understand and minimise the risks associated with flooding due to climate change.

5. Review of effectiveness

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. 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 audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- *Internal Audit Plan and Reports.*
- *External Audit Plan and Reports.*
- *Foundation Trust project groups.*
- *Service Improvement Project Board Reports.*
- *Health & Safety Reports.*
- *Clinical Audit Reports.*
- *Complaints Reports.*
- *Claims Reports.*
- *Incident Reports.*
- *Clinical Governance Reports.*
- *Patient Environment Action Teams (PEAT) Assessments.*
- *NHSLA and CNST standards and*
- *International Organisation for Standardisation (ISO) accredited standards in Medical Engineering.*
- *Patient feedback from National NHS Patient surveys and local surveys.*
- *Health Overview & Scrutiny Committee Reports.*
- *Staff feedback from National NHS Staff Surveys.*

- *Royal College reports.*
- *External accreditation.*

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, Audit Committee, Finance & Performance Committee, Quality and Safety Committee, Management Executive, Clinical Governance Executive and, Risk Group.,* A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board is responsible for ensuring that the Trust follows the principles of sound governance and this responsibility rests unequivocally with the Board. The Board is required to produce statements of assurance that it is doing its "reasonable best" to ensure the Trust meets its objectives and protect patients, staff, the public and other stakeholders against risks of all kinds. The Trust Board is able to demonstrate:

- *That they have been informed through assurances about all risks not just financial.*
- *That they have arrived at their conclusions on the totality of risk based on all the evidence presented to them.*

In relation to this strategy the Trust Board will:

- *Oversee and participate in the risk assurance process.*
- *Identify and consider strategic and corporate level risks, including agreeing any risk control measures and monitoring their implementation.*
- *Ensure communication with partner organisations on risks of mutual concern.*
- *Assess and consider the provision of financial support for any necessary risk management requirements.*
- *Demonstrate and support model behaviour throughout the organisation, consistent with good governance practice and an organisational culture based on openness and learning.*

The Trust Board has delegated responsibility for risk management to the Management Executive which is the Trust committee with overarching responsibility for risk. The Management Executive provides assurance to the Trust Board that the systems for risk management and internal control are effective. A summary of the Management Executive's meetings are submitted to the Trust Board. This is being replaced by a dedicated Risk Management Committee, meeting monthly with clinical leads and chaired by the CEO to give greater focus on the management of risks

The Audit Committee, a formal sub-committee of the Board, provides overview and scrutiny of risk management. This meets bi-monthly. It is chaired by a Non-Executive Director and the terms of reference have been devised in line with the Audit Committee Handbook to reflect its role as the senior Board committee taking a wider responsibility for scrutinising the risks and controls which affect all aspects of the organisation's business. It has responsibilities to:

- *Ensure that the clinical governance processes and outcomes are used to provide assurance on the overall processes of risk management, governance and internal control.*
- *Conclude upon the adequacy and effective operation of the organisation's overall internal control system linked to the Trust's Assurance Framework.*
- *Maintain a focus on ensuring that an effective system of strong financial management underpins operational developments, which includes the review of the Annual Report and Accounts and recommendation for adoption to the Board.*
- *Co-ordinate the governance of reported clinical and non-clinical risks and review the operation of the Risk Register and the processes that support it. The register should contain all risks identified by the organisation and external agencies, e.g. Auditors. The Committee must ensure that these risks are allocated to existing sub-committees and working group to manage and/or mitigate the risks.*

- Ensure that all significant risks are reported to the Board throughout the year and that risk treatment plans and contingency plans are developed and monitored.

From November 2010 a Quality & Safety Committee has been established chaired by a non-executive Director to oversee clinical quality and safety standards across the trust. This has led to a revision to the Audit Committee terms of reference, with greater focus on the robustness of assurance received.

During 2010/11 the remit of the Management Executive was to inform and implement the Trust Board's policy and strategic direction of the organisation and to reach decisions on, and monitor the progress of, the Trust's business and organisation objectives. The Management Executive had overarching responsibility for risk and was chaired by the Chief Executive. The Management Executive provides assurance to the Trust Board that the systems for risk management and internal control are effective. The remit of the Management Executive is to inform and implement the Trust Board's policy and strategic direction of the organisation and to reach decisions on, and monitor the progress of, the Trust's business and organisation objectives. The governance structure of the trust has been reviewed and from May 2011 when the new Centre structure is in place, a Risk Management Committee chaired by the Chief Executive will be established.

The Trust's ability to handle risk is further enhanced through the Governance and Committee/Group structure. Each Committee/Group has terms of reference that clearly define their role and responsibilities with clearly stated deputies.

The Trust has a Finance & Performance Committee, chaired by a Non-Executive Director that focuses on financial and performance management and reduction of financial and organisational risk.

The Clinical Governance Executive focuses on Clinical Risk and is currently chaired by the Deputy Medical Director.

The Trust Board has received assurance on the effectiveness of the controls within the organisation through the following means:

- Reports from Committees set up by the Trust Board.
- Reports from Executive Directors and key managers.
- External Reviews.
- Participation in relevant Committees e.g. Clinical Governance Executive, Risk Register Group.
- Assurance Framework, which was constructed by the full Board at a Development session in 2010, is scrutinised and challenged by Non-Executive Directors at each Audit Committee and regularly received and reviewed by the Board.
- Internal Audit provide the Board, through the Audit Committee, and the Accounting Officer with an independent and objective opinion on risk management, control and governance and their effectiveness in achieving the organisation's agreed objectives. This opinion forms part of the framework of assurances that the Board receives. The annual Internal Audit Plan is aligned to the Trust's Assurance Framework and Risk Register.
- Self assessment for core standards and CQC registration.

During 2010/11 the Board received information through Incident reports of incidents occurring in outpatients (January, July, and October 2010). However management assurances were relied upon that subsequently proved to be inadequate. The Board approved an external review by the Intensive Support Team (IST) of systems and processes which has resulted in an action plan led by the Chief Operating Officer to improve standards and performance. The Board has also asked for a review of the current reporting suite with a greater focus on evidence to support assurances.

During 2010/11 the health economy was reviewed by the West Midlands Quality Review Service (WMQRS). This process identified a number of immediate risks which are being addressed by an action plan monitored by the Strategic Health Authority. The Trust's Director of Compliance and Risk Management oversees the development and effectiveness of the Trust's governance structure, although it is acknowledged that governance is a responsibility of the entire Board.

The Head of Internal Audit Opinion is that Based on the work undertaken in 2010/11, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk

Based on the work we have undertaken on the Trust's system of internal control we do not consider that within these areas there are any issues that need to be flagged as significant issues within the SIC.

The Trust objectives and specific limited assurance opinion which may have put the achievement at risk of the Trust objectives fall within the two areas:-

- Enhancing safety, effectiveness and patient experience; and

- Ensuring a clinically viable and financially sustainable organisation.

Control weaknesses were identified regarding the findings of:

- Catering,
- Data Quality (for the chosen indicators, 62 day cancer and Thrombolysis),
- Charitable Funds
- Junior Doctors – Management of Planned Absence

All of the weaknesses identified are being addressed through the recommendation tracking process monitored by the Audit Committee.

Based on the work Internal Audit have undertaken on the Trust's system on internal control, they do not consider that within these areas there are any issues that need to be highlighted as significant within the SIC.

6.   Summary

With the exception of the internal control issues that I have highlighted above, my review confirms that The Shrewsbury and Telford Hospital NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and those control issues have been or are being addressed

Signed: Date:

....   9/6/2011

Chief Executive (on behalf of the Board)

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[i] Audit Committee Handbook 2006