Reporting to:	**Trust Board, 4ᵗʰ June 2015**
Title	Annual Governance Statement
Sponsoring Director	Chief Executive
Author(s)	Head of Assurance
Previously considered by	Exec Directors, (April 2015), Audit Committee (April, May and June 2015), Risk Committee (May 2015)
Executive Summary	The Annual Governance Statement (AGS) forms part of the annual accounts and replaces the Statement of Internal Control (SIC). The Department of Health (DH) produces guidance on the content, and requires that the AGS is completed in line with the submission requirements for the annual accounts. Draft v7 was submitted to the External Auditors and NTDA by the deadline of the 23rd April. Feedback on this draft is still awaited at the time of writing. The final version (v13) of the statement is attached. The Annual Governance Statement will be submitted with the Annual Accounts on 5th June. Significant issues for 2014/15 are considered to be: • Fit to transfer list • Income and expenditure • Public consultation on future of clinical services
Strategic Priorities 1. Quality and Safety 2. People	☒ Reduce harm, deliver best clinical outcomes and improve patient experience. ☒ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☒ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☐ To undertake a review of all current services at specialty level to inform future service and business decisions ☒ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme ☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation 4 Community and Partnership 5 Financial Strength: Sustainable Future	☐ Support service transformation and increased productivity through technology and continuous improvement strategies ☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies ☒ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☒ If the local health and social care economy does not reduce the **Fit To Transfer** (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm ☒ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☒ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards

	☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☒ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☒ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☐ Effective ☐ Caring ☐ Responsive ☒ Well led
☐ **Receive** ☐ **Review** ☐ **Note** ☒ **Approve**	**Recommendation** The Trust Board is asked to APPROVE the final version of the Annual Governance Statement.

Organisation Code: RXW

Annual Governance Statement – 2014/15

1 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of The Shrewsbury and Telford Hospital NHS Trust policies, aims and objectives. I also have responsibility for safeguarding quality standards, public funds and the organisation's assets for which I am personally responsible in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the NHS Accountable Officer Memorandum, including recording the stewardship of the organisation to supplement the annual accounts.

In the delivery of my responsibilities and objectives, I am accountable to the Board and my performance is reviewed regularly and formally by the Chairman on behalf of the Board. During 2014/15, the organisation routinely reported on financial, operational, and strategic matters to the Trust Development Authority (TDA). During 2014/15 meetings were held with senior officers at the TDA in relation to performance and the Trust's trajectory towards achieving full compliance against required targets under the Accountability Framework.

2 The governance framework of the organisation

2.1 Board Committee Structure

The Trust Board has overall responsibility for the activity, integrity, and strategy of the Trust and is accountable, through its Chair, to the TDA. The role of the Board is largely supervisory and strategic, and it also has the following key functions:

- To set strategic direction, define Trust objectives and agree Trust operating plans
- To monitor performance and ensure corrective action is taken where required
- To ensure financial stewardship
- To ensure high standards of corporate and clinical governance
- To appoint, appraise and remunerate directors
- To ensure dialogue with external stakeholders

The Director of Corporate Governance is the Trust Secretary and provides senior leadership in corporate governance. The Board approves an annual schedule of business and a monthly update which identifies the key reports to be presented in the coming quarter. Exception reports to the Board ensure that the Board considers the key issues and makes the most effective use of its time. Tier 2 Assurance Committees also report through the Chair of the Committee and written summaries to the Board. The Trust Board met a total of twelve times in public during the year and Board papers are published on the Trust website.

Trust Board Attendance	Year ending 31st Mar 15
Name and Title	Attendance (or deputy)
Professor Peter Latchford - Chair	12/12
Robin Hooper - Non-Executive Director	6/12
Dennis Jones - Non-Executive Director	10/12
Simon Walford - Non-Executive Director	11/12
Donna Leeding – Non-Executive Director	6/12
Harmesh Darbhanga – Non-Executive Director	8/12
Brian Newman – Non-Executive Director	9/12
Peter Herring - CEO	12/12
Neil Nisbet - Finance Director	12/12*
Debbie Kadum - Chief Operating Officer	12/12
Edwin Borman - Medical Director	11/12
Sarah Bloomfield - Director of Nursing and Quality	12/12*

* Represented by a deputy at one meeting

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were updated in February 2015 to take account of changes to the Trust's governance arrangements and legislation. The Standing Orders were adhered to throughout the year and no suspensions were recorded.

The Trust's policy on Standards of Business conduct was revised in 2014 to take account of new requirements following the enactment of The Bribery Act (2010). The policy includes amendments from our Local Counter Fraud Specialist to clarify the requirements on declaration of gifts who recommended that the requirement to declare interests be extended to wider groups of staff. This recommendation has been implemented to include all permanent medical staff; all staff at band 8 and above; specialist nurses; and all procurement and stores staff. The Board's Register of Interests was kept updated during the year.

2.2 Board Performance

Membership of the Board of Directors is made up of the Trust Chair, six independent Non-Executive Directors, and five Executive Directors (including the Chief Executive). There were no changes in personnel of executive and non-executives during the year.

Directors are required to adhere to the highest standard of conduct in the performance of their duties. In respect of their interaction with others, the Trust Board operates under an explicit Code of Conduct, which is compliant with the NHS Code of Governance. The Board of Directors of the Trust are required to agree and adhere to the commitments set out in the Code of Conduct, which includes the principles set out by the Nolan Committee on Standards in Public Life. Once appointed, Board Members are required to sign a declaration to confirm that they will comply with the Code in all respects.

2.3 Board Committees

The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness. The Board has standing orders, reservation, and delegation of powers and standing financial instructions in place which are reviewed annually.

The Board operates with the support of seven Tier 2 committees accountable to the Trust Board. All have at least one Non-executive Director member who may also be the Chair, apart from the Hospital Executive Committee, which is the Trust's senior management meeting. The chairs of each of the sub-committees routinely present written and verbal reports to the Board highlighting key issues and decisions at their meetings. Approved minutes of each sub-committee area also presented at public Board meetings. All meetings were quorate during the year.
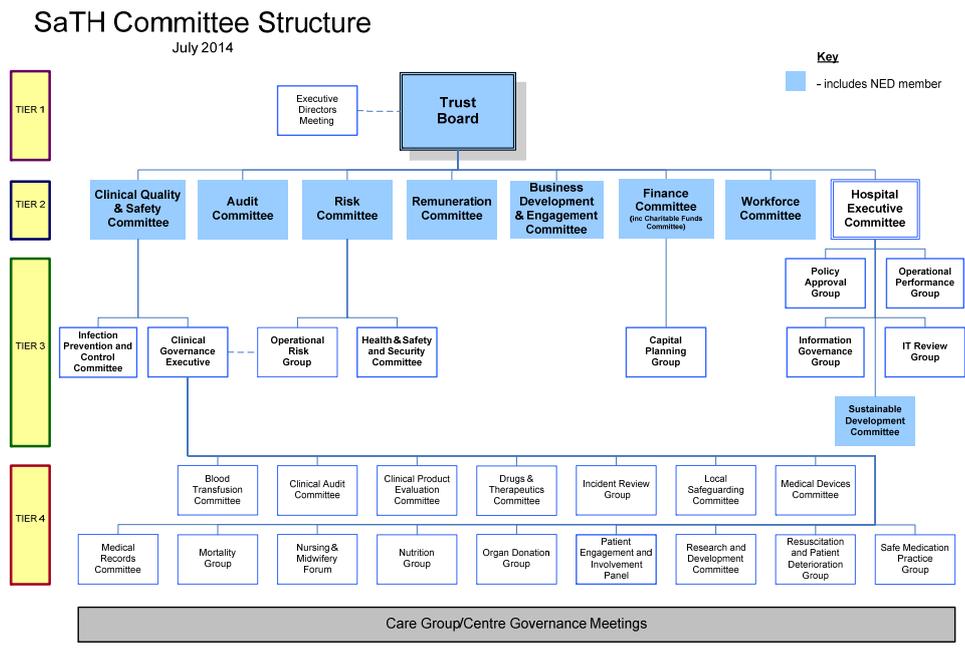
Two of the Tier 2 Committees are Non-Executive Committees (Audit, Remuneration). Although these Committees have a membership consisting of only Non-Executive Directors, other Directors will attend as required.

- The Audit Committee is the senior board committee responsible for oversight and scrutiny of the Trust's systems of internal control and risk management. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. The Committee reviews the work and findings of External Audit and maintains oversight of the Trust's Counter Fraud arrangements. Attendance through the year was in line with the requirements of the Terms of Reference. The Audit Committee met 5 times during 2014/15. It was chaired by a Non-Executive Director, who submits a regular report to the Trust Board. Items brought to the attention of the Board included:

  o The Committee were pleased to receive assurance from Internal Audit that in terms of Recommendation Tracking, and Declarations of Interest/Code of Business Conduct the Trust was out-performing some flagship FT clients

  o The Workforce Pay Controls Audit, requested by the Board, was brought back to Audit Committee. There was discussion around the current nursing template and the plan to externally benchmark SaTH's position with peers, whilst recognizing that this issue and that of nurse agency was a national issue. It was noted that Workforce Committee will be providing assurance to the Board on progress and that any recommendations that needed to be revised would be agreed in this forum

  o Noted that Internal Audit has raised the on-going problems in relation to timely signing of commissioner contracts. This is likely to be an even more protracted process this year as there are problems around the tariff. The Contracts Team were asked to provide assurance to Audit Committee around the processes in place.

Two other Committees are chaired by a Non-Executive Director, (Finance (including charitable funds), and Quality and Safety). Minutes of these meetings demonstrate that Non-Executive Directors oversee progress and provide challenge to the Directors. The Chairs of Finance Committee and Quality & Safety Committee are also members of the Audit Committee.

The remaining three Committees (Hospital Executive Committee, Risk Committee and Workforce Committee) are executive in nature, although Risk Committee and Workforce Committee have Non-Executive members.

- The Risk Committee is a quarterly committee with NED membership. It is chaired by the Chief Executive. It is responsible for providing leadership for the co-ordination and prioritisation of clinical, non-clinical, and organisational risk, ensuring that all significant risks are properly considered and communicated to the Trust Board. The Committee provides assurance to the Trust Board that the systems for risk management and internal control are effective.

2.4 Corporate Governance

Work continues to assure compliance with the Board Governance Assurance Framework; (mandated as part of the Foundation Trust development process), to ensure the Trust Board is fit to lead the organisation towards achieving Foundation Trust status and beyond. The Board Governance Assurance Framework was reviewed by the Audit Committee in February 2015. There were two 'red flags'. One is the requirement to have an independent evaluation of Board effectiveness and the committee structure within two years. It has been agreed that this review will not take place until the new Chief Executive has been in post for a year. The second red flag concerns Board succession planning. The Audit Committee recommended that a skill matrix and Equality and Diversity self-assessment is used.

Through its governance arrangements and the reviews undertaken by Deloitte and the construction of the Board Governance Memorandum, I am assured that the Trust complies with the HM Treasury/Cabinet Office Corporate Governance Code and does not have any significant departures from the Code.

2.5   Quality Governance

The Director of Nursing and Quality has delegated responsibility for Quality and Safety. The performance of Quality has been monitored closely by the Board with detailed, monthly performance reviews. Scrutiny of this aspect is also part of the role of the Quality and Safety Committee. The Trust has worked with clinical staff to establish Key Performance Indicators to monitor quality from the ward to the Board.

The annual clinical audit plan is linked to the Trust priorities and risks and is monitored by the Clinical Audit Committee, which reports to the Quality and Safety Committee. A patient panel was established in 2013 which enables suitably trained patients and members of the public to undertake clinical audits. The patient panel has been recognised as an area of good practice, winning a national award in autumn 2014.

All serious incidents are reported to Commissioners and to other bodies in line with current reporting requirements. Root cause analysis is undertaken with monitored action plans. There were no 'never events' reported in 2014/15.

The Care Quality Commission has continued to publish their Intelligent Monitoring Reports (IMR). These reports have highlighted some areas of risk; however the Trust was aware of, and taking action to mitigate these risks which included compliance with all nine standards of care measured within the National Hip Fracture Database; In-hospital mortality - Nephrological conditions; and two items from the staff survey. There has been an improvement in performance over the four publications of the IMR as shown:

	October 2013	March 2014	July 2014	December 2014
Elevated Risks	4	2	1	1
Risks	5	5	7	6
Score	**13**	**9**	**9**	**8**
Band	1	3	3	**Not allocated band due to recent inspection**

During the year the Trust was subject to comprehensive inspection in October 2014 by the Care Quality Commission (CQC). The inspection report was published by the CQC in January 2015 which identified important areas for improvement. The overall rating for the Trust is 'Requires Improvement'. The CQC rated the Trust good for caring for patients, but requiring improvement in providing safe care, effective care, being

responsive to patients' needs, and being well-led.

Overall, nine services were rated as good, including maternity, gynaecology and children's services. Nine services were rated as requiring improvement; and end of life care at Royal Shrewsbury Hospital was rated as Inadequate. Progress against the actions and measurement of improvement are considered by the Clinical Governance Committee with the Quality and Safety Committee managing the line of accountability.

The 2014/15 Quality Account is currently in preparation and the content and two of the indicators will be reviewed by External Audit to provide some assurance on the accuracy of the account.

2.6   Arrangements in place for the discharge of statutory functions

The Civil Contingencies Act 2004 (Contingency Planning) (Amendment) Regulations 2012 made changes to the way Civil Contingencies requirements are delivered. This resulted in NHS England producing a set of Emergency Preparedness, Resilience and Response (EPRR) core standards for Trusts. The requirement was set out for NHS Trusts to identify an Accountable Emergency Officer. In this Trust the Chief Operating Officer (COO) is the Accountable Officer. In September 2014 the Trust was required by NHS England to submit a compliance statement set against the EPRR Core Standards to their Area Team. The November

Board approved the Trust's assessment of its current status of compliance against the core standards, along with an implementation plan and associated quarterly monitoring.

The Trust has met its legal requirements for exercise and testing under the Civil Contingencies Act.

The Trust continues to work with the Shropshire and Staffordshire Area Team of NHS England, the Local Health Resilience Partnership (LHRP) and other responders within the local community to ensure continuity of robust EPRR.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity, and human rights legislation are met. Equality Impact Assessment forms part of the Trust documentation for policy creation and ensures all policies are assessed.

Control measures are in place to ensure that patients, the public, and staff with disabilities are able to access buildings on the Trust's sites. All new estates schemes, as well as refurbishments, or ad-hoc improvements, are assessed to ensure that they meet the requirements of the Disability Discrimination Act.

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 met. 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.

Supplementing our Sustainable Development Management Plan, a Carbon Reduction Strategy and action plan was approved by Trust Board in March 2014. The five year action plan incorporates the requirement of the Good Corporate Citizen initiative and enables delivery of the organisation's obligations under the Climate Change Act. To this end we are working to the NHS Energy Targets and as at the most recently available data (FY14), we are successfully on target to deliver CO_2 reductions of. 10% in 2014/15 and 15% in 2015/16 compared to the 2007 baseline. Based on the success of an number of innovative 'invest-to-save' schemes this year, a bid submitted for capital funding for further efficiency schemes has been successful and will contribute towards the Trust's energy reduction obligations next year.

The Trust remains highly committed to Sustainable Development, and can proudly claim to lead the way nationally. The Trust was 'highly commended' in the Community Engagement category of the national NHS Sustainability Awards in 2014. At the time of writing, the Trust is shortlisted in an unprecedented five categories in 2015 – more than any other Trust is the country.

Each month, the Board completes a self-certification on Monitor requirements and Board Statements which is reported to the Trust Development Agency. The Board has declared compliance with all requirements, subject to continued financial support from the TDA, except the governance requirement due to the financial position and performance against the national targets.

The Trust has been rated as Escalation Level 4 (of 5) in the NHS Trust Development Authority's (TDA) Accountability Framework. This is classified as a 'Material issue' requiring interaction led by the Director of Delivery & Development. Regular meetings are held with the TDA to update on SaTH's improvement trajectories.

The Trust has a robust system in place to assure the quality and accuracy of elective waiting time data. The Trust has in place a system to validate and audit its elective waiting time data on a weekly and monthly basis with random specialty audits being carried out to quality assure the validation process. The process has been audited by Internal Audit, and implementation of recommendations monitored. External Audit will carry out a review as part of their 2014/15 audit programme.

3   Risk Assessment
The Trust's Risk Management Strategy is updated and approved each year by the Trust Board. The Strategy describes an integrated approach to ensure that all risks to the achievement of the Trust's objectives, are identified, evaluated, monitored, and managed appropriately. It defines how risks are linked

to one or more of the Trust's strategic or operational objectives, and clearly defines the risk management structures, accountabilities, and responsibilities throughout the Trust.

Risk assessment is a key feature of all normal management processes. All areas of the Trust have an ongoing programme of risk assessments, which inform the local risk registers. This process was audited by the Trust's Internal Audit who found there was Substantial assurance around the processes in place. Risks are evaluated using the Trust risk matrix which 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. The risk registers are reviewed regularly and if a risk cannot be resolved at a local level, the risk can be escalated through the operational management structure to the Risk Committee or ultimately to the Trust Board. Each risk and related action has an identified owner who is responsible for monitoring and reporting on the risk to the appropriate committee(s) and for implementing changes to mitigate the risk in a specified timeframe. In line with the Risk Management Strategy Care Groups and Departments complete an annual sub-certification that their risk registers are complete and up-to-date.

The Chief Executive chairs the Risk Committee, and the other Directors with delegated responsibility for risk management sit on this committee which is the Board sub-committee responsible for managing risk and reviewing the Board Assurance Framework (BAF).

The BAF enables the Board to undertake focused management of the principal risks to achievement of the organisations objectives. 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 risks during the year were:
- **If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience.** This risk has shown a slight deterioration during the year. There are good clinical outcomes are reported in the CQC Intelligent Monitoring reports; and there has been a reduction in pressure ulcers and complaints. However, a number of factors (staffing shortages and the impact on training rates; and the numbers of patients who are fit-to-transfer), has meant that patient experience has sometimes fallen short of our standards.
- **If we do not implement our falls prevention strategy then patients may suffer serious injury.** This risk has improved during the year with a reduction in the number of serious patient falls and with all actions implemented on the original action plan.
- **Risk to sustainability of clinical services due to potential shortages of key clinical staff.** This risk was newly identified in March 2014 and is a significant issue for the Trust. The risk relates to risks of staffing gaps in key clinical areas for which the longer term plan is being developed through NHS Future Fit. One of the key drivers for NHS Future Fit is the difficulty in attracting staff to a split site service with onerous on-call commitments which, unless changes are made, is likely to struggle in future to meet key national standards and guidance**.**
- **If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards** The Trust improved performance during 2014 and achieved the Referral-to-Treatment targets in Autumn 2014 but failed to sustain the improvement largely due to the increased demand for services in the early part of 2015. There has also been an improvement in the achievement of the cancer waiting times targets. In common with many Trusts, the A&E targets have not been met due to the high demand for services and the numbers of patients who are fit-to-transfer, but occupying a hospital bed.
- **If we do not have a clear clinical service vision then we may not deliver the best services to patients**. A significant amount of work has taken place but the public consultation will take place in autumn 2015 led by the Commissioners.
- **If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale and patient outcomes may not improve.** The Trust values have been developed with staff and there was a high level of staff engagement with this work. Underpinning the values, a set of behavioural standards was developed and these were launched at the third annual leadership conference which was very well attended. A number of initiatives are under way including the coaching scheme an in-house management development programme.

- **If we are unable to resolve our (historic) shortfall in liquidity & the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties & address the modernisation of our ageing estate & equipment** One element of this risk was significantly improved during the year, when the NTDA gave the trust a non-repayable loan of £19.2m in order to resolve the Trust's historic liquidity issues. However, the I&E position deteriorated as the deficit increased from a forecast £8.2m to £12.2m

- **If CCGs do not reduce the Fit To Transfer (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm.** This risk was added by the Trust Board in November 2014 to reflect the high numbers of patients who are fit to transfer (FTT) from the hospital. At times, there have been almost a quarter of patients in hospital beds who are fit to be discharged from acute care, and routinely FTT patients have occupied 15% of bed capacity. This risk impacts on many of the other risks the Trust is facing:
  - o Costs of escalation wards, additional bed capacity and facilities including outsourced provision, and premium costs for agency and locum staff
  - o Pressure on staff leading to high levels of sickness and low staff morale, further increasing staffing costs
  - o Cancelled / delayed elective activity with resultant loss of income for activity and performance penalties; and additional costs incurred eg Waiting List Initiative payments to recover the performance
  - o Quality and safety issues including increased risk of infection, pressure sores, and falls

  In January 2015, the Secretary of State requested that the Clinical Commissioning Groups and Councils reduce the number of patients on the FTT list by 50% in two weeks. However, this has not yet been a sustainable reduction in the number of patients on the FTT list. As a result, the Trust is exploring alternative solutions with the independent sector.

As currently structured, the NHS contract with commissioners does not require these patient safety, access and financial risks to be integrated within any agreement about levels of activity. Given the over-riding responsibility of the Board for patient safety and experience, this remains a source of difficulty.

Data security

Information Governance incidents are reported via the Trust's incident reporting system. There were no data lapses in the year which were classified as level 2 incidents (these are the incidents which are formally reported to the Information Commissioner)

The Finance Director is the nominated Senior Information Risk Officer (SIRO) who is responsible along with the Medical Director as Caldicott Guardian, for ensuring there is a control system in place to maintain the security of information. The result of the Information Governance Toolkit Assessment provides assurance that this is being managed. The overall result for SaTH was 82% (Satisfactory). The Trust attained at least level 2 compliance in all 45 requirements.

4   The Risk and Control Framework

Risk Management is embedded within the organisation in a variety of ways including policies which require staff to report incidents via the web-based reporting system.

The Annual Plan is agreed by the Trust Board and reported to the NHS England and the TDA. This includes objectives, milestones, and action owners and is revised by the board quarterly.

Rigorous budgetary control processes are in place with robust management of Cost Improvement Plans. Outcomes are measured by monthly review of performance to the Board. The Quality and Safety Committee review Quality Impact Assessments required across all aspects of change, cost improvement programmes, or capital build prior to discussion at the Trust Board.

The organisation provides annual mandatory and statutory training for different levels of staff depending on their responsibilities as detailed in the Risk Management Training Policy. This includes risk awareness training which is provided to all staff as part of their mandatory corporate induction programme. Risk management awareness training was provided throughout 2014/15 at all levels of the organisation.

The Integrated Performance Report is a standing Board agenda item. The report summarises the Trust's performance against all the key quality, finance, compliance, and workforce targets, and also contains the Board self certifications required to be submitted to the TDA in relation to Governance and Monitor Licence Conditions.

The Trust has a Local Counter Fraud Specialist (LCFS) whose work is directed by an annual workplan agreed by the Audit Committee. The LCFS has given presentations to groups of staff to inform them of the need to be particularly vigilant to the possibility of fraud. As well as investigating potential frauds, notified to the LCFS by the Trust, there have been proactive exercises to detect potential fraud including an examination of fraud red flags in sickness absence; consultant job planning, and centralised recruitment. The LCFS has commended the policy review process, and the process for declarations of interest in place at the Trust.

The Head of Internal Audit provides an opinion on the overall arrangements for gaining assurance through the BAF, and on the controls reviewed as part of Internal Audit's risk-based annual plan. Internal Audit's review of the Trust's Assurance Framework gave substantial assurance and noted, "*It is my opinion that we can provide Substantial Assurance that the Assurance Framework is sufficient to meet the requirements of the 2014/15 AGS and provide a reasonable assurance that there is an adequate and effective system of internal control to manage the significant risks identified by the Trust.*"

During the year, Internal Audit reported on nine core audits and three performance audits. Internal Audit issued substantial assurance ratings for five of the core audits, moderate assurance ratings for two core audits and a limited assurance rating for two core audits. The moderate assurance ratings relate to budgetary control and data quality. The limited assurance ratings relate to the audit of workforce budget controls where four high priority recommendations were made; and IT controls where one high priority recommendation was made. Actions to rectify these weaknesses are being implemented.

- **Workforce controls:** Four high priority recommendations made. These related to upfront visibility of the costs incurred when booking bank / agency staff; that a Confirm and Challenge process is adopted to ensure that matrons are using E-Rostering effectively; consider setting budgets in E-rostering; and Reduce dependency on bank and agency
- **IT controls:** A high priority recommendation was that a formal assessment of the Trust's cooling controls should be completed to protect assets and services.

Formal actions plans have been agreed to address the significant control weaknesses in all areas. Implementation of the recommendations has been tracked and has demonstrated an improvement in the timeliness of implementation with no overdue actions at year-end. There have been no common weaknesses identified through Internal Audit reviews.

The Head of Internal Audit's Opinion is based on the work undertaken in 2014/15. The overall opinion is that:

"*Moderate assurance can be given as there is a generally sound system of internal control, designed to meet the organisation's objectives, but the level of non-compliance in certain areas puts some system objectives at risk. There is a basically sound system of internal control for other system objectives*"

The system of internal control has been in place in the Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

5   Significant Issues

5.1   Progress on 2013/14 Significant Issues
In the 2013/14 Annual Governance Statement, the Trust disclosed three significant issues. Progress on these issues is outlined below.

5.1.1 Patient Flow and Access targets

Performance against cancer waiting times targets improved significantly during the year, and referral to treatment (RTT) waiting times targets were achieved in autumn 2014, but deteriorated in the early part of 2015. However in the latest versions of the CQC Intelligent Monitoring Report this risk was reduced from an elevated risk and then removed altogether, which indicates that SaTH's performance is in line with other providers. Performance against the A&E target deteriorated, but this was against a national picture of pressure on EDs and has not featured as a risk in the CQC IMR reports. It is recognised that the backlog of Fit to Transfer (FTT) patients has exacerbated the position at SaTH and the Trust has worked closely with partners to support them achieving a reduction in these numbers.

- For admitted Referral to Treatment (RTT), 6 specialities out of 11 achieved the 90% target in March 2014. A Remedial Action Plan (RAP) was implemented and all specialties achieved the target from October 2014; however, performance was not sustained and the targets were not achieved from February 2015. This was expected as it was largely as a result of the impact of the large number of emergency admissions and the number of patients waiting for transfer out of the hospital (FTT). It was also affected by a deliberate focus on treating patients who had been waiting on waiting lists in excess of the standard.

- The Trust underperformed against two of the cancer targets in 2013/14 with the position deteriorating in the early part of 2014/15. A Remedial Action Plan [RAP] was implemented and included recommendations made by the Intensive Support Team [IST]. All targets have been achieved from November 2014.

- The A&E 4-hour target is 95%. In 2013/14 the Trust achieved 93.4% Work continued within the Emergency Centre to work with the capacity team and other specialties to develop plans to avoid patients spending longer than required within the Emergency Department [ED]. Internal actions are being reviewed to ensure appropriate escalation and flow of patients is managed accordingly. A Remedial Action Plan (RAP) is in place. The transfer of the Urgent Care Centre in December 2014 to the ED at RSH should also reduce pressure on the ED service. However, despite this, and in common with many Trusts, performance deteriorated during the year. This is due to increasing numbers of emergency admissions and A&E attendances as well as large numbers of patients occupying hospital beds who were fit to be transferred.

5.1.2 Liquidity

In order to address a significant cash problem, the Trust worked with the TDA to access a permanent funding solution. For the Financial Year 2014/15 the Trust has recorded a deficit of £12.2m. The Trust had originally planned a deficit of £8.2m, the increased deficit principally associated with increased pay costs, particularly in respect of nursing and medical staff.

On the 16th January 2015 the Trust was successful in its application to the ITFF Committee for permanent PDC for the £12.2million to cover the cash consequences of this deficit. Historically the Trust has recorded Income and Expenditure Deficits. The cash consequences arising from these deficits have been absorbed internally through the Trust's working capital. In doing so, the Trust has progressively experienced difficulty in making payments to creditors on a timely basis. Within the application to the ITFF in January the Trust was also successful in its application for £7m non repayable PDC to cover these historic cash shortfalls allowing the Trust to substantially reduce backlog creditors and ensure a significant improvement in compliance with the Better Payment Practice Code (BPPC).

The Trust's External Finance Limit was changed to reflect this.

5.1.3 Public consultation on future of clinical services

The Trust is experiencing day-to-day difficulties in medically staffing some key areas and whilst most gaps are covered this is becoming an increasing struggle and often relies on factors such as consultants "working down" to provide the full level of medical support needed within acute hospitals. These issues form part of the case for change for the NHS Future Fit programme. Other factors include the need to move towards seven day working providing earlier access to senior clinical decision makers. Full implementation of seven day working will need radical changes in the way that acute hospital services are provided for our communities and a transition plan will be needed in some areas ahead of the conclusions of NHS Future Fit.

5.2 Significant Issues

5.2.1   Fit To Transfer List

The Fit to Transfer [FTT] list is a list of patients who are deemed medically fit enough to leave to the hospital but require on-going care in another setting, or an assessment to determine what care may be required. This was identified as a new risk in the Board Assurance Framework. The volume of patients on the FTT list is large, resulting in up to 23% of the inpatient adult medical bed base being unavailable for acutely ill patients at any one time. The Trust has demonstrated a direct correlation between the numbers of patients who are on the FTT list and achievement of the A&E targets. Whilst actions are being taken by the Clinical Commissioning Groups [CCG's], Shropshire Community Trust and the Local Authorities this has not impacted on the total number of patients who remain on the FTT list on a daily basis. As part of contract negotiations for 2015/16 the Trust is seeking assurance from the CCG's that they will be commissioning sufficient capacity to deal with this demand. Discussions have commenced on the development of a facility on the Royal Shrewsbury Hospital site in support of reducing the number of patients who are fit to transfer.

The impact of the FTT list has been non-achievement of the A&E and RTT targets at year end, significantly increased costs, and impacts on quality and safety.

The extended Fit-to-Transfer list had an adverse effect on many of the challenges facing the Trust. These effects include quality and safety issues, performance issues and consequential financial implications. In highlighting the aggregate effect of these consequences, there needs to be an urgent Health Economy wide solution to reduce the Fit-to-Transfer numbers if the Trust's position is not to be further and continually undermined.

5.2.2   Income and Expenditure

The initial full plans submitted to the NTDA in April illustrate the Trust's 2015/16 deficit to be £18.2m, the increase from the previous year principally due to increase Clinical Negligence Contributions, loss of transitional support funding and the full year implications of the new Women and Children's Centre.

The Trust is expecting to record deficits in each of the years 2015/16 to 2018/19. In order to become financially sustainable it is necessary for reconfiguration to take place so as to release substantial levels of duplicate costs.

The cash consequences of all future year deficits will require continued cash support to avoid the Trust being required to absorb these cash shortfalls within its working balances resulting in deterioration in compliance with the Better Payment Practice Code (BPPC). However all cash consequences of historic deficits (up to and including 2014/15) were fully addressed by the successful loan application in January 2015.

5.2.3   Public consultation on future of clinical services

The Trust continues to experience day-to-day difficulties in medically staffing some key areas and whilst most gaps are covered this is becoming an increasing struggle and often relies on factors such as consultants "working down" to provide the full level of medical support needed within acute hospitals. These issues form part of the case for change for the NHS Future Fit programme. Although proposals have been developed the consultation has been delayed until winter 2015: this has resulted in a continuing challenge to provide some services across two sites. Other factors include the need to move towards seven day working providing earlier access to senior clinical decision makers. Full implementation of seven day working will need radical changes in the way that acute hospital services are provided for our communities and a transition plan will be needed in some areas ahead of the conclusions of NHS Future Fit.

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. 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.

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 Committee, Clinical Quality and Safety Committee, Hospital Executive Committee, and Risk Committee. 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.

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 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
- Board Assurance Framework.
- 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.

The system of internal control has been in place at the Trust for the year ended 31 March 2014 and up to the date of approval of the Annual Report and Accounts.

Accountable Officer: Peter Herring

Organisation: The Shrewsbury and Telford Hospital NHS Trust

Signature

Date