The Shrewsbury and Telford Hospital NHS

NHS Trust

Reporting to:	**Trust Board, June 5th 2014**
Title	Annual Governance Statement
Sponsoring Director	Chief Executive
Author(s)	Head of Assurance
Previously considered by	Audit Committee (April and May); Exec Directors, (March 2014)
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. This draft was submitted to the External Auditors and NTDA to meet the deadline of the 28th April. The final version will be submitted with the Annual Accounts on 9th June. Comments had already been received from External Audit prior to submission. Significant issues for 2013/14 are considered to be: • Patient Flow and Access Targets • Liquidity • Public consultation on future of clinical services
Strategic Priorities ☒ Quality and Safety ☒ Healthcare Standards ☒ People and Innovation ☒ Community and Partnership ☒ Financial Strength	**Operational Objectives**
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 we do not implement our **falls** prevention strategy then patients may suffer serious injury ☒ 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 have a clear **clinical service vision** then we may not deliver the best services to patients ☒ 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 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** **To APPROVE the Annual Governance Statement**

Paper 6

Shrewsbury and Telford Hospital NHS Trust

Organisation Code: RXW

Annual Governance Statement – 2013/14

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 2013/14, the organisation routinely reported on financial, operational, and strategic matters to the Trust Development Authority (TDA). Meetings were held with senior officers at the TDA in relation to performance and the Trust's trajectory towards achieving foundation trust status during 2013/14 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. Its role is largely supervisory and strategic, and it 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. The Trust Board met a total of twelve times in public during the year and Board papers are published on the Trust website. **Year ending 31st Mar 14**

Trust Board Attendance	Year ending 31st Mar 14
Name and Title	**Attendance**
Professor Peter Latchford – Chair from November 13	4/4
Robin Hooper Non-Executive Director	8/12
Dennis Jones Non-Executive Director	10/12
Simon Walford Non-Executive Director	12/12
Donna Leeding Non Executive Director from September 13	5/6
Harmesh Darbhanga Non Executive Director from September 13	5/6
Martin Beardwell Acting Chair until October 13	8/8
Peter Vernon Non-Executive Director until September 13	3/6

Peter Herring CEO	11/12
Neil Nisbet Finance Director	12/12
Debbie Kadum Chief Operating Officer	11/12
Edwin Borman Medical Director	11/12
Sarah Bloomfield, Acting Director of Nursing and Quality – from Sept 13	7/7
Vicky Morris Director of Quality and Safety until September 13	5/5

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were updated in June 2013 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 year 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. 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, seven independent Non-Executive Directors, and five Executive Directors (including the Chief Executive). The past year has been one of rebuilding and consolidation for the Trust Board, with one Executive Director and three Non-executive Director posts being recruited into during 2013/14. The Trust was without a substantive Chair for over a year, until the agency responsible for making appointments to NHS Trust Boards (the NHS Trust Development Authority), identified Professor Peter Latchford as a suitable and desirable candidate. After commencing in November, the Chair is now leading on a comprehensive five-year programme of development for the Board.

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 part of SaTH's FT Constitution and compliant with the NHS Foundation Trust Code of Governance (2013). 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 four standing Committees and three executive committees accountable to the Trust Board. 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.

SaTH Committee Structure
February 2014
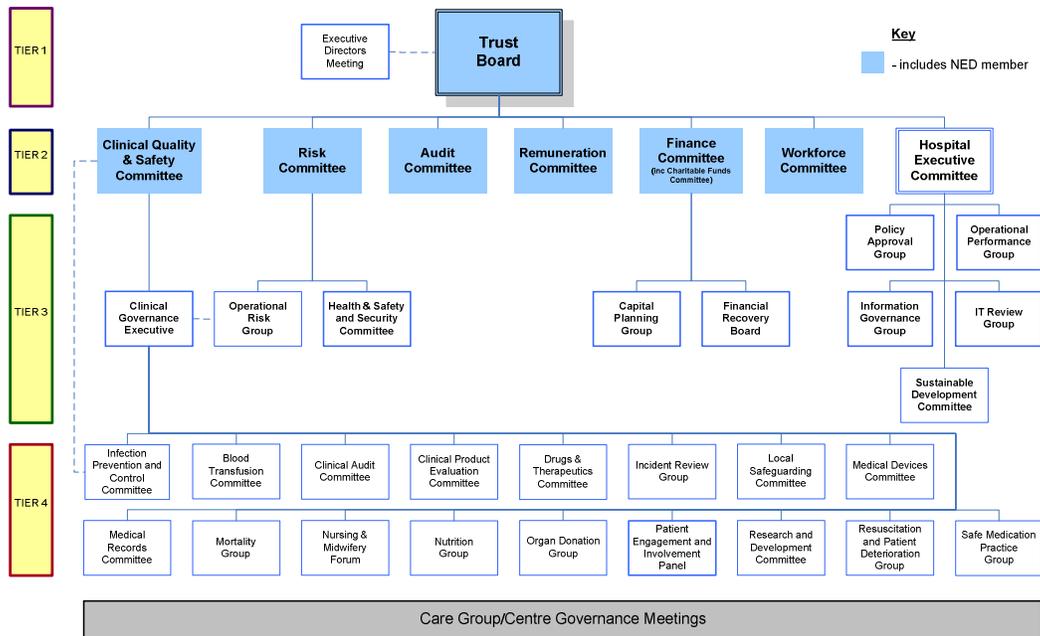
Two of the standing Committees are Non-Executive Committees (Audit, Remuneration). Although these Committees have a membership consisting of only Non-Executive Directors, other Directors will attend as required.

- 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 6 times during 2013/14. 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 Concern was expressed at the potential impact of the outcome of the contract negotiations on our risk profile and the concomitant effect on the findings of our auditors. The Committee felt a more open and transparent approach to contract discussions would be a useful area for a future meeting of the Tri-partite Board meeting to examine in order to ensure that quality diligence was applied as well as financial diligence
  - o The 18 week RTT Audit and the Finnamore Follow-up audit, which both received limited assurance and highlighted that whilst good work and clear protocols and understanding were in place in the Patient access Centre (PAC) this left roughly 40% of activity without such a robust framework. It was noted that these audits will be followed up by Finance Committee and the Booking & Scheduling Board, but until process and systems are firmly in place, with adequate staff training, this continues to be a risk for the Trust and the rigour within PAC needs to be built upon.

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 remaining three Committees (Hospital Executive Committee, Risk Committee and Workforce Committee) are executive in nature.

- 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. To this end, our memorandum self-assessing the Board's current capacity and capability, supported by appropriate evidence, achieved 'substantial assurance' when assessed and reported by the Trust's internal auditor, Deloitte, in March.

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 Acting Director of Nursing and Quality has delegated responsibility for Quality. The Quality Improvement Strategy was updated by the Trust Board in June 2013 to ensure it continues to be an iterative document supporting continuous Quality Improvement.

The performance of Quality has been monitored closely by the Board with detailed, monthly reviews 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.

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 2013/14.

During 2013/14, the Trust maintained a system to provide a 'Ward-to-Board' view of compliance with the CQC outcomes which requires individual areas to assess their performance against the CQC Outcomes which aggregate up to Care Group and Trust level. The Care Quality Commission introduced a new quarterly Intelligent Monitoring Report to replace their Quality and Risk Profile in October 2013. 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; referral to treatment times; and one item from both the inpatient and staff survey.

During the year the Trust was subject to two separate assessments by the CQC. In April 2013 an unannounced inspection was carried out at Princess Royal Hospital where the Trust was judged not be to be meeting the required standards for outcomes 1 and 4. ('Respecting and involving people who use services' and 'Care and welfare of people who use services') The CQC inspected the Royal Shrewsbury Hospital in October 2013 and made a number of observations across 6 wards which resulted in notification that 3 of the 5 health care outcomes reviewed were not being fully met ('Consent', 'Complaints'; and 'Records'). The CQC identified areas where care needed to be improved. 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 2013/14 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 October 2013 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.

A Sustainable Development Management Plan/Strategy was approved by Trust Board in March 2014. The Strategy outlines a vision and three goals based on the challenges that factor in the environmental impact of the health and care system and the potential health co-benefits of minimising this impact. The five year action plan incorporates the requirement of the Good Corporate Citizen initiative.

There is a Carbon Reduction Strategy and action plan approved by the Board. Good progress has been made year on year and is reported to the Board annually. 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 met.

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. 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

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 improved during the year with good clinical outcomes reported in the CQC Intelligent Monitoring report and reductions in pressure ulcers and complaints.
- **If we do not implement our falls prevention strategy then patients may suffer serious injury.** This risk has improved during the year with a statistically significant reduction in the number of patient falls.
- **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 difficulties 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** (significant issue). This risk has improved during the year, but remains an area of significant challenge for the Trust. In relation to the key national priorities, the Trust did not meet the access targets although performance improved over the year.
- **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 and a 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. The second annual leadership conference was well attended. There were a record number of nominations for staff awards and a number of initiatives are under way including the coaching scheme and the commissioning of 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** Discussions have continued with the NTDA regarding the Trust's historic liquidity balance sheet position are ongoing to enable the Trust to progress its FT application.
- **If Board members are not appointed in a timely fashion then this may impact on the governance of the Trust** (resolved). With the appointment of the Medical Director, COO, new NEDs, and Chair in October, this risk has been resolved.

Data security
In line with the requirements of the Information Governance Toolkit, all staff are required to undergo annual IG training. As of March 31st 2014, 75% of staff had completed this training. This was a small improvement on 2012/13 but short of the 95% target set out within the toolkit.

Information Governance incidents are reported via the Trust's incident reporting system. There were 2 data lapses in the year which were classified as level 2 incidents (these are the incidents which are formally reported to the Information Commissioner)

▪ One incident related to a problem with the letter folding machine where the dial had been accidently set to fold 2 letters per envelope. This resulted in unauthorised disclosures. The machine has been adjusted so that this dial cannot be altered, and staff now count throughput and output to ensure this does not occur again.

▪ A near-miss incident occurred when a member of staff emailed over 5000 patient details to the newly established Commissioning Support Unit (CSU). This was non malicious and arose due to confusion over the new arrangements about sharing information with CSU/CCGs, and invoice validation. The team is now aware of the correct procedures which have been communicated to all relevant staff.

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 78% (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 Trust Development Authority. 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 2013/14 at all levels of the organisation, including the Board.

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 working in areas where they need to be particularly vigilant to the possibility of fraud (eg Facilities and Procurement). As well as investigating potential frauds, notified to the LCFS by the Trust, there have been proactive exercises to detect potential fraud including a spot check of the management of patient's property and money on the wards; and a review of the use of the e-rostering system in

maternity services. Additionally the LCFS has commented on Trust policies as part of the review process: this was commended as best practice as part of the NHS Protect Quality Assessment in March 2014.

In the National Health Service Litigation Authority (NHSLA) General Standards the Trust currently holds level 1. The Trust achieved Clinical Negligence Scheme for Trusts (CNST) Level 3 in maternity in year.

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, *"The implementation of prior year recommendations demonstrates the progress made by management to improve controls over the BAF and risk management."*

During the year, Internal Audit reported on nine core audits and five performance audits. Internal Audit issued substantial assurance ratings for seven of the core audits and moderate assurance ratings for two core audits. These moderate assurance ratings related to budgetary control and asset maintenance and resulted in one high priority recommendation related to asset tracking and disposal. Actions to rectify this weakness are being implemented.

Although the budgetary control and cash management audits did not identify any control weaknesses, Internal audit raised concerns to the Chair of the Audit Committee, about the current and forecast financial position.

Limited assurance ratings were provided in four performance reviews, all of which were identified for audit due to Trust concerns:

o **Falls Management:** Four high priority recommendations made. These related to raising the profile of falls at ward level; consistent prioritisation of alls risks at all levels; updated Falls Group agenda; and escalating local root cause analysis actions to the Falls Group action plan if applicable. This is also an area which the local Health & Safety Executive have investigated and the Trust continue to help them with their enquiries

o **Complaints Management:** Five high priority recommendations made**.** These related to appraisals for the complaints team; development of standing operating procedures; improved reporting; structured complaint team meetings; and development of a robust complaints tracking process.

o **Performance Reporting and Follow up (Finnamore**). Two high priority recommendations made. These related to mapping the outstanding Finnamore recommendations to the existing booking and scheduling action plan; and improving focus and pace of change.

o **18 week pathway (RTT).** Four high priority recommendations made. These related to developing a plan for further centralisation of booking; developing a comprehensive 18 week training programme; agreeing a universal validation process; and carrying out a comprehensive review of SEMA rules.

Formal actions plans have been agreed to address the significant control weaknesses in these areas. There have been no common weaknesses identified through Internal Audit reviews.

The system of internal control has been in place in the Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

5   Significant Issues

5.1   Progress on 2012/13 Significant Issues
In the 2012/13 Annual Governance Statement, the Trust disclosed three significant issues. Progress on these issues is outlined below.

5.1.1 Failure to meet national targets

In 2012/13 the Trust failed the 95% A&E target, the Referral to Treatment (RTT) targets, and the cancelled operations target. Although performance improved over the year, this has remained a significant issue (see section 5.2.1)

5.1.2 Number of serious falls

The Trust saw a statistically significant decrease in the number of falls during 2013/14. A comprehensive action plan to ensure ongoing reduction of falls and the impact/harm for patients was presented to the Trust Board in February 2013 with most of the identified actions now completed.

5.1.3 Liquidity

At the end of the 2012/13 financial year the Trust recorded a liquidity rating 2. This issue has remained challenging during 2013/14 and discussions continued with the NTDA regarding the Trust's historic liquidity balance sheet position. (see section 5.2.2)

5.2 Significant Issues

5.2.1 Patient Flow and Access targets

Performance against the A&E, RTT and cancer waiting times targets is slowly improving but is also proving challenging.

- The A&E 4-hour target is 95%. In 2012/13 the Trust achieved 90.62% and this improved to 93.4% this year. Work is ongoing 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.

- For admitted Referral to Treatment (RTT), only 3 specialities out of 11 achieved the 90% target in March 2013; this improved to 6 specialities out of 11 in March 2014. A Remedial Action Plan (RAP) is in place for the 18 weeks targets and all specialties are on trajectory to achieve this target in accordance with the RAP, with the exception of ophthalmology where demand is increasing and outstripping capacity. The commissioners are aware of this and are working with the Trust to develop a solution.

- The Trust achieved the cancer standards in 2012/13 but this year, underperformed against two of the targets. The Trust achieved 93.35% for 31-day referral to treatment, against a target of 94%; and achieved 81.48% for 62-day referral to treatment against a target of 85%. A Remedial Action Plan [RAP] is in place for cancer, which details the actions to be taken in the four challenged tumour sites, which are contributing to the non-performance of the 62-day standard. The Intensive Support Team [IST] has undertaken a review of cancer services. This review took place over two days in March with a draft report being completed by 28th March 2014. Once the report is received, the recommendations will be incorporated in to the RAP and will be monitored at the Cancer Board. The IST will be working with the clinical centres to review patient pathways so that we deliver all of the cancer standards from Quarter 2 in 2014/15.

5.2.2 Liquidity

In order to address a significant cash problem, the Trust requested temporary borrowing. The level of temporary borrowing requested amounted to £7.5 million which was repaid in full by March 2014. The Trust is working with the TDA to access a permanent funding solution. The 2014/15 cash plan has been constructed based upon an assumed income and expenditure deficit for the year of £8.2 million. There are particular challenges for the year ahead including the continued financial austerity across the country, the requirement from our commissioners to deliver significant

efficiency savings, the transfer of funding through the Better Care Fund which will reduce the amount of overall funding available to hospitals linked to a country-wide expectation that investment will take place in the community to prevent the need for hospital admission and support timely transfer from hospital. Also, the continued additional costs faced by the Trust through duplication across two small hospital sites are not reflected within the "tariff" we receive through the national Payment By Results system and this reduces our ability to deliver the sort of efficiency savings that are needed to support that shift to community whilst also protecting the safety and sustainability of our hospital services.

Overall this means that the Trust is currently forecasting a deficit in each of the next three years (2014/15 to 2016/17) returning into in-year balance from 2017/18. This forecast relies on us managing the risks to our financial position whilst also seeking transitional support whilst the whole health system agrees a radical and affordable vision for the future with patients at its heart.

5.2.3   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; This was identified as a new risk in the Board Assurance Framework. These issues form part of the case for change for the NHS Future Fit programme. An independent review will be commissioned to provide assurance for the Trust Board. However there is a need to expedite the consultation in 2014 due to continuing challenges of providing 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

5 June 2014