Paper 5

Reporting to:	**Trust Board, 2 June 2016**
Title	Annual Governance Statement
Sponsoring Director	Director of Corporate Governance
Author(s)	Head of Assurance
Previously considered by	Audit Committee (April and May and June 2016), Directors and NEDs
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. A draft was submitted to the External Auditors and NTDA to meet the deadline of the 22nd April. The final version will be submitted with the Annual Accounts on 2nd June. Significant issues for 2015/16 are considered to be: • Financial Risks Associated with the 2016/17 Financial Plan • Sustainable Transformation Plan • Performance • External maternity review • Lack of embedded Business Continuity Plans • Estates and Infrastructure A final version of the document is attached.
Strategic Priorities 1. Quality and Safety	☐ 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
2. People	☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	☐ Support service transformation and increased productivity through technology and continuous improvement strategies
4 Community and Partnership	☐ 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
5 Financial Strength: Sustainable Future	☐ 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 Annual Governance Statement

Shrewsbury and Telford Hospital NHS Trust **Organisation Code: RXW**

Annual Governance Statement – 2015/16

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 2015/16, the organisation routinely reported on financial, operational, and strategic matters to the Trust Development Authority (TDA). During 2015/16 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 ten times in public during the year in addition to the AGM; and Board papers are published on the Trust website.

Trust Board Attendance	**Year ending 31st Mar 16**
Name and Title	**Attendance**
Professor Peter Latchford - Chair	10/10
Robin Hooper - Non-Executive Director	7/10
Dennis Jones - Non-Executive Director (until Oct 2015)	5/6
Simon Walford - Non-Executive Director	8/10
Donna Leeding – Non-Executive Director	9/10
Harmesh Darbhanga – Non-Executive Director	8/10
Brian Newman – Non-Executive Director	9/10
Clive Deadman – Non Executive Director (from Feb 2016)	1/1
Paul Cronin - Non Executive Director Designate (from Dec 2015)	3/3
Peter Herring - CEO – until July 2015	4/4
Simon Wright – CEO – from Sept 2016	5/5
Neil Nisbet - Finance Director (Acting CEO Aug and Sept 2015)	10/10
Debbie Kadum - Chief Operating Officer	10/10
Edwin Borman - Medical Director	9/10
Sarah Bloomfield - Director of Nursing and Quality	10/10

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were updated in March 2016 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.

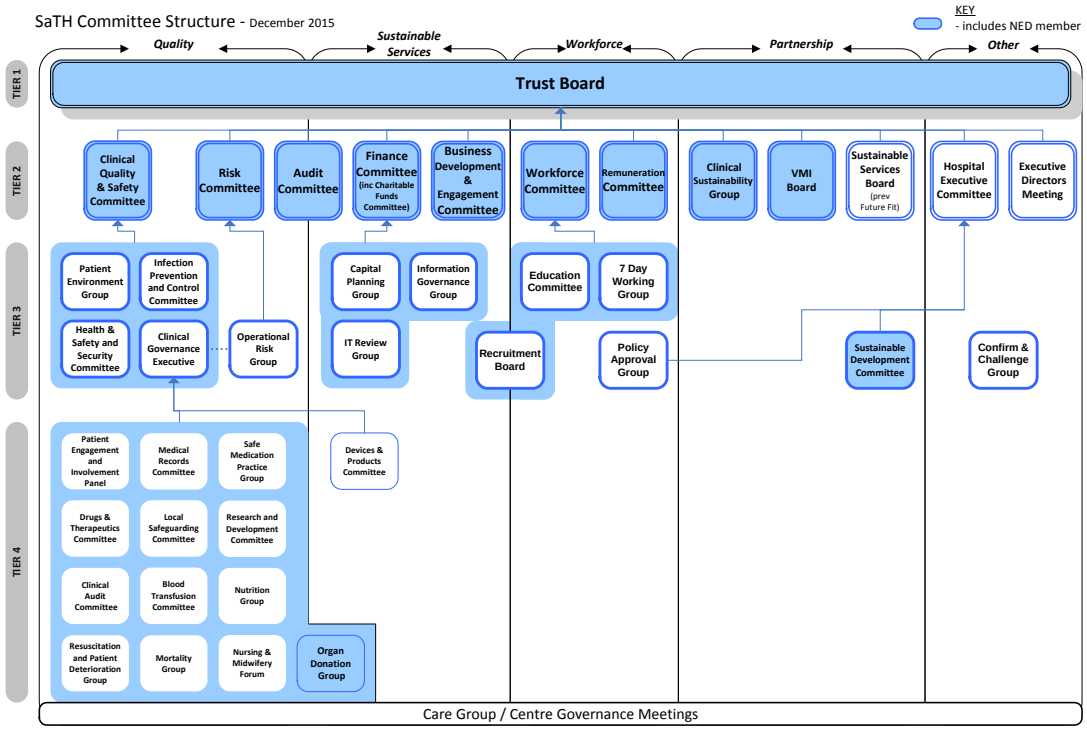
2.2 Board Performance

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). The Chief Executive, Peter Herring, retired in July 2015 and was replaced by Simon Wright from September 2015. In the intervening period, the Finance Director was the acting Chief Executive. One of the non-executives retired in October, having served for two full terms. A replacement took up position in February 2016. In addition, a non-executive director designate was appointed in December 2015 to facilitate succession planning.

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 eleven Tier 2 committees accountable to the Trust Board; and the Executive Directors meeting. Nine of these committees 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 and the Sustainable Services 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.

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 6 times during 2015/16. 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:

    - The Internal Audit report on Governance of Future Fit. This report provides moderate assurance and contains two high priority recommendations. The first of these related to the finding that expectations and intentions are not completely aligned, and this needs to be very tightly monitored. The Programme Execution Plan (PEP) will be re-circulated to Board members. The second high priority recommendation related to defining affordability in relation to the proposed options. There is no absolute position on this, and the Trust's commitment is substantial. The Trust needs to feed in affordability discussions with the TDA to include capital costs and on-going revenue costs and efficiency assumptions. There is concern that operational responsibility rests with SaTH, which will result in difficult and controversial decisions to maintain safety.

    - The Internal Audit report on Delayed Transfers of Care. This report provides moderate assurance and notes that Length of Stay is shorter that national average but that SaTH does not experience the same seasonal variation as other Trusts. The audit also found that 7-day discharge planning meetings don't happen and this significantly delays discharges. The Trust also needs to look at admission avoidance and support following discharge to avoid readmissions. The report recognised the pressure that staff are working under in very difficult circumstances and the opportunity that working with Virginia Mason presents.

    - A report from the Local Counter Fraud Service on Consultant job planning and was pleased to note the progress with job plans, but recognised that the actual planning process needs more rigour with more involvement of the management teams to ensure plans reflected reality and operational needs.

    - The limited assurance report on IT controls, and noted that although last year this core audit had received substantial assurance, the scope had changed significantly. The Committee agreed that the high priority recommendations in relation to the Computer Rooms need to be actioned promptly to ensure that adequate cooling controls are implemented at both sites to protect assets and services. It was noted that urgent discussions are being held with the interim Estates Director to progress the issues raised through the capital planning process.

    - The External Auditors Ernst & Young (EY) submitted their audit planning report outlining scope and audit approach for 2015/16 audit, which summarised the key issues and their strategy in relation to identified risks. Their audit of Economy, Efficiency and Effectiveness comprises 3 main aspects (i) Informed decision-making – which will consider break-even duty and CIP position (ii) sustainable resource deployment - which will consider performance against national performance targets and (a new criterion) working with partners and other third parties. The Audit Committee stressed that the auditors should begin the process by looking at the contractual arrangements commissioned at the beginning of the year and to consider the actual

levels of activity experienced by SaTH and the impact of under-investment and under-commissioning from the outset in terms of patient experience, financial penalties and achieving national targets. Although there are planned changes nationally in relation to the penalties applied for non-achievement of targets the Trust has historically been blighted by having unrealistic and insufficient activity levels set in contracts which it was forced to accept following arbitration despite not matching actual demand. An analysis of Trust performance had accurate contract activity levels been set would be helpful and the Committee hoped the work by EY would reflect some of these aspects. Furthermore it was noted that for the last three years the Trust had been one of the top 40 performing hospitals in the country and received national recognition from CHKS across a range of performance and efficiency indicators. Audit Committee asked that EY deliver some headline findings at the April meeting

- IT Disaster Recovery and Business Planning. The Audit Committee meeting considered the Limited Assurance opinion issued on this report by Deloitte, which contained 5 High Priority and 4 Medium Priority recommendations. These centred around the lack of an overarching business continuity plan, disaster recovery plan and business impact analysis. The Audit Committee have asked for an update at the April meeting or Trust Board on the position. There was also concern around the apparent lack of a business continuity framework across the Trust and have asked Internal Audit to include this in the 2016/17 Audit Plan

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 Committees (Hospital Executive Committee, Risk Committee, Workforce Committee, Business Development and Engagement Committee, Sustainable Services Committee, Clinical Sustainability Group and Virginia Mason Institute Board) 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

At the start of 2015/16, work continued to assure compliance with the Board Governance Assurance Framework (mandated as part of Foundation Trust development) to ensure the Trust Board remains fit to lead the organisation towards achieving Foundation Trust status and beyond. However, this has been superseded by the Well-Led Framework, which combines the Board Governance Assurance Framework and the Quality Governance Framework. There have also been some revisions nationally around the 'Fit and Proper Persons' test. The Trust Board is assured on a monthly basis that we continue to demonstrate compliance with relevant governance requirements at all times. An enhanced Board Development Programme is in place and it has been agreed that a Well Led Framework compliant review of Board effectiveness, led by the Chair, will take place once the new Chief Executive has been in post for over a year.

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 nationally as an area of good practice.

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 two 'never events' reported in 2015/16. The first was a case of wrong site surgery when in incorrect skin lesion was removed. The procedures for removal of skin lesions have been changed. The second was a retained swab following a dental extraction and a number of changes to procedure have been implemented. This case supports the work already on going within the Trust to implement the National Standards for Safety of Invasive Procedures (NATSSIPS)

The 2015/16 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 2015 the Trust was required by NHS England to submit a compliance statement set against the EPRR Core Standards to their Area Team and the CCG for assessment. Shrewsbury and Telford Hospital NHS Trust were reviewed by the panel and evaluated as substantial. The October 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 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.

The Trust remains highly committed to Sustainable Development, and can proudly claim to have led the way in the NHS during 2015. Nationally, the NHS Sustainable Development Unit acknowledges innovation and best practice through the NHS Sustainability Awards. In April, the Trust was 'highly commended' in an unprecedented five categories – more than any other Trust is the country, and in November the Trust was a finalist for the first time at the prestigious Health Service Journal Awards in the Improving Environmental and Social Sustainability category, shortlisted from 1600 entries. The Trust has again been shortlisted in NHS Sustainability Awards in 2016; for the third year in a row.

During 2015, the Board was required to complete monthly self-certification on Monitor requirements and Board Statements by the Trust Development Agency. The Board declared compliance with all requirements, subject to continued financial support from the TDA, except for the governance requirements due to the financial position and performance against some national targets. Whilst this reporting requirement was

withdrawn by the TDA in December 2015, the Trust continues to use these metrics within its suite of key performance indicators, reported to the Board monthly.

During the period for which monthly reporting to the TDA was mandated, the Trust was consistently rated as Escalation Level 4 (of 5) in the TDA Accountability Framework. This is classified as a material issue requiring interaction led by the TDA's Director of Delivery & Development. Regular meetings with the TDA have been held throughout the year 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.

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 for the fourth successive year. 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 shown an improvement during the year. There are good clinical outcomes are reported in the mortality indicators; However, the Trust continues to experience exceptional levels of demand and concerns of capacity both in our inpatient and emergency areas. This has led to patients being escalated and occupying spaces that are sub-optimal in terms of our ability to care for them safely or with dignity and respect. The risks assessed and incidents such as from Datix, complaints, infection prevention control, safeguarding, staffing and legal claims are being triangulated by the corporate nursing team to gain assurance that where possible risks are lessened

  During 2015, the Trust was selected to work with the Virginia Mason Institute (VMI) who transformed its systems to become widely regarded as one of the safest hospitals in the world. Virginia Mason are providing training and coaching to draw inspiration from VMPS and develop new ways of working – prioritising the needs of patients and colleagues through eliminating waste and continuous improvement.

- **If we do not work with our partners to reduce the number of patients on the Delayed Transfer of Care (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges.** At times, there have been almost over 80 patients in hospital beds who are fit to be discharged from acute care, and routinely the patient worklist patients have occupied 15% of bed capacity. This risk impacts on many of the other risks the Trust is facing:

    - Costs of escalation wards, additional bed capacity and facilities including outsourced provision, and premium costs for agency and locum staff

    - Pressure on staff leading to high levels of sickness and low staff morale, further increasing staffing costs

    - 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

    - Quality and safety issues including increased risk of infection, pressure sores, and falls

  The three main reasons for delays are domiciliary care provision and nursing/residential home placements and an increase in further non-acute care including rehabilitation. Although the Trust has worked with partner agencies to improve the situation; and there has been an increase in funded care packages, this has not been sufficient to improve the situation. Given the over-riding responsibility of the Board for patient safety and experience, this remains a source of difficulty.

- **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 is now only mandated to achieve the incomplete standard in relation to Referral-to-Treatment target and this standard is being achieved. There has also been an improvement in the achievement of the cancer waiting times targets where the Trust is performing above the national average. 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**. Although a significant amount of work has taken place the public consultation has been further delayed and remains a significant issue for 2016/17.

- **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.** Work has started further develop as leaders in our organisation, in particular how leadership should look and feel. This work is focussing on behaviours and links to the previous work on Trust values and leadership do's and don'ts. This development has been a key feature in Virginia Mason Institute's (VMI) transformation journey and will support the Trust on its journey. The results of the national staff survey show a marked improvement over last year.

- **If we are unable to resolve 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** At the end of the 2015/16 Financial Year the Trust delivered a £14.7m deficit in line with the required stretch target set by the NHS Trust Development Authority. In the 2015/16 year, the deficit of the Trust was underpinned by a loan from the NTDA of £12.7 million

  The Trust is clear that it wishes to address its backlog maintenance issues and as stated within Section 5.1.2 Income and Expenditure, within the Trust's Medium Term Financial Plan the Trust

generates recurrent funds over the years 2016/17 – 2020/21 amounting to £6m to cover the revenue consequences of a £70m loan to address the backlog asset issues.

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.

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 73% (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 which were 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 all of the Estates staff and other 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 has been a programme of continuous control monitoring including review of agency timesheets; patient property checks; travel expenses; have been proactive exercises to detect potential fraud including an examination of fraud red flags in sickness absence; and review of invoices. The LCFS has commended the process for declarations of interest in place at the Trust and has worked with the Trust to further enhance the system in place.

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 made three low priority recommendations.

During the year, Internal Audit reported on eight core audits and two 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 one core audit. The moderate assurance ratings relate to CQC action plan follow up; and budgetary control. The limited assurance rating relates to the audit of Information Technology Disaster Recovery and Business Continuity Planning where two high priority recommendations were made. Actions to rectify these weaknesses are being implemented.

- **Information Technology Disaster Recovery and Business Continuity Planning:** One high priority recommendation was that the Trust should document a plan to cover the business continuity policy and strategy, covering all areas of the trust, and with a mechanism for structured testing. The second high priority recommendation was that the adequacy of the existing IT recovery arrangements should be documented for each service.

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 2015/16. 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 weaknesses identified which put some system objectives at risk relate to CQC, Income & Debtors, Budgetary Control and IT Disaster Recovery and Business Continuity Planning.

Significant assurance has been given in relation to the Board Assurance Framework and risk management arrangements at the Trust.

The system of internal control has been in place in the Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

5 Significant Issues

5.1 Progress on 2014/15 Significant Issues

In the 2014/15 Annual Governance Statement, the Trust disclosed three significant issues. Progress on these issues is outlined below.

5.1.1 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. The volume of patients on the FTT list is large, resulting in up to 80 inpatient beds being unavailable for acutely ill patients at any one time. The number of care packages available has increased during the year, although is still not at level to meet the demand. The Trust's average length of stay in 2013/14 (latest public data) was 4.1 days which is better than the national average of 4.6 for all NHS trusts. The Trust has developed its Patient Status at a Glance (PSAG) boards to support a case management approach in MDT meetings, whilst the Discharge Hub proactively supports complex discharges. The Trust has provided training and communications to staff in relation to the discharge process and Consultant Job Plans have been updated to include time for attendance at board rounds. The Trust is re-establishing a Service Improvement Team to further improve the operational processes and hopes to further
benefit from its work with Virginia Mason in the USA.

5.1.2 Income and Expenditure

In 2015/16 the Trust will end the year with an in year deficit of £14.75 million and carries forward a recurrent deficit of £20.2 million. The full plans submitted to the NTDA illustrate the Trust's 2016/17 deficit to be £5.9m, which includes a series of assumptions. The income assumptions incorporate non recurrent Sustainability and Transformation Funds received from NHS Improvement amounting to £10.5m. In the 2015/16 financial year the Trust carried forward under-achievement of recurrent cost savings. These are now recognised within the CIP target for the 2016/17 year. The level of CIP to be achieved in 2016/17 amounts to £13m.
The Trust also incurred losses as a result of the Junior Doctors strike which were out of the Trust's control.

The Trust is expecting to record deficits in each of the years 2015/16 to 2019/20. The Trust generates a surplus in the 2020/21financial year as a consequence of a reconfiguration of services which enables excess costs of split site working to be avoided. The Trust generates recurrent funds over the years 2016/17

– 2020/21 amounting to £6m to cover the revenue consequences of a £70m loan to address the Trust's backlog asset issues.

5.1.3 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 further delayed.

The Trust remains committed to the on-going work of the Future Fit Programme and the key role it plays within it, whilst recognising the need to progress solutions at pace to the critical workforce challenges it faces. The Trust has therefore agreed to lead and progress the work on developing an outline business case (OBC) that covers both options of a single emergency centre at PRH or a single emergency centre at RSH. This will ensure that in the summer of 2016 when Future Fit can conclude its work on a preferred option, the Outline Business Case (OBC) work will be completed so that formal Public Consultation takes place from end 2016 with a final decision reached in Summer 2017.

5.2 2015/16 Significant Issues

5.2.1 Financial Risks Associated with the 2016/17 Financial Plan.

Shropshire CCG Financial recovery plan

Shropshire County CCG have indicated that their expectation is for local QIPP schemes to reduce Income by £4.0 million. Shropshire CCG have also issued CQUIN targets for the year. The Trust is contesting the reasonableness of the scale and timescales attached to these targets.

Neighbouring Trusts

The Trust, though not formally aware, has learnt that Shropshire CCG wishes to substantially reduce its funding in support of services presently provided by Shropshire Community Trust. It is not clear what level of impact such changes will have upon the Trust.

Sustainability and Transformation Fund

It is not presently clear how the Sustainability and Transformation fund is to be released to the Trust and also the precise circumstances in which NHS Improvement will withhold funding. Guidance suggests that withholding of funds will be linked to performance targets and also failure to contain spending within levels attributed to the Trust in respect of the Agency Cap

Achievement of Agency Cap

The Trust is expecting to deliver £3.25 million as cost savings from implementing new Agency rates in the 2016/17 financial year. Introducing these new rates particularly within medical and consultant staff groups may result in immediate operational difficulties.

Value for Money assessment

The Board is concerned about the parameters of the annual value for money assessment. The Trust has a longstanding historic debt of circa £20m. The Trust has been told by external consultants that, because of duplication in the system, the Trust is spending an additional £12m each year in order to duplicate services to meet the contractual requirements of the two CCGs. In addition, the Board believes that with an outcome based contract, there would probably be greater savings on other associated activity as an indirect saving. If these two factors were resolved, it is certain that the financial outturn would be much improved.

This was compounded by the position relating to contracting and demand. If the Trust were only assessed against the contract figures then there would be a clearer position in terms of performance. The final element in the value for money assessment then was discharge and how the partners reacted to the timescales and the implication of not doing it.

5.2.2 Sustainable Transformation Plan

The Strategic Outline Case (SOC) for the acute service elements of the Future Fit Programme was approved by the Board in March 2016. The SOC, known internally as Sustainable Service sit describes the Trust's plans to address the significant challenges to the safety and sustainability of patient services specifically in emergency and critical care.

This work builds on the discussion and feedback from staff, patients and the public within the Future Fit Programme to address the most significant of workforce challenges. The Trust was requested to progress this work by the Future Fit Programme Board in October 2015. The SOC demonstrates that there are potential solutions which address the Trust's workforce challenges in A&E, Critical Care and Acute Medicine by developing a single Emergency Centre, a single Critical Care Unit and a Diagnostic and Treatment Centre with Urgent and Planned Care service provision at both PRH and RSH.

The SOC describes the case for change and a way in which a new clinical model for emergency and urgent care in the county could be implemented. The SOC includes the capital and revenue impact of changes to the Trust's workforce and estate in delivering this model of care within three potential configurations. The estimated timescales for implementation and the ongoing and new work required are also identified

Following approval by the Trust Board, the SOC will be forwarded to Commissioners and the Trust Development Authority for their support and approval. This document represents the Strategic Outline Case for the acute service elements of the Future Fit Programme; known internally as Sustainable Services, it describes the Trust's plans to address the significant challenges to the safety and sustainability of patient services specifically in emergency and critical care.

5.2.3 External Review of Maternity

An independent Maternity Review was published on 1 April 2016 following the death of a newborn (Kate Stanton-Davies) in 2009, hours after being born at Ludlow Midwife-Led Unit. The report looked at both the care and treatment provided to Kate and her mother and the Trust's subsequent handling of Kate's parents' concerns and the governance around the management of the incident itself. The full report was discussed at a special meeting of the Trust's Board in April 2016; the report was accepted in full and the implementation of the recommendations and any subsequent actions deemed necessary will be tracked to conclusion through the public session of the Trust Board.

5.2.4 Performance

The Trust is currently at Escalation Level 4 (of 5) in the NHS Trust Development Authority's Accountability Framework. This is classified as a 'Material issue' requiring interaction led by the Director of Delivery and Development. Regular meetings are held with the TDA to update on SaTH's improvement trajectories. The key areas of focus are the four hour access standard

The trajectory to deliver the 95% 4 hour performance has been recalibrated based on current performance. The Trust is currently in discussion with the Local Health Economy (LHE) on next year's trajectory, which should demonstrate a 3% improvement based on quarter 4 performance 2014/15.

5.2.5 Lack of embedded Business Continuity Plans

Internal Audit issued a limited opinion report on IT controls and highlighted the lack of embedded business continuity plans across the Trust. Although it was acknowledged that the Trust has a good policy and framework, some areas have not yet developed robust plants. The newly appointed Emergency Planning and Resilience Officer (EPRO) is working with the Care Groups to rectify this situation.

5.2.6 Estates and Infrastructure

The Trust is facing a number of significant risks in respect of backlog maintenance of IT infrastructure, necessary medical equipment as well as building maintenance. The Trust needs to fully understand the issues in view of the scale of the financial challenge. It is not however the Trust's expectation that buildings will close in the mmediately foreseeable future.

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, 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 2016 and up to the date of approval of the Annual Report and Accounts.

Accountable Officer: Simon Wright

Organisation: The Shrewsbury and Telford Hospital NHS Trust

Signature

Date
2nd June 2016