Enclosure 2

STATEMENT ON INTERNAL CONTROL 2010/11
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

As the Accountable Officer for the Trust I ensure that the Trust works closely with the Strategic Health Authority (SHA) and other partner organisations, through various reporting processes. Examples of such processes are:

A Risk Management Strategy, updated and reviewed each year by the Trust Board is in place. It clearly defines the risk management structures, accountabilities and responsibilities throughout the Trust and reflects the Trust's management and governance structure. All serious incidents are reported to NHS West Midlands and Commissioners and to other bodies in line with current reporting requirements (eg the Care Quality Commission (CQC). As Accountable Officer for the Trust I have overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of Governance.

Contract negotiations with commissioners are discussed and agreed with NHS West Midlands on an annual basis. Close working links with the whole health economy have been evident in a number of areas including stakeholder engagement with local authorities, all healthcare organisations and the voluntary and private sector as part of our Foundation Trust (FT) application and the development of clinical pathways with colleagues in primary care.

There have been extensive stakeholder meetings as part of 'Keeping it in the County' – the public consultation on proposals to change how and where some hospital services are provided. There have also been a number of engagement events for our 7500 FT members during the past year and through the development of the Cancer Centre build.

The Trust Board agrees the Annual Financial Plan, which is then reported to the NHS West Midlands. In addition to this the Trust sends regular financial monitoring returns throughout the year.

There is Primary Care Trust (PCT) involvement in the Trust's risk processes and an economy-wide Quality group that meets to ensure the highest quality standards are met across the health economy. The Trust has prepared a set of Quality Accounts for 2010/11.

The Quality Account is published annually. It discusses the care provided for patients, describing what is done well but also what needs to be improved.

The Quality Account acknowledges that there has been progress in stroke and Transient Ischaemic Attacks (TIA) services (now, over three quarters of high risk TIA patients are scanned and treated within 24 hours compared with less than a quarter at the start of the year), but states that there are more improvements needed for patients needing unplanned care.

The Trust has successfully tackled healthcare associated infections which has led to major reductions in MRSA bloodstream infections and Clostridium difficile, however, the Trust now needs to bring the same vigour to prevent pressure ulcers and avoidable falls.

The Trust identified an issue with high mortality rates through Hospital Standard Mortality Ratio (HSMR), which is a national measure of expected number of deaths against patients that actually died. In late 2009/10 the Trust discovered the rate had increased significantly. To understand the reason for the high mortality rate the Trust undertook a number of actions including:

- *A review of 50 case notes of patients that had died.*
- *An in depth analysis of the crude rate of deaths and HSMR deaths at each hospital site.*

The review told us that the problem was largely due to the way we coded the main diagnosis for patients, and not a reduced level of clinical care we were providing.

Improvements to the coding practices are being implemented as well as improvements to the way we record information in Patients notes. As a result the Trust is seeing a positive impact on the HMSR, however the HSMR is still high and the crude rate of deaths is not reducing in the same way. It is therefore wrong to assume that the coding of the primary diagnosis alone is the problem. The Trust has focussed, and is continuing to focus, on the improvements to the clinical care provided for our patients.

During 2010/11 there has been a major public consultation on changes to the way in which health services are provided in the County in order to tackle some significant clinical challenges, which if not tackled run the very real risk of deterioration in services. At the end of March 11 the Trust Board agreed that the Trust should develop a Full Business Case based on the consultation proposals to address the concerns that were raised during the consultation, and to make sure that the new services are safe and appropriate for people across Shropshire, Telford & Wrekin and mid Wales.

Also during 2010/11 the Trust has changed the way services are managed and run to give more power to frontline staff and to address one of our identified risks. Clinicians have been given more authority and responsibility to lead, plan and deliver patient services by appointing of clinical Centre Chiefs.

The Trust also took part in 'Leading Improvements in Patient Safety'. This national programme builds the knowledge and abilities of hospital teams to improve patient safety. At its heart is the principle that if we get it right first time, every time, then patients will need to spend less time in hospital, their recovery will be quicker, their experience will be improved and their quality of life will be better. The programme will be rolled out to over 100 staff in June 2011.

The Assurance Framework sets out the Trust's objectives and provides a clear template to identify any risks to achieving those objectives and a clear framework against which to measure progress.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in The Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust clearly documents its leadership arrangements in the Risk Management Strategy. These arrangements are further reinforced through job descriptions and objectives.

Leadership starts with the Chief Executive Officer having overall responsibility, with powers to delegate to other Executive Directors. The leadership is further embedded by having ownership at a local level, with operational managers having the responsibility for risk identification, assessment and control.

All new members of staff are required to attend a mandatory induction, an element of which covers the key elements of risk management. This is further supplemented by their local induction. The organisation provides annual mandatory and statutory training for different levels of staff depending on their responsibilities as detailed in the Risk Management Strategy - training for all staff is encouraged and supported by the Trust. There has also been a concentrated approach in relation to incident reporting and root cause analysis training across the organisation. All senior managers have also received training in risk and assurance processes. The Trust also has an active Institute of Occupational Safety and Health (IOSH) training programme.

Training is designed to demonstrate the processes and tools available to enable staff to identify and treat risk and to explain how risk is escalated through teams to the Trust Executive and Board. Risk management awareness training was provided throughout 20010/11 at all levels of the organisation, including the Board. Some elements of risk management training are mandatory and attendance at these sessions continues to be recorded with follow-up by service managers and heads of services on those staff who have not attended the appropriate training sessions. During 2010/11, the statutory training programme included a session on vulnerable adults. In addition the Trusts corporate induction programme includes awareness sessions on risk related areas including incident reporting, Health and Safety, Governance, Information Governance, Fire, Moving and Handling and Security.

There are many ways in which the Trust seeks to learn from good practice, for example:

- *Healthy incident reporting and alert mechanisms*
- *Pro-active risk assessment with a risk reporting policy finalised providing clear guidance to Divisions.*
- *Sharing experiences through the monthly Clinical Governance meetings.*
- *Co-ordinated response to Internal and External Audit recommendations, with Executive Director involvement through recommendation tracking*
- *A clear schedule of assurances which complements the Assurance Framework and provides assurance to the Board.*
- *Sharing results of health and safety audits.*
- *Senior Risk Group that considers all risk-related issues.*
- *Incident Review Group to review all serious incidents, and complaints*
- *Board review of the Serious Incident Policy and dissemination across the Trust*

The Trust is also undertaking a complete management restructure as capacity and capability have been identified as a risk to achieving objectives. This is aligned to the change to a clinically-led organisation. The Trust is also developing leadership and improvement academies to embed this approach.

4. The risk and control framework

The Risk Management Policy and Strategy clearly defines leadership, structure and the risk management process, to ensure a continuous assessment of risk throughout the organisation. The strategy is reviewed annually and held on the intranet. In the National Health Service Litigation Authority (NHSLA) General Standards the Trust currently holds level 2 and the Trust's Risk Management processes scored 80%. The Trust also currently holds Clinical Negligence Scheme for Trusts (CNST) Level 1 in maternity and again the risk management processes were favourably highlighted.

Risk registers are managed at Divisional and Directorate level with all potentially high level risks reported on the Trust's Corporate Risk Register. This is a continuous and ongoing process. The Corporate Risk Register is then considered through the Governance Structure, with very high risk assessments being reported to Trust Board at the next Board meeting following the identification of the risk. The Corporate Risk Register is also presented to the economy-wide Quality Group on a quarterly basis.

The Trust has a risk matrix which identifies risks across a number of criteria including patient experience, objectives risk, business interruption/HR issues/adverse publicity, and financial implications. The likelihood of each risk is also considered, giving an overall risk rating score, which is then mitigated according to the controls in place to minimise the risk. The Risk Group receive all Divisional risks rated above an acceptable level (according to the Risk Management Strategy) to review and ensure consistency before referring to the Board. These are then reviewed and updated by the relevant manager every month. The Audit Committee reviews outcome summaries of the Risk Group's meetings. Divisions report to the Audit Committee on their key risks and governance arrangements. The Risk Register has been refined and provides a working tool for the organisation and a source of assurance for the Trust Board. During the year, 18 risks were added to the corporate risk register and 19 risks were removed owing to them having been mitigated or resolved. The total number of risks (scoring 15 or above) on the register at the end of March 2011 was 49

As at 31 March 2011, there were 12 major risks (scoring 25 or 20) on the corporate risk register compared with 10 at the end of March 2010.

In line with best practice, a system of sub certification was introduced to inform the development of the Statement on Internal Control (SIC). Divisional General Managers were asked to certify that the Divisional Risk Register was complete and up-to-date, and that actions were taken if lapses were identified. Completed sub certifications were received from all Divisions and corporate areas.

The 12 major risks facing the organisation during 2010/11 were:

1. *We don't provide the right clinical care (resulting in poor clinical outcomes) - A plan of work has been drafted, which will form the basis of a patient safety strategy over the next three years. The Chief Executive hosted a Leading Improvement in Patient Safety (LIPS) taster event in March 2011 with a further event planned for June 2011 so that a significant number of clinical staff can be trained.*
2. *We don't respond to patient needs and views (resulting in poor patient outcome) - Interventions are being targeted at wards with higher than average numbers of complaints, pressure ulcers and falls with the aim of providing support and development to improve quality to patients*
3. *We don't deliver the Trust Improvement Programme (resulting in inability to invest in quality) - controlled through measures to manage pay and agency costs, introducing strengthened robust business planning processes and financial reviews.*
4. *We have poor information systems and processes (resulting in poor decision making and planning) - It has been recognised that there is a lack of resource, knowledge and infrastructure for IT and performance management. There were problems in relation to*

patient waiting times which arose from this risk. A project is being developed by Innovations Group.

5. *We don't have enough suitably trained or supervised staff delivering care (resulting in poor quality and patient experience) - The nurse recruitment strategy has been successful in reducing the numbers of nursing vacancies. However, it is proving more challenging to fill medical posts. The reconfiguration options currently being discussed will mitigate some of these risks if successful. There are particular risks in obstetrics linked to insufficient staffing to provide dedicated obstetric and anaesthetic cover to the labour ward and to sustain midwifery levels in line with the recommendations of 'Safer Childbirth'. Recruitment is in progress for these posts.*
6. *We don't have sufficient clinical leadership across the organisation (resulting in lack of improvement in safe patient care) - Senior Clinicians have been appointed to the role of Centre Chiefs and a development programme is in place to support the transition to clinical management.*
7. *The Health Economy fails to deliver the QIPP agenda (resulting in financial risk across the Health Economy and deteriorating patient experience) - Both PCTs have made very challenging assumptions as part of the Quality, Innovation, Productivity and Prevention (QIPP) agenda (Quality, Improvement, Productivity and Prevention). These schemes are intended to provide savings in the latter half of the year however have not delivered the promised savings.*
8. *The public consultation on 'keeping it in the county' fails to deliver on the agreed way forward (resulting in loss of local services to patients) - The public consultation on 'Keeping it in the County' took place between January and March 14th and accepted the reconfiguration plans.*
9. *We don't have enough capital to upgrade estate and equipment (resulting in substandard environment and poor patient experience) - requests for capital expenditure are risk assessed and must be included within a divisional risk register in order to be considered for capital investment.*
10. *We don't deliver an Income and Expenditure (I&E) surplus (resulting in inability to invest in quality) - scrutiny of plans through programme Board and Finance & Performance Committee. The Trust achieved a small surplus at year end; however, this was following £5M support from the SHA*
11. *We don't deliver national priorities (resulting in a loss of confidence in the service) - The Infection Control targets for 2010/11 were met. Although the Trust achieved most of the access targets last year, sustaining and improving performance remained a concern. The Trust worked with the Department of Health Intensive Support Team to identify areas for improvement.*
12. *We deliver national targets through poor management processes (resulting in unintended consequences e.g. development of outpatient pending lists) - The Intensive Support Team (IST) has visited the trust and made a number of recommendations to improve performance in respect of cancer waits and management of outpatients.*

There were some issues which caused particular problems in year including issues with cancer waiting times, 18 week waiting times and outpatients. These are reflected in the risks above, in particular risks 4, 11 and 12. There were gaps in control which where not immediately apparent. The Trust had placed an overreliance on management assurances. More robust controls have now been put into place and independent assurances sought alongside management assurance. There is an ongoing review into the circumstances of the gaps in the control process.

The Trust is also reviewing its performance reporting processes to ensure that there is clear evidence-based reporting to the Board.

The Trust had a financial plan to achieve a surplus of £2.6m but delivered a small surplus of £26k following support of £5m from the SHA. The main reasons for this variance are as follows:

- *£14m over performance in activity*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actions are in place to address these limited assurance items.

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

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

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

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

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

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

As an employer, with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

There is a Carbon Reduction Strategy and action plan approved by the Board which is monitored through the trust's Good Corporate Citizen Forum. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UK Climate Impact Programmes (UKCIP) 2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and the adaptation Reporting requirements are complied with.
The Trust works with the West Mercia Resilience Forum to study and exercise/test arrangements for localised fluvial and run off flooding. The Trust has been a part of a number of exercises in recent years looking at the specific issues within the West Mercia Area (including Shropshire.)

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

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

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

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

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the *Trust Board, Audit Committee, Finance & Performance Committee, Quality and Safety Committee, Management Executive, Clinical Governance Executive and, Risk Group.,* A plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

In relation to this strategy the Trust Board will:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- *Enhancing safety, effectiveness and patient experience; and*
- *Ensuring a clinically viable and financially sustainable organisation.*

Control weaknesses were identified regarding the findings of:

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

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

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

6. Summary

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

Signed: Date:

…… ……..
Chief Executive (on behalf of the Board)

[i] *Audit Committee Handbook 2006*