

Report to: Trust Board, 6th June 2013

Enclosure 3

Title	Annual Governance Statement
Sponsoring Executive Director	Director of Corporate Governance
Author(s)	Head of Assurance
Purpose	To approve the final Annual Governance Statement
Previously considered by	Audit Committee (April and May); Executive Directors (April)

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) guidance requires the AGS to be completed in line with the submission requirements for the annual accounts.

- The first draft of the statement was provided to the Trust External Auditors by **22 April 2013** and they have provided feedback
- The Trust's auditors are required to send signed original copies of the governance statement to the Department of Health (DH) by **10th June**.

Attachment 1 is final version of the AGS.

Related SATH Objectives	SATH Sub-Objectives
Related to all SATH objectives	C5: Meet regulatory requirements and healthcare standards

Risk and Assurance Issues	Describes the systems in place throughout the year to manage risk and gain assurance
Legal and Regulatory Issues	Required as part of submission of Annual Accounts

Action required by the Trust Board

To **APPROVE** the Annual Governance Statement.

Shrewsbury and Telford Hospital NHS Trust**Organisation Code: RXW****Governance Statement – 2012/13****1 Scope of Responsibility**

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 Shrewsbury and Telford Hospital NHS Trust (the Trust) 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 NHS Accountable Officer Memorandum. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

Accountability for risk management is set out in the Trust's Risk Management Strategy. The Executive Team is collectively responsible for maintaining the systems of internal control and directors are accountable to me for ensuring effective governance arrangements in their individual areas of responsibility. These areas of responsibility are detailed in the Scheme of Delegation.

2 The governance framework of the organisation

The Trust has developed and refined its governance structures over a period of time to deliver an integrated governance approach. This ensures decision-making is informed by a full range of corporate, financial, clinical and information governance, and ensures compliance with the five main principles of the Corporate Governance Code.

2.1 The Board Committee Structure

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 Trust commissioned Deloitte to undertake formal evaluations of the Board and Committees during 2012/13, consistent with the NHS Foundation Trust Code of Governance and the Corporate Governance Code. A new Committee structure, based on Deloitte's recommendations was implemented by early 2013. The Board can clearly identify a number of changes/improvements in Board and Committee effectiveness as a result.

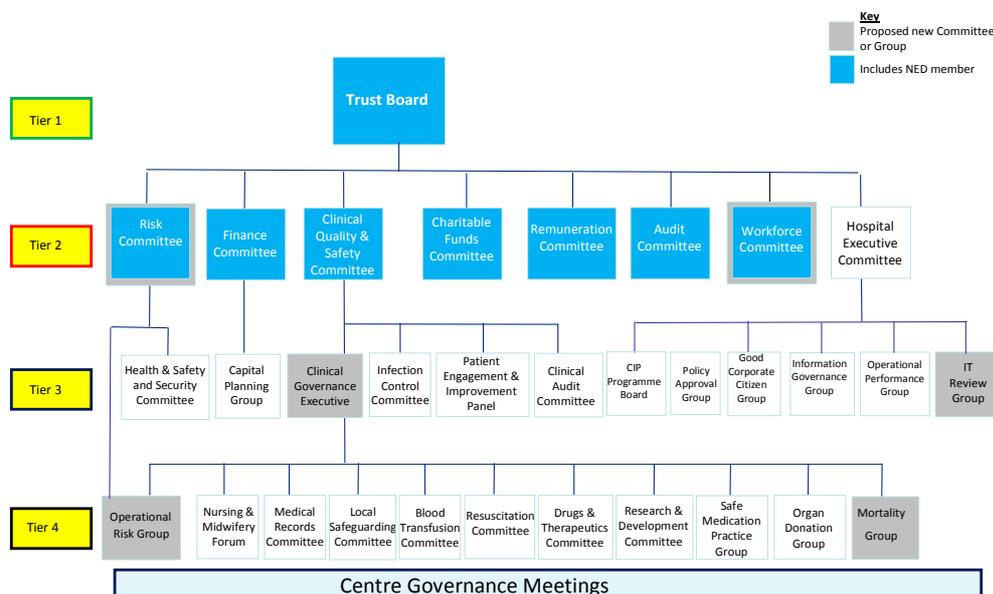
Membership of the Board of Directors is made up of the Trust Chair, six independent Non-Executive Directors, and five Executive Directors (including the Chief Executive). During the year there were significant changes in the members of the Board, including a new Chief Executive and Chief Operating Officer. The Trust Chair resigned due to ill health in September 2012 resulting in the appointment of an acting Chair. This coupled with a further Non Executive Director resignation resulted in vacancies at non-executive level throughout the year.

The Trust Board met publicly fourteen times during the year. In addition to the regular meetings there were meetings in April to approve the business case for the Future Configuration of Hospital Services; June to approve the Annual Accounts and Report; and September for the AGM. Board papers are published on the Trust website. The agenda included an opportunity for members of the public to ask questions related to the matters under discussion.

Trust Board Attendance	Year ending 31 st Mar 13
Name and Title	Attendance
John B Davies Chair - Resigned Sept 2012	7 out of 7
Martin Beardwell Non-Executive Director. Acting Chair from Oct 12	14 out of 14
Peter Vernon Non-Executive Director	10 out of 14
Dennis Jones Non-Executive Director	14 out of 14
Sue Assar Non-Executive Director – appointment ended May 12	2 out of 2
Barry Simms Non-Executive Director	11 out of 14
Simon Walford Non-Executive Director	13 out of 14
Robin Hooper Non-Executive Director – appointed Sept 12	4 out of 5
Adam Cairns CEO – resigned June 12	2 out of 5
Steve Peak Interim CEO – Appointed June-Sept 12	3 out of 3
Peter Herring CEO – Appointed Sept 12	7 out of 7
Neil Nisbet Finance Director	13 out of 14
Vicky Morris Director of Quality and Safety	12 out of 14
Ashley Fraser Medical Director	9 out of 14
Debbie Kadum Chief Operating Officer – appointed Dec 12	3 out of 3

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 Board has five standing Committees and three executive committees accountable to the Trust Board through the Accountable Officer.



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 responsible for oversight and scrutiny of the Trust’s systems of internal control and risk management. It is the senior Board committee taking a wide responsibility for scrutinising the risks and controls which affect all aspects of the organisation’s business. The Audit Committee met 6 times during 2012/13. It was chaired by a Non-Executive Director, who is a qualified accountant, and who submits a regular report to the Trust Board. Attendance through the year was in line with the requirements of the Terms of Reference.

Three other Committees are chaired by a Non-Executive Director, (Finance, Clinical Quality and Safety, and Charitable Funds). 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 which replaced the Risk Management Executive in November 2013. The Risk Committee has NED membership but 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. The Risk Committee met in November 2012 and February 2013. Prior to this, the Risk Management Executive met monthly from April to September 2012.

All of the Committee Chairs present a summary of each meeting to the Board highlighting areas of concern. For example the Audit Committee raised issues around the delivery and governance of systems in respect of medical records, and patient access within the transformation programme and also capital funding for replacement clinical equipment; Finance Committee highlighted concerns relating to capturing lower value initiatives in the CIP schemes.

In support of our wider organisational development and specifically our NHS Foundation Trust application the Trust has implemented a Board Development programme in line with the key components of High Performing Boards and Monitor's requirements. During 2011/12 we focused on Board Capacity and Capability with a review led by Chantrey Vellacott looking at (a) Board Papers (b) Board Capacity and Capability Assessment; and (c) Board Development Workshop and Action Plan. This work continued in 2012/13, aligned with the Board Governance Assurance Framework (BGAF) published by the Department of Health and rolled out nationally from January 2012; a mandatory requirement for aspirant FTs to undertake as part of their FT application.

A comprehensive rolling development programme continues, with protected time and mandated attendance, which has enabled the Trust to construct a Board Governance Memorandum (BGM). This is a mandatory process where Boards self-assess their current capacity and capability, supported by appropriate evidence. It provides assurance of effective Board governance against the following five indicators:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);
2. Board evaluation, development and learning (e.g. The Board has a development programme in place);
3. Board insight and foresight (e.g. Performance Reporting);
4. Board engagement and involvement (e.g. Communicating priorities and expectations);
5. Board impact case studies (e.g. a case study that describes and demonstrates how the Board has responded effectively to a recent financial/performance/quality issue).

The Board carried out a review of Board Effectiveness using a questionnaire to all Board members covering the key roles of the Board. This highlighted a number of areas for development including Board composition and developing a Board performance culture. A further independent review is planned later in 2013.

The resulting action plans are overseen and progressed through Audit Committee.

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 UK Corporate Governance Code and does not have any significant departures from the Code.

2.2 Arrangements in place for the discharge of statutory functions

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. 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 continued to work with its partners to understand and minimise the risks associated with flooding due to climate change. Risk assessments have been undertaken - on behalf of the whole Local Resilience Forum by the Environment Agency. The Trust has also held a multi-agency tabletop exercise (2012/13) looking at various scenario's, and potential risks and responses prior to, and including, the Olympic Games as well as two live multi-agency exercises on both Hospital sites.

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

Following a change in the Equality Act in 2010, all NHS organisations have to demonstrate that they are complying with the new public duty to ensure that decision making does not discriminate against the 9 'protected' groups: age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The Trust has developed outcomes against the Equality Delivery System (EDS) following a consultative process which engaged with staff, commissioner, and community partners. An action plan is being monitored through Board which details the outcomes and the progress made with delivery. The Local Health Economy (LHE) EDS Steering Committee has determined that the Trust has made good progress with its actions.

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. 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 with.

The national priorities for the NHS were set out in the NHS Operating Framework 2012/13. Examples of progress against these priorities are:

Preventing people from dying prematurely

- Implemented a specialist cardiology rota which provides 24/7 cover with on site weekend consultant ward rounds.
- Made considerable progress to ensuring that our patients are seen by the most appropriate person including earlier senior clinical decision making into acute medical admissions.

Enhancing quality of life for people with long term conditions

- Worked with commissioners to review and redesign clinical pathways including headache and epilepsy pathways
- Introduced an integrated Frail Complex Service in partnership with the community services and social services teams which provides early assessment and interventions to help either to prevent admissions or to reduce the time spent in hospital.

Ensuring that people have a positive experience of care

- Revised our Admission and Assessment Tool to ensure that our patients are involved in decisions about their care and enables patients to be involved in planning their care including nutrition, mobility and communication

Helping people to recover from episodes of ill health following injury

- Physiotherapists working within the inpatient setting deliver a rehabilitation service to all patients who have injured themselves, for example Head Injured patients, Trauma and Orthopaedic patients and link with colleagues working in the community to ensure continuity of care wherever possible. The Outpatient Physiotherapy teams serve the population of patients who are referred by GP's and consultants following Musculoskeletal injuries providing services within the Fracture Clinic and A&E settings as well as the main physiotherapy department

Treating and caring for people in a safe environment and protecting them from avoidable harm

- Our Pharmacy Team have redesigned and launched revised medicine charts to reduce the potential for errors and we have developed a learning package to increase education and knowledge
- Through the national Leading Improvement in Patient Safety (LIPS) Programme we have successfully introduced a structured method for communicating critical information.

3 Risk Assessment

The key aim of the Trust's risk management approach is to ensure that all risks to the achievement of the Trust's objectives (whether clinical or non-clinical) are identified, evaluated, monitored, and managed appropriately. The system of risk management is described in the Trust's Risk Management Strategy which is reviewed annually by the Board and is accessible to all staff via the Trust Intranet. The Risk Management Strategy includes a clear management process. If a risk cannot be resolved at a local level, the risk can be referred through the operational management structure to the Risk Committee or ultimately to the Trust Board. Risks are reviewed to ensure that any interdependencies are understood.

Risk assessment is a key feature of all normal management processes. All areas of the Trust have an ongoing programme of risk assessments. Risks are evaluated using the Trust risk matrix which is a 5 x 5 scoring system based the Australia/New Zealand risk management standard. This risk scoring system 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. Each risk has an identified owner who is responsible for monitoring and reporting on the risk to the appropriate committee(s). Each action has a named action owner responsible for implementing the changes to reduce the risk to an acceptable level in a specified timeframe.

At the highest level, the Board Assurance Framework (BAF) enables the focused management of the principal risks to achievement of the organisations objectives. The BAF is developed annually by the Board who review known and potential risks, the existing control measures and where assurances are gained. It identifies any gaps in control or assurance. 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 was formally presented to the Board three times during the year with updates to four meetings of the Audit Committee in year.

Underpinning the BAF, the Trust has a web based system which holds a structured set of risk registers for each area, including strategic and Trust-wide risks. This allows both risk and action owners to update the status of assigned risks and actions and drives accountability. It enables reporting at corporate, operational, centre or departmental level. All risks are mapped to the key organisation objectives.

The Operational Risk Group regularly reviews all the risk registers and receives all risks rated above an acceptable level to review and ensure consistency before referring to the Risk Committee. (in line with process described in the Risk Management Strategy) Risks are reviewed and actions updated by the relevant manager every month.

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 BAF. The format of the BAF was reviewed in 2012/13 and was organised into six key risks, some of which were new, as follows:

If we do not achieve safe and efficient patient flow then we will fail the national quality and performance standards

This risk carried over from the previous year, although the wording was refined. This is the most significant risk the Trust faces. There are a number of interrelated components including failure to deliver national targets linked to a mismatch in capacity and demand. During the year, the Trust did not meet the A&E performance target; the RTT target or the cancelled operations target. This is declared as a significant issue. There is significant work ongoing with the local health economy to deliver sustainable solutions to this issue. There are a number of associated action plans (Patient Flow sustainable action plan; Booking and Scheduling action plan) and progress is actively monitored by the Board.

If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience

This risk was carried over from the previous year, with revised wording.

The Trust saw a decrease overall in the number of falls during 2012/13 and reduced the number of falls resulting in serious harm by a third. However there was an increase in the number of falls which had the injury identified as contributing to the patient's death. This is declared as a significant issue. A detailed update and the comprehensive action plan was presented to the Trust Board in February 2013 and good progress has been made.

The Trust has continued to improve infection prevention and control, with reductions in both MRSA bacteraemia and C difficile during 2012/13.

Mortality data is an important indicator and this has shown improvements throughout the year. This information was reported regularly to the Board throughout the year. The performance report currently includes information on both the Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). The Trust remains within the expected range for all categories of the SHMI and HSMR based on rolling 12 month averages.

Progress against this objective is closely monitored by the Clinical Quality and Safety Committee and reported to the Trust Board each month as the first part of the Integrated Performance Report.

If we do not have a clear clinical service vision then we may not deliver the best services to patients

This was a new risk identified in year. Over the year there has been a structured programme of work to arrive at service delivery models led by a Clinical Service Strategy Group which reports to the Board. The Board considered revised service delivery models in November 2012 and February 2013. The intention is to present a Clinical Service Strategy for public consultation in autumn.

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

This is a new risk. In recent years the Trust has not scored well on the national staff surveys. A programme of leadership development has been established including the Management Development Programme and the Leadership / Development Academy. Staff induction is linked to the values of the Trust. There is a Staff Wellbeing Programme in place. During the year, the

Workforce Committee was established and part of its remit is to monitor work to improve staff morale. Progress is reported to Board via Committee updates.

If Board members are not appointed in a timely fashion then this may impact on the governance of the Trust.

This was a new risk which was linked to the high turnover a Board level. During the year, the Trust appointed a new Chief Executive (from September 2012), Chief Operating Officer (from December 2012) and Medical Director (takes up post April 2013). The Trust Chairman had to stand down due to ill health in September 2012, and there is an acting Chairman in place, as well as Non-executive Director vacancies. These vacancies are being progressed by the Trust and the NTDA. Progress with mitigating this risk is provided in the monthly update to the Board by the Trust Chair.

If we do not achieve a financial risk rating of 3 then we will not be authorised as a FT

This risk carried forward from 2011/12 and had a number of components including failure to achieve Income and Expenditure (I&E) surplus, liquidity and CIP plans. Scrutiny of plans took place through the Finance Committee.

The Trust is forecasting a Financial Risk rating of 2 for the first three quarters of 2013/14. This improves in Quarter 4 on the assumption that our liquidity ratio improves due to a liquidity loan being granted in Month 12 (2014).

The Trust is planning a £1.2m surplus within the financial year 2013/14 with a strategy to use all the in year surplus to improve the cash held by the Trust. However, this alone will not deliver the improvement to the liquidity metric required to meet Foundation Trust requirements, during that year without a provision of a liquidity loan the Trust will continue to deliver a Liquidity Rating of 2. Discussions are taking place with the NTDA regarding a liquidity adjustment.

Within the Trust's 5 year plans illustrate we plan to deliver surpluses of £2.3m in 2014/15 and £3m in years 2015/16- 2016/17 and our strategy remains to use all these surpluses to improve cash held by the Trust. If we deliver this, our liquidity metric improves to 3 within 2014/15 and level 4 from 2015/16 onwards.

There are currently discussions taking place with the NTDA and the current financial plan for 2013/14 highlights this liquidity issue, ensuring that through this planning process we can agree a way to accelerate the improvement of currently underlying liquidity weakness through the receipt of an appropriate working capital loan.

The Finance Committee was established to provide additional assurance to the Board on finance and meets monthly to provide objective scrutiny of the Trust's financial plans and major investment decisions. The purpose of the Committee is to provide the Board with an objective review of the financial position of the Trust and oversee the delivery of financial performance. It reports to the Board via the committee reports. Detailed financial updates forms part of the monthly Integrated Performance Report.

There were no data lapses in the year which were classified as level 2 incidents (these are the incidents which are formally reported to the Information Commissioner)

4 The Risk and Control Framework

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. Key elements of the framework are:

A Risk Management Strategy updated and approved each year by the Trust Board which clearly defines the risk management structures, accountabilities, and responsibilities throughout the Trust and reflects the Trust's management and governance structure.

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

Rigorous budgetary control processes in place and 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 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.

All serious incidents are reported to Commissioners and to other bodies in line with current reporting requirements (eg the Care Quality Commission (CQC)). Root cause analysis is undertaken with monitored action plans.

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 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 Training Policy - training for all staff is encouraged and supported by the Trust. 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 2012/13 at all levels of the organisation, including the Board. The Trust also has an active Institution of Occupational Safety and Health (IOSH) training programme.

The Trust registered with the CQC without conditions on 1 April 2010. During the year the Trust was subject to two separate assessments by the CQC and the Trust was judged compliant with all of the core outcomes reviewed.

During 2012/13, the Trust implemented 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 are aggregated up to Centre and Trust level. The results are shared with Centres on a quarterly basis to allow discussion at Governance meetings and can be drilled down to individual ward/department level by outcome/standard.

The Director of Quality and Safety/Chief Nurse has delegated responsibility for Quality. The Quality Improvement Strategy was approved by the Trust Board in March 2012 and provides a basis for a continuous improvement drive over the next five years.

The Quality Governance Framework assesses the combination of structures and processes in place, both at and below board level, which enable a Trust board to assure the quality of care it provides. The Trust has undertaken a self-assessment against the ten core quality questions and ensured that the evidence base against each of the core questions is robust based on current systems and processes. 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 score from the Quality Governance Framework will improve as centres establish robust governance arrangements to support quality care and delivery with clear evidence to back up these arrangements at each level.

An Historic Due Diligence review was undertaken by Grant Thornton in 2012 and progress is reviewed through Finance Committee.

In 2012, the new Integrated Performance Report was introduced as a standing Board agenda item. The report summarises the Trust's performance against all the key quality, finance, compliance, and workforce targets, and indicators for 2012-12 and considers all elements of the Provider Management Regime. It therefore provides an assessment of the quality of care provided to patients.

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 Payroll, Human Resources, and Pharmacy). These sessions raise awareness and increase confidence to report suspicions of fraud to the LCFS whilst emphasising the zero tolerance approach of the Trust to fraud. The LCFS also facilitated a Bribery Act risk assessment workshop with senior managers.

In the National Health Service Litigation Authority (NHSLA) General Standards the Trust currently holds level 1. The Trust also currently holds Clinical Negligence Scheme for Trusts (CNST) Level 2 in maternity.

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 noted "the significant amount of work undertaken by the Trust during 2012/13 to develop the format of the BAF and the overall risk management process, and are confident this provides an adequately designed framework to facilitate robust risk management and assurance arrangements going forward"

During the year, Internal Audit identified and reported on control weaknesses which need to be addressed. Whilst positive opinions were issued in respect of the majority of audits for the period, limited opinions were provided in four instances. Formal actions plans have been agreed to address these control weaknesses. These are being monitored through recommendation tracking and reported, by exception, to the Audit Committee.

Whilst positive opinions were issued in respect of the majority of audits for the period, limited opinions were provided in four instances:

- **Statutory/Mandatory Training** There was one Priority 1 recommendation with respect to ensuring the Board has visibility of statutory and mandatory training compliance levels. Actions have been taken to address this and compliance levels are now reported by Centre as part of Centre Performance Reports which are summarised for each meeting of the Trust Board.
- **Savings Plans.** There was one Priority 1 recommendation with respect to the completion of Quality Impact Assessments (QIAs) for all Cost Improvement Plan (CIP) schemes. This is being proactively addressed.
- **Creditors and Payments.** There was one Priority 1 recommendation with respect to limited segregation of duties in the purchase to pay process. Mitigating controls are being implemented to address this weakness.
- **Cash and Treasury Management.** There were two medium and one low priority recommendations. A follow up review was undertaken towards the end of 2012/13 which resulted in **substantial** assurance.

In addition, Internal Audit carried out five performance reviews during 2012/13 two of which included Priority 1 recommendations as follows:

- **Mortality Indicators:** Three Priority 1 recommendations with respect to formalising the business of the Mortality Group, ensuring Consultant review of case notes where mortality has occurred in hospital under the care of a locum consultant and increasing focus on actions to address high incidence, high mortality diagnoses.
- **Quality Governance Framework:** Two Priority 1 recommendations with respect to providing

members of the Trust Board responsible for reviewing the framework with access to the centralized evidence file so that they may scrutinize it and increasing the senior management focus on assurance through delegation of collection of evidence.

Annual Quality Account

The Quality Account is developed by senior clinical managers and clinicians within the Trust in conjunction with stakeholders and partnership organisations. The Director of Quality and Safety has overall responsibility to lead and advise on all matters relating to the preparation of the Quality Account.

The 2012/13 Quality Account is currently in preparation and the processes and some of the indicators will be reviewed by External Audit to provide assurance on the accuracy of the account. The Trust's second Quality Account was audited by the Trust's external auditors by June 2013 in order to provide assurance that the information contained within the account was accurate. The Auditors tested three indicators in the Quality Account and raised two medium grade recommendations relating to Venous Thromboembolism (VTE) risk assessment and Hand Hygiene compliance:

VTE – testing did not reveal any issues with the accuracy of the information captured and reporting. However, the instances where a VTE risk assessment had not taken place were in the Day Surgery Unit where a paper based system is in use, rather than the hand held VitalPAC system. Since then, the Thrombosis Committee has redesigned the paper audit form in use with input from senior clinicians. This has been successfully implemented and the Day Surgery Unit is now reporting close to 100% compliance.

Hand hygiene – The Trust wards undertake monthly audits of hand hygiene which are submitted to the Clinical Audit Department where they are collated and published within the monthly performance report. However, a number of wards were failing to submit their audits on a monthly basis. This may indicate that the audits have not been undertaken and the indicator therefore not accurately recorded. As a result of this recommendation, the method of reporting the results has changed so that any ward which fails to submit results will now be included in the reports, with a score of 0%. If wards do not submit results then the overall score will be significantly reduced. It is anticipated that this will improve compliance.

The system of internal control has been in place in the Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

5 Review of the effectiveness of risk management and internal control

5.1 Progress on Significant Issues from 2011/2012

In the last Annual Governance Statement, the Trust disclosed three significant issues.

Never events

The Trust had a cluster of similar 'never events' reported in ophthalmology when the wrong strength of lens was inserted during cataract surgery. Amended procedures and further training have been put in place to prevent a recurrence. At the request of the Trust, experts from the Royal College of Ophthalmologists reviewed the processes in place and concluded that "the measures put in place at the Trust following the wrong lens incidents were robust and would strongly mitigate against future wrong lens implantation events". The report also said that 'as no patient harm arose in the wrong (lens) incidents that required further treatment, bar in one case, that the recent patient safety incidents did not meet, in our opinion, the definition of a 'Never Event' as described by the Department of Health'.

Outpatient management

During 2010/11 issues relating to the management of outpatients were highlighted in the Statement of Internal Control. An external review took place and the resulting action plan has been progressed through the year. The review highlighted a significant number of patients waiting for follow up appointments. Due to the emphasis on these cases the waiting times for new patients was consistently outside the national targets during 2011/12. Enhanced performance management arrangements were regularly reported to the Board and largely brought performance back into line with the targets by year end.

Finance

The Trust had a financial plan to achieve a balanced position at year end 2011/12 but delivered a small surplus following transitional support of £6.5m from the SHA which was non-repayable. For the year 2012/13 the Trust's draft account deliver an Adjusted Financial Performance Retained Surplus for the year of £0.081m, having received £4.9m non recurring support from the SHA. In delivering the in year position the Trust has generated £13m (4%) of efficiencies. The Financial Risk Rating at the end of the year will remain at level 2 and the cumulative deficit within the Trust accounts is £22m

5.2 Significant Issues for 2012/13

There are three significant issues to report:

5.2.1 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. Factors contributing to affect performance are:

- an increase in the number of ED attendances
- an 8% increase in the number of non-elective admissions
- a significant cohort of patients who are fit to transfer but remain in a hospital bed
- a lack of available capacity (beds to meet expected demand)

- i The A&E 4hour target will end the year with an overall performance of between 91-92% compared to the target of 95%. The most significant cohort of breaches has been GP admissions diverted to A&E due to lack of bed availability within the medical assessment units. The challenges to both reduce the demand on SaTH and to improve patient flow throughout the health economy are recognised by all relevant organisations within the health economy and there are a number of workstreams in place, with a set of agreed actions, to take this forward.
- ii With the exception of Ophthalmology and Trauma and Orthopaedics (T&O) which have had significant challenges all year, most specialties had been delivering the admitted RTT target of 90% within 18 weeks during the first 9 months of the year. However, the heightened level of patient flow issues associated with emergency activity during the winter period has resulted in a significant reduction in elective capacity and activity during the final 3 months of the year. The consequence of this has been deterioration in performance across all specialties. Weekly meetings are held with our commissioners and current plans are, with the exception of T&O, to achieve and sustain the required RTT level of performance by the beginning of Quarter 2 2013/14. Non-admitted performance has also been below the required standard (95%) since the autumn, predominantly due to a number of backlog issues within the sub-specialties of general medicine. Current plans indicate that this position will be recovered during Quarter 1 2013/14.
- iii The Trust remains a national outlier in relation to the cancelled operations target. A Remedial Action Plan (RAP) has been agreed with our commissioners and the number of breaches has reduced from 45 in Quarter 2 to 18 in Quarter 3. However, due to the capacity issues highlighted in (1) and (2) above, it is looking unlikely that we will achieve the required level of performance in Quarter 4.

5.2.2 Number of serious falls

The Trust saw a decrease overall in the number of falls during 2012/13 and reduced the number of falls resulting in serious harm by a third. However there was an increase in the number of falls which had the injury identified as contributing to the patient's death. In 2012/13 this increased to 4 patients compared with one in the previous year. 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. The Quality and Safety Committee are monitoring the impact of those actions.

5.2.3 Liquidity

At the end of the 2012/13 financial year the Trust recorded a liquidity rating 2. This is made up of the Trust having £10.1m Net Liquid Assets and operating expenditure of £289.3m. this gives the Trust a 'Liquidity days' metric of 13 days and therefore a Liquidity rating of 2.

The Trust is planning a £1.2m surplus within the financial year 2013/14 with a strategy to use all the in year surplus to improve the cash held by the Trust. However without a provision of a liquidity loan the Trust will continue to deliver a Liquidity Rating of 2, as the Net Liquid Assets are £11m and the forecast Operating Expenditure is £286m, giving a Liquidity Days Metric of 14 days, a Liquidity Rating remaining at 2.

As a result, discussions with the NTDA regarding the Trust's historic liquidity balance sheet position are ongoing to enable the Trust to progress its FT application.

6 Conclusion

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.

Accountable Officer: Peter Herring

Organisation: The Shrewsbury and Telford Hospital NHS Trust

Signature

Date