NHS
The Shrewsbury and Telford Hospital
NHS Trust

Paper 4

Reporting to:	**Trust Board, 30 May 2017**
Title	Annual Governance Statement
Sponsoring Director	Chief Executive
Author(s)	Head of Assurance
Previously considered by	Exec Directors, Audit Committee
Executive Summary	The Annual Governance Statement (AGS) forms part of the annual accounts. NHS Improvement (NHSI) produce guidance on the content, and require that the AGS is completed in line with the submission requirements for the annual accounts. The final version will be submitted with the Annual Accounts on 1st June. Significant issues for 2016/17 are considered to be: • Cash flow • Fragility of services A final draft 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 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. ☐ 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 – 2016/17

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 2016/17, the organisation routinely reported on financial, operational, and strategic matters to NHS Improvement (NHSI). During 2016/17 meetings were held with senior officers at NHSI 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 NHSI. 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 regular 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 eight times in public during the year including the AGM; and Board papers are published on the Trust website.

Trust Board Attendance	**Year ending 31st Mar 17**
Name and Title	**Attendance**
Professor Peter Latchford – Chair	8/8
Harmesh Darbhanga – Non-Executive Director	7/8
Brian Newman – Non-Executive Director	7/8
Clive Deadman – Non Executive Director	5/8
Paul Cronin – Non-Executive Director – from Sept 16	3/3
David Lee – Non-Executive Director – from Dec 16	2/2
Chris Weiner – Non-Executive Director – from Dec 16	2/2
Robin Hooper – Non-Executive Director – until Sept 16	5/5
Donna Leeding – Non-Executive Director – until April 16	0/1
Simon Walford – Non-Executive Director – until Sept 16	5/5
Simon Wright – CEO	8/8
Neil Nisbet – Finance Director	8/8
Debbie Kadum – Chief Operating Officer	7/8
Edwin Borman – Medical Director	8/8
Sarah Bloomfield – Director of Nursing and Quality (until Jan 2017)	5/6

Helen Jenkinson – Acting Director of Nursing and Quality (Feb 17)	0/1
Colin Ovington – Interim Director of Nursing and Quality (Mar 17	1/1

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

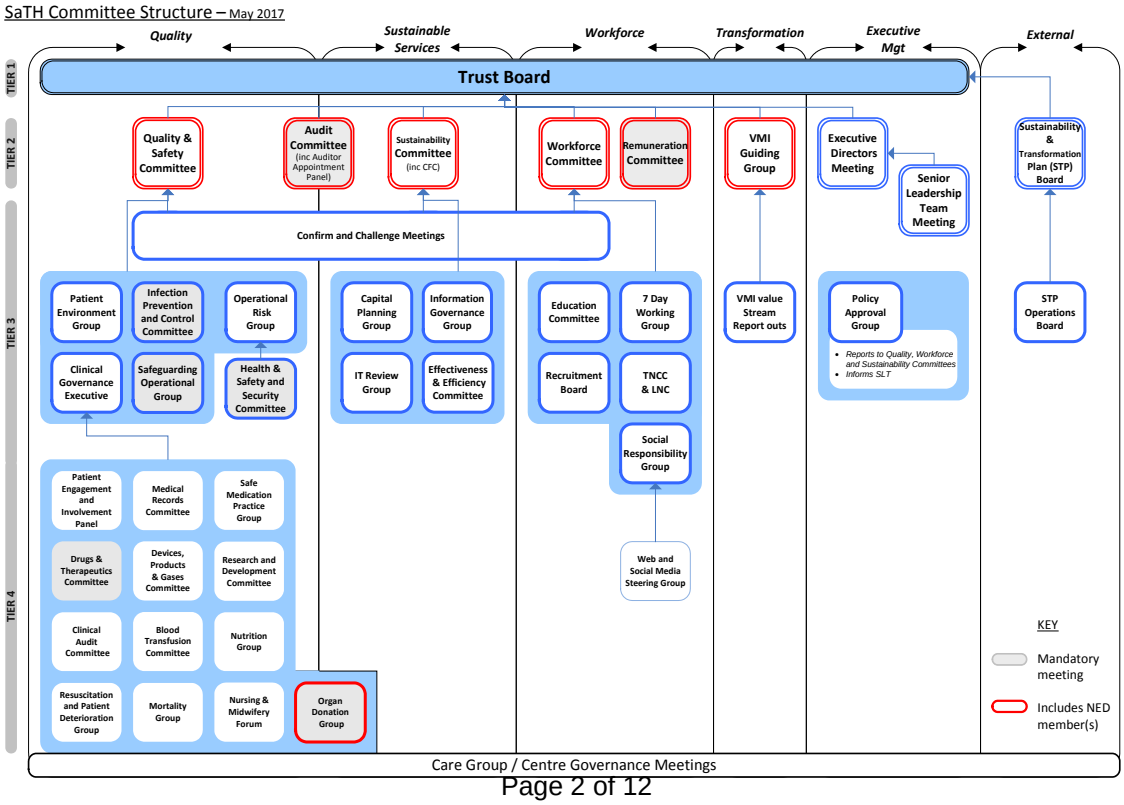
2.2 Board Performance

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 Director of Nursing and Quality left the Trust in January 2017. In the period until the end of the financial year, the Deputy Director of Nursing and Quality was the acting Director during February, and an interim Director was in post from March. One of the non-executives retired in September 2016, having served for two full terms and a further two non-executives stepped down during the year. Replacements took up position in December 2016. In addition, a non-executive director designate was appointed in December 2016 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 five Tier 2 committees accountable to the Trust Board; the VMI Guiding Group and the Executive Directors meeting. All the Tier 2 committees have at least one Non-executive Director member. 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 other three Committees are chaired by a Non-Executive Director, (Sustainability, Quality and Safety, and Workforce). Minutes of these meetings demonstrate that Non-Executive Directors oversee progress and provide challenge to the Directors. The Chairs of Sustainability Committee and Quality and Safety Committee are also members of the Audit Committee. The Virginia Mason Institute (VMI) Guiding Group is executive in nature, but has a Non-Executive member.

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 2016/17. 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 during the year included (meeting date in brackets):

- **Counter Fraud Annual Report 2015/16 (14th April 2016)**
  The Committee was pleased to note that the Trust continued to attain full compliance with NHS Protect Standards (Strategic Governance, Inform and Involve, Prevent & Deter, Hold to Account) and was awarded Green – Standard Met. It was noted that many other Trusts do not achieve the standards. It was noted that there was one red area in the Prevent & Deter standard relating to weaknesses in the Estates Department in procurement processes, which have been addressed through workshops to ensure staff are clear on correct processes.

- **Annual Accounts 15/16 (2nd June 2016)**
  There was extensive discussion around the difference in opinion between the Trust and External Audit on the treatment of depreciation. External Audit explained that they considered that as depreciation was an estimation it should be applied in line with IAS08, ie prospectively. They therefore classified this as an uncorrected error and wished to bring it to the attention of Audit Committee. They confirmed it was not a material difference and would not affect the unqualified opinion on the accounts if it was not corrected. The Finance Director explained that, whilst accepting depreciation was an estimation, the Trust has treated depreciation in accordance with IAS 16 – Property, Plant and Equipment whereby equipment is depreciated by adopting a "straight line basis" and using predetermined asset lives as established by the NHSE. The exercise of reassessing asset lives also confirmed that the level of internally generated resources available to the Trust would, for the foreseeable future, be insufficient to support the replacement of equipment more quickly and as such the actual usage of asset lives provided a more accurate description of the "pattern of consumption" of these assets than used previously. IAS 16 requires organisations to review on an annual basis the asset lives. Given the findings of the review it was decided to change the asset lives to one based upon actual usage. This ensures that the carrying amount on the books is correctly stated. This approach was notified to the external auditors, and the methodology was audited in January as part of the pre – end of year review.

  It was noted that the positions could not be reconciled and was an argument over the technical treatment of a change. It was further noted that previous differences in treatments had occurred between the Trust and previous External Auditors (KPMG) so this was not a novel situation. It was further noted that the TDA had been contacted and they confirmed over recent years a number of Trusts have found themselves in this position. Their Financial team have (as ours have) declared the one off benefit in year, as we have, and had a similar debate with their auditors which also saw them submit their annual accounts statement based upon their interpretation of the position and not correcting the position as suggested by External Audit.

In light of this the Committee agreed that it would reflect the difference in the management representation Letter and recommend that the Board adopt the accounts as stated

- **Value For Money (2nd June 2016)**
  The Committee considered the qualified 'except for' opinion on Value for Money (VFM) to be a substantive issue. It was noted that against other external metrics the Trust is performing in the upper quartile and the Opinion seemed perverse and unfair in this context. The Committee recognised the framework that External Audit had to operate within but felt this was a framework constructed at a time when the NHS was in surplus and did not make sense in a national position where 80% of Trusts were in deficit and therefore breaking their statutory duty, which was a key, albeit unfair, condition applied to arriving at the VFM opinion, which did not reflect the efforts and hard work of NHS workforce both nationally and locally

  The Committee discussed the many contributory factors to the Trust's financial position included a gap between contracted and actual activity levels, with associated impact on staffing levels and costs, along with an equally serious impact on achieving targets and pursuing clinical excellence and expressed its disappointment that External Audit had been unable to reflect this in their findings.

  It was noted that the independent evidence for the Trust's very good VFM position included the Award for the 4th year from CHKS as being in the top 40 of the most efficient and effective hospital. Furthermore the Trust's Reference costs were low (95 compared to an NHS average of 100) and that the Trust delivered and exceeded all the targets and measures that it committed to at the beginning of the year. So the technical evaluation by External Audit based on rigid criteria was a gross misinterpretation and reflected an inappropriate and unjust framework.

  The Audit Committee asked for this view to be submitted nationally by the External Auditors and resolved to have their position recorded in the strongest terms in both the minutes of the Audit Committee and the Board meeting that followed to receive and adopt the financial statements.

- **Board Assurance Framework (15th Sept 2016)**
  The Committee reviewed the Board Assurance Framework and were pleased to note the new arrangements whereby the appropriate tier 2 Committee (Workforce, Quality and Safety, Sustainability) reviewed the BAF risks at each meeting

- **Annual Audit Letter (15th Sept 2016)**
  The Committee discussed External Audit's use of the word "unlawful" within their Annual Audit Letter. It was confirmed that this referred to the delivery of a deficit control total, which, as in previous years, would be reported to the Secretary of State. It was noted that the Trust's previous External Auditors described the position as a "breach of statutory regulations" which more accurately reflected that the breach had been agreed with the TDA and that there were plans in place to work to a sustainable position and 85% of Trusts were in this position.

- **In year changes to the Internal Audit Plan (15th Sept 2016)**
  The Committee approved a change to the Internal Audit Plan to ensure the budget was not compromised. It was agreed that the planned audit of the Outline Business Case and Outpatients as they would be scrutinised independently through external review of the OBC. Prior to submission and on Outpatients work that the Transforming Care Programme will be picking up as Value Stream 4.

  Preliminary work was carried out on the Budgetary Control audit; however, it was suggested that there be an extension to scope. The Committee discussed this approach and agreed with the auditors that although the controls in finance are good, the operational practice in the Care Groups and wider Trust result in a failure of the controls. The auditors proposed reviewing practice outside of finance to better understand the position. The Audit Committee supported the extension of scope to this audit.

2.4 Corporate Governance

The Well-Led Framework combines the Board Governance Assurance Framework and the Quality Governance Framework and includes 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. Performance of the formal sub-committees of the Board are periodically reviewed to ensure the structure is fit-for-purpose; with clear focus on key strategic imperatives, assurance of systems, the reduction of duplication and delivery against robust plans. The Chair observed the Tier 2 Committees of Quality, Sustainability and Workforce, supported by the Director of Corporate Governance during January and February 2017. Specific issues were discussed with the relevant Committee Chair and Lead Director by the Trust Chair and CEO respectively and a number of general recommendations made which apply to all Committees.

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 2016/17. 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 the removal of a wrong tooth and a number of actions have been implemented, including Human Factors training. These cases support the work already on going within the Trust to implement the National Standards for Safety of Invasive Procedures (NATSSIPS)

The 2016/17 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.

Following a serious case in maternity in 2009 and a number of external reviews, the Secretary of State for Health commissioned an independent review of the investigation of maternity serious incidents in February 2017.

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 2016 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 partially compliant. This is a lower level of compliance from the 2015-2016 assessment due to a change in the scoring system. Key areas that required attention include training and preparedness within RSH ED and Trust wide Business Continuity. Plans are in place to address these and we are confident that we will be able to improve the compliance level. The September Board approved the Trust's assessment of its current status of compliance against the core standards, along with an implementation plan and associated monitoring.

The Trust continues to work with the 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.

As the basis for our five-year Sustainable Development Management Plan (SDMP), the Trust self-assesses performance annually using the NHS Sustainable Development Unit 'Good Corporate Citizen' (GCC) tool. Self–assessment carried out in December 2016 against the nine domains again shows an increase in the Trust's GCC score from 62% (2015) to 65%, continuing to demonstrate how the Trust is leading the way in its commitment towards sustainability. This past year's highlights include successfully improving the environment for our local population and reducing consumption of finite resources. Factoring in the increased footprint of our estate, carbon emissions have reduced by 5.3% compared with the 2007/08 baseline. Although the Trust produced around 36,000 tonnes of carbon over the last financial year as a result of procurement activities, relative to total spend this equates to an overall reduction of 13% since our SDMP was launched in 2014. We continually seek to reduce the emissions locally by assessing our top 20 suppliers via an annual sustainability questionnaire to evaluate their performance. This will help the Trust consolidate our 'Getting There' score and achieve a score of 'Excellent' in the Procurement standard by 2018/19. Also, to further demonstrate our ambition to covet finite resources, the Trust achieved national recognition for the third year running in 2016, being highly commended at the national NHS Sustainability Awards for our successful efforts in significantly reducing water consumption through investing in food waste digesters.

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 fifth 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, 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 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 continued to improve during the year. There are good clinical outcomes 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 triangulated by the corporate nursing team to gain assurance that where possible risks are lessened The Trust continued 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 and develop new ways of working.

- ***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.*** The has been a 14% increase in Fit for Transfer lost bed days compared to the previous year**.** At times, there have been almost 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. 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.

- ***If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to*** **patients** This new risk was identified in October 2016. An internal winter planning group was established with representation from all four Care Groups. The aim of the group was to look at ways to create additional capacity on both sites and protect activity. Trusts need to have sufficient capacity to manage the random variation inherent in the number of shorter stay admissions. This is achieved by having a bed occupancy rate of no more than 85%. SaTH consistently has bed occupancy of approximately 98%.

  Several options were considered. It proved challenging to engage with external partners to create a whole system plan due to the financial pressures within the system. £1.2m was assumed to be available from Commissioners but was in dispute. The total cost of the winter plan was not affordable within the control total for 16/17. The Board therefore had to balance the competing risk of not delivering the financial control total with the risk of having insufficient capacity to safely care for patients who present over the winter period and maintain the current RTT position. During March 2017 the Trust and Shropshire CCG Commissioners agreed a financial year end settlement which enabled the Trust to deliver its required control total. However this position was agreed based on actual levels of activity being performed by the Trust and did not include any specific funding for the Trust's Winter Plan.

- ***Risk to sustainability of clinical services due to potential shortages of key clinical staff*** This risk continues to be 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. Further delays in the Future Fit process resulted in more resignations of staff from key clinical areas due to the uncertainty engendered. There are a number of fragile services including the Emergency Departments where there are 5 Substantive Consultants for both Emergency Departments at RSH and PRH and 4 Locum Consultants. Across the substantive and locum staff a 1:5 on call is worked (1:4 = tipping point). Other services at risk include dermatology (a single consultant due a resignation; spinal surgery (no consultant due to sudden long term sickness) Ophthalmology particularly glaucoma surgery; and neurology (two consultants instead of the required six).

- ***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 has failed the incomplete standard in relation to Referral-to-Treatment target. The growth in the volume of emergency activity and the acuity of patients combined with increased length of stay has reduced elective bed capacity and as such compromised the performance in respect of admitted activity. In addition, capacity has again been substantially impacted upon by winter pressure. The Trust has maintained performance for the cancer waiting times targets where the Trust is performing above the national average. The A&E performance has not been achieved and the Trust has consistently underperformed on both the original TDA trajectory and the revised trajectory. A confounding factor has been a shift in complexity with a 12% rise in patients with major complications when compared with the previous year. Other reasons for the failure to meet the target include due to the high demand for services and the increase in 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*** The Trust has a clear clinical service vision, but has been unable to progress the plans due to external constraints. Many services are fragile, due to staff shortages. 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 & patient outcomes may not improve*** Work has started to further develop leaders in our organisation, and the Leadership Academy will be formally launched during 2017. Values based recruitment is used to inform recruitment decisions at all levels of the organisation. The results of the national staff survey show an 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 2016/17 Financial Year the Trust delivered a £5.9m deficit in line with the required target set by the NHSI and subsequently received a level of bonus Sustainability and Transformation Fund in recognition of delivering the required control total. As a result the Trust's year end financial position for 2016/17 is a deficit of £5.631m, £269k improvement on the £5.9m control total. A number of cash restrictions were put in place to aid the Trust's cash shortfall, including extending suppliers' payment terms. Capital accruals were used to temporarily ease the situation, however without a serious reduction in spend; there will be a very significant cash problem in the opening months of the new financial year. The Trust has begun to address the highest backlog maintenance issues using risk prioritisation but the capital available is very limited and so a high level of risk remains.

Data security

Information Governance incidents are reported via the Trust's incident reporting system. There were four data lapses in the year which were reported to the Information Commissioner. These cases were

1. A patient received a letter from SaTH containing appointment letters relating to 5 other patients
2. A patient received a letter containing letters relating to 6 other patients that was intended for the GP Surgery. Staff have been asked to be vigilant when printing letters.
3. A member of staff treated as a patient had their confidentiality breached –information was shared with the department where they work. This is the subject of a HR investigation.
4. A file containing patient survey details was inadvertently attached and sent to the wrong recipient - the national patient survey centre, who immediately deleted the file and informed the Trust.

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 75% (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 NHSI. 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 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 2016/17 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.

The Trust has a Local Counter Fraud Specialist (LCFS) whose work is directed by an annual workplan agreed by the Audit Committee. As well as investigating potential frauds, notified to the LCFS by the Trust, there has been a programme of continuous control monitoring including Conflicts of Interest; Recruitment; Overtime Claims; Agency Timesheets; and Patients' Property. There have been proactive exercises to detect potential fraud including examining the anti-fraud controls within the Estates Department; and looking at Consultant Job Planning. The LCFS has worked with the Trust to further enhance the system in place for declarations of interest.

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 four medium and three low priority recommendations mainly relating to reporting within the electronic risk register system.

During the year, Internal Audit reported on seven core audits and one performance audit. Internal Audit issued substantial assurance ratings for four core audits, and moderate assurance ratings for three core audits. The moderate assurance ratings relate to debtors and income (no high priority recommendations) procurement (four high priority recommendations); and computer-based IT controls (two high priority recommendations). Actions to rectify these weaknesses are being implemented.

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 one overdue action at year-end due to a delay in reassigning an action 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 2016/17. The overall opinion for the year ended 31 March 2017 is that moderate assurance can be give 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 Income & Debtors, Procurement (Contracted Expenditure & Stores), Policy and Procedure Compliance in Maternity Services (Non-core review) and Computer based IT Controls.

Substantial 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 2017 and up to the date of approval of the annual report and accounts.

5 Significant Issues

5.1 Progress on 2015/16 Significant Issues

In the 2015/16 Annual Governance Statement, the Trust disclosed six significant issues. Progress on these issues is outlined below.

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

The Trust was set a target of delivering a deficit of £5.9 million, after allowing for the receipt £10.5 million STF Funds. Unfortunately, because of a sharp decline in their financial position, Shropshire CCG has not been able to release winter funding to the Trust to cover increased costs over this period. During March 2017 the Trust and Shropshire CCG Commissioners agreed a financial year end settlement which enabled the Trust to continue to deliver its required control total. However this position was agreed based on actual levels of activity being performed by the Trust and still did not include any specific funding for the Trust's Winter Plan. At the end of the 2016/17 Financial Year the Trust subsequently received a level of bonus Sustainability and Transformation Fund (STF) in recognition of delivering the required control total. As a result the Trust's year-end financial position for 2016/17 is a deficit of £5.631m, £269k improvement on the £5.9m control total

The Trust began the year with a recurrent deficit of £20.2 million and will take into the 2017/18 a recurrent deficit of £17.9 million, an improvement of £2.3 million.

5.1.2 Sustainable Services 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 Services describes the Trust's plans to address the significant challenges to the safety and sustainability of patient services specifically in emergency and critical care.

Following this, the Future Fit Programme Board had made a recommendation around the preferred sites; however, when the proposal was presented to the CCGs Joint Committee for approval in February 2017, the decision was put on hold, rather than being sent out for public consultation.

A document has been produced internally "Putting Patients First" which has been borne out of work undertaken by sustainable services. The document outlines SaTH's preferred option, following extensive engagement. The history of the Future Fit process is peppered with delays; which is impacting on both retention and recruitment of staff

5.1.3 External Review of Maternity

An independent Maternity Review was published on 1 April 2016 following the death of a newborn in 2009, hours after being born at Ludlow Midwife-Led Unit. 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 the subsequent actions have been tracked to conclusion through the public session of the Trust Board. At year end, 66 actions have been completed and 4 actions are outstanding.

5.1.4 Performance

The trust has not achieved the A&E performance and has consistently underperformed on both the original TDA trajectory and the revised trajectory with a projected year-end performance of 81.02%. The main reason for the inability to meet the targets is the increased activity and complexity of cases. Similarly the Trust has struggled to achieve the admitted RTT targets but have achieved the expected Non-admitted level of performance. The reasons for not achieving the expected level of admitted performance are the growth in the volume of emergency activity and the acuity of patients combined with increased length of stay amongst the medically fit for discharge (MFFD) patients has reduced elective bed capacity and as such compromised the performance in respect of admitted activity. In addition, the current year to date Fit for Transfer lost bed days (M1- 11) are 25,742 against 22,602 for the same period last year. This is a percentage increase of 14%

5.1.5 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. Progress has been made on business continuity planning but remains an area of concern due to significant operational challenges.

5.1.6 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. Funding has been released to rectify some of the most serious risks. It is not however the Trust's expectation that buildings will close in the immediately foreseeable future.

5.2 2016/17 Significant Issues

5.2.1 Cash Flow

The year was difficult for cash, with significant in year pressures, however the end of year settlement with Shropshire CCG allowing for the delivery of the control total and the receipt of the additional Sustainability and Transformation Fund (STF) the cash position at the year end was stabilised.

The cash shortfall was accommodated in the short term by the slippage in delivery of the capital programme and extension of payment terms to revenue creditor suppliers. However this has resulted in a projected £5.4 million growth in capital creditors which will result in a significant level of creditors that will need to be financed in the opening months of the new financial year. As the Trust demonstrated that it is on target to achieve its control total, it has been able to secure a loan facility from the Department of Health– Uncommitted Single Currency Interim Revenue Support. However, the Trust has been informed that access to revenue financing during 2017/18 will be subject to increased challenge and scrutiny and will only be provided in exceptional circumstances.

5.2.2 Fragility of services

The Trust has a number of risks relating to the fragility of services. This is particularly difficult for emergency services including; Accident and Emergency Department (AED), ITU, Paediatrics, and Surgery & Trauma. In March 2016, the Trust Board received a paper outlining a number of options to maintain safe and effective urgent and emergency care services. This paper followed on from an earlier paper in December 2015, in which the risks and challenges being faced at that time in relation to maintaining two emergency departments at the PRH and RSH sites were described. This paper was in response to the challenge facing the Trust around the continued unavailability of medical staff to provide two 24-hour emergency departments and the associated clinical services. This risk is the greatest risk on the Trust Board Assurance Framework and the Trust Risk Register. It has also formed part of the programme of review and scrutiny by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin. Both papers recognised the medium and long-term vision for health services continued through the NHS Future Fit Programme, which at this time were planning public consultation later in 2016, ahead of a decision on the future configuration of hospital services in spring 2017. However, the NHS Future Fit Programme has again been delayed with no date set for public consultation.

The Trust Board was advised September 2016 that an ED Consultant resignation had been received with effect from 16 December 2016. This meant that the Trust had reached its defined 'tipping point' for Emergency Department Consultant capacity as there would be insufficient senior medical staff to provide a safe service 24-hours a day in two A&E Departments. The Trust Board approved the Sustainable Services Programme draft Outline Business Case in November 2016. The Trust has developed and agreed a business continuity plan in in order to maintain adequate consultant staffing levels to sustain the safe effective functioning of two 24 hour A&E services.

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, Sustainability Committee, Workforce Committee and Quality 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 2017 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
30th May 2017