

Paper 4

Recommendation <input checked="" type="checkbox"/> DECISION <input type="checkbox"/> NOTE	The Trust Board is asked to APPROVE the Annual Governance Statement.
Reporting to:	Trust Board
Date	25 May 2018
Paper Title	Annual Governance Statement
Brief Description	<p>The Annual Governance Statement (AGS) forms part of the annual accounts. NHS Improvement produces guidance on the content, and requires that the AGS is completed in line with the submission requirements for the annual accounts..</p> <p>The final version will be submitted with the Annual Accounts on 29th May. Significant issues for 2017/18 are considered to be:</p> <ul style="list-style-type: none"> • Cash flow • Emergency Department staffing • Patient Flow <p>A final draft of the document is attached.</p>
Sponsoring Director	Chief Executive
Author(s)	Head of Assurance
Recommended / escalated by	
Previously considered by	Audit Committee (April 2018); External Audit and circulated to Directors
Link to strategic objectives	All
Link to Board Assurance Framework	All
Equality Impact Assessment	<input checked="" type="radio"/> Stage 1 only (no negative impacts identified) <input type="radio"/> Stage 2 recommended (negative impacts identified) <ul style="list-style-type: none"> <input type="radio"/> negative impacts have been mitigated <input type="radio"/> negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	<input checked="" type="radio"/> This document is for full publication <input type="radio"/> This document includes FOIA exempt information <input type="radio"/> This whole document is exempt under the FOIA

Paper 4**Shrewsbury and Telford Hospital NHS Trust****Organisation Code: RXW****Annual Governance Statement – 2017/18****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's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Shrewsbury and Telford Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

The Chief Executive is the Accountable Officer for the Trust and for ensuring the Trust meets its statutory and legal requirements. The Chief Executive is supported by the Director of Corporate Governance who is the lead director for risk management and fulfils the role of Board Secretary. The Director develops corporate risk management strategies and policies interpreting national guidance to fit the local context and the Board Assurance Framework in conjunction with the entire Trust Board. All the Directors have delegated authority for specific areas of risk.

The Non-Executives are accountable to the Secretary of State. They are expected to hold the Executive to account and to use their skills and experience to make sure that the interests of patients, staff and Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.

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 2017/18 at all levels of the organisation. The Trust seeks to learn from good practice as described in our Quality Improvement Strategy and particularly through our partnership with the Virginia Mason Institute; from other areas by benchmarking practice against national standards and reports; reviews of incidents, complaints and claims; and the ward exemplar programme.

4 The risk and control framework

The Trust's Risk Management Strategy is updated and approved 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 on-going 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 sixth 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 is 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 and for implementing changes to mitigate the risk in a specified timeframe.

The organisation's current overall risk appetite has been described by the Board as 'open' as the Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even where there are elevated levels of associated risk.

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 Board.

The Trust Board and our other senior leaders gain assurance that the performance information that they are being provided with is current, accurate and reliable and has been validated to ensure that it is robust; this is done through a process of triangulation. This provides a picture of the organisation as a whole and can help to validate feedback from patients and staff and enables appropriate actions and decisions to be taken.

The different elements of Quality Governance are brought together in the overarching Quality Improvement Plan which is updated by Corporate Nursing and collates the evidence that we have completed all must do and should do actions for the CQC and that we are compliant with the CQC requirements.

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.

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.

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. The review has continued throughout the year and the report is due to be published in 2018/19.

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 70% (Satisfactory). The Trust attained at least level 2 compliance in all 45 requirements

The BAF enables the Board to undertake focused management of the Trust's major risks. 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 risks is proactively monitored and reported to Trust Board. The BAF risks during the year were:

- **If we do not work with our partners to reduce the numbers of patients who are medically fit for discharge and delayed transfers of care, alongside streamlining our own internal processes, we will not reduce length of stay or increase the number of simple and complex discharges to reduce the bed occupancy levels to 92%.** At times, there have been over 140 patients in hospital beds who are fit to be discharged from acute care although the length of time individual patients are waiting has decreased. Routinely these 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 we do not have the patients in the right place, by removing medical outliers, patient experience will be affected.** 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
- 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** An internal winter planning group was established early in the year and a winter plan agreed. A number of actions were implemented including SaTH2Home scheme (facilitated discharge with clinical support); bed realignment; increasing the number of medical staff in medicine to support discharge, clinical staff to support A&E departments and additional bed capacity. The level of expenditure incurred in response to the winter demands this year (£5.0m) has been higher than in any previous financial year. Funding levels have been provided by Commissioners and NHSI (£4.9m) to support the majority of the predicted levels of spend. Nevertheless, even with all these elements in place, winter has been challenging with high levels of escalation leading to additional patients on wards, with all the concurrent risks associated with this.
- If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage.** This new risk was added to the BAF in April 2017 in light of incidents which have caused significant harm and the intense scrutiny that the Trust is under. The Secretary of State commissioned a review which was due to report in early 2018; however, the publication of the report has been delayed until later in 2018. The Trust is working with a wide range of organisations to deliver the Maternity Transformation Programme which aims to achieve the vision set out in 'Better Births'. The Maternity Service has made significant progress in improving systems and processes to embed learning and the latest clinical quality metrics show good clinical outcomes compared with the national average. However, until the Secretary of State review is published, and the Trust can demonstrate that learning has been embedded, then this will remain a risk.
- 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 A&E performance has not been achieved and the Trust has consistently underperformed on both the original TDA trajectory and the revised trajectory with a performance of 76.6% Other reasons for the failure to meet the target include due to the high demand for services and the numbers of patients who are fit-to-transfer, but occupying a hospital bed. A number of actions have been taken to improve performance including the opening of a Clinical Decision Unit at RSH, and a second unit opening at PRH in April 2018. The Trust has put in place a 'fit to sit' model to help with the process, this prevents patients from taking up a cubicle for the duration of their time in the A&E, and ED patient flow coordinators focusing on the minors stream commenced in March.

The Trust maintained performance for the cancer waiting times targets where the Trust is performing above the national average. The Trust achieved the standards in relation to Referral-to-Treatment target from September 2017 although performance deteriorated in March due to severe operational pressures as capacity was substantially impacted by winter pressure.

- If we are unable to implement our clinical service vision in a timely way then we will 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 on NHS Future Fit was delayed. A decision was taken in March 2018 to proceed to public consultation in May 2018. Once the outcome of the consultation is known, then the Trust will be in a position to implement our clinical service vision however this will remain a risk throughout 2018/19.

- Risk to sustainability of clinical services due to shortages of key clinical staff** This risk continues to be a significant issue for the Trust and 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 challenged services including the Emergency Departments where there are three Substantive Consultants for both Emergency Departments at RSH and PRH and three Locum Consultants as well as insufficient middle grade doctors. There is also a shortage of permanent nursing staff in some areas. Other services in the spotlight include dermatology (a single consultant), and neurology (two consultants instead of the required six). Until the outcome of Future Fit is implemented, this will remain a risk.
- 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 was launched in June 2017. Values based recruitment is used to inform recruitment decisions at all levels of the organisation. The results of the latest national staff survey show deterioration and so robust action will be needed to be taken.
- If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision.** The Trust appointed a Community Engagement Facilitator in August 2017 who is now delivering the People's Academy which is an interactive and educational programme for our local communities. The Academy has been developed with input from a range of public representatives with their input around what topics the academy should cover. In addition we have over 10,000 public members and 900 volunteers. Our trust has been highlighted as an area of good practice for our young volunteer scheme as well as our induction and training for volunteers.

The Trust continues 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. Many of the workstreams now involve patients as well as staff

- 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** The 2017/18 financial year has been challenging for the Trust. The Trust agreed a planned in year deficit for 2017/18 as a control total with NHS Improvement of £6.1 million, subject to the receipt of Sustainability and Transformation Funding (STF) monies of £9.3 million. The effect of workforce challenges has led to increased spending in respect of Agency staffing and an inability to secure the full level of cost improvement savings. This combined with reduced Income has resulted in the Trust overspending in the year by £12 million. Significantly, in failing to limit the overspend to the level agreed with NHSI the Trust has then been unable to secure the full level of available STF monies. The level of STF monies withdrawn has amounted to £5.4 million and as a consequence the Trust will end the year with a deficit of £17.4 million.
- If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients** The Trust has been set a Control Total target by NHSI to achieve a deficit in the 2018/19 year of £8.615m. In order to achieve this level of deficit it is necessary for the Trust to generate cost improvement savings equivalent to 2.2 per cent of Trust expenditure budgets, amounting to savings of circa £8.2 million. Schemes have been identified to deliver this level of saving however considerable levels of risk presently exist in respect of a number of these schemes. A waste reduction working group has been established chaired by the Chief Operating Officer and attended by senior members of the operational teams along with Finance and Workforce. This group will oversee the production and monitoring of the detailed plans for each scheme along with all quality impact assessments.

The Well-Led Framework combines the Board Governance Assurance Framework and the Quality Governance Framework. The work on the Well-Led framework has been led by the Corporate Nursing Team. An enhanced Board Development Programme is in place and the senior Board Committees (Workforce, Performance, Quality and Safety and Audit Committee) are chaired by Non-Executive Directors.

The Trust has included the requirement for members of Trust Board to make a declaration against the Fit and Proper Persons Test has robust arrangements in place for new appointments to the Board (whether non-executive or executive). The Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The Chair and Non-Executive Directors have a broad base of skills and experience and each Non-Executive Director also brings individual skills and personal experience of their community and the NHS to guide the work of the Trust, including financial, commercial, community engagement, and health care.

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.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by NHSI. The Trust Board undertakes on-going Board development, using external expertise where required. The Chief Executive is subject to formal review by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. All appointments to senior management positions are subject to rigorous and transparent recruitment processes including values based interviews. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation.

The Trust also has a leadership academy for leaders at all levels of the organisation, which aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level.

The risk of not having suitably qualified individuals at all levels of the organisation is mitigated by our robust recruitment and selection processes for staff at all levels. The Trust Board is assured on a monthly basis that we continue to demonstrate compliance with relevant governance requirements at all times.

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 new Trust Chair is reviewing the Committee structure to ensure it is fit for purpose. During the year NHSI undertook a review of the Trust's governance structures. A report was received in March 2018 and the recommendations will be considered and actions implemented over 2018/19.

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). There have been a number of changes to the Board during the year. The Chair of the Trust stepped down at the end of his term of office in December 2017 with a new Chair taking up post in February 2018. In April 2017, a new Director of Nursing,

Midwifery and Quality commenced in post. The Chief Operating Officer retired in December 2017 and an interim was in post until the permanent replacement took up their role in February 2018. One of the non-executives stepped down in January 2018 and the Trust is currently recruiting additional non-executive directors. Each Director has delegated authority for the delivery of specific objectives as outlined below:

- Chief Executive - statutory accountable officer, overall management of the Trust and its performance
- Finance Director – Finance, fraud prevention, performance and contracts, information governance, information and IT and estates
- Chief Operating Officer – Operational delivery including business continuity and major incident planning
- Director of Nursing, Midwifery and Quality – Nursing and midwifery practice, patient safety and experience
- Medical Director – medical practice and education, Caldicott Guardian, Research and Development
- Director of Corporate Governance – Trust Board Secretary, corporate governance, and communications and community engagement (non-voting)
- Workforce Director – Human resources, training and development and organisational development (non-voting)

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 Board approves an annual schedule of business and a regular update which identifies the key reports to be presented in the coming quarter. 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 18
Name and Title	Attendance
Professor Peter Latchford – Chair - until Dec 2017	6/6
Ben Reid – Chair - from Feb 2018	1/2
Harmesh Darbhanga – Non-Executive Director	6/8
Brian Newman – Non-Executive Director	7/8
Clive Deadman – Non Executive Director	6/8
David Lee – Non-Executive Director – from Dec 16	8/8
Chris Weiner – Non-Executive Director – from Dec 16	7/8
Paul Cronin – Non-Executive Director – until Jan 2018	5/6
Simon Wright – CEO	8/8
Neil Nisbet – Finance Director	7/8
Debbie Kadum – Chief Operating Officer – until Dec 2017	5/6
Sara Biffen – Acting Chief Operating Officer – Jan 2018	1/1
Nigel Lee – Chief Operating Officer – from Feb 2018	1/1
Edwin Borman – Medical Director	8/8
Deidre Fowler – Director of Nursing, Midwifery & Quality - from Apr 2017	8/8

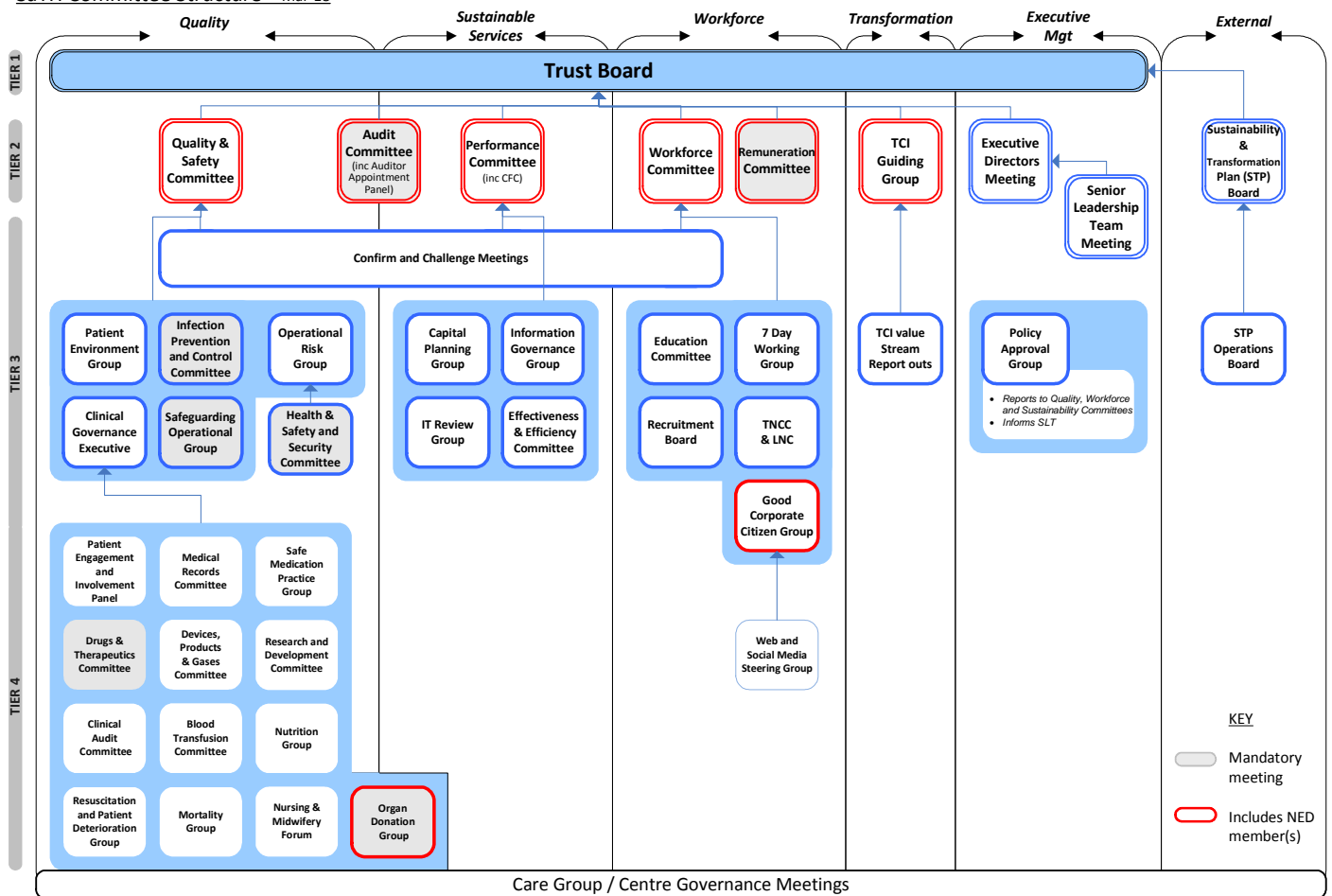
The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness.

Exception reports to the Board ensure that the Board considers the key issues and makes the most effective use of its time.

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.

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, (Performance, 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 Performance 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.

SaTH Committee Structure – Mar-18



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.

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were updated in June 2017 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 Managing Conflicts of Interest in the NHS was revised in 2017 to take account of new requirements following the publication of revised national guidance. 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.

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.

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. All papers to Trust Board and Tier 2 Committees are required to consider risks and assurance; and to have an Equality Impact Assessment carried out and this forms part of the cover sheet for each paper. All new and revised policies are required to have an Equality Impact Assessment undertaken prior to approval and ratification.

Incident reporting is in place across the Trust via a web-based reporting system supplemented by paper forms. A network of safety advisers encourage reporting and the Trust supports an open culture. A weekly rapid review meeting of moderate and severe harm incidents was established, which demonstrates better learning from complaints and incidents as well as assurance around duty of candour.

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.

The trust is fully compliant with the registration requirements of the Care Quality Commission.

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 into 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.

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

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 UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5 Review of economy, efficiency and effectiveness of the use of resources

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 one 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. Internal Audit issued substantial assurance ratings for three core audits; moderate assurance ratings for three core audits and limited assurance for one core audit. The moderate assurance ratings relate to cash management (no high priority recommendations); income and debtors (one high priority recommendation); and computer-based IT controls (three high priority recommendations). The limited assurance rating relates to budgetary controls with two high priority recommendations. Actions to rectify these weaknesses are being implemented. Based on the assurances given for the core reports issued, and the current financial position of the Trust, Internal Audit issued an overall opinion for the year of Moderate.

As part of their annual internal audit plan, Internal Audit also deliver a number of risk based advisory and performance reviews. In discussion with the Trust, these are focussed on areas identified as offering the greatest scope for improvement to maximise the benefit and learning to the Trust. Three performance reviews took place during 2017/18.

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 have been proactive exercises to detect potential fraud. These have included examining the anti-fraud controls within the Estates Department; and looking at staff absence, clinic duration, and private practice. The LCFS has worked with the Trust to further enhance the system in place for declarations of interest and auditing disclosures made in comparison to those on Disclosures UK.

Formal actions plans have been agreed to address the significant control weaknesses in all areas. Implementation of the recommendations has been tracked with two overdue actions at year-end. There have been no common weaknesses identified through Internal Audit reviews.

6 Information governance

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

1. A patient received a letter that was put into a 'window' envelope and was folded inappropriately which resulted in 'sensitive' data being visible **Actions:** Full investigation (RCA) Remedial Action taken and Shared Learning.
2. Nine individual patient letters were accidentally put into an envelope addressed to one other patient. **Actions:** Full investigation (RCA) Remedial Action taken and Shared Learning. Provision of additional training for respective staff/department. Implementation of electronic communications with GP surgeries
3. A handover book containing information relating to >150 patients was missing from a secure office on ITU PRH. The book was used for the Out-reach team management of patients. **Actions:** A thorough search was made throughout the hospital on several occasions. It is felt that the book may turn up in time as it has probably been picked up with other patient notes/documents. A full RCA was performed and an action plan implemented to mitigate further risks

7 Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The 2017/18 Quality Account is currently in preparation and the content and two of the indicators will be reviewed by External Audit to provide assurance on the accuracy of the account. The draft Quality Account is shared with partner organisations who are asked to provide a commentary on the account and to check the accuracy. These commentaries are included as part of the Quality Account.

The Trust has a robust system in place to assure the quality and accuracy of performance information. 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.

8 Significant Issues

8.1 Progress on 2016/17 significant Issues

In the 2016/17 Annual Governance Statement, the Trust disclosed two significant issues. Progress on these issues is outlined below.

Cash Flow

The 2017/18 year was difficult for cash, with significant in year pressures, as a result of the Trust's failure to deliver the required control total. 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, before securing authorisation from NHSI to secure cash support to underpin the increased level of in year deficit.

Faced with a sizeable 2018/19 Income and Expenditure deficit, the Trust will, in order to ensure that sufficient cash resources exist, need to again secure authorisation from NHSI to underpin the deficit with an equivalent level of cash support. The Trust has been informed that access to revenue financing during 2018/19 will be subject to increased challenge and scrutiny and will only be provided in exceptional circumstances

Fragility of services

The Trust has a number of risks relating to the services under the spotlight. This was particularly difficult for the Accident and Emergency Department (AED) and the situation remains precarious with further resignations of consultants but the business continuity plan has not been invoked as locums have been secured to sustain the service. There has been progress with other services, particularly neurology, dermatology, ophthalmology and spinal surgery where a range of options to provide these services have been developed.

8.2 2017/18 significant issues

Medium Term Financial Plan

The Trust's financial difficulties in the 2018/19 year can be traced to an inability to achieve the required level of cost improvement savings in the 2017/18 year and also growing levels of Agency spending. This has meant that the Trust instead of taking forward into the 2018/19 year a recurrent deficit of £12 million is carrying forward a deficit of £20.5 million. The recurrent financial position of the Trust is critical. A review of the Trust's Medium Term Financial Plan has demonstrated that the deterioration in the Trust's recurrent position will need to be addressed in order for the Trust to be able to take forward its plans to reconfigure clinical services and address severe backlog estate and equipment issues.

Emergency Department staffing

The staffing of the Emergency Department was extremely fragile throughout the year with a significant risk that the Trust may have to enact its business continuity plan resulting in overnight closures of the Princess Royal Hospital Emergency Department. Although the plan was not enacted, safely staffing the Emergency Departments was challenging. 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.

Patient Flow

The A&E performance has not been achieved and the Trust has consistently underperformed on both the original TDA trajectory and the revised trajectory. The Trust has been working hard with partner organisations to increase flow, and reduce the numbers of 'stranded' and 'superstranded'. The aim is to reduce bed occupancy levels to the nationally accepted safe levels of 92%. At times, bed occupancy has been over 100% with additional patients on wards.

9 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, and the Audit Committee and 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, particularly the Audit Committee,
- Reports from Executive Directors and key managers
- External Reviews
- Board Assurance Framework.
- Clinical Audit
- 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 moderate assurance 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.

10 Conclusion

Three significant control issues have been identified for the year 2017/18:

- Medium Term Financial Plan
- Emergency Department Staffing
- Patient Flow

The system of internal control has been in place at the Trust for the year ended 31 March 2018 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

Signed

Chief Executive

Date 25th May 2018