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

Annual Governance Statement – 2018/19

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 2019 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 (SoS)**. 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 the 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 (RM04). 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 2018/19 at appropriate levels of the organisation. The Trust seeks to learn from good practice particularly through the development of our Transforming Care 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** (RM01) 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 Auditor at the commencement of 2019/20 who found there was

moderate assurance around the processes in place**.** 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 and 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.

Throughout 2018/19, the Director of Nursing, Midwifery and Quality has had 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 Ward to Board**.

The Trust Board and senior leadership teams 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 through a process of triangulation. This provides a picture of the organisation as a whole, helping to validate feedback from patients and staff, and enables appropriate actions and decisions to be taken.

In October 2018 the **CQC undertook a full inspection** of Trust services which concluded an overall 'Inadequate' rating[1]. Individual ratings against each domain were:

- **Safe** - Inadequate
- **Effective** - Requires improvement
- **Caring** - Good
- **Responsive** - Requires improvement
- **Well-led** - Inadequate

In response, the different elements of Quality Governance are brought together in the overarching **Quality Improvement Plan** which is managed by a recently established programme management function, and collates the evidence that we have completed all 'must do' and 'should do' actions recommended by the CQC, assuring that we will be compliant with all other 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 in February 2017 of the investigation of maternity serious incidents. The full final report is expected to be published in 2019/20.

The Finance Director is the nominated Senior Information Risk Officer (SIRO), 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 **Data Security & Data Protection Toolkit Assessment** provides assurance that this is being managed. After an initial assessment, the Trust

[1] CQC inspection findings for SaTH are published in full at https://www.cqc.org.uk/provider/RXW

formalised an improvement plan with NHS Digital[2], and concluded the overall result for SaTH for 2018/19 was 'standards not fully met (plan agreed)'. Further details are set out in section 6.

The Board Assurance Framework (BAF) enables the Board to undertake focused management of the Trust's strategic 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 the 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 95%.** Although some improvements have been made, there are continued difficulties with patients in hospital beds who are fit to be discharged from acute care, although the length of time individual patients are waiting has decreased. Historically such patients have occupied up to 15% of our 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, exacerbated by reductions in social care funding. Although the Trust has worked with partner agencies to attempt to improve the situation and there has been an increase in funded care packages, this has not been sufficient to significantly improve the situation. Given the over-riding responsibility of the Board for patient safety and experience, this remains a risk.

- **If we do not have the patients in the right place, by removing medical outliers[3], 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, but action has been taken to ensure that escalation measures in occupying spaces that are not sub-optimal in terms of our ability to care for patients safely, with dignity and respect are in place. There is an increased focus on risks assessed and incidents captured from Datix incidents, complaints, infection prevention control, safeguarding, staffing and legal claims, which 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.** A Board-approved winter plan was agreed which continues to include the innovative 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 has been higher than in any previous financial year. Funding levels have been provided by Commissioners and NHSI 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 risk was added to the BAF in April 2017 in light of historic incidents at the Trust. The Secretary of State commissioned a review which was due to report in early 2018; however, the publication of the report has been delayed. 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.

[2] NHS Digital is '…the national information and technology partner to the health and social care system' https://digital.nhs.uk/about-nhs-digital

[3] NHSI definition - '[Medical] patients are admitted as 'outliers' to wards that are not best suited to manage their care' https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017___13_July_2017.pdf

- **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**. A&E performance has not been achieved and the Trust has been unable to sustain performance improvement initiatives over the year. Other reasons for the failure to meet the target include the high demand for services and the numbers of patients who are fit-to-transfer but are 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 continues to be utilised. The Trust has faced deteriorating performance against national targets for Referral-to-Treatment due to severe operational pressures as capacity was substantially impacted over the winter period, and Cancer treatment waiting times are also failing to be consistently met.

- **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 the delayed implementation of the Future Fit vision. Many services are fragile, due to staff shortages. Although a significant amount of work has taken place including completion of the public consultation on NHS Future Fit and approval of the Strategic Business case by Commissioners, the implementation has been delayed. The Trust continues to work hard to implement our clinical service vision; however, this will remain a risk throughout 2019/20.

- **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. The Trust's efforts to recruit never stops, and during 2018/19 we increased our full time equivalent workforce by 140 to 5,187. During the year we recruited 71.45 FTW Staff Nurses, 65.07 FTE Health Care Assistants and 23.60 FTE Consultants (including those recruited on a locum basis). Efforts to improve the working experience have resulted in an increase in Bank Staff from an average of 489 per week in April/May 2018 to 642 in January 2019. We have worked hard to reduce the number of agencies we use for temporary staff, to improve the continuity of care where agency staff are required. We have also reduced agency staff spending over the year by £1.2million. In spite of these successes, we anticipate that difficulties in recruitment and retention of permanent staff, particularly in some challenged specialties, will remain a risk until the outcome of Future Fit is implemented.

- **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.** Through the Workforce and Quality and Safety Committees the Board receives assurance on workforce (people) strategies and monthly workforce assurance reports. In addition the Board receives bi-annual updates on nurse staffing. The Trust is ensuring full compliance with Developing Workforce Safeguards. Through the year, development of our Organisational Development plan has focused on staff engagement. This has been identified as a strategic objective of the Trust, and monitored monthly through the Workforce Committee. Approaches taken this year include:
    - Think on methodology – meaningful conversations
    - Response to staff survey
    - Staff engagement in the future of our hospitals
    - Pulse surveys
    - Health and Wellbeing
    - Values Based Conversations
    - Leadership Development

- **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 has a Community Engagement Facilitator who is successfully 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 on what topics the academy should cover. In addition we have over 10,000 public members and over 950 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 provides 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 and address the modernisation of our ageing estate and equipment.** The 2018/19 financial year has been challenging for the Trust. The Trust agreed a planned in-year deficit as a control total with NHS Improvement of £8.615 million (after receipt of £9.8m Provider Sustainability Funding (PSF)). The effect of workforce challenges has led to increased spending in respect of staffing particularly within the Emergency Department, requirement for additional ward capacity to manage demand and an inability to secure the full level of cost improvement savings. As a result the Trust was not eligible for the full level of PSF of £9.824m available and instead received a reduced level of £5.184m. The Trust's overall deficit for 2018/19 was £18.743m against a control total of £8.615; a variance of £10.128m, with £5.5m as a result of in year pressures and £4.6m due to non-receipt of PSF.

- **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 was set a Control Total target by NHSI to control its deficit in the 2018/19 year to £8.615m. In order to achieve this level of deficit it was 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. While schemes were identified, considerable levels of risk in respect of a number schemes materialised and the Trust ended the year delivering an in-year efficiency saving of £5.1m. The Chief Operating Officer is leading the production and monitoring of the Waste Reduction Programme for 2019/20. The Trust will utilise both NHSI support and external specialist support to continue to develop and deliver the 2019/20 plan.

In January 2019 the Board reviewed and refined the BAF, making the risk descriptions more concise and combining risks where an overlap was identified. The revised framework was approved at the Board in February 2019.

Revised BAF wording for 2019/20	BAF Risk wording 2018/19
PATIENT AND FAMILY Listening to and working with our patients	
We need real engagement with our community to ensure that patients are at the centre of everything we do (BAF1186)	*If we do not develop real engagement with our community we will fail to support an improvement in health outcomes and deliver our service vision*
SAFEST AND KINDEST Patients and staff feel they were safe and received kind care	
Our maternity services need to evidence learning and improvement to enable the public to be confident that the service is safe (BAF1204)	*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*
We need to deliver plans jointly agreed with the local health and care system so our admission and discharge processes ensure patients are receiving safe and effective care in the right place (BAF1134)	*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*

Revised BAF wording for 2019/20	BAF Risk wording 2018/19
We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients (BAF1533)	*If we do not develop and fully implement the Action Plan rising from the CQC Report we will not move from inadequate to good. The consequence of the risk is that we do not improve patient care*
SUSTAINABLITY and HEALTHIEST HALF MILLION Working with our partners for all our communities	
We need to have system-wide effective processes in place to ensure we achieve national performance standards for key planned activity (BAF561)	*If we do not work with our partners and streamline our own processes to reduce length of stay and increase the rate of discharges, we will not reduce bed occupancy levels to 92% thus allowing the right patients to be in the right place and reducing ward moves*
LEADERSHIP Innovative and Inspirational Leadership to deliver our ambitions	
We need to deliver our £312m hospital reconfiguration to ensure our patients get the best care (BAF668)	*If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients*
We need to live within our financial means so we can modernise our ageing estate and equipment and invest in service development and innovation (BAF670)	*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 and address the modernisation of our ageing estate and equipment*
	If we do not deliver our Waste Reduction Schemes and budgetary control totals then we will be unable to invest in services to meet the needs of our patients
We need an agreed Digitisation Strategy to underpin service improvement (BAF1492)	*If the Trust does not have an up-to-date Information Management and Technology strategy, then the Trust will not be able to benefit from up-to-date clinical and performance information to drive improvements*
OUR PEOPLE Creating a great place to work	
We need positive staff engagement to create a culture of continuous improvement (BAF423)	*If we do not get good levels of staff engagement to get a culture of continuous improvement and understand and act upon staff reporting increased experience of bullying and harassment, then staff morale and patient outcomes will not improve*
We need a recruitment strategy for key clinical staff to ensure the sustainability of services (BAF859)	*Risk to sustainability of clinical services due to potential shortages of key clinical staff particularly in ED and Emergency Medicine, Gastroenterology, Dermatology and Neurology, Critical Care, Acute Medicine and Nursing*

The Care Quality Commission's (CQC) Well-Led Framework is another important element of the Trust's governance. In September 2019 the Trust commissioned Deloitte to undertake an independent review of the Well-led domain as defined by the CQC assessment criteria. The review identified several areas of concern and an improvement plan was agreed by the Board prior to the CQC inspection which commenced in October.

After the CQC concluded an inadequate rating for both the Safety and Well-led domains, the Trust was placed into special measures by NHSI in January 2019. The Trust is now receiving **external support and has developed an improvement plan**, built upon all subsequent recommendations from CQC findings and previous independent reviews to form the Well-Led action plan. This was agreed between the Board of Directors and NHSI, which is being led by the Trust Chair. Two additional Board level roles, recommended as part of the Well-led assessment, are currently being recruited into.

The Board recognised this as a risk to the delivery of Trust objectives and added to the BAF in February 2019:

> **We need to have sufficient, competent and capable Directors to deliver the Trust's agenda (BAF1558)**

The Trust has included the requirement for members of the Trust Board to make a declaration against the Fit and Proper Persons Test and 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.

Recognising the agenda ahead of the Trust, approvals were made to establish two new Director roles; Director of Clinical Efficiency *and* Director of Transformation & Strategy, to supplement new Medical and Nurse Director appointments.

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 appraisals by the Chair, both of whom inform individual development plans for all Board members.

Continuous professional development of clinical staff, including medical staff, supports the Trust's objective to deliver high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners who provide care on behalf of the Trust have met the relevant professional registration and revalidation 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. In 2019/20, all leaders at SaTH will have a formal training programme to support the development of compassionate leadership across the Trust.

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 Trust Chair has reviewed the Committee structure to ensure it is fit for purpose and responded to issues raised through

independent assessment, for instance a Maternity Taskforce Oversight Committee, working alongside the Quality & Safety Committee and reporting to the Board, was constituted in-year to oversee improvements identified within our maternity services. This is chaired by the Trust Chair to ensure the highest levels of scrutiny and assurance.

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 are also three Associate Non-Executive Directors and currently two non-voting Directors. Whilst still supporting the Board, two of the Non-Executives stepped down to an associate level during the year and the Trust has recruited three additional Non-Executive Directors.

Each Executive 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, legal services, security, communications and community engagement (non-voting)
- **Workforce Director** – Human resources, training and development and organisational development (non-voting).

A number of developments are ongoing and the Board is currently establishing two additional executive director positions for a) **Strategy & Transformation** and b) **Clinical Effectiveness & Innovation**. These new roles will add capacity and capability to the Board and are fully supported by NHSI.

The Trust Board has overall responsibility for the activity, integrity, and strategy of the Trust and is accountable, through its Chair, to 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**
Ben Reid – Chair	11/11
Brian Newman – Non-Executive Director	10/11
Clive Deadman – Non Executive Director	11/11
David Lee – Non-Executive Director – from Dec 16	8/11
Chris Weiner – Non-Executive Director – until Feb 19	9/10

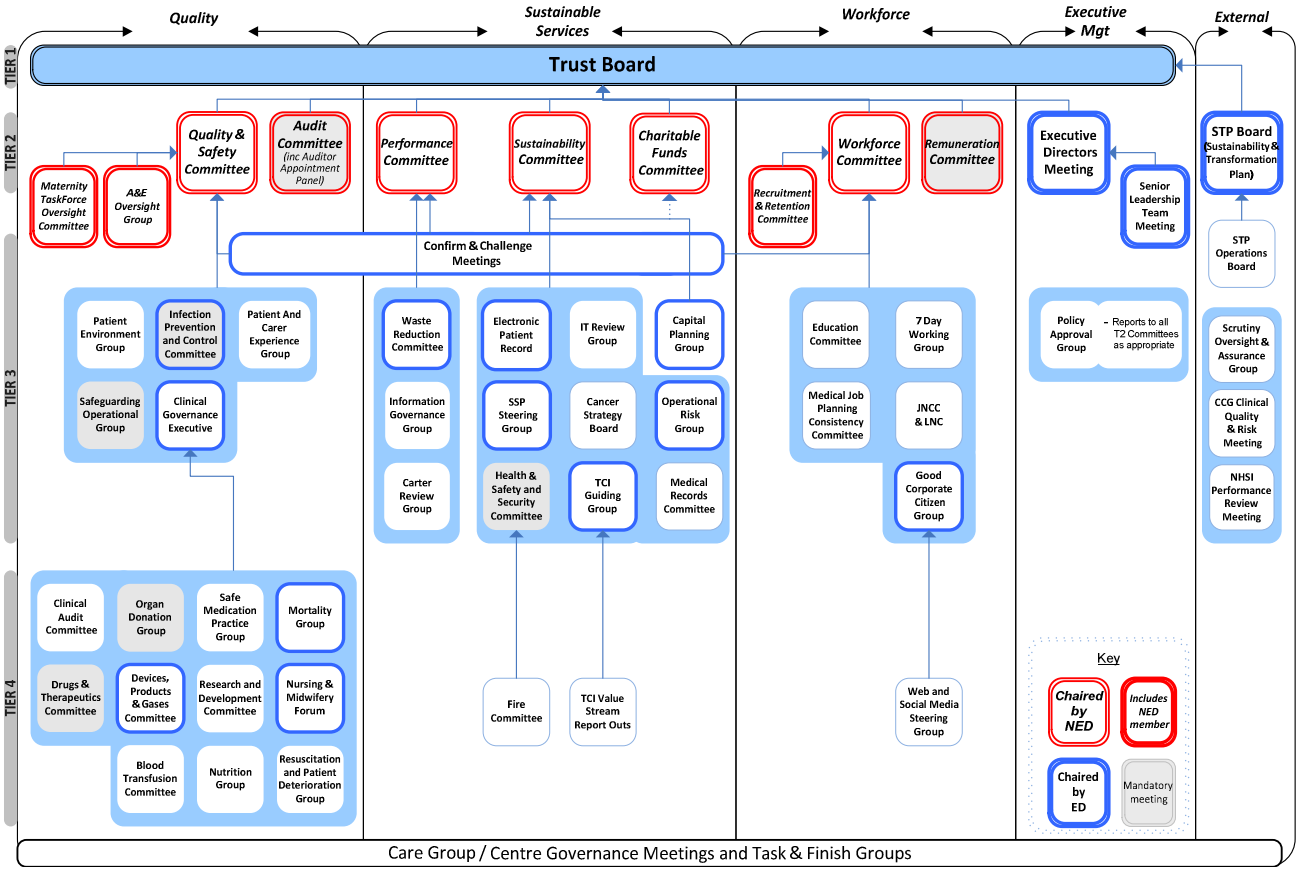
Tony Allen - Non Executive Director - from Sep 18	6/6
Tony Bristlin - Non Executive Director - from Sep 18	6/6
Mandy Edwards - Non Executive Director - from Feb 18	1/1
Simon Wright – CEO	11/11
Neil Nisbet – Finance Director	5/5 (11/11)*
Nigel Lee – Chief Operating Officer	11/11
Edwin Borman – Medical Director	11/11
Deidre Fowler – Director of Nursing, Midwifery & Quality	11/11

** FD covered by Deputy*

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 describe the duties, responsibilities and accountabilities, and 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 has refined its **governance structure** during the year and currently operates with the support of seven Tier 2 committees accountable to the Trust Board. All 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. A meeting summary from the Chair of each Tier 2 sub-committee is also presented at public Board meetings.

Two of the Tier 2 Committees are **Non-Executive Committees** (Audit and Remuneration). Although these Committees have a membership consisting of only Non-Executive Directors, other Directors will attend as required. The other five Committees are **chaired by a Non-Executive Director**, (Performance, Quality and Safety, Sustainability and Workforce). Minutes of these meetings demonstrate that Non-Executive Directors oversee progress and **provide challenge to the Executive**. Non-Executive Directors form the core of the Audit Committee, and the Sustainability Committee is chaired by the Trust Board Chair.



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 2018/19. 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 to take account of changes to the Trust's governance arrangements and legislation and approved by the Board in March 2018. 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 permanent medical staff, senior managers, specialist nurses, and procurement and stores staff. The Board's Register of Interests was kept updated during the year and is a standing item at every Trust Board meeting.

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 the 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; this forms part of the cover sheet for each paper. This was independently reviewed by Deloitte and refined in December to ensure that Board papers have a standard approach that is clear and logical. 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, enabling any concerns to be raised in confidence with our Freedom to Speak Up Guardians. 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, oversight and the reviews undertaken by Internal and External Auditors, 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.

Through the Workforce and Quality and Safety Committees the Board receives assurance on workforce (people) strategies and monthly workforce assurance reports. In addition the Board receives six monthly updates on nurse staffing. The Trust is ensuring full compliance with Developing Workforce Safeguards.

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

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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 has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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 most recent review of the Trust's Assurance Framework (April '19) gave **moderate** assurance overall and made one high, three medium and five low priority recommendations. During the year, Internal Audit reported on seven core audits, five of which related to financial control and management. Internal Audit issued a substantial assurance rating for one core audit; moderate assurance ratings for three core audits and limited assurance for three core audits. The moderate assurance ratings relate to Income and Debtors (two high priority recommendation); computer-based IT controls (no high priority recommendations) and Board Assurance Framework (one high priority recommendation). The limited assurance ratings relate to Cash Management (two high priority recommendations), the Waste Reduction Programme (five high priority recommendations), and Budgetary Control and Financial Reporting (three 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 **limited.**

As part of their annual internal audit plan, Internal Audit also delivers a number of risk-based advisory and performance reviews. In discussion with the Trust, these are focused on areas identified as offering the greatest scope for improvement to maximise the benefit and learning to the Trust. Three performance reviews were also undertaken during 2018/19, amounting to one moderate and two limited assurance ratings.

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 management and control of prescriptions and looking at recruitment and retention of locum staff to GMC guidelines, and a review of private patient policy. The LCFS has also audited staff declarations of interest in accordance with Trust policy in comparison with Disclosure UK data[4].

Formal action plans have been agreed to address significant control weaknesses in all areas where these have been identified. Implementation of the recommendations has been tracked with no overdue actions at year-end.

6. Information Governance

In 2018 the UK's third generation of data protection law received the Royal Assent and its main provisions commenced on 25 May 2018. The new Act aims to modernise data protection laws to ensure they are effective in the years to come. The General Data Protection Regulation (GDPR) also came into force on 25 May 2018. The Information Governance (IG) Toolkit has also been replaced with the NHS Digital's Data Security and Protection Toolkit (DSPT) which replaced the IG Toolkit in April 2018. Due to the size of our organisation and the amount of information that we

[4] Disclosure UK is an industry-led initiative to deliver a searchable database that shows payments and benefits in kind made by the pharmaceutical industry to doctors, nurses and other health professionals and organisations in the UK.

process, the Trust submitted a baseline DSPT submission in October 2018 and its final assessment in March 2019.

Information Governance incidents are reported via the Trust's incident reporting system and there have been a number of incidents which have been reported to the Information Commissioner in 2018/19:

1. A discharge from clinic letter was accidently sent to another patient as the member of staff transposed the hospital identifier.
2. A letter to a patient was accidently inserted to a letter to another patient from the same clinic.
3. A parent of a child contacted the hospital to alert them that a letter sent about her daughter had 9 other children's letters in the envelope.
4. A member of the public handed in a collection of patient notes to a General Practice in Liverpool, which were found in the boot of a car that they had recently purchased. These notes contain identifiable demographic information.
5. A patient invoice was sent to the wrong address. The invoice contained personal and sensitive information.
6. Maternity handheld notes (purple notes) were sent home with the wrong patient.

An improvement plan has been agreed with NHS Digital to ensure the learning from these incidents is acted upon to minimise the risk of exceptions in 2019/20.

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 2018/19 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 2018/19 significant Issues

In the 2017/18 Annual Governance Statement, the Trust disclosed three significant issues. Progress on these issues is outlined below.

Medium Term Financial Plan

The Trust's financial difficulties in the 2018/19 year were traced back 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 meant that instead of taking forward a recurrent deficit of £12 million into the 2018/19 year, the Trust carried forward a deficit of £20.7 million. A review of the Trust's Medium Term Financial Plan demonstrated that the deterioration in the Trust's recurrent position needed 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. The recurrent financial position of the Trust remains a critical issue.

Emergency Department staffing

The staffing of the Emergency Department was extremely fragile throughout the year and the Trust made public its plans 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 was not achieved and the Trust has been unable to sustain the required levels of improvement against the national target. The Trust has been working hard with partner organisations to increase flow, and reduce the numbers of patients classified as 'stranded' and 'superstranded'. The aim to reduce bed occupancy levels to the nationally accepted safe levels of 95% continued throughout the year but at times, bed occupancy exceeded 100% with additional patients on wards.

8.2 2019/20 significant issues

- Medium Term Financial Plan
- Patient Flow
- Maternity SoS Review
- CQC/Special measures
- Unstable Board
- Estate/Equipment fragility and IT

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 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 protects patients, staff, the public and other stakeholders against risks of all kinds. The Trust Board is able to demonstrate:

- That it has been informed through assurances about all risks to the delivery of objectives, not just financial.
- That it has arrived at its 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 provides 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 **limited 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

A number of control Issues, classified as High Priority by our core internal audit processes were noted during the 2018/19 year. These are described in section 5 of this Annual Governance Statement and were in the areas of Income and Debtors, Business Assurance Framework, Cash Management, Waste Reduction and Budgetary Control / Financial Reporting. Formal action plans have been agreed to address significant control weaknesses in all areas where these have been identified. Implementation of the recommendations has been tracked with no overdue actions at year-end.

As the Accountable Officer, I can provide Moderate assurance that the Assurance Framework is sufficient to meet the requirements of the 2018/19 AGS and provide a Moderate assurance that there is **an adequate and effective system of internal control** to manage the significant risks identified by the Trust.

The system of internal control has been in place at the Trust for the year ended 31 March 2019 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