Shropshire Community Health NHS
NHS Trust

Board meeting date: 14 July 2012	Agenda Item number: 9.2	Enclosure: 6

Title	Governance Report

Accountable Director:	Julie Thornby, Director of Governance and Strategy
Author (name & title):	Peter Foord, Corporate Risk Manager

Action required from the Board:	Decision / Approval	Gain assurance	Discussion	Information
	✓	☐	☐	✓

What other Trust Committee has considered this report?	Committee	Date reviewed	Key points or recommendations
	Extraordinary Audit Committee	6th June 2012	The Audit Committee considered the Annual Report, Annual Accounts, Annual Governance Statement, External Audit Governance Report and Internal Audit Annual Report at its extraordinary meeting. The committee approved the Annual report , Annual Accounts and Annual Governance Statement
	The Board	14th June	The Board considered the Board Assurance Framework (BAF). It was reported to the Board that the Audit Committee had approved the documents as listed above.

	Audit Committee	3rd July 2012	The Audit Committee received and discussed the Board Assurance Framework (BAF). Recommendations are included in this report

Purpose of the report	This report details the main points discussed at the Audit Committee meetings on the 6th June and 3rd July. The report proposes changes recommended to be made to the Board Assurance Framework

What are the key issues that the board needs to consider in this report?	The Board is asked to note the work carried out in the Committee, and ratify certain key documents approved by the Committee . The Board needs to consider if the Board Assurance Framework , with the changes recommended by the Committee, accurately reflects the most important strategic risks facing the Trust.

Recommendation(s) to Board	The Board should: ▪ Note the external audit governance report ▪ Ratify the annual accounts and Trust annual governance statement as agreed by the Audit Committee. ▪ Consider any changes needed to the Board Assurance Framework. ▪ Approve the revised Audit Committee Terms of Reference. ▪ Note that the Committee approved the updated Risk Management Policy, and the Policy on Procedural Documents, and that the Trust Annual Report will be presented to the August Board meeting for final approval.

Strategic Objective(s) to which this paper relates: ✓ / ✖	To increase quality, safety and productivity of the services we provide ✓	To explore every opportunity to innovate and improve	To build financial strength and resilience ✓	To develop strong community links and a reputation for responsiveness

Which key standards or assurances does this report relate to?		**State specific standard / outcome or BAF risk**
	CQC	Aspects of Governance are included within the standards for Safeguarding and Safety, Suitability of Staffing and Quality and Management.
	NHSLA	Standard 1.4 Risk Management Processes Standard 1.5 Risk Register
	Board Assurance Framework	Relates to all entries

IMPACTS & IMPLICATIONS	
Patient safety & experience	Good governance processes will have a positive impact on the safety and quality of patient care.
Financial (revenue & capital)	The Board Assurance Framework details major financial risks which could impact on the Trust objectives.
Equality & Diversity	There are no direct implications.
OD/Workforce	There are no direct implications.
What patient & public involvement has there been in this issue?	There are no direct implications.

Title	Governance Report

Introduction

This report sets out governance work that has taken place or is planned since the last Board meeting.

The report summarizes the main points discussed at the Audit Committee meetings on the 6th June and 3rd July. The Information Governance Committee has not met again before the issue of these Board papers.

Attached is the Board Assurance Framework for consideration by the Board.

Governance activity since the last Trust Board meeting

Audit Committee extraordinary meeting 6th June 2012

The main purpose of this meeting was to receive and approve key reports from Internal and External Audit, which formed the context for the Committee to scrutinize and approve the Annual Accounts, Annual Report and Trust Annual Governance Statement. In addition to this the committee received the Risk Management and Procedural Documents Policies for approval, allowing them to be completed in the timescales for NHSLA assessment. The committee also considered and approved the Trust Quality Account prior to it being considered at the Board meeting in June.

External Audit Governance Report

External audit's report provided an unqualified opinion on both the Trust's financial statements and value for money. The committee approved the letter of representation.

It was noted that good working papers had been provided and Finance staff were thanked for their work.

The External Audit Governance Report is appended to this report (Appendix 2)

Internal Audit Annual Report

Internal Audit presented their annual report. An opinion of significant assurance was given against the systems of internal control. It was noted that the BAF supported the Annual Governance Statement, and that no significant issues needed to be included within the statement. Two issues were raised within the report, one relating to patients monies and one relating to Trust compliance with level 2 of the Information Governance (IG) Toolkit. Following discussion it was agreed that the Trust had met Level 2 of the IG Toolkit within 2011/12 and that this would be removed as an issue from the report.

The committee agreed that the above reports were positive and consistent with other reports received.

Trust Annual Governance Statement

The Annual Governance Statement has replaced the Statement of Internal Control, which all NHS organizations had to produce annually until this year. This has brought the NHS in line with other government departments. The Governance Statement details the governance systems within the Trust which are designed to ensure that risk is managed in line with legal and NHS requirements, and that the systems are in accordance with the organisation's aims and objectives. The statement must detail any control issues that have occurred during the previous year.

No significant control issues have been identified within the statement. The committee had previously been sent the statement for comment, and no additional changes were made at the extraordinary meeting. The Committee approved the statement, which is attached to this report (Appendix 3). The Board is asked to ratify the statement.

Annual Accounts

The Committee received the Annual Accounts. Members noted that there were no historical comparisons that could be made. It was noted that the accounts did not include any values for land and buildings as yet, recognizing that these assets had not transferred. Members approved the accounts.

The committee's findings were reported to the Board on the 14th June. The summary accounts are appended to this report (Appendix 5). The Board is asked to ratify the accounts.

Policies

The Committee approved the revised Risk Management and Procedural Document policies.

Quality Account

The Committee received and approved the Quality Account, which is a further document which falls within the Committee's terms of reference to comment on. The Committee noted that the document was easy to read, and approved the Account, which was then approved at the 14 June Board meeting.

Trust Annual Report

The committee had previously received and commented on the draft report, and at the extraordinary meeting, noted the addition made to the report to include information on pay multiples which is a new requirement. The Committee approved the document. The Annual Report is now being designed before publication to

include photographs and graphics, and will be brought to the Board's August meeting for approval, before being presented at the Trust's AGM, to take place before the end of September (date to be confirmed).

Audit Committee Meeting 3rd July 2012

Standing Financial Instructions (SFIs) / Standing Orders (SOs)

The Committee approved minor amendments to the SFIs/SOs. These will be presented to the August Board for approval.

Risk Registers

The Committee received the Corporate Risk Register. The following points were made:

Entry 1057, Clinical Information

The Committee questioned the initial risk rating of 16, compared with the current rating of 12. It heard that the initial rating is the level of risk if no mitigation controls were applied. The implications to clinical safety if no risk controls were in place would be very significant, leading to the high initial rating. The current risk rating is with the current mitigation measures in place, e.g. record tracking processes. The Committee was satisfied with this explanation.

Entry 956, Staff Engagement.

This entry has an action to implement director visits to sites, and it was agreed to follow up on progress on implementing this.

Members raised two risks relating to the Ludlow re-development project:

- Risks associated with the project fees/costs totalling £500,000. This is a shared risk with the PCT; meeting these costs has not yet been agreed, but the likelihood of this becoming a serious risk is low. Members requested that this be added to the Corporate Risk Register.
- Support for the services provided by the project by other providers and commissioners. It was agreed that the specific issues relating to Ludlow be added to the risk about 'Investment by Commissioners' on the Board Assurance Framework

Hospitality Register

The Committee received the annual hospitality report and register. No particular issues were raised. The need for continuous awareness raising about the requirements was noted.

Clinical Audit

The Committee received the Clinical Audit Annual Report and Work plan. The report had previously been presented to the Quality and Safety Committee. Members asked what audits were planned relating to clinical handover, and it was noted there are two audits planned for inter hospital handovers. It was agreed that as the Clinical Transfer of Care Policy has just been approved, further audits would be required in the future, once the policy has been fully implemented.

Terms of Reference

The Terms of Reference were reviewed in line with the work plan. Small amendments relating to the accounts, financial statements, annual report and quality account were made. The updated terms are appended to this report for the Board's approval with the amendments highlighted (Appendix 1).

Annual Review of Effectiveness

The Committee carries out an annual review of effectiveness in line with the recommendation in the Audit Committee Handbook. A draft was presented to the committee. It was agreed members should submit their comments, and that the Chair would meet with the Risk Manager to complete the assessment taking into account these comments.

Counter Fraud Report

The committee received the Counter Fraud Annual Report and Work Plan. Members felt assured that the work being carried out was comprehensive and was in line with requirements. Issues were raised on the conformity of processes in relation to completion of timesheets. The committee did not feel that this was a high risk fraud issue but felt that there were other risks e.g. proof of compliance with Working Time Regulations. The Committee requested that these issues be raised at the Organisational Development and Workforce Group and be added to the Corporate Risk Register.

The Committee approved the following Counter Fraud Policies:

- Counter Fraud Strategy
- Fraud and Corruption Response Policy
- Local Counter Fraud Communication Strategy
- Interaction between Local Counter Fraud Specialist and Workforce Department Protocol
- Interaction between Local Counter Fraud Specialist and Internal Audit Protocol
- Protocol between the Local Counter Fraud Specialist and the Security Management Specialist
- Anti Bribery Policy and Procedure

External Audit

The committee noted the reduction in fees from £75,000 to £45,000. There will be additional charges of approximately £12,000 for work on the Quality Account and Charitable Funds.

The Annual Audit Letter was presented, with an unqualified opinion being given on both the annual accounts and value for money audits

Internal Audit

The Committee received and approved the Internal Audit Strategy for 2012/13. Minor amendments have been made.

One completed audit was received relating to Charitable Funds; this was an advisory piece of work benchmarking the Trust's arrangements. The report concluded that extra income was possible, but only if certain provisions in the arrangements were met. This work will be taken forward as part of the Treasury Management Policy

Information Governance Committee

The next meeting of the committee is due to take place on the 10th July 2012, and will be reported to the August meeting of the Board

Board Assurance Framework

The committee made the following amendments to the BAF(Appendix4)

Entry 957 Failure to develop a genuinely integrated organisation

All actions relating to this have been completed and the risk level has been reduced to the target level of moderate. The committee agreed the risk be removed from the BAF to the Corporate Risk Register

Entry 959 Patient Handovers

It was agreed at the last meeting this risk would be removed when the Clinical Transfer of Care Policy was approved. This was approved on the 11th June. The risk is now reduced to its target level. The committee agreed the removal of the risk from the BAF to the Corporate Risk Register

These two risks have been removed from the attached BAF

Entry 991 Clinical Quality and Safety

The committee discussed the advantages and disadvantages of either keeping the risk in its current form or splitting into its component parts, e.g. pressures sores, falls and compliance with the quality governance framework. It was agreed that the entry represented the strategic risk of clinical quality as a whole and should remain in its

current format. It was felt that as the elimination of avoidable pressure sores is a high priority that this should be considered at the October meeting of the Audit Committee. Dependant on progress towards the target a separate entry for pressure sores may be considered.

BAF index

ID	Title	Risk level (initial)	Rating (initial)	Risk level (current)	Rating (current)	Risk level (Target)	Rating (Target)	Risk is:	Page
991	Clinical Quality and Patient Safety	HIGH	20	HIGH	16	MOD	8	Level	1
1063	Failure to have appropriate IMT systems in place e.g. replacement PAS	HIGH	16	HIGH	16	MOD	9	Level	3
1074	Insufficient investment in services by commissioners	HIGH	16	HIGH	16	MOD	9	Increasing	5
1098	Failure to deliver CIPs longer term	HIGH	16	HIGH	16	MOD	12	Increasing	6
1099	Inability to grow the Trust's business, leading to sustainability risks	HIGH	20	HIGH	16	MOD	9	Level	7
1068	Failure to achieve FT status	HIGH	20	HIGH	15	MOD	10	Level	4
1071	Failure to develop business skills for key staff	HIGH	16	MOD	12	MOD	9	Level	5
1065	Compromise to partnership working due to competitive factors, and impending use of AQP	HIGH	20	MOD	12	MOD	8	Level	3
1062	Failure to deliver CIPs 12-14	HIGH	16	MOD	12	MOD	8	Increasing	2
1096	Quality Impact of Cost Improvement Programs longer term	HIGH	20	MOD	8	LOW	4	Increasing	6
958	Quality Impact of Cost Improvement Programs 12-13	HIGH	20	MOD	8	LOW	4	Increasing	1

Conclusions/Recommendations/Board action required

- The Board is asked to note the contents of the report
- The Board is asked to consider whether this report, or any other item on the Board agenda, will affect the risks to the Trust's objectives detailed in the BAF, and whether the risks require updating as a result of these considerations
- The Board is asked to ratify the Annual Accounts, and Trust Annual Governance Statement.
- The Board is asked to approve the amended Audit Committee Terms of Reference.

Attached:
Appendix 1 – Audit Committee Terms of Reference
Appendix 2 – External Audit Report – Annual Governance Report
Appendix 3 – Trust Annual Governance Statement
Appendix 4 – Board Assurance Framework
Appendix 5 - Accounts

Appendix 1

Audit Committee Terms of Reference

Version: **2.0**

Approved by: **Trust Board**

Date approved	
Date issued:	July 2012
Review date:	July 2013

Shropshire Community Health NHS Trust

AUDIT COMMITTEE

Terms of Reference

Document History:	
Version:	2.0
Ratified by:	Shropshire Community Health NHS Trust Board
Date ratified:	
Name of author(s):	Stuart Rees, Director of Finance, Contracting & Performance Julie Thornby, Director of Governance & Strategy Sarah Lloyd, Deputy Director of Finance
Committee Chair	Chris Bird, Non-Executive Director

Name of responsible committee/individual:
Shropshire Community Health NHS Trust Board

Target audience: Shropshire Community Health NHS Trust Board

Contents

Section

1. Introduction

These Terms of Reference build on original work based around the Cadbury Committee, the Combined Code, subsequent guidance, best practice in the private and public sector and use the model from the NHS Audit Committee Handbook 2005. They reflect the particular nature of Audit Committees in the NHS and the growing role of the Committee in developing integrated governance arrangements and providing assurance that NHS bodies are well managed across the whole range of their activities.

In line with the Higgs Report recommendations, three Non-executive Directors will be appointed, unless the Board decides otherwise; of which one will have significant, recent and relevant financial experience.

2. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a Non-Executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

3. Membership

The Committee shall be appointed by the Board from amongst the Non-Executive Directors (NEDs) of Shropshire Community Health NHS Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Board.

The Chair of the Trust shall not be a member of the Committee. The Chair of the Audit Committee shall be seen as independent and therefore should not chair any other governance committees.

All Non- Executive Directors will be informed of the dates of Audit Committee meetings and can attend meetings is they wish to

The Non-Executive Chair of the Quality and Safety Committee will be one of the Non-Executive Director Members. The Executive Director of Finance, Contracting and Performance, a representative from Internal Audit and a representative from External Audit shall normally attend meetings. The Executive Director(s) responsible for quality, governance and risk and the Trust's Governance and Risk Managers should also be invited to attend the meetings to address, as a standing item, issues around the Assurance Framework and other matters related to the Trust's Internal Control and risk management systems. However, at least once a year the Committee may wish to meet privately with the External and Internal Auditors, without any Executive Board Director present.

The Chief Executive shall be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement of Internal Control.

The Chief Executive, other Executive Directors and Senior Managers shall be invited to attend for discussions when the Committee is discussing areas of risk or operation that are the responsibility of that Director/Manager.

The Local Counter Fraud Specialist (LCFS) has the right of access to the Audit Committee. The LCFS will be invited to at least two meeting a year to update the Audit Committee on the LCFS's work, including presenting an annual report and Annual Work plan.

The Local Security Management Specialist (LSMS) has the right of access to the Audit Committee. The LSMS will be invited to at least one meeting a year to update the Audit Committee on the LSMS's work, including presenting an annual report.

4. Meetings and Quorum

The Chair will preside at all meetings. In extraordinary circumstances where the Chair cannot attend, the Chair will nominate one of the other NEDs to act as vice-chair.

A quorum shall be two members of the Committee. If the Committee is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting.

Meetings shall be held not less than four times a year. The current work plan for the Trust is four regular meetings together with an additional meeting to focus on the annual accounts. The External Auditor or Head of Internal Audit may request additional meetings, through the Chair of the Committee, if they consider that one is necessary.

Members are expected to attend all meetings; however, as a minimum should attend at least two thirds of all meetings.

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he / she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the Audit Committee's consideration has been completed.

The Chair of the Audit Committee and one of the other members, in consultation together, may also act on urgent matters arising between meetings of the Committee.

5. Authority

The Trust Board is required to establish an Audit Committee as a committee of the Board. The Audit Committee is a non-executive committee and has no executive powers other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The budget for such advice should be within agreed financial constraints.

6. Role and Duties of the Audit Committee

The Committee will provide an overarching governance role and review the work of other governance committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include any risk management and / or governance committees that are established. Minutes of the meetings of such committees and associated action plans will be presented to the Audit Committee for review, including especially the Quality and Safety Committee.

The duties of the Committee can be categorised as follows:

a) Ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board;

b) Reviewing and monitoring the independence, objectivity, work and findings of the external auditor appointed and considering the implications of and management's responses to their work;

c) Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the organisation;

d) Ensuring that the systems for financial reporting to the Board, including those of budgetary control, performance, safety and quality are subject to review as to completeness and accuracy of the information provided to the Board;

e) Reviewing financial and information systems, monitoring the integrity of the financial statements of the Trust and any formal announcements relating to

the Trust's financial performance and reviewing significant financial reporting judgments;

f) Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. This will include the receipt of annual self-assessments and reports from other Board Committees. The Committee will use an effective Assurance Framework to guide its work;

g) Monitoring compliance with Standing Orders, Standing Financial Instructions and the Scheme of Delegation;

h) Reviewing schedules of losses and compensations and making recommendations to the Board;

i) Review, scrutinise and approve the annual report, quality account and financial statements prior to ratification by Board focusing particularly on;

   i. the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
   ii. changes in, and compliance with, accounting policies and practices;
   iii. unadjusted mis-statements in the financial statements;
   iv. major judgmental areas;
   v. significant adjustments resulting from audit.

j) Reviewing, scrutinising and approving the annual financial statements;

k) Reviewing the external auditors report on the financial statements and the annual management letter;

l) Conducting a review of the Trust's major accounting policies;

m) Reviewing any incident of fraud or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the Trust's published financial accounts or reputation;

n) Reviewing the adequacy and effectiveness of the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

o) Reviewing any objectives and effectiveness of the internal audit services including its working relationship with external auditors;

p) Reviewing major findings from internal and external audit reports and ensure appropriate action is taken;

q) Reviewing 'value for money' audits reporting on the effectiveness and efficiency of the selected departments or activities;

r) Reviewing the mechanisms and levels of authority (e.g. Standing Orders, Standing Financial Instructions, delegated limits) and make recommendations to the Trust Board;

s) Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance;

t) Reviewing the scope of both internal and external audit including the agreement on the number of audits per year for approval by the Trust Board;

u) Investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation;

v) Reviewing Hospitality and Sponsorship Registers;

w) Reviewing the information prepared to support the controls assurance statements prepared on behalf of the Board and advising the Board accordingly;

x) Maintaining and reviewing a register of contracts for services held by the Trust;

y) Review arrangements by which staff or the Trust may raise in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

z) Satisfying itself on assurances from the clinical audit function in relation to clinical risk, and reviewing the findings of other significant assurance reports e.g., by regulators such as CQC or NHSLA, via reviewing minutes and action plans of the relevant Committees, especially Quality and Safety.

7. Monitoring Effectiveness

Through receipt of the minutes and the Annual Report of the Audit Committee the Board will monitor the effectiveness of the Committee. The Committee also assesses itself against the Audit Committee checklist and draws up an action plan where further work is required. This will be submitted to the Board.

A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair of the Audit Committee.

8. Administrative Arrangements

The Committee will receive appropriate administrative support. Duties will include:

- preparing and circulating the agenda and papers with the Chair;
- maintaining accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting;
- drafting minutes for circulation to members within five full working days of the meeting;

- maintaining a database of any documents discussed and/or approved and recall them to the Committee when due;
- organising future meetings;
- filing and maintaining records of the work of the Committee; and
- advising the Committee on pertinent areas

9. Relationships and Reporting

The minutes of Audit Committee meetings shall be formally recorded and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Standards for Better Health and any subsequent regulatory regime.

As part of its Annual Report to the Board, the Committee will prepare an 'impact assessment' to identify specific areas where the Committee has made important positive differences to the governance of the Trust.

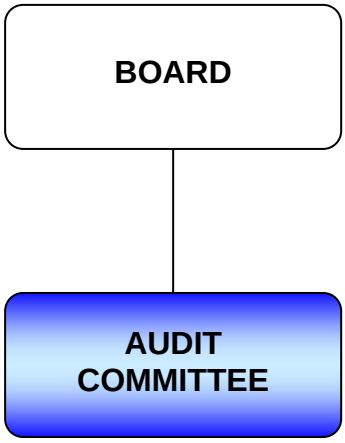
Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally the matter may need to be referred to the Department of Health.

10. Review of Terms of Reference

This document will be reviewed annually or sooner if agreed by the Audit Committee or Trust Board.

Any amended Terms of Reference will be agreed by the Audit Committee for recommendation to a subsequent meeting of the Trust Board for its approval.

11. Committee Structure



Annual governance report

Shropshire Community Health NHS Trust

Audit 2011/12

audit commission

Contents

Key messages

This report summarises the findings from the 2011/12 audit which is substantially complete. It includes the messages arising from my audit of your financial statements and the results of the work I have undertaken to assess your arrangements to secure value for money in your use of resources.

Financial statements

As at 6 June 2012 I expect to issue an unqualified audit opinion.

For the first year of the Trust, the closedown went well with good quality working papers provided to support the financial statements.

There remain some non-adjusted errors, none of which are material. The main item is the unadjusted provision for the Mutually Agreed Resignation Scheme (MARS) which is £0.26m overstated.

There were some minor amendments and disclosure changes for the financial statements and supporting NHS consolidation Schedules (TRU forms), none of which changed the overall view given by the accounts.

Value for money (VFM)

I expect to conclude that you have made proper arrangements to secure economy, efficiency and effectiveness in your use of resources.

Before I give my opinion and conclusion

My report includes only matters of governance interest that have come to my attention in performing my audit. I have not designed my audit to identify all matters that might be relevant to you.

Independence

I can confirm that I have complied with the Auditing Practices Board's ethical standards for auditors, including ES 1 (revised) - Integrity, Objectivity and Independence.

I am not aware of any relationships that may affect the independence and objectivity of the Audit Commission, the audit team or me, that I am required by auditing and ethical standards to report to you.

I ask the Audit Committee to:

- take note of the adjustments to the financial statements included in this report (appendices 2 and 3); and
- approve the letter of representation (appendix 4), on behalf of the Trust before I issue my opinion and conclusion.

Financial statements

The Trust's financial statements and annual governance statement are important means by which the Trust accounts for its stewardship of public funds. As Directors you have final responsibility for these statements. It is important that you consider my findings before you adopt the financial statements and the annual governance statement.

Opinion on the financial statements

Subject to satisfactory clearance of outstanding matters, I plan to issue an audit report including an unqualified opinion on the financial statements. Appendix 1 contains a copy of my draft audit report.

Before the opinion can be given, we will need the final signed originals of the;

- Annual Governance Statement;
- Statement of Chief Executive's Responsibilities as accountable officer
- Directors' Statement of Responsibilities;
- letter of management representation: and
- final version of the annual report.
- Authenticated 'free text' sheets for TRU forms

Uncorrected errors

MARS Provision £0.26m

A local Mutually Agreed Resignation Scheme (MARS) was set up during the 2012 year. The provision is £263,794.16 overstated. This is for the staff listed in the MARS listing as being "considered" as at the year end. Unfortunately there was no formal SHA approval for these 18 staff and the staff had not confirmed acceptance or been requested to confirm acceptance before the year end.

Without this I do not think that the requirement of IAS37, that there is a present obligation from a past event, can be demonstrated as being in place as at 31/3/2012.

However, we have been informed that the Trust is likely to push forward with this scheme and incur cost during the following financial year 2012/13. Therefore the error is considered by the Trust to be one of financial period allocation, rather than the costs not being incurred.

There are some other minor errors not adjusted for as detailed on Appendix 2

Corrected errors

Property land and Equipment (Fixed Assets) Note 15.1,

There was a formula error in the accounts provide by the DoH that linked the Furniture & fittings Merger adjustment in Note 15.1 to an incorrect value of £1.97m on the consolidation schedules (TRU forms), overstating the opening cost as at 1 April 2011. This did not impact on the net book value disclosed on the face of the Statement of Financial Position (Balance sheet). The correct figure for the merger adjustment was £192,000, which had been correctly included in the consolidation schedules.

There were other corrected errors in relation to the consolidation schedules (TRU forms), none of which impacted upon the accounts as they related to agreement of balances with other public sector bodies. These have been corrected and no significant imbalances remain.

Significant risks and my findings

I reported to you in my March 2012 Audit Plan the significant risks that I identified relevant to my audit of your financial statements. In Table 2 I report to you my findings against each of these risks.

Table 1: **Risks and findings**

Risk	Finding
Transfer of Staff from the former PCT bodies into the newly formed Community Trust. *	I reviewed controls over ensuring the transfers of staff were accurately recorded as being applicable to the new Trust. I reviewed on a sample basis that the correct pay and grade information was transferred for a random selection of staff transferred to ensure correctly assimilated onto the Trust's payroll. No concerns were noted that I need to bring to your attention at this time.

Risk	Finding
Merger accounting and restructuring	I reviewed with the PCT Auditor the arrangements for agreeing plans with your host PCT on the accounting amendments needed. I confirmed: ■ that income and expenditure had been agreed for the whole year correctly, despite the Trust being formed on 1 July 2011; and ■ that the PCTs and Trust's accounts were consistent in relation to the transfer and merger accounting entries in the Trust's financial statements No concerns were noted that I need to bring to your attention at this time.
Risk of financial manipulation due to pressure to meet targets	I reviewed material accounting estimates and changes to accounting policies; Confirmed in year financial reporting compared with year end financial position to ensure consistency. Sample tested the authorisation of journals were for appropriate transactions. No concerns were noted that I need to bring to your attention at this time.

** Due to the late change in DoH guidance on the transfer of assets from PCTs to newly formed Community Trust this risk was introduced and the risk in relation to the "Valuation and depreciation of property plant and equipment" was removed. This was noted to the Audit Committee in April 2012.*

Significant weaknesses in internal control

It is the responsibility of the Trust to develop and implement systems of internal financial control and to put in place proper arrangements to monitor their adequacy and effectiveness in practice. My responsibility as your auditor is to consider whether the Trust has put adequate arrangements in place to satisfy itself that the systems of internal financial control are both adequate and effective in practice.

I have tested the controls of the Trust only to the extent necessary for me to complete my audit. I am not expressing an opinion on the overall effectiveness of internal control. I have reviewed the Annual Governance Statement and can confirm that:

- it complies with the requirements of the Manual for Accounts; and
- it is consistent with other information that I am aware of from my audit of the financial statements.

I have not noted any significant weaknesses during the audit that are relevant to preparing the financial statements.

Other weaknesses in internal control

The Trust has significant operating leases. During the review of leases we found that the original leases were not kept on the Trust premises, but were held at the Estate Advisors home address. We appreciate that there has been difficulties in securing office accommodation, but key documents of the Trust's should be kept securely on the Trust's premises. This safeguards both the Trust's and employees best interests.

This also contributed to our inability to trace £49,000 of source documents to support changes to lease costs, such as rent reviews as suitable evidence was not available. As not material this was not considered an opinion issue and does not indicate that rents were overpaid.

Other matters

I am required to communicate to you significant findings from the audit and other matters that are significant to your oversight of the Trust's financial reporting process

I have no matters I wish to report.

Summarisation schedules

Alongside my work on the accounting statements, I have also reviewed and reported on the summarisation schedules submitted by the Trust to the Department of Health. I have also reported to the National Audit Office under its Group Audit Instructions. Other than the errors noted in Appendix 2, I have no other matters to report.

Annual Report

I have reviewed the Draft Annual Report dated 15 May 2012 and have found that it is consistent with the audited financial statements.

Summary financial statements

I have reviewed the summary financial statements prepared by the Trust and reported they are consistent with the audited financial statements, subject to correction of the errors noted in appendix 2.

In additions to there amendments the remuneration report did not contain the new disclosure for 2011/12. For this year entities must report the mid-point of the banded remuneration of the highest paid director, whether or not this is the Accounting Officer or Chief Executive, and the ratio between this and the median remuneration of the reporting entity's staff.

This gives an indication of the level of difference between the mid-point salary at the Trust and the highest paid employee.

Value for money

I am required to conclude whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is the value for money conclusion.

I assess your arrangements against the two criteria specified by the Commission. In my March 2012 Audit Plan I reported to you the significant risks that were relevant to my conclusion. I have set out below my conclusion on the two criteria, including the findings of my work addressing each of the risks I identified.

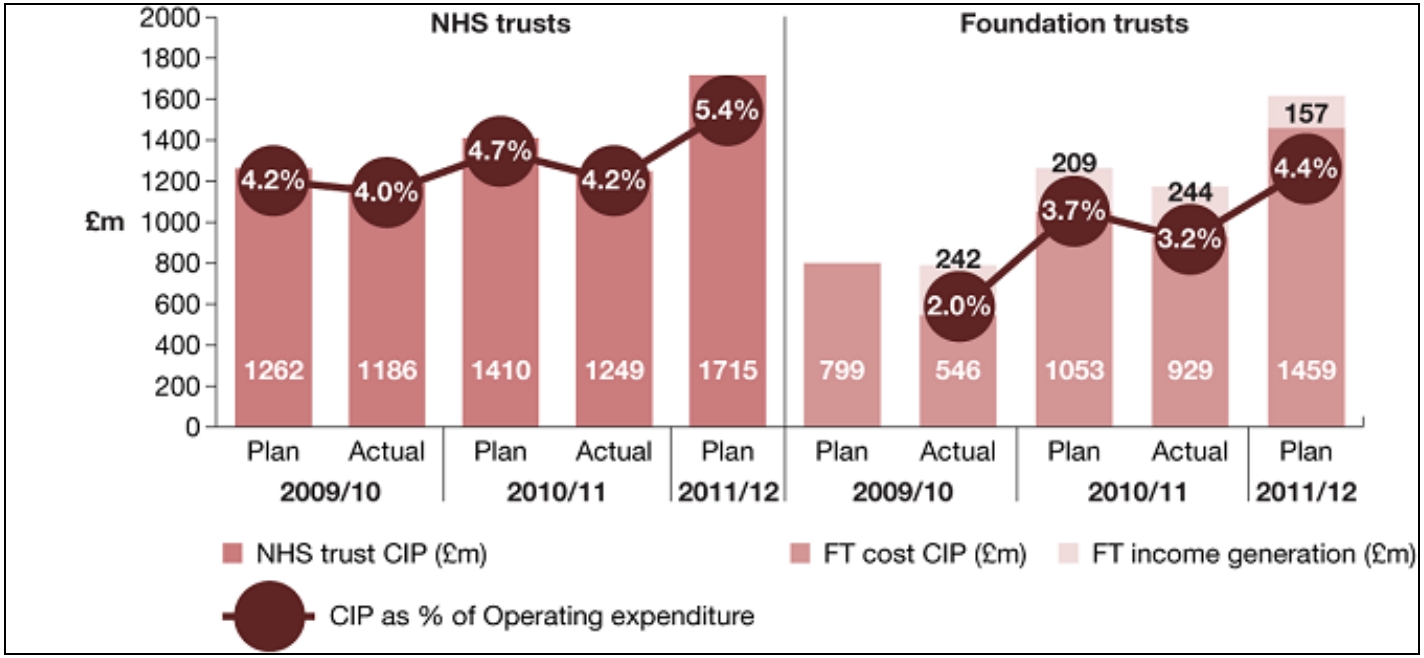
I intend to issue an unqualified conclusion stating that the Trust has proper arrangements to secure economy, efficiency and effectiveness in the use of its resources. I include my draft conclusion in Appendix 1.

Table 2: **Value for money conclusion criteria and my findings**

Criteria	Risk	Findings
1. Financial resilience The organisation has proper arrangements in place to secure financial resilience. Focus for 2011/12: The organisation has robust systems and processes to manage effectively financial risks and opportunities, and to secure a stable financial position that enables it to continue to operate for the foreseeable future.	The Trust has a challenging financial savings target of £2.67m. As at quarter 2, nearly £1.03m of the savings remained to be achieved in year. The Trust has indicated this is an “Amber” risk. The Trust has plans to reach Foundation Trust status by 2013/14 and this will require the development of robust forward looking financial plans in order to satisfy submission requirements.	The Trust has achieved its savings targets, mainly due to late non-recurrent income from the PCT for increased performance. Looking forward the Trust has revised its IBP and set out realistic but challenging savings targets with CIP targets of between 4%-5% which is the normal average observed in NHS Trusts (see fig 1 bellow). The Trust has developed project plans to support the IBP that the Board will now have to ensure are delivered to plan to achieve FT status in the timeframe remaining.

Criteria	Risk	Findings
2. Securing economy efficiency and effectiveness The organisation has proper arrangements for challenging how it secures economy, efficiency and effectiveness. Focus for 2011/12: The organisation is prioritising its resources within tighter budgets, for example by achieving cost reductions and by improving efficiency and productivity.	No specific risk noted	I have reviewed the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness, and have not identified any significant weaknesses.

Figure 1: **Cost Improvement Plan savings in NHS and Foundation Trusts**



Source - AC guide to Delivering sustainable cost improvement programmes

I am required to consider the Authority's arrangements to secure economy, efficiency and effectiveness.

For 2011/12 the Commission has determined that the scope of my work on value for money at the Authority is limited to:

- reviewing the Annual Governance Statement (AGS);
- reviewing the results of the work of other relevant regulatory bodies or inspectorates, to consider whether there is any impact on my responsibilities; and
- other risk-based work as suitable.

I have reviewed your AGS and I have no matters that I need to report.

As I reported in my March 2012 Audit Plan:

- I am not aware of any relevant work of other relevant regulatory bodies or inspectorates; and
- I identified the risk in table 2 noted above in relation to achievement of CIP in year, this has been addressed by the audit review and the CIP was achieved.

Fees

I reported my planned audit fee in the October 2011 Audit Fee Plan.

Table 3: **Fees**

	Planned fee 2011/12 (£)	Expected fee 2011/12 (£)
Audit - opinion	£76,000	£76,000
Audit – quality accounts	N/A for 2011/12	£0
Non-audit work	None requested for 2011/12	£0
Total	**£76,000**	**£76,000**

The fee above is net of VAT.

The Audit Commission has paid a rebate of 8% to reflect attaining internal efficiency savings, reducing the net amount paid to the Audit Commission. This is not reflected in the above.

Appendix 1 – Draft independent auditor's report

Independent Auditor's Report to the Directors of Shropshire Community Health NHS Trust

I have audited the financial statements of Shropshire Community Health NHS Trust for the year ended 31 March 2012 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. I have also audited the information in the Remuneration Report that is described as having been audited.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- *the table of salaries and allowances of senior managers;*
- *the table of pension benefits of senior managers; and*
- *the table of pay*.

This report is made solely to the Board of Directors of Shropshire Community Health NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the financial position of Shropshire Community Health NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I report to you if:

- in my opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- I refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because I have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- I issue a report in the public interest under section 8 of the Audit Commission Act 1998

I have nothing to report in these respects

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2011, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2012.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2011, I am satisfied that, in all significant respects, Shropshire Community Health NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2012.

Certificate

I certify that I have completed the audit of the accounts of Shropshire Community Health NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Tony Corcoran

Date

District Auditor

Audit Commission

2nd Floor, No.1 Friars Gate

1011, Stratford Road

Solihull

B90 4EB

Appendix 2 – Uncorrected errors

I identified the following errors during the audit which management have not addressed in the revised financial statements.

		Statement of comprehensive [net expenditure/income]		Statement of financial position	
Item of account	Nature of error	Dr £'000s	Cr £'000s	Dr £'000s	Cr £'000s
Note 35 – Provisions	The Trust has not fully complied with the requirements of IAS 37. The provision includes 18 staff being considered under MARS process, where there is no formal SHA approval or confirmed acceptance as at the year end. ■ Provision ■ Expenditure		264	264	
Note 28 Trade and other payables	An accrual had been raised for £15,000 against an expected invoice, but then the actual invoice had been included in year end creditors. This meant the amount was double counted. ■ Non - NHS accruals ■ Expenditure		15	15	
Note 39.1 Financial instruments	■ Financial instruments omitted a long term receivable of £29,000. This is a disclosure note only.				

Appendix 3 – Corrected errors

Property land and Equipment (Fixed Assets) There was a formula error in the accounts provide by the DoH that linked the Furniture & fittings Merger adjustments to an incorrect value of £1.97m on the consolidation schedules (TRU forms), overstating both gross cost and accumulated Depreciation. This did not impact on the net book value. The correct figure was £192,000, which had been correctly included in the consolidation schedules.

There were other corrected errors in relation to the consolidation schedules (TRU forms), none of which impacted upon the accounts as they related to agreement of balances with other public sector bodies. These have been corrected and no significant imbalances remain.

Appendix 4 – Draft letter of management representation

Shropshire Community Health NHS Trust - Audit for the year ended 31 March 2012

To:

Tony Corcoran
Engagement Lead

I confirm to the best of my knowledge and belief, having made appropriate enquiries of other directors of Shropshire Community Health NHS Trust, the following representations given to you in connection with your audit of the Trust's financial statements for the year ended 31 March 2012.

Compliance with the statutory authorities

I have fulfilled my responsibility under the relevant statutory authorities for preparing the financial statements in accordance with the NHS Manual for Accounts which give a true and fair view of the financial position and financial performance of the Trust, for the completeness of the information provided to you, and for making accurate representations to you.

Uncorrected misstatements

The effects of uncorrected financial statements misstatements summarised in the attached schedule are not material to the financial statements, either individually or in aggregate.

Supporting records

All relevant information and access to persons within the entity [as agreed in the engagement letter] has been made available to you for the purpose of your audit, and all the transactions undertaken by the Trust have been properly reflected and recorded in the financial statements.

Irregularities

I acknowledge my responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud or error.

I also confirm that I have disclosed:

- my knowledge of fraud, or suspected fraud, involving either management, employees who have significant roles in internal control or others where fraud could have a material effect on the financial statements;
- my knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others; and
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Law, regulations, contractual arrangements and codes of practice

I have disclosed to you all known instances of non-compliance, or suspected non-compliance with laws, regulations and codes of practice, whose effects should be considered when preparing financial statements.

Transactions and events have been carried out in accordance with law, regulation or other authority. The Trust has complied with all aspects of contractual arrangements that could have a material effect on the financial statements in the event of non-compliance.

All known actual or possible litigation and claims, whose effects should be considered when preparing the financial statements, have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

Accounting estimates including fair values

I confirm the reasonableness of the significant assumptions used in making the accounting estimates, including those measured at fair value.

Related party transactions

I confirm that I have disclosed the identity of Shropshire Community Health NHS Trust related parties and all the related party relationships and transactions of which I am aware. I have appropriately accounted for and disclosed such relationships and transactions in accordance with the requirement of the framework.

Subsequent events

All events subsequent to the date of the financial statements, which would require additional adjustment or disclosure in the financial statements, have been adjusted or disclosed.

Contingent liabilities

There are no other contingent liabilities, other than those that have been properly recorded and disclosed in the financial statements. In particular:

- there is no significant pending or threatened litigation, other than those already disclosed in the financial statements; and

- there are no material commitments or contractual issues, other than those already disclosed in the financial statements.

Related party transactions

I confirm the completeness of the information disclosed regarding the identification of related parties.

The identity of, and balances and transactions with, related parties have been properly recorded and where appropriate, adequately disclosed in the financial statements

Signed on behalf of Shropshire Community Health NHS Trust

I confirm that this letter has been discussed and agreed by the Audit Committee on behalf of the Board on 6 June 2012.

Signed

Director of Finance

Appendix 5 – Glossary

Annual Audit Letter

Report issued by the auditor to the [Trust/Authority] after the completion of the audit that summarises the audit work carried out in the period and significant issues arising from auditors' work.

Annual Governance Report

The auditor's report on matters arising from the audit of the accounting statements presented to the Audit Committee before the auditor issues their opinion and conclusion.

Annual Governance Statement (AGS)

The governance statement records the stewardship of the Trust to supplement the accounts. It gives a sense of how successfully it has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be. This statement draws together position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism.

Audit of the accounts

The audit of the accounts of an audited body comprises all work carried out an auditor under the Code to meet their statutory responsibilities under the Audit Commission Act 1998.

Audited body

A body to which the Audit Commission is responsible for appointing the external auditor.

Auditing Practices Board (APB)

The body responsible in the UK for issuing auditing standards, ethical standards and associated guidance to auditors. Its objectives are to establish high standards of auditing that meet the developing needs of users of financial information and to ensure public confidence in the auditing process.

Auditing standards

Pronouncements of the APB that contain basic principles and essential procedures with which auditors must comply, except where otherwise stated in the auditing standard concerned.

Auditor(s)

Auditors appointed by the Audit Commission.

Code (the)

The Code of Audit Practice for local NHS bodies issued by the Audit Commission and approved by Parliament.

Commission (the)

The Audit Commission for Local Authorities and the National Health Service in England.

Ethical Standards

Pronouncements of the APB that contain basic principles relating to independence, integrity and objectivity that apply to the conduct of audits and with which auditors must comply, except where otherwise stated in the standard concerned.

Internal control

The whole system of controls, financial and otherwise, that the [Trust/Authority] establishes to provide reasonable assurance of effective and efficient operations, internal financial control and compliance with laws and regulations.

Materiality

The APB defines this concept as ‘an expression of the relative significance or importance of a particular matter in the context of the accounting statements as a whole. A matter is material if its omission would reasonably influence the decisions of an addressee of the auditor’s report; likewise a misstatement is material if it would have a similar influence. Materiality may also be considered in the context of any individual primary statement within the accounting statements or of individual items included in them. Materiality is not capable of general mathematical definition, as it has both qualitative and quantitative aspects’.

The term ‘materiality’ applies only to the accounting statements. Auditors appointed by the Commission have responsibilities and duties under statute, as well as their responsibility to give an opinion on the accounting statements, which do not necessarily affect their opinion on the accounting statements.

Quality Account

A Quality Account is a report about the quality of services provided by an NHS body. The report is published annually and available to the public.

Significance

The concept of ‘significance’ applies to these wider responsibilities and auditors adopt a level of significance that may differ from the materiality level applied to their audit of the accounting statements. Significance has both qualitative and quantitative aspects.

Statement on Internal Control (SIC)

The annual report on the [Trust’s/Authority’s] systems of internal control that supports the achievement of the Trust’s policies aims and objectives.

Summarisation schedules

To produce the DH’s consolidated accounts the DH requires NHS bodies to produced their financial statements in a standard excel format called summarisation schedules along side their actual accounting statements.

If you require a copy of this document in an alternative format or in a language other than English, please call:
0844 798 7070

Design and production by the Audit Commission Publishing Team.

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors, members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
- any third party.

www.audit-commission.gov.uk

May 2012

Appendix 3

Shropshire Community Health NHS
NHS Trust

Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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 Trust from its formation on the 1st July 2011, for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

As Accountable Officer I work with partner organisations, including the local authorities, voluntary organisations, other healthcare providers, commissioning organisations the strategic health authority and patient representative groups. I work with these organisations to ensure that the Trust meets its obligations in fulfilling services agreements with commissioning bodies, meeting statutory duties and ensuring proper stewardship of public money.

The governance framework of the organisation

The Trust was established on the 1st July 2011, formed from the provider services of Shropshire County Primary Care Trust and NHS Telford and Wrekin.

The Corporate Governance arrangements of the Trust are set out in the Standing Orders, the Standing Financial Orders and the Schemes of Reservation and Delegation. These detail the committee structures and responsibilities. There are five Board sub-committees:

Audit Committee

The Audit Committee is responsible for ensuring that risk management systems, and systems for internal control are operating effectively by scrutinising assurance of their effectiveness. This applies to financial, clinical and governance systems. In doing this the committee utilises the work of internal and external audit in addition to internal management systems.

Quality and Safety Committee

The purpose of the Quality and Safety Committee is to oversee, co-ordinate, review and assess the clinical governance arrangements in place and issues relating to safety, effectiveness and patient experience throughout the Trust.

The primary aim is to ensure the robustness of systems and processes and behaviours that stand up to scrutiny and thus provide assurance to the Trust Board.

Resources and Performance Committee

The Resources and Performance Committee is responsible for the review and monitoring of Trust performance, contract delivery, financial systems, business risks, capital investments and charitable funds.

Information Governance Committee

The information Governance Committee is responsible for the review and monitoring of all aspects of the supply and use of information, including the use of information technology. This includes:

- information security and information risk management
- IT equipment use and security,
- Data integrity and control.

Appointments, Nomination and Remuneration Committee

This committee reviews the arrangements for succession planning and development of senior managers, and the appointment and remuneration of Executive Directors.

The Board continually monitors its performance. A programme of Board development sessions is in place to enhance the Board's effectiveness in its management of the Trust. Each Board sub-committee prepares a report of the key decision and findings at each meeting. The Board has a program of work which is reviewed annually.

The Board met 8 times on the year 2011/12. 3 meetings were fully attended. For the other 5 meetings there were 6 Voting Director non attendances over this period. The Audit Committee has an annual plan of work which it confirms is being met at each meeting. The Committee will assess itself against the Audit Committee Handbook self assessment tool annually and prepares an annual report to the Board. This is informed by the work of internal and external audit, management reports, the committee own assurance findings and any reports submitted to the Trust by regulatory or advisory bodies.

Risk assessment

The Trust's risk management arrangements are set out in the Risk Management Policy, which includes detailed guidance on the process of risk assessment. All risks are recorded on the Trust's risk management software

Risks are identified through

- The recording and investigation of incidents, complaints and claims
- Specific group and committee sessions to identify and analyse risks

- Clinical, internal and external Audit
- Other work carried out by Groups and Committees
- External and Internal reports and inspections
- Other external bodies, e.g. commissioners
- Being raised by individual managers and staff

All risks are rated using a 5 by 5 risk matrix. Risk consequences are defined on the matrix using four categories:

- Injury or harm
- Finance
- Service delivery
- Reputation

Dependant on the rating, risks are recorded at 4 levels

Departmental	Risks that are low level and can be managed locally
Directorate	Risks of a moderate level that impact on the directorates service objectives
Corporate	Risks that are moderate and have impact on the Trusts strategic objectives
Board Assurance Framework	Risk that are high level and pose a significant threat to the Trust's strategic objectives

The mitigation controls are identified at all levels, along with any further actions necessary to further control or mitigate the risks. The risk management policy identifies the groups and committee whose responsibility it is to monitor risks at the four levels, the effectiveness of their controls and the implementation of actions to further mitigate the risks.

The Audit Committee reviews the Board Assurance Framework and tests assurances with management. Internal Audit has reviewed the framework in place and used by the Trust during 2011/12. The Audit Committee reports its finding to the Board, which reviews the framework at each meeting.

The risks underneath have been assessed as the those which pose the greatest threat to the strategic objectives of the Trust:

Title	Nature of Risk	Summary of Mitigation
Clinical Quality and Patient Safety	Risks associated with high numbers of pressure sores and falls, compliance with CQC essential standards of quality and safety, the Monitor Quality Governance Framework and commissioners requirements.	Each area is managed though key committees who receive regular performance and trend reports. Where issues are identified action plans and initiatives are developed to improve quality and safety provision.
Compromise to effective partnership working with other providers due to , for example,	Partners compete rather than co-operated to improve market share and	Participation in local health economy strategy discussions and groups to

others' differing priorities or competitive forces given diminishing resources	gain extra resources.	produce and agree systems plans.
Failure to achieve FT status	Risks associated with sustainability, size and meeting Monitor requirements.	Project management structure in place, monitored by program board. Involvement of stakeholders.
Failure to deliver CIPs	CIPS are not delivered recurrently or in full resulting in insufficient funds for planned developments and the Trust's Financial Risk Rating possibly falling below the required Monitor standard=	Performance monitoring. Additional CIPs identified to mitigate 'downside' risks or risk of non delivery of CIPs in year.
Failure to develop a genuinely integrated organisation	As the organisation consists of the former Telford and Shropshire provider arms there are risks relating to service provision and finance if policies and practice are not harmonised.	An organisational development plan is in place to ensure harmonisation of skills and knowledge in the organisation. Prioritised plan for policy development is in place. Program of staff engagement events.
Failure to have appropriate IMT systems in place eg replacement PAS	Fragmentation of clinical systems jeopardise service development.	Project group in place to develop new PAS system. Delivery of IMT strategy.
Inability to grow the Trust's business, leading to sustainability risks on the basis of small size	Contracting systems and mechanisms do not allow sufficient growth to sustain the Trust in the future.	Development of commercial strategy including contracts and tariff strategy. Partnership working to develop tariffs.
Insufficient investment in services by commissioners	Investment due to financial challenges within the Local Health Economy, timescales for service development and effect of AQP. Slow development of PAM.	Joint working with commissioners to develop plans. Business contingency plan to enable challenges to be addressed.
Quality Impact Assessment of Cost Improvement Programs (CIPs)	Risk that if the quality assessment of CIPs have not been fully completed then services may be adversely affected.	Clinical involvement in decision making and impact assessment. Involvement by Director of Nursing and Medical Director & Finance Director in CIP Planning and on-going monitoring to ensure mitigated action taken if there are any unintended consequences.

The Board, as part of it Integrated Business Plan development work has considered in detail the risks associated with the plan. This is reflected in the risks detailed above.

Data Security

The Trust has robust measures in place to protect sensitive information. This includes paper based information and electronic data. An assessment of the risks related to information security has taken place and are reviewed annually. Where concerns are raised these are investigated thoroughly and further data controls are introduced where necessary. The Trust has an Information Governance Committee which is a sub committee of the Board. This committee, supported by operational groups, assesses and tests the robustness of the systems employed. All mobile electronic devices used by the Trust are fully encrypted to ensure that unauthorised personnel cannot access the data.

The Trust has reported two data security significant incidents

- Within the School Nursing services a list of childrens names and dates of birth due for health screening was lost. The information sheet did not have any health information and did not pose a significant risk. Parents were informed and the methods used to carry these documents were made more secure to ensure a similar event does not re-occur.

- A laptop belonging to a community nurse containing patient information was stolen from a locked cupboard in an office following a break in. The laptop was fully encrypted and access by an unauthorised person would not be possible.

The risk and control framework

The purpose of the risk and control framework is to ensure risk is managed at a reasonable level that allows the Trust to meet its strategic objectives. It is neither possible or desirable to eliminate all risk. The framework can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

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

The Trust's systems of Internal Control have been in place since the Trust's formation in July 2011

The Risk Management Policy details the structure for the risk and control mechanisms. This includes the duties of individuals, groups and committees and the responsibility for the identification of risks, controls, further mitigation control and assurances.

The Quality and Safety Committee has the overall responsibility for the monitoring of the Trust's Risk Registers, which is conducted via the operational quality and safety group. (With exceptions being notified to the committee). The Audit Committee, through its work programme, scrutinises the registers and risk management processes, seeking additional assurance where necessary.

The Resources and Performance Committee considers the detailed work and reports related to finance, performance indicators and in future contract monitoring performance indicators and in future contract monitoring. It identifies any risks associated with these areas and reports these to Executives and the Board for inclusion in the risk management framework where it is appropriate to do so. It monitors the effectiveness of any controls in place and the implementation of further controls.

Serious Incidents are reported to the Strategic Health Authority, Commissioners and the Care Quality Commission through the National Reporting and Learning Service. All of these incidents are investigated using the Root Cause Analysis tools provided by the National Patient Safety Agency. The purpose of the investigation is to identify the key contributory factors that if addressed would prevent re-occurrence.

Since its formation on July 1st 2011 to the 31st March 2012 the Trust reported 50 serious incidents. 41 of these related to Grade 3 or 4 pressure sores. The other 9 consisted of the following:

- 2 community acquired MRSA Bacteraemia
- 2 information governance incidents
- 2 medication incidents
- 1 Patient fall
- 1 clinical diagnosis incident.
- 1 Child protection issue

Where risks are identified relating to these incidents they are assessed and added to the risk management framework as appropriate.

None of the above incidents raised significant issues related to the risk and control framework.

The Trust employs a Local Counter Fraud Specialist and assistant. A Counter Fraud program is developed annually. The program details the work to be carried out to raise awareness of issues, reporting and how cases are managed. Progress against the plan is reported to the Audit Committee. An annual report is prepared and presented to the Audit Committee.

Review of the effectiveness of risk management and internal control

The process for reviewing the effectiveness of the system for internal control is continuous and has many aspects. The Head of Internal audit provides an opinion on the effectiveness of the System of Internal Control.

The opinion for 2011/12 includes that the Trust has a generally sound system of internal control which meets the organisations objectives, and that controls are generally being applied consistently. Internal Audit identified some weaknesses relating to an audit of patients monies, which they identified as not being a significant issue, and that recommendations have been agreed and are being implemented

The systems for providing assurance that risks are being managed effectively are monitored by the Audit Committee. Assurance sources include:

- NHSLA assessment against their Risk Management Standards
- Counter Fraud and Security Management Compound Indicator Assessment
- Audit Committee programmes and reviews
- Internal and External Audits
- Risk Management Reports
- Staff and Patient Surveys
- Clinical Audit Reports
- CQC Self Assessment, inspections and reviews
- Strategic Health Authority Reports
- Counter Fraud Reports
- Management Reports
- Performance and Quality Reports

The above and any other sources of assurance are reviewed by the Trust Board, Audit Committee, Resources and Performance Committee, Quality and Safety Committee and individual members of staff who contribute to the system for internal control.

Significant Issues

No significant issues have been identified at the year end or during the year

Accountable Officer : Name

Organisation:

Signature

Date

Strategic Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
The Strategic objective(s) which the risk refers to	*Risk to the delivery of the objective(s)*	*How will these risks be managed or controlled*	*What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	*What extra controls are needed to manage the risk*	*What extra evidence is required that the risk controls are effective*

ID 958 — Quality Impact of Cost Improvement Programs 12-13 — **Lead: Dr Alastair Neale** — **Initial rating C x L: 5 x 4 = 20** — **Current rating C x L: 4 x 2 = 8** — **Target rating C x L: 4 x 1 = 4**

To exceed expectations in the quality of care delivered	Quality impact assessment process is incomplete or not fully effective; CIP's have a negative impact on quality & safety. Have to find additional CIPs May need to re-employ or reinstate staffing to deliver care required Reputational risk to the Trust	QIA developed bottom up approach by clinical staff (in line with Monitor Best practice Guidance) - completion of spreadsheet outlining risks against effectiveness, experience and safety, using 5x5 matrix. Submitted to MD and DoN and FD - who assess risk and if feel not appropriate - return for information and clarification Monthly monitoring by Quality and Safety Committee - to ensure early warning of unintended consequences. Regular reporting of quality metrics to Quality and Safety Committee Performance report tp Quality and Safety Operational Group	NON Performance Reports, reviewed by the Resource and Perfomance Committee NON Summary performance report to the Board NON Robust assurance processes in place to ensure that we are able to detect early potential adverse impact on quality and safety NON Positive clinical indicators	Operational Teams to develop robust action plans for delivery	

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Updated CIP impact assessments require more detail to enable appropriate and proportionate decision making by DoN, MD and DoF to sign off revised position. Further updates and amendments being finalised and assessments will go to the Quality & Safety Committee.	Completed	*Completed*	29-Feb-2012	Mrs Jo Banks
Process to be compiled to ensure quality impacts of CIPs is discussed with Director of Nursing/Medical Director by Service Manager responsible.	Completed	*Completed*	31-Mar-2012	Mr Ted Wilson
Operational teams to develop robust action plans for delivery. Monitored via CIP review meeting with Director of Finance and Chief Executive	In progress	*CIP strategy for the next 3 years agreed by the R&P Committee on 30th November. CIP templates completed by service delivery managers by 5th December. Working through the financial and workforce issues during December to inform the LTFM, also action plans being updated with a clear process for delivery. Due date extended to May 12*	31-May-2012	Ms Maggie Bayley

CQC Links

Outcome 16: Assessing and monitoring the quality of service provision

Risk Indicator ▲

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

ID 991 — Clinical Quality and Patient Safety — **Lead: Ms Maggie Bayley** — **Initial rating C x L: 4 x 5 = 20** — **Current rating C x L: 4 x 4 = 16** — **Target rating C x L: 4 x 2 = 8**

Printed 05 Jul 2012

Strategic Objective *The Strategic objective(s) which the risk refers to*	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*
To exceed expectations in the quality of care delivered	Quality and safety targets agreed as part of contract with commissioners not being met. CQC requirements not being met Failure to develop quality and clinical governance to achieve score of 3.5 or less on the Monitor Quality Governance Framework Risk of patients in their own homes or in-patients developing pressure ulcers due to lack of education, non-concordance with treatment; failure of staff to review appropriately and/or visit frequently enough. Risk of patients falling and have resulting harm either in their own homes or in-patient beds	Regular Monitoring via Lead Managers of CQUINs on a quarterly basis to Q&S Operational Group with monthly exception reports when there are variance from targets, to agree remedial action required. Quarterly monitoring of CQC essential standards via star chambers. Monthly QRP review Action plans to address any deficits monitored via Operational Q&S Group. Board development and transparent reporting processes in relation to quality. Quality walkabouts by Board as part of a rolling programme. Active engagement at Q&S committee with robust challenge of data and deep dives into areas of concern Use of safety thermometer to identify hotspots in falls and pressure ulcers (as point prevalence audit). Targeted action plans to improve assessments, equipment provision, carer awareness and treatment - early intervention. Mandatory training for all staff Monthly performance reporting to Q&S Committee	INDEP Internal Audit plan to measure quality issues NON Clinical Audits. INDEP Patient experience/outcomes. NON Board reports with use of quality dashboard. INDEP NHSLA assessments. INDEP CQC reports. NON Quality Dashboard	Co-ordinated approach to quality reviews to include key stakeholders including GP commissioners and patients.	

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Relevant policies agreed and signed off by the Board.	Ongoing action re	*Policies for review within 3 months being reviewed currently*		Ms Maggie Bayley
Quality review visits, announced and unannounced planned.	Completed	*Plan in place, commencing in June*	31-May-2012	Ms Martine Tune
Structured review of mortality/morbidity.	In progress	*Scoping requirements. group is being established, due date extended to end June 12*	30-Jun-2012	Dr Alastair Neale

CQC Links

Outcome 15: Statement of purpose

Risk Indicator ▶

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

ID													
ID	1062	Failure to deliver CIPs 12-14	Lead	Mr Stuart Rees	Initial rating C x L	4 x 4	16	Current rating C x L	4 x 3	12	Target rating C x L	4 x 2	8

To provide the best services for patients by becoming a more flexible and sustainable organisation	CIPS are not delivered recurrently or in full resulting in insufficient funds for planned developments and the Trust's Financial Risk Rating possibly falling below the required Monitor standard	Regular review of the LTFM Long- and short-term cash flow forecasting Development of SLR Robust management of CIPs and ownership of the Programme CIP monitoring and forecasting produced on a monthly basis with sign-off from relevant Directors and reported to the Better Value Group and Resource and Performance Committee. Joint financial monitoring.	IA - Internal Audit review of governance arrangements INT - Performance reports detailing sound financial position INT - meeting all SHA and Monitor requirements		

Strategic Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
The Strategic objective(s) which the risk refers to	*Risk to the delivery of the objective(s)*	*How will these risks be managed or controlled*	*What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	*What extra controls are needed to manage the risk*	*What extra evidence is required that the risk controls are effective*

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
	In progress	*No current further actions planned, into monitoring mode.*		

CQC Links

Outcome 26: Financial position

Risk Indicator ▲

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

ID	1063	Failure to have appropriate IMT systems in place eg replacement PAS	Lead	Mr Stuart Rees	Initial rating C x L	4 x 4 = 16	Current rating C x L	4 x 4 = 16	Target rating C x L	3 x 3 = 9

To provide the best services for patients by becoming a more flexible and sustainable organisation	Risk that the Trust will not be able to operate effectively without appropriate IT infrastructure Risk of disjointed clinical systems that are not fit for purpose; incurring significant running costs whilst not being able to meet patient, public and healthcare professionals requirements. Inability to operate an effective overarching business model across the Trust because of the multiple systems fragmentation of data and information e.g. would not be able to support wide spread deployment of mobile working for clinical staff groups.	Earmarked resources to improve IT/data capture Trust performance framework alignment across mental and physical health Look to develop standalone system as a fall back Trust purchases outside of the National Contract to the minimum requirement to deliver a PAS system (£500k) The use of SLR would identify any Cost & Volume or PbR services showing above average cost-per-unit of activity which would highlight any areas potentially under-recording activity. These areas would be investigated thoroughly to determine the cause of above expected costs/under-recovery of income.	EXT External support by SHA GROUI Partnership working across LHE	Lack of control over the national program for IT	Ability to influence

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Monitoring National Contract negotiations	In progress	*Process is ongoing*		Mr Stuart Rees
IMT to bring all data into the data warehouse.	In progress	*Most activity data currently captured. 3 or 4 more challenging areas need completing. Due date extended to 31/10*	31-Oct-2012	Mr Stuart Rees

CQC Links

Outcome 11: Safety, availability and suitability of equipment

Outcome 16: Assessing and monitoring the quality of service provision

Outcome 21: Records

Risk Indicator ▶

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

Full PAS system dependant on national contract

ID	1065	Compromise to partnership working due to competetive factors, and impending use of AQP	Lead	Ms Julie Thornby	Initial rating C x L	4 x 5 = 20	Current rating C x L	4 x 3 = 12	Target rating C x L	4 x 2 = 8

Strategic Objective *The Strategic objective(s) which the risk refers to*	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*
To deliver well-co-ordinated effective care by working in partnership with others	Ineffective partnership working with other providers, for example over integrated pathways, would significantly impact on the Trust's ability to deliver service transformation, generate new income and deliver on commissioning expectations. In the face of reducing overall resources, there is potential for providers to compete for total ownership of activity and income in any areas of growth or transferred resource.	Commitment to participate in collaborative service development proposals sponsored by local CCGs. Full participation in local health economy strategy development, led by commissioners, agreeing assumptions and plans. Exploring partnering and income sharing arrangements with other providers including SATH to ensure that contract arrangements support development of integrated pathways. Continued dialogue with councils and voluntary sector	NON Joint work to date with some other partners on joint development/tender opportunities NON Some progress to date with local system plan NON Initial discussions and workstreams underway with SATH		Timescale for strategies and system plan means that provider-specific implications are still emerging

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Development of partnership mechanisms for working with other providers	In progress	*Initial discussions held with some partners including SATH*	31-Jul-2012	Ms Julie Thornby
Development of FT stakeholder relationships	In progress	*FT stakeholder group underway supported by comms team*	31-Jul-2012	Ms Julie Thornby

CQC Links

Outcome 16: Assessing and monitoring the quality of service provision

Risk Indicator ▶

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

Strategies of other providers or their boards

ID **1068** **Failure to achieve FT status** **Lead Ms Julie Thornby** **Initial rating C x L** 5 x 4 = **20** **Current rating C x L** 5 x 3 = **15** **Target rating C x L** 5 x 2 = **10**

To provide the best services for patients by becoming a more flexible and sustainable organisation	Failure to demonstrate to SHA/DoH/Monitor that the Trust is well-governed, financially viable and can be legally-constituted in its current form, as a result of for example, inadequate evidence of sound Board governance, financial sustainability and business planning, sound quality governance. Failure to meet FT deadlines with quality outputs.	Programme management arrangements including FT lead with previous FT application experience; action plan in response to diagnostic assessment regularly monitored; programme risk register includes adequacy of resources and this is reviewed at each Programme team and board meeting; IBP and LTFM regularly reviewed by whole Trust Board meeting as Programme Board; additional commercial expertise in place to address income risks	GROUI Tri partite agreement with SHA and DoH for timetable and steps to FT agreed without significant amendment. EXT First stage FT self assessment GROUI Project Plan EXT SHA RAG rating green GROUI Project structure and initiation document agreed by board and implemented. EXT Feedback on IBP to date by SHA and Deloittes		BGAF external validation not due till August 12 May iteration of IBP submitted and awaiting feedback

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Submit to SHA end of May IBP, LTFM and supporting strategies	Completed	*Submitted on time; awaiting feedback*	1-Jun-2012	Ms Julie Thornby
Complete Monitor quality assessment	In progress	*First iteration complete, due to go to June Programme Board*	13-Jun-2013	Ms Maggie Bayley
Complete board governance assurance framework	In progress	*Board completed self assessment April 2012; draft memorandum to board in June*	30-Jun-2013	Ms Julie Thornby

CQC Links

Outcome 26: Financial position

Risk Indicator ▶

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

Characteristics of Trust e.g. size does not conform with national policy.

Strategic Objective *The Strategic objective(s) which the risk refers to*	Risk *Risk to the delivery of the objective(s)*	Controls *How will these risks be managed or controlled*	Assurance *What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	Gaps in Control *What extra controls are needed to manage the risk*	Gaps in Assurance *What extra evidence is required that the risk controls are effective*

ID 1071 Failure to develop business skills for key staff — **Lead** Ms Maggie Bayley — **Initial rating C x L** 4 x 4 = 16 — **Current rating C x L** 4 x 3 = 12 — **Target rating C x L** 3 x 3 = 9

To provide the best services for patients by becoming a more flexible and sustainable organisation	Risk that the Trust does not sufficiently develop business skills of key staff resulting in poor business decisions which have a detrimental impact upon the Trust achieving its strategic objectives	- Key staff identified for training through skills gap analysis - Staff engagement sessions reinforcing importance amongst staff - Development and implementation of OD plan.	NON Progress against OD plan NON Aston development programme progress		

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Development of events for senior managers &directors by external support (CIPD)	In progress	*Various workshops and events.*	9-Jun-2012	James Bunt

CQC Links

Outcome 14: Supporting workers

Risk Indicator ▶

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

PCT cannot enter into contracts as commissioning arrangements are put into place

ID 1074 Insufficient investment in services by commissioners — **Lead** Mr Stuart Rees — **Initial rating C x L** 4 x 4 = 16 — **Current rating C x L** 4 x 4 = 16 — **Target rating C x L** 3 x 3 = 9

To provide the best services for patients by becoming a more flexible and sustainable organisation	Insufficient investment from commissioners particularly given financial challenges within LHE position. Trust is unable to fund significant transformational change, or is only able to do so at a limited pace, resulting in a failure to deliver efficiencies and benefits to patients Failure to win AQP tenders resulting in loss of income. Local health economy strategy is on a longer timescale than Trust requires for clarity on service developments. Delays at service line level causes uncertainty.	Development of Commercial Strategy Market services outside of local health economy Robust contractual framework and positive culture to defend organisational profile Development of Section 75 agreements with Local Authorities. Improvement in performance management of data quality and activity recording Introduction of Service Line Reporting to bring together activity and income and service efficiency to inform business plan and ensure the Trust does not cross-subsidise Ensure clinical leadership of redesign and commissioner engagement Development of contractual relationships	INDEP Trust is part of the local QIPP Board, with active engagement in the LHE system plan NON Positive audits of Service Line Reporting processes. NON Allocation of "shift to community" funding and service developments not signed off by commissioners	Business development opportunities identified and business cases submitted to PCTs to agree additional funding. SLR implementation underway Agree robust contract variation process with commissioners.	

Strategic Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
The Strategic objective(s) which the risk refers to	*Risk to the delivery of the objective(s)*	*How will these risks be managed or controlled*	*What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	*What extra controls are needed to manage the risk*	*What extra evidence is required that the risk controls are effective*

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Market analysis of services	In progress	*Ongoing work as part of IBP development process*		Ms Julie Thornby
Active involvement in system plan and discussions/feedback for SHA and PCT Cluster	In progress	*System plan being refreshed, aiming to be done by end of June*		Mr Stuart Rees
Set up meeting to agree/confirm the contract income with commissioners and agree a robust Price and Activity Matrix with commissioners.	In progress	*Initial meetings undertaken and principles now agreed, results due May*		Mr Stuart Rees

CQC Links

Outcome 26: Financial position

Risk Indicator ▲

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

Commissioning intentions may not mitigate risks identified as part of CIPs

ID	1096	Quality Impact of Cost Improvement Programs longer term	Lead	Ms Maggie Bayley	Initial rating C x L	5 x 4	20	Current rating C x L	4 x 2	8	Target rating C x L	4 x 1	4

To exceed expectations in the quality of care delivered	Quality impact assessment process is incomplete or not fully effective; CIP's have a negative impact on quality & safety.	Clinical involvement Q&S committee Establishment of CIP group which includes membership of DoN and MD. Terms of Reference developed. Currently following Monitor best practice for CIPs Trust is aware that the National Quality Board will be producing a single operating model for CIPs that the Trust will follow.	NON NON	Quality impact assessment process and reports Performance reporting process		

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Actions to be formulated as issues arise				

CQC Links

Outcome 26: Financial position

Risk Indicator ▲

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

ID	1098	Failure to deliver CIPs longer term	Lead	Mr Stuart Rees	Initial rating C x L	4 x 4	16	Current rating C x L	4 x 4	16	Target rating C x L	4 x 3	12

To provide the best services for patients by becoming a more flexible and sustainable organisation	CIPS are not delivered recurrently or in full resulting in insufficient funds for planned developments and the Trust's Financial Risk Rating possibly falling below the required Monitor standard 24 month plans in place	Regular review of the LTFM Long- and short-term cash flow forecasting Development of SLR Robust management of CIPs and ownership of the Programme 24 month plan in place	INDEP NON INDEP	- meeting all SHA and Monitor requirements - Performance reports detailing sound financial position - Internal Audit review of governance arrangements	Joint financial monitoring established.	CIP monitoring and forecasting produced on a monthly basis with sign-off from relevant Directors and reported to the Better Value Group and Resource and Performance Committee.

Strategic Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
The Strategic objective(s) which the risk refers to	*Risk to the delivery of the objective(s)*	*How will these risks be managed or controlled*	*What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	*What extra controls are needed to manage the risk*	*What extra evidence is required that the risk controls are effective*

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Actions will be formulated as issues are identified				

CQC Links

Outcome 16: Assessing and monitoring the quality of service provision

Outcome 26: Financial position

Risk Indicator ▲

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

ID			Lead	Initial rating C x L	Current rating C x L	Target rating C x L
1099	**Inability to grow the Trust's business, leading to sustainability risks**		**Mr Stuart Rees**	4 x 5 = **20**	4 x 4 = **16**	3 x 3 = **9**

To provide the best services for patients by becoming a more flexible and sustainable organisation	Risk that national and local contracting systems and mechanisms work to hinder growth of the Trust's services, and as a result, the size of the Trust could present risks to its future sustainability. For example, majority of Trust activity is on block contracts, and there are disincentives in the system to greater moves to tariff.	- Commercial strategy - Tariff Strategy - Develop tender process - Commercial culture via OD strategy - Service line reporting - Partnership mechanisms with other providers	NON	Development and acceptance of service plans	System plan not agreed

Actions required to address any gaps in control or assurance

Action	Status	Progress	Due	By
Development of commercial and tariff strategies	In progress	*Commercial strategy draft complete*	30-Jun-2013	Mr Stuart Rees

CQC Links

Outcome 26: Financial position

Risk Indicator ▶

Residual Risks

Risks that cannot be mitigated or are outside the control of the organisation

Strategic Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
The Strategic objective(s) which the risk refers to	*Risk to the delivery of the objective(s)*	*How will these risks be managed or controlled*	*What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	*What extra controls are needed to manage the risk*	*What extra evidence is required that the risk controls are effective*

Risk Rating Chart

Injury/Harm	Finance	Service	Reputation	Consequence Score	Will undoubtedly occur, possibly frequently	Will occur but not persistently	May occur occasionally	Do not expect to happen but is possible	Cannot believe this will ever happen
Likelihood Score					Almost certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Very minor or no harm	Less than £10,000	No or very little impact on services	Some negative publicity	None 1	LOW 5	LOW 4	VERY LOW 3	VERY LOW 2	VERY LOW 1
Minor injury/Illness (e.g. cuts and bruises) will resolve within a month	£10,000 to £50,000	Disruption of services causing inconvenience. May cause efficiency/ effectiveness problems	Regular negative publicity	Minor 2	MODERATE 10	MODERATE 8	LOW 6	LOW 4	VERY LOW 2
Injuries of illness which requires extra treatment or protracted period of recovery. Should resolve within a year	£50,000 to £500,000	Loss of service for a significant period of time (less that a month)	Loss of public confidence, protest action	Moderate 3	HIGH 15	MODERATE 12	MODERATE 9	LOW 6	VERY LOW 3
Single serious (life threatening) injuries/illness	£500,000 to £3.5m	Loss of services to such an extent that effects on public health will be measurable	Punitive action, e.g HSE, CQC significant organisational change results	Major 4	HIGH 20	HIGH 16	MODERATE 12	MODERATE 8	LOW 4
Multiple Serious (life threatening) injuries/illness	£3.5m plus	Permanent loss of a significant service. Threatens the viability of the organisation	Damage to such an extent that the organisation must cease to exist as is	Catastro-phic 5	HIGH 25	HIGH 20	HIGH 15	MODERATE 10	LOW 5

Strategic Objective	Risk	Controls	Assurance	Gaps in Control	Gaps in Assurance
The Strategic objective(s) which the risk refers to	*Risk to the delivery of the objective(s)*	*How will these risks be managed or controlled*	*What and from what source is the evidence that the risk controls are effective* *NON = Internal Assurance* *INDEP = Independent Assurance*	*What extra controls are needed to manage the risk*	*What extra evidence is required that the risk controls are effective*

Appendix 5

Shropshire Community Health NHS Trust

Statement of Comprehensive Income For Year Ended 31st March 2012

	2011/12 £'000
Employee benefits	(54,769)
Other costs	(24,439)
Revenue from patient care activities	76,350
Other operating revenue	4,452
Operating surplus/(deficit)	1,594
Investment revenue	6
Surplus/(deficit) for the financial year	1,600
Public dividend capital dividends payable	
Retained surplus/(deficit) for the year	1,600
Other Comprehensive Income	
Net gain/(loss) on revaluation of property, plant & equipment	6
Total comprehensive net expenditure for the year	1,606
Financial performance for the year	
Retained surplus/(deficit) for the year	1,600
Adjustment in respect of donated asset/gov't grant reserve elimination	-203
Adjusted retained surplus (deficit)	1,397

The adjustment to arrive at reported financial performance relates to the benefit to the Trust of the change in accounting policy for assets funded by donations or government grants.

Shropshire Community Health NHS Trust

Statement of Financial Position As At 31st March 2012

	31 Mar 2012	31 Mar 2011 After Merger Adj
	£'000	£'000
Non-current assets		
Property, plant & equipment	2,600	2,609
Trade & other receivables	26	36
Total non-current assets	2,626	2,645
Current assets		
Inventories	130	88
Trade & other receivables	3,908	2,363
Cash & cash equivalents	2,915	19
	6,953	2,470
Non-current assets held for sale		
Total current assets	6,953	2,470
Total assets	9,579	5,115
Current liabilities		
Trade & other payables	-6,538	-4,663
Provisions	-1,003	
Borrowings		-20
Total current liabilities	-7,541	-4,683
Non-current assets plus/less net current assets/liabilities	2,038	432
Non-current liabilities		
Total non-current liabilities	0	0
Total assets employed	2,038	432
Financed by :		
Taxpayers equity		
Public dividend capital		
Retained earnings	1,951	350
Revaluation reserve	87	82
Total taxpayers equity	2,038	432

Shropshire Community Health NHS Trust

Statement of Changes in Taxpayers Equity For the Year Ended 31st March 2012

	Retained Earnings £'000	Revaluation Reserve £'000	Total Reserves £'000
Balance at 1 April 2011	0	0	0
Merger adjustments	350	82	432
Re-stated balance at 1 April 2011	350	82	432
Changes in taxpayers equity for 2011/12			
Retained surplus/(deficit) for the year	1,600		1,600
Net gain/(loss) on revaluation of property, plant, equipment		6	6
Transfers between reserves	1	-1	0
Total recognised revenue/(expense) for the year	1,601	5	1,606
Balance at 31 March 2012	1,951	87	2,038

Shropshire Community Health NHS Trust
Summary Financial Statements

Statement of Cashflows For The Year Ended 31st March 2012

	2011/12 £'000
Cash flows from operating activities	
Operating surplus/(deficit)	1,594
Depreciation and amortisation	680
Donated assets received credited to revenue but non-cash	-259
Dividend paid	-530
(Increase)/decrease in inventories	-42
(Increase)/decrease in trade and other receivables	-1,005
Increase/(decrease) in trade and other payables	1,869
Increase/(decrease) in provisions	1,003
Net cash inflow/(outflow) from operating activities	3,310
Cash flows from investing activities	
Interest received	6
(Payments) for property, plant & equipment	-659
Net cash inflow/(outflow) from investing activities	-653
Net cash inflow/(outflow) before financing	2,657
Cash flows from financing activities	
Capital grants & other capital receipts	259
Net cash inflow/(outflow) from financing activities	259
Net increase/(decrease) in cash & cash equivalents	2,916
Cash & cash equivalents (& bank overdrafts) at start of period	
Opening balance adjustments - TCS transactions	-1
Re-stated cash & cash equivalents (& bank overdrafts) at start of period	-1
Cash & cash equivalents (& bank overdrafts) at year end	2,915