Sheffield Health and Social Care NHS Foundation Trust

# Board of Directors' Open

| Date: | 12 August 2020 | Item Ref: | 15a |
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| **TITLE OF PAPER** | **Audit & Risk Committee – 21 July 2020**<br>**Summary Report to the Board of Directors in respect of Significant Issues** |
| **TO BE PRESENTED BY** | Ms. Ann Stanley, Chair – Audit & Risk Committee<br>Non-Executive Director |
| **ACTION REQUIRED** | For assurance and to note. |

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| **OUTCOME** | To provide assurance to the Board that the Audit & Risk Committee has discharged its duties as directed by the agreed terms of reference by the timely reporting of items of significance discussed at the meeting held on 21 July 2020.<br><br>To note the issues raised and receive assurance that the committee will action the resulting issues as appropriate. |
| **TIMETABLE FOR DECISION** | None required. |
| **LINKS TO OTHER KEY REPORTS / DECISION** | Minutes of the committee. |
| **STRATEGIC AIM**<br>**STRATEGIC OBJECTIVE**<br><br>**BAF RISK NUMBER & DESCRIPTION** | Aim 2 Create a Great Place to Work<br>CQC Getting Back to Good<br><br>BAF.0002 There is a risk the Trust does not deliver on its Well Led Development Plan. This would result in a failure to meet the regulatory framework, get back to good and a failure to remove additional conditions placed on the Trust's Provider Licence. |
| **LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC** | Trust Board Assurance Framework<br>NHS Audit Framework |
| **IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT** | Timely reporting to the Board of Directors |
| **CONSIDERATION OF LEGAL ISSUES** | None required. |

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| **Author of Report** | Ann Stanley |
| **Designation** | Chair – Audit & Risk Committee |
| **Date of Report** | July 2020 |

Sheffield Health and Social Care NHS Foundation Trust

# Audit & Risk Committee – 21 July 2020
# Significant Issues Report

## 1. Purpose

| For approval | For assurance | For collective decision | To seek input | To report progress | For information | Other (Please state) |
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| | | | | X | X | |
| To report in a timely manner, items of significance discussed at the Audit & Risk Committee meeting held on 21 July 2020. | | | | | | |

## 2. Summary

Audit & Risk Committee – 21 July 2020

The committee approved the notes of the Audit & Risk Committee meeting held on 23 June 2020, with one minor amendment, for receipt at the August Board of Directors' meeting – attached at appendix A.

Also attached for the Board's awareness are the approved notes from the meeting held on 28 May 2020 – attached at appendix B.

Board members will receive the minutes of the Audit & Risk Committee meeting held on 21 July 2020 in due course, however, at the end of the meeting, the committee agreed by means of this report to notify Board members of the following significant issues:

360 Assurance Internal Audit Progress Report:
CQC Action Plan Assurance

The committee noted the limited assurance received as a result of this audit report. Due to timing, the full audit report had been issued after the CQC report had been published, however, there were clear and specific learning points from the report which were considered relevant to present CQC action plans currently under review at Quality & Assurance Committee. It was confirmed by QAC Chair that this audit report would appear on the QAC agenda for discussion and it was requested that feedback be received to ARC following those discussions.

360 Assurance 2020/21 Audit Plan Update

The committee received and approved an updated 2020/21 Internal Audit Plan, noting that 360 Assurance resourcing required for delivery of the audit plan had been severely impacted by the CoVid pandemic. Members reviewed the proposed reduction in days/audits but were assured that the plan had been amended appropriately, ensuring the impact on quality audits was minimised. Concerns were raised regarding deferrals of some audits – notably Estates and Business Planning. It was, therefore, agreed that the plan would be kept under regular review by the committee to enable any further impacts re timing of audits to be assessed and addressed.

Information Governance & Assurance

Following changes to the Committee`s remit, the committee received the information governance assurance reports in respect of:

- Information Governance Incidents / Security Breaches
- Senior Information Risk Officer Annual Report 2019/20
- DSPT Internal Audit Report

The Committee noted that DIGB quarterly meetings provided assurance regarding scrutiny of the information breaches and confirmation that DIGB had also received the SIRO Report. The committee requested bi-annual reporting from DIGB into ARC regarding progress against risks highlighted, together with progress reports regarding the Trust's compliance with DSPT guidelines for 2018/19 and updates regarding the revised guidelines, which are imminent.

The SIRO Annual Report 2019/20 is attached to this report for the Board's awareness – appendix C.

Well Led Development Plan

The committee received an update on the progress against the Well Led Development Plan which it was confirmed is now incorporated as an official workstream of the Back to Good Programme.

It was also agreed that consideration will be given to establishing a task and finish group to include the Non-Executive Directors to provide their input, given the potential for change in governance/ committee structure as a result of this plan.

Changes in Level of Assurance – Board Assurance Framework

In considering the initial iteration of the 2020/21 Board Assurance Framework, the committee asked that an additional strategic risk be included in respect of potential weakness across the Trust's IT and digital network.

The committee also considered the assurance rating for Risk Ref BAF.0002, referencing progress against actions for the Well Led Development Plan. This was a risk specifically assigned to ARC for review with an assurance rating currently rated green. Given the amount of work still to be progressed against the plan, it was agreed that the level of assurance should be amended to amber. This was in view of the substantial amount of work yet to be progressed. It was agreed that this would be amended for the version received at Board.

## 3 Next Steps

The above items will be taken forward by the committee as appropriate and to timescales agreed via the action log.

## 4 Required Actions

For the Board of Directors to note:

- the issues raised and receive assurance that the committee will action the resulting issues as appropriate;
- the approved notes of the Audit & Risk Committee meetings held on 26 May and 23 June 2020;
- the 2019/20 SIRO Annual Report.

## 5 Monitoring Arrangements

Through the Audit & Risk Committee.

## 6 Contact Details

For further information please contact:

Ann Stanley, Chair – Audit & Risk Committee
Non-Executive Director

AS/jch
Approved AS
Aug 2020

Sheffield Health and Social Care NHS Foundation Trust

# Audit & Risk Committee (ARC)

ARC 21.07.20
Item 04

**Notes of the Audit & Risk Committee meeting held on Tuesday, 23 June 2020**
**At 2.00 p.m. – Microsoft Teams Meeting**

**On the teleconference:**

**Present:** Mrs. Ann Stanley, Non-Executive Director, Chair: Audit & Risk Committee
Ms. Sandie Keene, Non-Executive Director, Chair: Quality Assurance Committee
Mr. Richard Mills, Non-Executive Director, Chair: Finance & Performance Committee

**In Attendance:** Ms. Jan Ditheridge, Chief Executive
Mr. Phillip Easthope, Executive Director of Finance
Mr. David Walsh, Director of Corporate Governance/Board Secretary
Mr. James Sabin, Deputy Director of Finance
Ms. Samantha Harrison, Governance Consultant
Ms. Beverley Murphy, Director of Improvement
Ms. Leanne Hawkes, Deputy Director, 360 Assurance
Ms. Lianne Richards, Client Manager, 360 Assurance
Mr. Rashpal Khangura, Director, KPMG
Ms. Imogen Holland, KPMG
Mrs. Jeanine Hall, PA (minutes)

**Apologies:** Mr. Clive Clarke, Interim Chief Executive
Mr. Robert Purseglove, Principal Anti-Crime Specialist

| No | Item | Action |
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| **ARC 01/06/2020** | **Agree Meeting Behaviours**<br>As the meeting was to be held via MS Teams arrangements, prior to the commencement of formal business, the Chair reaffirmed meeting etiquette to ensure that agenda items received the appropriate level of discussion and consideration, and that members could contribute to the discussion/ask questions as necessary. | |
| **ARC 02/06/2020** | **Welcome & Apologies for Absence**<br>The Chair welcomed members to the Audit & Risk Committee and apologies noted. | |
| **ARC 03/06/2020** | **Declaration of Interests**<br>None. | |
| **ARC 04/06/2020** | **Notes of the meeting held on 28 May 2020**<br>The notes of the meeting held on 28 May 2020 were agreed as an accurate record and would be received at the July 2020 Open Board of Directors' meeting for information. | |
| **ARC 05/06/2020** | **Matters Arising & Action Log**<br>Members noted the actions from the previous meeting and updated the action log accordingly. Note was made of the following:<br><br><u>11/07/19; 17/10/19; 05/04/20 & 05/05/20 Information Governance Requirements (ARC) & Consideration of Third Party Assurances</u><br>Confirmed that these items were on the Committee bring forward for July's meeting and that the Chair and Mr. Easthope would discuss the format of these items | AS/PE |



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| | outside of the meeting prior to receipt.<br><br>07/04/20 & 05/05/20 Internal Audit Plan<br>Confirmed that this item was on the Committee bring forward for July's meeting. The Chair asked that specific consideration be given to the timing of individual audit reviews given the unforeseen delay in commencement of the plan due to CoVid19.<br><br>11/0719 Board Committee – Review of Reporting Sub Groups/Alignment of Terms of Reference<br>With reference to this long-standing action, Mr. Walsh advised that the schedule and timing of committees is currently being considered. He would be discussing this further with the Trust Chair prior to any proposals being put forward.<br><br>10/01/20 Emergency Planning, Resilience & Response/EU Exit<br>The Chair noted that this item was included on the Committee bring forward for July and that she would discuss with Mr. Clarke the required content of this item.<br><br>06/05/20 CoVid19 Governance Briefing – Good Practice<br>Mr. Sabin confirmed that as requested a paper has been prepared to provide an overview of the Trust's finance function measured against the good practice guide. This is scheduled to be received at Finance & Performance Committee at its June meeting and Audit & Risk Committee in July.<br><br>12/05/20 – SHSC Register of Interests/Register of Hospitality, Sponsorship & Gifts<br>The Chair requested that the additional assurance requested for receipt of July also incorporates a review of the current policy.<br><br>16/05/20 Audit & Risk Committee – Self-Assessment Outcome<br>The Chair reiterated the comment made at the last meeting under this item, regarding the visibility of the committee's Significant Issues Reports at Board and it was agreed that this was also the case for the other committee SI Reports. Agreed that consideration needs to be given to making these reports more prominent within the Board agenda, as well as addressing consistency across the committees. Mr. Walsh agreed to give this matter some consideration.<br><br>17/05/20 Well-Led Development Plan<br>Mr. Walsh advised that he anticipated taking a further update on this plan, including timescales, to the next Board meeting. | 360<br><br>DW<br><br>DW |
| **ARC 06/06/2020** | **360 Assurance Updated 2019/20 Head of Internal Audit Opinion Statement & Annual Report**<br>Members noted receipt of an updated 2019/20 Head of Internal Audit Opinion Statement and Annual Report.<br><br>Ms. Hawkes advised that, whilst the overall opinion had not changed since receipt of the draft, following the issue of the recently completed audit on CQC Action Plan assurance, it had been necessary to include an additional high risk within the statement, predominantly due to the significant delays in the Trust progressing the actions.<br><br>The Chair confirmed for members that the audit in question was commissioned on the previous CQC action plan, prior to the February inspection and noted that the actual audit report would be received as part of the 360 Assurance Progress Report for discussion at the July meeting.<br><br>Ms. Keene noted the intention to discuss the recently issued audit report at the July Quality Assurance Committee, and agreed to feed into that discussion any pertinent points from discussion at July's ARC meeting. | |

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| | Ms. Hawkes noted that in discussion with key officers regarding the high risk action and the narrative relating to the previous action plan, it has been determined that this has been superseded by the new action plan but that the issues still remain and there is a need to ensure that the actions relating to the new inspection outcome are followed through.<br><br>Members were agreed that there were key lessons to be learnt from the governance oversight issues that have been raised through a number of reports recently and a need to gain assurance that the same issues will not arise. Completion of agreed actions is key and the Chair reiterated the need to escalate any difficulties in completing actions in a timely manner at an early opportunity.<br><br>Mr. Easthope confirmed that the delay in response from the Trust had been escalated by 360 Assurance on a number of occasions and that this had been escalated internally as a result, however, it was apparent that the recent role changes and capacity issues had impacted and that this should have been raised at an early opportunity.<br><br>NED members were keen to ensure there was a clear escalation process in place and it was agreed that this would be discussed further at Board, together with the general implementation of actions from audit reports.<br><br>Ms. Stanley confirmed, that as Chair of ARC, it may be appropriate that she receives notification of potential delays for follow up. Mr. Easthope also noted that he meets on a regular basis with Internal Audit colleagues and would be happy to link into Ms. Stanley in terms of any issues or concerns being raised during his meetings.<br><br>Members noted receipt of the amended Head of Internal Audit Opinion Statement and Annual Report. | |
| **ARC 07/06/2020** | **Final Draft SHSC Annual Report 2019/20**<br>Ms. Harrison presented the final iteration of the Trust's 2019/20 Annual Report. She confirmed that the summary paper provided an overview of the development/ changes since it was received in May and she noted confirmation had been received from the External Auditors that all mandatory requirements and disclosures had been met.<br><br>The committee advised that they were happy to accept the report and recommend the Board of Directors to sign it off at their meeting to be held on 23 June 2020 at which point it will also contain the final External Auditors Opinion Statement and all relevant signatures. | |
| **ARC 08/06/2020** | **Final Draft SHSC Annual Governance Statement 2019/20**<br>Ms. Harrison presented the final Annual Governance Statement and confirmed that all changes and/or amendments made to date have now been incorporated, including ensuring that the statement accurately reflects the position post CQC inspection outcome.<br><br>Confirmation has been received from the External Auditors that the statement provides a balanced and accurate view of the Trust's position.<br><br>Ms. Harrison confirmed that this statement, once approved at Board, will be incorporated into the final Annual Report prior to issue.<br><br>The committee were pleased to recommend the final Annual Governance Statement to the Board of Directors for approval and sign off. | |
| **ARC 09/06/2020** | **Final Draft SHSC Audited Annual Accounts 2019/20**<br>Members received and noted the final version of the 2919/20 Audited Annual Accounts. It was confirmed that there had been no change to the primary | |

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| | submission, the only changes being in respect of additional wording and disclosures, as well as some presentational changes as detailed on the accompanying summary paper.<br><br>The Chair confirmed that, at its May meeting, the committee had received and acknowledged the supporting analytical review document, which highlighted the changes to key figures within the Accounts since last year.<br><br>The committee approved the Accounts for formal adoption at the Board meeting to be held on 23 June 2020 and asked that its thanks and appreciation for the work undertaken be passed onto everyone who contributed to the process. | |
| **ARC 10/06/2020** | **KPMG External Audit Annual ISA 260 Report**<br>Mr. Khangura presented the final ISA 260 External Audit Report relating to the audit of the 2019/20 Trust financial statements and advised that this report discharges the responsibilities of External Audit under International Audit Standard 260, which this year requires them to report back and provide assurance to the Trust on two primary areas – financial statements and value for money conclusion.<br><br>Mr. Khangura expressed his team's appreciation of the efforts of the finance team in the process this year and ensuring it is delivered to the required timeframes, under what have been unusual circumstances. He commended the quality of the Accounts and supporting working papers provided, as well as the responsiveness of the team.<br><br>In terms of the financial statements element, Mr. Khangura confirmed that as reported under the previous agenda item, their work had been completed and that no material changes were necessary to the draft Accounts and he was pleased to confirm a clean audit opinion in respect of this element of the audit.<br><br>Ms. Holland provided an overview of the assessments undertaken as part of the financial statements audit, including the specific risk areas and the summary findings and the level of assurance provided in terms of these risk areas.<br><br>The review of the Trust's draft Annual Report is also included in this element of the audit and as previously reported all compliance work in this area had been satisfactorily concluded.<br><br>Moving onto the value for money element of the audit process, Mr. Khangura confirmed that, as indicated at the May meeting, an adverse VFM conclusion has been issued, resulting from the significant risk identified in respect of the outcome of the most recent CQC inspection, as explained at the last meeting.<br><br>He further advised that this outcome would not result in any additional actions being required of the Trust, as it is acknowledged that this is a known risk with a supporting action plan in place. It will, however, be identified as a potential risk in next year's audit plan.<br><br>Mr. Khangura provided an overview of the report's appendices for members' awareness.<br><br>In conclusion, at a summary level, he confirmed that he was in a position to issue a clean audit opinion on the financial statements and an adverse VFM conclusion, upon receipt of the approved and signed documentation from the Trust. | |
| **ARC 11/06/2020** | **KPMG External Audit Draft Opinion – Annual Accounts 2019/20**<br>Members noted receipt of the auditor's statement in respect of the consolidation schedules completed as part of the Annual Accounts process, which confirmed the unqualified audit opinion on the audited financial statements, noting no differences identified. | |

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| | **KPMG Independent Auditor's Report**<br>Members also noted receipt of the formal report to the Council of Governors on the audit of the financial statements, noting that this had been received earlier today. Confirmed that this will be formally received by the Council of Governors at a meeting in July.<br><br>On behalf of the committee, the Chair thanked external audit colleagues and all staff involved in the completion of the year-end statements. | |
| **ARC 12/06/2020** | **SHSC Draft Management Letter of Representation**<br>The draft management letter of representation was formally received by members and, noting that no additional narrative was required, it was agreed to endorse the letter to the Board of Directors for sign off. | |
| **ARC 13/06/2020** | **i. Significant Issues Report**<br>It was agreed that due to the nature of today's meeting, being solely related to the approval of year-end documentation, it would not be necessary to issue a significant issues report to the Board of Directors.<br><br>**ii. Changes in Level of Assurance**<br>Not applicable due to the nature of today's meeting.<br><br>**iii. Review of Future Meeting Agenda**<br>The meeting reviewed the forthcoming meeting planner. A number of amendments/ updates were made which will be reflected in a revised planner to be circulated to all members in due course.<br><br>In terms of the Well-Led Development Plan and any potential impact on the committee's agenda, Mr. Walsh agreed to confirm the committee's specific actions and feed these into the agenda planner. | JCH<br><br>DW |

Date and time of next meeting:
Tuesday, 21 July 2020 @ 1.00 p.m. MS Teams / Committee Room 1, Fulwood House
*Apologies to: Jeanine Hall, PA to Chief Executive & Executive Director of Finance*
*Tel 2716716; email* Jeanine.hall@shsc.nhs.uk

*June 2020 approved AS*
*Amended ARC July 2020*

Sheffield Health and Social Care NHS Foundation Trust

# Audit & Risk Committee (ARC)

ARC 23.06.20
Item 04

**Notes of the Audit & Risk Committee meeting held on Thursday, 28 May 2020**
**At 1.00 p.m. – Microsoft Teams Meeting**

**On the teleconference:**

**Present:** Mrs. Ann Stanley, Non-Executive Director, Chair: Audit & Risk Committee
Ms. Sandie Keene, Non-Executive Director, Chair: Quality Assurance Committee
Mr. Richard Mills, Non-Executive Director, Chair: Finance & Performance Committee

**In Attendance:** Ms. Jan Ditheridge, Chief Executive
Mr. Clive Clarke, Interim Chief Executive (part meeting)
Mr. Phillip Easthope, Executive Director of Finance
Mr. David Walsh, Director of Corporate Governance/Board Secretary
Mr. James Sabin, Deputy Director of Finance
Ms. Samantha Harrison, Governance Consultant
Ms. Leanne Hawkes, Deputy Director, 360 Assurance
Ms. Lianne Richards, Client Manager, 360 Assurance
Ms. Joanna Clarke, Anti-Crime Specialist, 360 Assurance
Mr. Rashpal Khangura, Director, KPMG

Mrs. Jeanine Hall, PA (minutes)

**Apologies:** Mr. Robert Purseglove, Principal Anti-Crime Specialist

| No | Item | Action |
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| **ARC 01/05/2020** | **Agree Meeting Behaviours**<br>As the meeting was to be held via MS Teams arrangements, prior to the commencement of formal business, the Chair reaffirmed meeting etiquette to ensure that agenda items received the appropriate level of discussion and consideration, and that members could contribute to the discussion/ask questions as necessary. | |
| **ARC 02/05/2020** | **Welcome & Apologies for Absence**<br>The Chair welcomed members to the Audit & Risk Committee and apologies noted. | |
| **ARC 03/05/2020** | **Declaration of Interests**<br>None. | |
| **ARC 04/05/2020** | **Notes of the meeting held on 21 April 2020**<br>The notes of the meeting held on 21 April 2020 were agreed as an accurate record and would be received at the June 2020 Open Board of Directors' meeting for information. | |
| **ARC 05/05/2020** | **Matters Arising & Action Log**<br>Members noted the actions from the previous meeting and updated the action log accordingly. Note was made of the following:<br><br><u>11/07/19; 17/10/19 & 05/04/20 Information Governance Requirements (ARC) & Consideration of Third Party Assurances</u><br>Noted that this matter was still outstanding and that the Chair and Mr. Easthope would progress information governance requirements outside of the meeting with | July |



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| | the intention of a paper being received at the July ARC meeting.<br><br>The Chair further noted that the matter of third party assurances was one which was to be covered as part of the original self-assessment session led by 360 Assurance. Unfortunately, following the format change for that session, this will not now be possible and the Chair proposed that she followed this up with Mr. Easthope outside of the meeting.<br><br><u>07/04/20 Internal Audit Action Tracker</u><br>It was confirmed that the tracker continues to be issued to Executive leads for follow up of actions and is now a scheduled regular agenda item on the Executive Team Meeting for escalation/follow up.<br><br><u>07/04/20 Internal Audit Plan</u><br>Following discussion at the last meeting, and subsequent discussion with the Medical Director, it was confirmed that Mental Capacity Act compliance had now been included in the plan for 2020/21. Confirmed that timing of this audit needs to be given careful consideration.<br><br>This addition to the plan was formally approved and it was agreed that the plan should be received at the July ARC meeting to review changes since agreement of the original plan.<br><br><u>17/04/20 Corporate Risk Register</u><br>Confirmed that agreement had been reached at Board of Directors that the Covid19 Risk Register will be received at Board as part of the ongoing monthly Covid19 update and that receipt of the Corporate Risk Register will remain quarterly, except where it is felt there needs to be escalation. | ARC<br><br>AS/PE<br><br>July ARC |
| **ARC 06/05/2020** | **360 Assurance Internal Audit Progress Report**<br>Ms. Richards advised that the report identifies the work completed against plan since the last meeting, identifying those matters relevant to the responsibilities of the Audit & Risk Committee.<br><br>Since the last meeting, two reports had been issued:<br>• Integrity of the General Ledger & Financial Reporting – Significant Assurance (three low risk actions agreed)<br>• Data Security & Protection Toolkit (DSPT) – Limited Assurance, noting the Trust has a plan in place to address the identified toolkit gaps by end of June.<br><br>In terms of completion of the 2019/20 Plan, Ms. Richards advised that there were three audits outstanding which are all being progressed to be completed as soon as possible.<br><br>Ms. Richards noted that the report includes the 360 Assurance Covid19 Governance Briefing as well as the 360 Assurance Client Briefing.<br><br>Mr. Easthope provided an assurance regarding the internal plan in place to address the agreed actions arising from the DSPT audit and further confirmed that arrangements were already in place for these reports and the relevant update from leads on progress against actions to be received at Finance & Performance Committee and Audit & Risk Committee.<br><br>NED members noted the “good practice” elements identified as part of the Covid19 Governance Briefing and asked if the committee could be provided with an indication of how the Trust’s finance function measures up against the specific finance good practice measures. Mr. Sabin agreed to follow this up. To be shared with both Audit & Risk Committee and Finance & Performance Committee. | July ARC<br><br>JS |

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| | It was also suggested that the Covid19 Governance Briefing be shared with other committee chairs for their awareness.<br><br>In considering the outcome of the DSPT audit, the Chair noted that an open action for the committee was to clarify and confirm the committee's information governance needs. She further noted her request for a report to be received at July's ARC meeting in respect of this action.<br><br>Mr. Easthope confirmed that the SIRO Annual Report 2019/20 is currently progressing through relevant governance processes with the intention of being received at ARC in July.<br><br>The Chair asked that the July ARC meeting receives the SIRO 2019/20 Annual Report; the intended update on the DSPT Audit Report plus confirmation of the intended arrangements to fulfil the information governance element of the committee's terms of reference and an update on recruitment to key IMST vacant posts.<br><br>Members noted receipt of the progress report. | JCH<br><br>PE<br><br>B/F |
| **ARC 07/05/2020** | **360 Assurance Final 2019/20 Head of Internal Audit Opinion Statement & Annual Report 2019/20**<br>Members noted receipt of the final 2019/20 Head of Internal Audit Opinion Statement, which confirmed, as discussed at the meeting in April, the rating of Moderate Assurance, that there is a generally a sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.<br><br>The Chair confirmed that the opinion statement had been the subject of lengthy discussion at the meeting in April and is noted by the committee.<br><br>Ms. Hawkes also confirmed that the report incorporates the 360 Assurance 2019/20 Annual Report providing a summary of the work delivered during the year, together with a summary of the client satisfaction questionnaires, which was duly noted by members. | |
| **ARC 08/05/2020** | **360 Assurance Counter Fraud, Bribery, & Corruption Annual Report 2019/20**<br>Members received and noted the Annual Report presented by Ms. Clarke on behalf of Mr. Purseglove, who noted that the report provided a summary of the work undertaken during the course of the 2019/20 Plan, the details of which have been received throughout the year as part of the progress reports from Mr. Purseglove.<br><br>Ms. Clarke advised that the report also incorporates the outcome of the Self Review Tool (SRT), which will require sign off by the ARC Chair and Executive Director of Finance.<br><br>At Ms. Clarke's request, members reviewed and confirmed their agreement with the "amber" rating on the two standards.<br><br>Members were pleased to note the continued strong overall "green" rating in respect of the SRT and confirmed that the relevant on-line declaration should be made in accordance with this assessment.<br><br>Ms. Clarke left the meeting at this point. | AS/PE |
| **ARC 09/05/2020** | **2019/20 Draft Annual Accounts & Remuneration Report; Financial Disclosures and Analytical Review**<br><br>i. <u>Draft 2019/20 Annual Accounts</u><br>Members received and noted the draft 2019/20 Annual Accounts which it was confirmed are the subject of External Audit review. Mr. Easthope confirmed that, | |

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| | whilst the final report is awaited, a small number of minor amendments have been made but nothing of any significance to raise with the committee at this stage.<br><br>ii. <u>Remuneration Report; Financial Disclosures & Analytical Review</u><br>The committee then went on to consider the Remuneration Report; Financial Disclosures and Analytical Review. Mr. Easthope confirmed that the Analytical Review provides an overview of some of the key variances within the draft Accounts and enables the committee to triangulate some of the key variances, including those which are outside of the Trust's control.<br><br>The Chair commented that the review appeared to indicate no particular areas of concern. She noted that in terms of the increased operating income, a large proportion of the additional £7.5m operating income was received in year from NHSE, through the CCG in terms of funding for new initiatives/pilots. The Chair also noted a substantial decrease in PSF funding from last year's position and it was confirmed that this was as expected due to the absence of any bonus funding system from the centre.<br><br>The committee noted receipt of these papers and the assurance they provided to support the sign-off of the Annual Accounts, in accordance with the Annual Reporting Manual 2019/20 at the June meeting. | |
| **ARC 10/05/2020** | **Updated Material Estimates Paper (Property, Plant & Equipment 2019/20)**<br>Members received an updated Material Estimates Paper (Property, Plant & Equipment 2019/20), noting that detailed discussion regarding this paper had taken place at the committee's meeting in May.<br><br>The committee were pleased to note and endorse the methodology utilised by the Trust in determining the carrying value of property, plant and equipment, provisions and other material estimates as at 31 March 2020. | |
| **ARC 11/05/2020** | **KPMG External Audit Progress Report**<br>Mr. Khangura updated the committee on progress to date in respect of the year-end audit, noting that the majority of the audit work has been completed and confirmed the formal outcome will be received at the June ARC meeting. As previously noted, he advised that were no significant issues to be raised at this time.<br><br>In terms of the areas still under review, and in this respect areas of uncertainty, he noted that these are very much related to the current CoVid19 pandemic with specific reference to the Going Concern Statement and whether there is any impact on this statement and any rewording required. NHS guidance is currently being reviewed to determine any impact, which would be limited to the wording and preparation notes.<br><br>The second area concerns Property, Plant & Equipment (PPE) Valuation and potential impact of the material uncertainty clause being used by some valuers. Mr. Khangura advised that he did not expect this to pose any difficulties to the Trust and the completion of the Annual Accounts audit, however, the external audit team needed to reflect upon most recent guidance to provide that assurance.<br><br>With reference to work around the Value for Money (VFM) conclusion. Mr. Khangura noted that this is very much impacted by the receipt of the Section 29a warning and full CQC inspection report and its associated rating. Under the Code of Audit Practice, he is required to form a view on the Trust's arrangements to secure economic, efficient and effective (properly informed) decisions and deploying resources in a sustainable manner and working with partners; and is duty bound to consider the outputs from any inspectorate. The audit team have reviewed the outcome of the CQC inspection report which they believe casts doubt on some of the arrangements in place. | |

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| | As a result, and following due consideration, he advised that a qualified adverse VFM conclusion is likely to be issued, although this is still subject to internal review processes and will be formally confirmed at June's meeting.<br><br>Mr. Easthope noted his disappointment in this outcome, from many perspectives and welcomed a further discussion with Mr. Khangura outside of the meeting to understand fully the specifics of the arrangements under consideration in reaching this conclusion. Mr. Khangura confirmed that he would be happy to provide this further clarity.<br><br>The Chair advised that she would be keen to understand the implications of a qualified VFM conclusion upon the whole of the audit opinion but also what action needs to be put in place to enable the Trust to get into a better position.<br><br>In response, Mr. Khangura confirmed that the financial statements audit will progress as in previous years and at this time there is no indication to the contrary on the basis that the remaining minor issues will be resolved. He reiterated that the qualified adverse conclusion will only relate to the VFM statement of the audit and that there are no concerns regarding the financial statements audit, which he believed would be a clean audit opinion.<br><br>He further clarified that the concerns that are being raised within the qualified VFM conclusion are issues that another regulator has identified, and not new issues. Therefore, it is not anticipated that the Trust will require any additional actions on top of the already agreed comprehensive CQC action plan. In this respect there will be no implications in terms of additional actions. The completion of the CQC action plan and the supporting evidence will be the marker for improvement.<br><br>Agreed that the committee need to consider how ARC can receive the appropriate assurances regarding the completion of the CQC action plan. It was confirmed that whilst oversight of the action plan will be a regular agenda item on the Quality Assurance Committee, all governance Board committees will need to be involved and this once again raises the issue of reporting between committees.<br><br>Noted that some of this will be addressed through the Well-Led Development Plan but there was a recognised need for further consideration.<br><br>The committee acknowledged Mr. Khangura's update and noted the final outcome would be received at the meeting in June. | PE/RK |
| **ARC 12/05/2020** | **SHSC Register of Interests / Register of Hospitality, Sponsorship and Gifts**<br>Members acknowledged receipt of the 2019/20 Register of Interests and were duly assured regarding the robust process in place to maintain this register within the Trust.<br><br>It was noted that there was no declaration record of hospitality, sponsorship and/or gifts within the report received by members and Mr. Walsh agreed to provide an assurance to the meeting in July in respect of this element of the process and the current policy.<br><br>Mr. Mills noted an amendment required in respect of the record of his declaration which Mr. Walsh agreed to follow up. | DW<br><br>DW |
| **ARC 13/05/2020** | **Draft Annual Governance Statement 2019/20**<br>Ms. Harrison presented the draft Annual Governance Statement for 2019/20. She confirmed that the draft is still currently a live document, that she would welcome members comments outside of the meeting and that further updates are still happening in terms of the mandatory text elements and the emerging clarity regarding the Trust's position following issue of the CQC inspection report and rating. | |

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| | Ms. Harrison outlined those changes made since the draft statement was last received at ARC.<br><br>She also noted that following discussion at ARC in April and on publication of the final CQC inspection report on 30 April, it is proposed that the issues raised by the CQC inspection report, and associated Warning Notices issued under section 29a, constitute a significant control issue and this has been incorporated at the end of the AGS where declaration on this issue is required.<br><br>Ms. Harrison advised that she had received confirmation from KPMG the draft statement provides an accurate and honest reflection of the current position.<br><br>Members approved the proposed conclusion.<br><br>Ms. Harrison was asked to review the statement to ensure consistent terminology was used regarding special measures arrangements within paragraphs 4.4 and 6.<br><br>Members thanked Ms. Harrison and everyone involved in compiling this statement and noted that the final version would be received at the meeting in June for sign off prior to ratification by the Board of Directors. | |
| **ARC 14/05/2020** | **Self-Certification Against Conditions G6, CoS7 and FT4 within the Provider Licence – Corporate Governance Statement**<br>Members noted receipt of the proposed declarations prepared by Mr. Walsh in respect of Provider Licence conditions (G6, CoS7 and FT4), an early draft having been received at the May meeting. Mr. Walsh confirmed that he proposed that both FT4 and G6 provide a non-compliant outcome, being impacted by the outcome of the CQC inspection rating and that this proposal was supported by recent discussions with NHS Improvement.<br><br>Following due consideration, members agreed with the proposed declaration. It was agreed that statement G6 would be submitted in accordance with the Board's delegated powers agreed at May's Board meeting; and that CoS7 and FT4 would be submitted for approval to the June Board of Directors' meeting. The Chair requested that this be received under a separate agenda item at Board, rather than being incorporated into the committee's Significant Issues Report. | DW |
| **ARC 15/05/2020** | **Draft SHSC Annual Report 2019/20 & Related Issues**<br>Ms. Harrison presented the draft SHSC Annual Report 2019/20 and confirmed that the final version would be received at the June ARC meeting for agreement prior to Board sign off.<br><br>Members were invited to review the draft document outside of the meeting and provide comment to Ms. Harrison via email. Ms. Harrison advised that confirmation had been received from KPMG in respect of the mandatory narrative and disclosures within the report and that it also now accurately reflects the findings of CQC inspection.<br><br>In response to a query from Ms. Keene regarding the inclusion of detail of the Trust's response to the CoVid19 pandemic, Ms. Harrison noted that much of the content reflects a period pre-CoVid and that national guidance had been followed in respect of the level of coverage expected within the 2019/20 report. It was agreed that as a minimum a statement to reflect compliance with national guidance and the escalation arrangements put in place during the early stage of the pandemic be included. Ms. Harrison also agreed to reflect upon the current coverage during the final read through of the report to determine whether there should be more reference made to this area. She also agreed to review the CoVid related QIA documents to ensure the timeframe is correct. | SH |

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| | Members noted receipt of the draft report and that the final version would be received at the June ARC meeting for agreement prior to Board sign off and submission on the 25th June. | |
| **ARC 16/05/2020** | **Audit & Risk Committee – Self-Assessment Outcome**<br>Mr. Walsh presented a summary of the recent ARC annual self-assessment exercise. He noted that appendix 1 to the report provided an indication of the scoring trajectory of each item, and whilst a number of these were downward, he advised this is based upon a very small number and did not evidence strong disagreement. Appendix 2 of the report provides an analysis of those areas indicating a downward trajectory or concern, correlating into five key themes, all of which feed directly into the proposed Well-Led Development Plan, some on an individual basis and some for teams.<br><br>The committee are asked to consider the findings, agree the outcomes and identified actions and determine if, following consideration of the feedback, whether there is anything they wish to specifically consider further.<br><br>Members agreed that the identified themes reflect those from the recent CQC inspection report and those that have been highlighted in previous discussions, particularly around exchanges, consistency and cross over between Board committees. It was agreed that this was a timely opportunity for the piece of work to be undertaken to address the themes identified.<br><br>The Chair noted the comment regarding the balance between financial and quality matters appearing on the ARC agenda and confirmed the intention to review this area of the agenda planner, acknowledging the need to avoid duplication and for there to be clarity on purpose. The potential to source work plans for other Audit & Risk Committees in "outstanding" NHS Trusts was suggested as a possible comparator.<br><br>The Chair also recognised the lack of awareness noted (particularly amongst external members of the committee) within the self-assessment regarding the committee's Significant Issues Reports. She acknowledged the need to make these reports more visible on the Board agenda and asked Mr. Walsh to consider this.<br><br>Mr. Easthope commented that he did not feel there was an imbalance between finance and quality related agenda items and, although he was happy to take learning from other organisations, he felt it was important that the focus of the committee is clear, towards governance, processes and internal controls for financial and quality; that assure the quality and safety of the services provided. For obvious reasons there is a strong finance focus for some items at year-end but overall, he believed there was a good balance of items on the agenda.<br><br>He also noted that he had identified the issue regarding the visibility of the Significant Issues Reports and questioned the need for committee minutes to be received at Board and whether their removal would heighten the profile of the committees' Significant Issues Report.<br><br>Mr. Easthope further noted that he would welcome the opportunity for discussion and mutual agreement regarding potential issues arising from this process.<br><br>The Chair acknowledged the need for this further work and that there is a clear commitment to do that.<br><br>Members approved the analysis and actions arising from the committee's self-assessment process. | |

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| **ARC 17/05/2020** | **Well-Led Development Plan**<br>Mr. Walsh presented an outline of the over-arching Well-Led Developmental Plan (WLDP) established to respond to the findings of the CQC well led assessment of the Trust. He advised that an external governance consultant had been engaged to work with the Trust in the development of this plan.<br><br>The report received by members provides an overview of the proposed actions through 12 workstreams split across all 8 of the key lines of enquiry (KLOEs) within the Well-Led Developmental Review Framework. It also incorporates the governance improvement work which has already been discussed by the Board. Each of the 12 workstreams will have an individual action plan which will be rag-rated and reported to Board who will monitor delivery and will feed directly into the Back to Good Programme.<br><br>Mr. Walsh advised that as this plan needs to be led by the Board, it is not proposed to be taken through any of the current assurance committees, unless there is a specific action requiring this.<br><br>Members welcomed the identified Executive leads for each area and Mr. Walsh confirmed that consideration will be given to NED involvement prior to receipt of the plan at Board. In this respect he was asked to give thought to enabling the NEDs to have easier access to larger documents/spreadsheets, noting that review via iPads is difficult.<br><br>The Chair asked for further clarity in the version received at Board regarding the timeframe terminology used within the plan, specifically around when something is being reported as "on track". She also noted that actions where commencement dates are not due are already being rated as red and wondered if alternative colour coding could be considered for these actions. She also felt there would be a need to review committee terms of reference to reflect the anticipated role these will play in the implementation of the plan. Mr. Walsh agreed to follow up these points.<br><br>The committee acknowledged the amount of work to be undertaken but welcomed the clarity this developmental plan provided. They also noted the key dates of approval of the plan by the Board on the 10th June and finalisation of the workplans for the remaining workstreams by 30th June 2020. | DW<br><br>DW |
| **ARC 18/05/2020** | **SHSC Single Tender Waivers**<br>Members noted receipt of three single tender waivers approved by the Executive Director of Finance in respect of:<br><br>**i. CTW20/21-01 – Support the Design & Creation of Well-Led Improvement Programme**<br>**ii. CTW20/21-02 – IAPTUS Patient Management Solution**<br>**iii. CTW20/21-3 – Project Management & Design Dormitories, MCC**<br>The committee noted receipt for information of the three single tender waivers which had been approved by the Executive Director of Finance since the last meeting, and the additional assurance provided by Mr. Easthope in respect of control and risks. | |
| **ARC 19/05/2020** | **Significant Issues Report**<br>The Chair noted the following for the Significant Issues Report, which she asked to be received at Confidential Board:<br><br>• Final 2019/20 Head of Internal Audit Opinion Statement<br>• 2019/20 360 Assurance Internal Audit Service Annual Report<br>• 2019/20 360 Assurance Counter Fraud, Bribery & Corruption Annual Report<br>• External Audit Progress Update<br>• Register of Interests / Register of Hospitality, Sponsorship and Gifts<br>• Self-Certification Against Conditions G6, CoS7 and FT4 within the Provider | |

| | | |
|---|---|---|
| | Licence – Corporate Governance Statement<br>• Well-Led Development Plan<br><br>The Chair took the opportunity to review the agenda planner in respect of July's ARC meeting and this was updated accordingly. | |

Date and time of next meeting:
Tuesday, 23 June 2020 @ 2.00 p.m. MS Teams / Committee Room 1, Fulwood House
*Apologies to: Jeanine Hall, PA to Chief Executive & Executive Director of Finance*
*Tel 2716716; email* Jeanine.hall@shsc.nhs.uk

*June 2020 Approved AS*

Sheffield Health and Social Care NHS Foundation Trust

# Audit & Risk Committee

Date 21 July 2020 | Item Ref 14ii

| | |
|---|---|
| TITLE OF PAPER | Senior Information Risk Owner (SIRO) Annual Report 2019/20 |
| AUTHOR | Karyn Whitaker, IMST Programme Manager<br>John Wolstenholme, Information Manager<br>Ben Sewell, Assistant Deputy Director of IMST |

## 1. Purpose

| For approval | For assurance | For collective decision | To seek input | To report progress | For information | Other (Please state) |
|---|---|---|---|---|---|---|
| | x | | | | x | |

## 2. Summary

This annual report presents assurances to the Digital Information Governance Board (DIGB) on the effectiveness of the Trusts information management and governance arrangements: that they are up to date; fit for purpose; effectively communicated and routinely complied with. It explains the current arrangements and an update on programmes of work undertaken during 2019/20.

The Caldicott Guardian is assured of the arrangements in place with regards to the confidentiality of patient and service-user data.

## 3 Next Steps

Audit & Risk Committee is asked to consider the contents of this report and the assurance provided as to the Trust's approach to information management and governance. It is asked to acknowledge the report as an accurate reflection of the broad issues over the last 12 months.

Proud to care in Sheffield

## 4 Required Actions

Audit & Risk Committee members to note progress made to date, necessary actions and timescales.

## 5 Monitoring Arrangements

All SIRO report updates to be tabled at DIGB.

## 6 Contact Details

Ben Sewell, Assistant Deputy Director of IMST
Ben.Sewell@shsc.nhs.uk
Ext. 11144

# SIRO Annual Report 2019/20

## Contents

## *1. Background Information*

1.1. The Trust, in line with recommended practice for health and social care bodies in the UK, continues to provide demonstrable arrangements which ensure that information assurance is addressed along with other aspects of information governance.

1.2. The Senior Information Risk Owner (SIRO) is responsible for the management of information risks within the organisation and for holding Directors and other Data & Information Asset Owners (DIAOs) to account for the management of information assets and related risks and issues within their areas of responsibility. The SIRO ensures that Information Governance, information and cyber security are dealt with at the highest level of management.

1.3. The framework for the management of data and information within the Trust is set out in the Data and Information Governance Policy – this specifies the relationship between the SIRO, other senior information governance roles (including the Caldicott Guardian, the Chief Information Officer and the Chief Clinical Information Officer) and Data & Information Asset Owners.

1.4. Within SHSC the SIRO is the Executive Director of Finance. The SIRO is a member of the Data & Information Governance Board (DIGB) and the Executive Directors Group (EDG). The SIRO is supported by the Chief Information Officer who has delegated decision making powers for information management and governance, although through 2019/20, this role has been vacant and has been supported by the Deputy Director IMST.

1.5. The Caldicott Guardian was fulfilled in 2019/20 by the Chief Operating Officer / Deputy Chief Executive. This is a strategic role responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing across Health and Social Care. Meetings are held with the Caldicott Guardian on a monthly basis to give updates on information sharing arrangements between health and social care partners, staff training and any high risk matters.

1.6. The General Data Protection Regulation (GDPR) requires the Trust, as a public authority, to designate a Data Protection Officer. The main tasks of the DPO are: to inform and advise the Trust of its obligations under GDPR when processing personal data; to monitor compliance with the GDPR; to provide advice where requested, particularly, with regards to data protection impact assessments and other high risk processing activities; and to act as the contact point with the supervisory authority (the Information Commissioners Office (ICO)). The DPO sits within the IMST function, under the Assistant Deputy Director for Information and Architecture.

## 2. 2019/20 SIRO Summary Position

2.1. There are a number of themes / work areas under the accountability of the SIRO, and the following table summarises the position of these at the end of 2019/20. Each area is expanded in further detail through the next sections of the report.

| Ref. | Area | Risk | Response | RAG |
|---|---|---|---|---|
| 3.1 | Policies | Policies maintained, reviewed and updated within agreed timescale. | All Data & Information polices reviewed and in date. 20/21 reviews have been scheduled in the Action Plan to this report | G |
| 3.2 | GDPR/DP | Maintain compliance, security and protection levels to GDPR requirement. | Raising and maintaining awareness is an ongoing activity. Actions required by for the DSPT will drive this forward during 20/21 | A |
| 3.3 | Incidents | Report and manage IG incidents to Trust policy and regulatory guidelines. | Systems & processes in place to deal with incidents and protect against threats. Tested and satisfied. | G |
| 3.4 | Data Security and Protection Toolkit | Maintain and provide evidence needed for DSPT compliance. | Work to achieve compliance continues. A work programme is underway to meet the revised deadline of 30 September 2020 | A |
| 3.5 | Data & Information Assets | Identification and management of all Trust data & Information assets to ensure appropriate protections, controls and ownership in place. | Foundation register for data, information, systems and flows continues to be maintained. Implementation of a new IMST Service Management tool is providing enhanced visibility and tracking of assets. Work to develop the Performance and Quality Management Framework (PQF) is ongoing. | A |
| 3.6 | New Processing | New processing assessed, protected and controlled to Trust policy and regulatory requirements | IG considerations incorporated at the design stage. Evidenced with recent examples using Data Protection Impact Assessments and supported discussion through DPO, services and relevant boards. | G |
| 3.7 | Training & Awareness | Trust maintains training and awareness to support Trust wide compliance and understanding. | The Trust is currently below the compliance level of 95%. This requires focused attention improve performance to reach this target at all levels of the organisation | R |
| 3.8 | Risk Analysis | Ensure incidents & risks are reported, escalated and managed according policy and response guidelines. | Appropriate policies and processes in place to ensure incidents are logged via and managed through corporate incident and risk register. | G |
| 3.9 | IG Audits | Maintain audit action and compliance within agreed timescales. | Rating relates to the audit process and does not attempt to anticipate or assess the findings of the audits | G |

| Ref. | Area | Risk | Response | RAG |
|---|---|---|---|---|
| 3.10 | CQC | Manage, maintain and implement quality IG services to Trust and CQC expectations and targets. | Following the recent CQC Inspection, both strengths and concerns were identified in the draft report, the final report is awaited. | A |
| 3.11 | System Protections | Take all reasonable steps to protect the Trust from Cyber attacks | Systems in the process of being upgraded. Actions are taken to protect against known risks. | G |
| 3.12 | Freedom of Information (FOI) | Respond to FOIs in compliance with legislative requirements and timescales | There are some delays in responding to FOIs currently and data quality issues with previous reporting which are being addressed through an action plan. | R |
| 3.13 | Subject Access Requests (SARS) | Respond to SARS in compliance with legislative requirements and timescales | Improvement in SAR process, management and reporting improved significantly. | G |

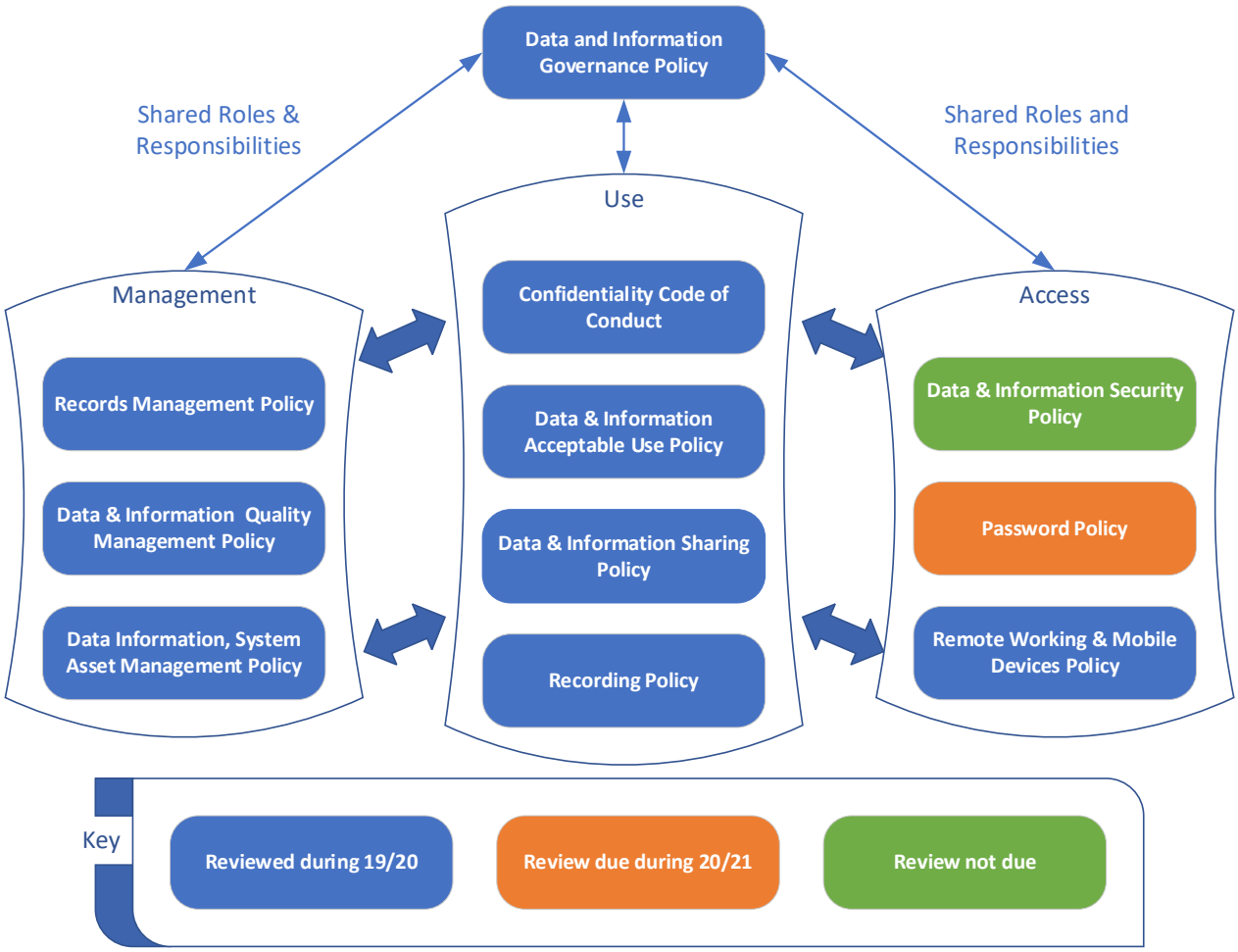
## 3. 2019/20 Position Update

### 3.1. IG Policies

| Area | Risk | Response | RAG |
|---|---|---|---|
| Policies | Policies maintained, reviewed and updated within agreed timescale. | All Data & Information polices reviewed and in date. 20/21 reviews have been scheduled in the Action Plan to this report | G |

3.1.1. The following diagram provides an overview of the suite of Information Governance policies and those which have been updated through 2019/20. The Password Policy is scheduled for review during 2020/21.

**Figure 1 Updated Information Goverance Policies**



### 3.2. GDPR/Data Protection Act 2018

| Area | Risk | Response | RAG |
|---|---|---|---|
| GDPR/DP | Maintain compliance, security and protection levels to GDPR requirement. | Raising and maintaining awareness is an ongoing activity. Actions required by for the DSPT will drive this forward during 20/21 | A |

3.2.1. Awareness raising of GDPR and the Data Protection Act 2018 is a continuing activity with input and advice provided to various projects. This includes but is not limited to the new Substand Misuse service (live 07 April 2020) and the Individual Placement Support (IPS) work with South Yourkshire Housing Association.

3.2.2. Compliance with general data protection regulations continues to be assessed through the Data Security & Protection Toolkit, and work has continued during the year to meet the required standards.

3.2.3. The COVID-19 response has required actions which have been expedited throught the use of the short-form Data Protection Impact Assessment, whilst mainitaining best Information Governance practice. The Trust has taken the necessary action to comply with the Control of Patient Information (COPI) notice requiring the sharing of patient information for COVID purposes.

3.2.4. Reporting of incidents and risk management are covered in sections 3.2 and 3.8 of this report respectively.

### 3.3. IG Incidents

| Area | Risk | Response | RAG |
|---|---|---|---|
| Incidents | Report and manage IG incidents to Trust policy and regulatory guidelines. | Systems & processes in place to deal with incidents and protect against threats. Tested and satisfied. | G |

3.3.1. Information Governance incidents and risks are reported internally with other incidents via the Trust's Ulysses incident monitoring system. These are managed at the local team and directorate level, and escalated to corporate level where appropriate.

3.3.2. Investigation has been undertaken at the end of 2019/20 to facilitate a themed based approach to risk management. Progress is expected to be made with a specific 'information' theme of risks across all departments through 2020/21 supported further through the Performance and Quality Framework (PQF) proactive approach to assure all trust data assets and identify related information risks. We expect this to lead to an increased trend in IG related incident reporting statistics during 2020/21. Lessons learned from the process of identifying and assessing the newly categorised risks will be shared to support further knowledge transfer.

3.3.3. Incidents and risks with an IG element are graded in terms of seriousness and any which reach a specified level are reported externally to the ICO via the the Data Security & Protection Toolkit (DSPT) incident reporting tool. Two incidents were assessed as being sufficiently serious to be reported to the ICO. One where information shared inappropriately with a patient's partner and a second where confidential information was accidentally given to the wrong patient. The ICO accepted the actions we took in both cases and did not require any further actions.

3.3.4. IG incidents/near misses are reported to DIGB as a standing agenda item and common themes identified, where incidents relating to patient safety are scrutinised in the trust Service User Safety Group (SUSG) chaired by the Medical Director. There were 73 IG incidents/near misses identified during 19/20.

3.3.5. During 2019/20 Data Protection Officer met weekly with the Calidcott Guardian to discuss IG incidents as they were identified and to ensure they were actioned appropriately.

## 3.4. Data Security & Protection Toolkit (DSPT)

| Area | Risk | Response | RAG |
|---|---|---|---|
| Data Security and Protection Toolkit | Maintain and provide evidence needed for DSPT compliance. | Work to achieve compliance continues. A work programme is underway to meet the revised deadline of 30 September 2020 | A |

3.4.1. The Data Security and Protection Toolkit (DSPT) requirements cover the National Data Guardian's ten data security standards which apply to all health and care organisations. These are:

3.4.1.1. Personal Confidential Data. All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

3.4.1.2. Staff Responsibilities. All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

3.4.1.3. Training. All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.

3.4.1.4. Managing Data Access. Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.

3.4.1.5. Process Reviews. Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.

3.4.1.6. Responding to Incidents. Cyber-attacks against services are identified and resisted and security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.

3.4.1.7. Continuity Planning. A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.

3.4.1.8. Unsupported Systems. No unsupported operating systems, software or internet browsers are used within the IT estate.

3.4.1.9. IT Protection. A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.

3.4.1.10. Accountable Suppliers. IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

3.4.2. The Trust has been working towards meeting the March 2020 deadline for submission, but due to COVID priorities, the NHS Digital deadline for DSPT has been moved to 30 September 2020. This has allowed us to relax the work in this area for a few weeks / months whilst maintaining our data and information security standards.

3.4.3. A report on the DSPT is being presented at DIGB in May 2020.

3.4.4. As part of the DSPT, work is underway to attain the mandated Cyber Essentials Plus certification.

3.4.5. A new version of the DSPT has been launched, a submission date for this is will be published after 30/09/20. The new version of the DSPT mandates that Cyber Essentials requirements are mandatory for all organisations and in general a reduction in the overall number of evidence items from 179 to 149. The Trust will commence work on the new version when the current work programme is completed. Progress on this work programme will continue to be reported to DIGB.

## 3.5. Data & Information Assets and Flows

| Area | Risk | Response | RAG |
|---|---|---|---|
| Data & Information Assets | Identification and management of all Trust data & Information assets to ensure appropriate protections, controls and ownership in place. | Foundation register for data, information, systems and flows continues to be maintained. Implementation of a new IMST Service Management tool is providing enhanced visibility and tracking of assets. Work to develop the Performance and Quality Management Framework (PQF) is ongoing. | A |

3.5.1. The foundation register for data, information, systems and flows continues to be maintained and will be enhanced during the coming year

3.5.2. A new IMST service desk management tool has been implemented. The tool will become a single point of access for all faults, defects, requests for service and requests for change. Requests for service and requests for change will be prioritised through the new IMST Change Advisory Board process which will be implemented early 2020/21.

3.5.3. The vision of the PQF is to provide 'the right information at the right time for the right purpose'. Having secured temporary funding to support this work a small programme team is now operational. Activity is montinored and delivered through a PMO approach with tranches and tasks in progress. Outputs are reported to a monthly Programme Board.

3.5.4. A data and information audit, metric and analysis library is in progress to keep hold of data items and a strong data kitemark system is in place. This ensures that all the trust

data items and data reports can be tracked back to source and the data definition, methodology, testing and sign off process can be accessed transparently to support any audit requests and assure the full sequence of events from start to finish.

3.5.5. There have been improvements to data outputs including increasing the number of items stored in the SHSC data warehouse including bed occupancy and waiting times, also a number of data sets have been streamlined, validated and improved. Data for external returns has been transformed and improved from a number of manual methods and data sources to being fully supported by the trusts datawarehouse which have supported MHSDS v4.1 and IAPT v2.0.

3.5.6. Staff development training sessions including the introduction of statistical process control charts (SPC) have taken place both at data analyst network level and board level.

### 3.6. New Processing

| Area | Risk | Response | RAG |
|---|---|---|---|
| New Processing | New processing assessed, protected and controlled to Trust policy and regulatory requirements | IG considerations incorporated at the design stage. Evidenced with recent examples using Data Protection Impact Assessments and supported discussion through DPO, services and relevant boards. | G |

3.6.1. Data Protection Impact Assessments are undertaken for all new data and IT system requests to support the identification of potential risks and how they may be mitigated. New projects are co-ordinated via the Trust PMO ensuring all projects are assessed for their data protection and information governance impacts.

3.6.2. Projects where new processing has been assessed in the past year include:

- Body worn cameras pilot
- Fixed surveillance cameras
- SoloProtect tracking/alarm system
- Substance Misuse Criminal Justice
- Individual Placement Support (IPS) Wave 2

3.6.3. COVID-19 has created additional demand for new systems to be implemented quickly. Whilst these fall outside the period of this report, they are included here for awareness. The following projects are currently being progressed:

- IAPTus
- Attend Anywhere
- Remote access to Insight from non-Trust devices
- Improved VPN systems
- Microsoft Teams
- Tablets for service users in inpatient areas
- New Workplace Wellbeing record system

### 3.7. Training and Awareness

| Area | Risk | Response | RAG |
|---|---|---|---|
| Training & Awareness | Trust maintains training and awareness to support Trust wide compliance and understanding. | The Trust is currently below the compliance level of 95%. This requires focused attention improve performance to reach this target at all levels of the organisation | R |

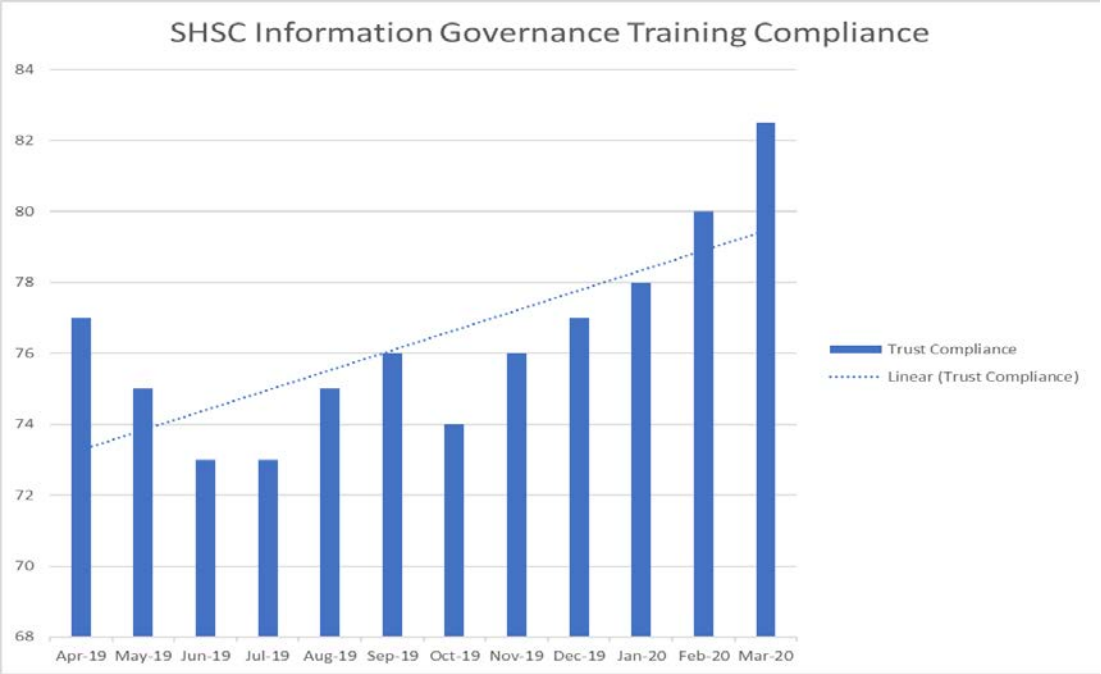
3.7.1. The SIRO has completed specific, relevant training in support of his role, and a reminder issued to all key information governance roles at DIGB in November 2019 of the responsibilities and expectations.

3.7.2. All staff are required to complete the mandatory national information governance training on an annual basis. Compliance is monitored and reported by the Mandatory Training Steering Group.

3.7.3. Training compliance in 19/20 was slightly below the Trust target of 80%, but this has improved in the final quarter. Further work is required to achieve the DPST target of 95% compliance.

3.7.4. An internal audit picked up Board level training compliance as a particular area which requires additional focus.

**Figure 2 IG Training Compliance**



### 3.8. Risk Analysis

| Area | Risk | Response | RAG |
|---|---|---|---|
| Risk Analysis | Ensure incidents & risks are reported, escalated and managed according policy and response guidelines. | Appropriate policies and processes in place to ensure incidents and risks are logged via and managed through corporate incident and risk register. | G |

3.8.1. Directorate level risks and incidents relevant to this report which are currently open are:

**Figure 3 Open Risks**

| Risk No | Risk Description | Risk Assessor/Owners |
|---|---|---|
| **3891** | There is a risk of financial penalties and Trust GDPR non-compliance due to lack of Information Governance resource within the Trust. | John Wolstenholme / Nick Gillott |
| **2331** | There is a risk to data fidelity and system security as a result of no longer receiving security updates and patches because MS Office 2003 and has now gone End of Life. This risk could impact Trust systems and operations. | Mathew Needham / Nick Gillott |
| **4364** | There is a risk that the Trust network could be compromised, leaving the organisation vulnerable to a potential cyber threat or attack on the Trusts network, as a result of a weak password management policy. This would impact the entirety of Trust operations, both clinical and corporate and key systems. | David Earney / Nick Gillott |

3.8.2. The following risks were closed during 2020/21

**Figure 4 Closed Risks**

| Risk No | Risk Description | Closed Date | Closed Reason |
|---|---|---|---|
| **2198** | Risk of confidential patient information being sent to wrong address which may require reporting to ICO and could result in monetary penalties. | 23/09/2019 | Risk controlled to an acceptable level |
| **3655** | Cyber security attacks having a detrimental impact on patient safety and clinical operations, which could result in adverse publicity, potential data loss and financial implications. | 03/11/2019 | Risk controlled to an acceptable level |

| Risk No | Risk Description | Closed Date | Closed Reason |
|---|---|---|---|
| **3659 (Corporate Level)** | Cyber security attacks having a detrimental impact on patient safety and clinical operations could result in adverse publicity, potential data loss and financial implications. | 28/02/2019 | Risk controlled to an acceptable level |
| **3779** | Global Cyber Security attack starting Friday 12th May leading to the risk of RansonWare infection on Trust ICT infrastructure. This would pose a significant risk to clinical services and patient data. | 06/11/2018 | Risk no longer applies |
| **4149** | There is a risk that service user information held on legacy Android devices becomes inaccessible to wider patient record used by clinical staff resulting in inappropriate or unsafe care delivery. This is because tablets deployed for use in the community are out of date with no agreed maintenance or replacement schedule. | 25/10/2019 | Risk no longer applies |

3.8.3. Information Governance risks including cyber security risks are reported to the DIGB. Sufficiently serious risks are included in the Corporate Risk Register.

3.8.4. Regular updates from Data & Information Asset Owners (DIAOs) reported through DIGB and SIRO. All digital project requests go through a robust process to identify and mitigate risks during project initiation. Greater risk analysis and reporting through SHSC Trust risk management system, external reporting systems and project and portfolio reporting procedures.

3.8.5. There is ongoing work being undertaken regarding the current Trust risk process and use of Ulysses functionality as a risk and incident management tool. We are exploring options and ideas to develop the existing functionality and engaging with Ulysses colleagues to be able to understand the art of the possible and plan this in and test appropriately.

3.8.6. The main areas, from an IT perspective, to include incident reporting and cross-service risks, notifications and alerts and alignment and connection of Directorate and Corporate risk updates.

## 3.9. Audits

| Area | Risk | Response | RAG |
|---|---|---|---|
| **IG Audits** | Maintain audit action and compliance within agreed timescales. | Rating relates to the audit process and does not attempt to anticipate or assess the findings of the audits | G |

3.9.1. The trust continues to actively involved in regular audit exercises internally through service improvement, acting on lessons learned and acting on feedback.

3.9.2. A number of audits were undertaken in 19/20 and results are tabled below:

**Figure 5 Audits undertaken during 19/20**

| Audit | Outcome |
|---|---|
| **Data Security and Protection Toolkit** | Draft rating – Limited Assurance<br><br>The discussion draft of the 360 assessment of the Data Security and Protection Toolkit was received on 31 March 2020. The draft gives the Trust a rating of 'Limited Assurance', however the Trust is yet to review and respond to the draft. The target date for DSPT submission has been moved to 30 September due to the COVID-19 situation, this has been included in the action plan section of this report. |
| **Clinical Coding** | Level 3 (Maximum) |
| **Penetration Test** | Penetration Test Report received from Chess Cyber Security 16/03/2020<br><br>Conducted by: Stuart White over 5.5 days.<br>Actions List drawn up and created to rectify high and critical recommendations from the report. |
| **HR for sickness rates** | Significant Assurance |
| **IAPT for recovery rates** | Significant Assurance |

## 3.10. CQC Inspection

| Area | Risk | Response | RAG |
|---|---|---|---|
| **CQC** | Manage, maintain and implement quality IG services to Trust and CQC expectations and targets. | Following the recent CQC Inspection, both strengths and concerns were identified in the draft report, the final report is awaited. | A |

3.10.1. The final report is due to be received on Thursday 30 April 2020.

3.10.2. The extract below is taken from the draft report, pending the pulication of the full CQC response.

*3.10.3. The trust had a designated Caldicott guardian, senior information risk owner, chief clinical information officer. The trust had a directorate for information management, systems and technology with a deputy director in post and a director-level post out for recruitment.*

*3.10.4. The trust had acted to comply with the introduction of the General Data Protection regulation.*

*3.10.5. The trust had an information technology system which was no longer fit for purpose. The information technology systems in place were purpose built by the trust approximately 16 years previously.*

*3.10.6. The trust were identified as 'fast follower' within the NHS England's global digital programme and offered grant funding to make improvements to their systems. The trust had undertaken a recent procurement process for new information management systems, however this had failed due to issues with the procured contractor. This had delayed trust wide improvements to information management systems. Leaders had responded by restarting pre-procurement processes and were working on their strategy for another system option. This meant that new and fit for purpose information management systems would not be introduced in the foreseeable future. In the interim, the information technology team continued to work on upgrades to databases and windows systems on trust computers.*

*3.10.7. The trust had an information technology team of 40 staff. The team comprised an information technology service desk, a second line team working on the network, a telephony and network team and server team (including pharmacy and insight application) a team of developers, and transitionary team supporting the new system strategy.*

*3.10.8. There was a quarterly data and information governance board which reported to the executive director group. The board discussed; risks, incidents, subject access request reports and updates on projects and programmes. The data protection officer also attended and shared updates on policy, incidents and data sharing.*

*3.10.9. The trust relied on data collection systems which were outdated and were not fully integrated into Trust management systems. This directly impacted on monitoring quality and performance in frontline services by Trust leaders.*

*3.10.10. There was an ongoing project to complete a revised 'quality and performance framework'. The purpose was to centralise data with operations teams and support the board to base decisions and gain assurance from a clearer picture of frontline services, including the development of visual analytics tools.*

*3.10.11. The trust had sound cyber security processes and had a lead for management of communication from NHS Digital's computer emergency response team.*

*3.10.12. The trust continued to have issues with their telephony systems. Patients continued to raise concerns that they could not contact teams, and staff were concerned about loss of signal and connectivity. The trust had identified that the network platform used was the issue and had sought the support of specialist engineers.*

## 3.11. System Protections

| Area | Risk | Response | RAG |
|---|---|---|---|
| System Protections | Take all reasonable steps to protect the Trust from Cyber attacks | Systems in the process of being upgraded. Actions are taken to protect against known risks. | G |

3.11.1. Microsoft 2008 lifecycle

3.11.2. This project aims to upgrade unsupported servers and data bases to meet compliance requirements. In 2019, extended support was purchased to ensure compliance, this will run out for some of the devices in August 2020, the other in January 2021.

3.11.3. CareCERT Cyber Security Risks

3.11.4. Notification of Cyber security risks from CareCERT are received and assessed by the IT Department weekly. Action is then taken as advised and as appropriate. In addition, IMST has received 5 advisory CareCERT notifications in the last year. IMST service improvement work continues for computer hardware, software and security patch management, the latter of which saw the introduction of a patching framework in 2019, agreed th Clinical Ops and approved through DSSG and DIGB.

**Figure 6 CareCERT notification**

| Date | Subject | Status |
|---|---|---|
| 15 May 2019 | Windows Remote Desktop Services RCE Vulnerability | Complete |
| 14 August 2019 | DejaBlue Windows Remote Desktop Services RCE Vulnerability | Complete |
| 02 October 2010 | CSOC High Severity Alert Test 1 | Not Applicable |
| 14 January 2020 | Citrix ADC and Gateway RCE Vulnerability | Not Applicable |
| 11 March 2020 | SMBGhost SMBv3 RCE Vulnerability CC-3390 | Complete |

3.11.5. Penetration Test 2019

3.11.6. Chess CyberSecurity were awarded the contract to perform a penetration test for Sheffield Health and Social Care (SHSC). The penetration test was conduct over a 5.5-day engagement and examined the Trust's internal and external infrastructure to determine that:

- Systems are configured to good security practices
- Systems are suitably protected against unauthorised access and malicious activity
- And Identify any vulnerabilities which could allow unauthenticated or authenticated attacker to comprise the internal and external networks to gain access, deface content or attack other users.

3.11.7. Positive Findings

- Two-factor authentication (2FA) in use via the SonicWall SSL-VPN for 'XCT' and 'Android' realms
- Guest and public WLANs used by public/staff and service users are correctly isolated from corporate networks.
- Privileged account management solution (Thycotic) in use and accounts well managed.

3.11.8. Areas for improvement

- The password policy needs to be revised and strengthened
- Implementation of a 2 Factor Authentication on the current staff access gateway
- Reduce the number of privileged accounts (Accounts with elevated permissions i.e. members of Domain Admins).
- Ensure that critical updates are installed and that obsolete devices and systems are retired.

3.11.9. IT Operations Team have created an action plan to rectify the identified critical, high and medium vulnerabilities.

## 3.12. Freedom of Information (FOI) Requests

| Area | Risk | Response | RAG |
|---|---|---|---|
| Freedom of Information (FOI) | Respond to FOIs in compliance with legislative requirements and timescales | There are some delays in responding to FOIs currently. An action plan to address this is in place | A |

**Figure 7 FOI Requests**

The tables below show validated FOI information:

| Period | Live FOI cases | | | Responses | | | N/A | Carried forward |
|---|---|---|---|---|---|---|---|---|
| | Carried forward | New | Total | On time | Out of time | Total | | |
| **Q4 19/20** | 36 | 90 | 126 | 24 (32%) | 51 (68%) | 75 | 24 | 26 |
| **Q3 19/20** | 16 | 94 | 110 | 6 (15%) | 33 (85%) | 39 | 35 | 36 |
| **Q2 19/20** | 9 | 63 | 72 | 5 (19%) | 22 (81%) | 27 | 29 | 16 |
| **Q1 19/20** | 43 | 61 | 104 | 26 (43%) | 35 (57%) | 61 | 34 | 9 |

N/A are those requests that are received but not applicable, for example relate to services that we do not provide. All requestors receive a response.

3.12.1. The total number of information requests received under the Freedom of Information Act for the year is 411, an average of 34 per month.

3.12.2. This is higher than the average number of requests received during 2018/19 which was 23.6 per month, a total of 284 for the full year and mirrors the increase in FOI requests across the public sector

3.12.3. An action plan to improve performance is in place and showed improvement in performance over the period from October to December 2019. This was reported to DIGB in February 2020.

### 3.13. Subject Access Requests (SARS)

| Area | Risk | Response | RAG |
|---|---|---|---|
| Subject Access Requests (SARS) | Respond to SARS in compliance with legislative requirements and timescales | There are some delays in responding to SARS currently. An action plan to address this is in place | A |

3.13.1. Data regarding SARS requests can be seen below.

3.13.2. The total number of Subject Access Requests for the year is 248, an average of 21 per month.

3.13.3. This information has been obtained from the excel record which is currently in use to record Access to Health Records Requests. An exercise has been undertaken to verify all records held on record on the local database.

**Figure 8 Subject Access Requests**

| | |
|---|---|
| **SARS received in Q4** | **74** |
| **Total processed** | **68** |
| **Processed within time** | 67 (98%) |
| **Processed out of time** | 1 (1%) |
| **Carried over to Q1 20** | 6 |

| | |
|---|---|
| **SARS received in Q3** | **55** |
| **Total processed** | **40** |
| **Processed within time** | 35 (88%) |
| **Processed out of time** | 5 (12%) |
| **Carried over to Q4** | 15 |

| | |
|---|---|
| **SARS received in Q2** | **51** |
| **Total processed** | **41** |
| **Processed within time** | 24 (59%) |
| **Processed out of time** | 17 (41%) |
| **Carried over to Q3** | 10 |

| | |
|---|---|
| **SARS received in Q1** | **68** |
| **Total processed** | **60** |
| **Processed within time** | 53 (88%) |
| **Processed out of time** | 7 (12%) |
| **Carried over to Q2** | 8 |

3.13.4. An action plan to improve performance was implemented during Quarter 4 of 2019/20.

## *4. Definitions*

| Role | Definition |
|---|---|
| **Senior Information Risk Owner (SIRO)** | The **SIRO** is an executive who is familiar with and takes ownership of the organisation's information risk policy, acts as advocate for information risk on the Board. |
| **Data & Information Asset Owners (DIAO)** | **Data & Information Asset Owners** are senior individuals involved in running the relevant business. Their role is to understand and address risks to the information assets they 'own' and to provide assurance to the SIRO on the security and use of those assets. |
| **Data & Information Asset Managers (DIAM)** | **Data & Information Asset Managers** ensure that policies and procedures are followed, recognise actual or potential security incidents, consult their IAO on incident management, and ensure that information asset registers are accurate and up to date. |
| **Information Assets** | The definition of **information assets** is wide ranging and includes:<br>Personal Information content<br>Other Information content<br>System and process documentation<br>Software<br>Hardware<br>Supporting resources and services |
| **Information Governance Toolkit** | The **Data Security and Protection Toolkit** is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.<br>All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. |
| **Caldicott Guardian** | A **Caldicott Guardian** is a senior person within a health or social care organisation who makes sure that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. |
| **Data and Information Governance Board (DIGB)** | **DIGB** is an SHSC Governance Board overseeing statutory duties and assuring quality in regard to data and information governance, reporting to the Executive Directors Group (EDG). |