Public Board meeting

SUMMARY	Meeting Date:	22 June 2022
	Agenda Item:	4

Report Title:	**Annual Governance Statement 2021/22 final draft**	
Author(s):	Deborah Lawrenson, Director of Corporate Governance	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Audit and Risk Committee
	Date:	14 June 2022
Key points/ recommendations from those meetings	The committee approved the Annual Governance Statement for endorsement by the Board. The committee noted an additional factual amendment requested by the Internal Auditors which has been reflected in the final version	

Summary of key points in report							
The Annual Governance Statement has been updated since last received at the Board and approved for submission to the Board, by the Audit and Risk Committee.							
Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**	**X**	**Assurance**		**Information**	
The Board is asked to approve the Annual Governance Statement 2021/22 for submission.							

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	*Yes*	*x*	*No*	
CQC Getting Back to Good	*Yes*	*x*	*No*	
Transformation – Changing things that will make a difference	*Yes*	*x*	*No*	
Partnerships – working together to have a bigger impact	*Yes*	*x*	*No*	

Is this report relevant to compliance with any key standards ?					State specific standard
Care Quality Commission Fundamental Standards	*Yes*		*No*	*x*	
Data Security and Protection Toolkit	*Yes*		*No*	*x*	
Any other specific standard?		*x*			Compliance with the Foundation Trust Annual Reporting Manual 2021/22

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*		*No*		
Financial (revenue &capital)	*Yes*		*No*		
Organisational Development /Workforce	*Yes*		*No*		
Equality, Diversity & Inclusion	*Yes*		*No*		
Legal	*Yes*		*No*		

3.7 Annual Governance Statement 2021/22

3.7.1 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that SHSC ('the Trust') is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

3.7.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an 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 for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

3.7.3 Capacity to handle risk

3.7.3.1 Senior Leadership and Structure

I am ultimately responsible and accountable for the Trust's provision of safe services and for ensuring that the systems on which the Board of Directors relies to govern the organisation are effective. I have been supported in these duties by members of the executive team.

The posts of Executive Director of Nursing and Professions, Executive Director of Finance, IMST and Performance, Executive Medical Director, Executive Director of People and the Director of Corporate Governance (Board Secretary), a non-voting board role, have remained in place throughout 2021/22.

The post of Director of Special Projects which had been in place since December 2020 was reviewed and became the Director of Strategy with the role successfully recruited to and an appointment made in February 2022 to strengthen our strategy development capacity.

An Improvement Director, appointed by NHS England and NHS Improvement has been in place for 2021/22 to support the organisation's regulatory status.

3.7.3.2 Risk management roles of leaders

The Trust's corporate and clinical governance teams provide leadership, support, guidance and advice for all matters relating to risk management and corporate and clinical governance. Executive directors are operationally responsible for safety and the effective management of risk within their areas of responsibility. All managers, including team managers, leaders and heads of departments, are responsible for health and safety and the effective management of risks within their teams, services or departments. All Trust staff, including those on temporary contracts, placement or secondments, and contractors must keep themselves and others safe. All staff have a duty of care to provide safe services and do no harm. All health and social care staff working directly with service users and carers are responsible for ensuring that their work is safe and that they use systematic clinical risk assessment and management processes in the delivery of care and treatment.

3.7.3.3. Staff training

Staff training and development needs with regards to risk management and safety are described in the Trust's Mandatory Training Policy. Staff receive appropriate training relevant to their post requirements. All staff receive an introduction to the organisation and core training (risk management, health and safety, equality and human rights, information governance, safeguarding and infection control). More specific training is provided, dependent upon the individual's job role or work location, and includes incident reporting and investigation, Safeguarding Adults and Children, Mental Health Act, Mental Capacity Act, First Aid and Life Support (including resuscitation), Clinical Risk Assessment and Management, Medicines Management and Respect (managing violence and aggression). Development and training needs will be reflected in personal development plans (PDPs) over and above mandatory training.

Overall compliance with mandatory training was at 89.79% by 31 March 2022.

Of the 31 subject areas:

- 3 exceeded 95% compliance
- 10 exceeded 90% compliance
- 8 exceeded 85% compliance
- 6 exceeded 80% compliance
- 4 were below 80% - and have recovery plans in place.

Mandatory training is kept under continuous review with floor to Board reporting and monitoring in place. The Board sees data on overall compliance; individuals and managers receive reminders throughout the year and can see their own data, with managers being able to see data for their teams.

3.7.3.4 Learning from good practice

The Trust uses a variety of mechanisms for ensuring that good practice and lessons learned are shared across the services. These have included:

- Quality Assurance Committee meetings and Flash Reports for the Board of Directors
- Preventing Future Deaths reports
- Quality Improvement Forum
- Daily Incident Huddle (review and follow up of all incidents with services)
- Weekly Investigation Panel (all clinical investigations to track, support and review)
- Safeguarding supervision (group)
- Bitesize safeguarding online open sessions
- Safeguarding Conferences (6 monthly with partners)
- Culture and Quality Visits
- Fundamental standards clinical reviews PICU and acute wards
- Lessons Learnt Staff Bulletin (Quarterly)
- `Talking Heads` online patient safety focussed groups
- Lived Experience Reports
- Care Opinion and Friends/Family Test
- Team and clinical directorate governance meeting reports and events
- Acute care forum
- Lessons learned events
- Service based development forums
- Clinical Quality and Safety Group
- Least Restrictive Practice Conference and Restrictive practice learning events
- Quality improvement forum
- Leadership Forum
- 48hr reports leading to Significant Event Analysis Reports with reflective learning
- Commissioned patient safety and staff safety reviews (external)
- Serious Incident Reports
- Mortality Reviews and Structured Judgement Assessments
- Blue light alerts
- Section 42 enquiries (safeguarding investigation)
- System learning panels (Firshill review)
- Clinical Executive Panel (monthly review with directorates of patients whose needs are not being well met by the system)
- Trust review and response to national reports e.g. Out of Sight review, Ockenden Report
- Board development learning e.g. Ockenden and Firshill

- Bespoke learning events e.g. root cause analysis (RCA) Quality Summit approach on the Firshill inspection looking at this from a system, Place and organisation perspective
- Suicide Reference Group (Sheffield wide)
- Complaints thematic review
- Claims thematic review

3.7.4. The risk and control framework

3.7.4.1 Risk Management Strategy

The Trust recognises that positive and managed risk taking is essential for growth, development and innovation. Risks are not seen as barriers to change and improvement; instead they are recognised, considered and managed effectively as part of service improvements. The Trust's Risk Management Strategy was refreshed and approved by the Audit and Risk Management Committee and Trust Board in May 2021. It describes the Trust's strategic approach to safety and risk management; it also sets out the Trust's governance arrangements, together with defining levels of authority, accountability, responsibility and escalation for risk management.

Risks are assessed using a stepped approach which identifies and analyses the risk, identifies the control measures in place and how effective these are and the actions that need to be taken to reduce/mitigate/remove the risk. Risks are graded according to their severity and likelihood of recurrence, using a 5x5 risk grading matrix based upon guidance produced by the former National Patient Safety Agency.

High level risks rated 12 or above as well as risks which affect more than directorate are considered for entry onto the Corporate Risk Register. Risks are recorded on an electronic risk management database (Ulysses Risk Management System), which is separated into teams and directorates. All recorded risks have an accountable individual and are reviewed and monitored by the appropriate operational governance group. Risk registers are held at corporate, directorate and team level. Each directorate has a risk register lead responsible for managing and maintaining their risk register. The Corporate Risk Register is administered by the Head of Board Assurance reporting to the Director of Corporate Governance (Board Secretary).

Risks on the Corporate Risk Register (CRR) are overseen by lead Directors, received and monitored through the Board sub committees, and received at each public Board meeting.

As at 31 March 2022, there were 21 risks on the Corporate Risk Register. There is one high risk with a current risk score of 16:

- *Risk that patients with a Learning Disability/and or with Autism will be admitted onto an acute mental health ward due to the current closure of ATS at the Trust*

  Mitigations:
  - The Community Intensive Support team and Community Learning Disability team are working closing with services users and providers to support into the community and to support admissions avoidance.
  - Learning Disability Multi-Disciplinary Team will in-reach into the wards to provide specialist support and training to mental health staff.
  - Standard Operating Procedure for emergency admission avoidance/admissions has been developed.
  - List of CQC rated Good ATS inpatient settings across the country was to be used if admission cannot be avoided (if available)
  - Risk action plans include ongoing work with the Learning Disability Programme Board and the development of a new community enhanced model for Sheffield; and discussion with regional Commissioners about future planning for Learning Disability beds at and Integrated Care system and regional level.

There were 5 risks with a current risk score of 15:

- *Risk to patient safety arising from the quality and safety of the ward environments across Trust hospital sites, including access to ligature anchor points.*

  Mitigations:

  - Policies and Standard Operating procedures are embedded, including ligature risk reduction, observation and risk management.
  - Inpatient environments have weekly health and safety checks.
  - The ward works on all adult acute wards is continuing in line with the programme.
  - 14 commissioned beds are in place to mitigate the reduced bed base whilst refurbishment work to remove Ligature anchor points is progressed.

- *Risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity.*

  Mitigations:

  - All referrals are triaged within a 24hr period to determine need and urgency.
  - Customer Service Improvement Programme Manager in post to improve response time and caller experience.

- Written information and advice on accessing help in a crisis given to services users waiting assessment.
- Waiting time trajectory is reported to Quality Assurance Committee. Voluntary, Community and Social Enterprise (VCSE) offer went live in February 2022 and will be evaluated in April 2022.

- *Risk that there are insufficient beds to meet service demand;caused by bed closures linked to the eradication of dormitories and ward refurbishment; resulting in a need to place service users out of city.*

Mitigations:

- Clinical Director and Executive Director (out of hours) approval for out of are authorisation.
- Crisis Resolution and Home Treatment team support for ward discharges and gatekeeping of admissions.
- Additional 12 acute beds and additional 6 PICU beds procured.

- *Risk to patient safety, caused by key clinical documents being deleted resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g., missed appointments.*

Mitigations:

- New Electronic Patient Record (EPR) programme which will deliver a new EPR allowing Insight to be fully recovered is the full mitigation for this risk.
- Improved backup infrastructure is in place to provide faster recovery of deleted documents.
- Hourly snapshots of data in place to reduce volume of data that could be lost in an incident.
- Standard Operating Procedure in place to handle document deletion incidents with oversight from Digital Information Governance Group (DIGG).
- Quarterly planning overseen by IMST Senior Management Team (SMT).
- Information Security Group within IMST for planning of security and governance actions.

- *Risk that complaints will not be responded to in a timely manner which will give rise to breaches of contractual standards and dissatisfaction from service users, carers and families.*

Mitigations:

- Complaints Manager and Complaints officer employed to support the administration and processing of complaints.
- Quality Directorate provides oversight.
- Rapid improvement plan developed and monitored through Quality Assurance Committee.

All risks on the Corporate Risk Register have a defined 'monitoring group' (assurance committee) and each of the risks described above are closely managed through the Ulysses system and receive scrutiny through the Quality Assurance Committee and Finance and Performance Committee. This scrutiny includes controls, assurances and any gaps in controls and assurance aligned to the actions being taken to achieve the target risk score.

The Trust Board reviews its risk appetite annually, aligning it to revised strategic objectives and determines whether an individual risk or a specific category of risks are considered acceptable or unacceptable based on the circumstances and situation facing the Trust. The risk appetite is included in the Risk Management Strategy and reflected in the Board Assurance Framework (BAF) and Corporate Risk Register. The Board will review risk appetite when the BAF for 2022/23 is agreed. The Trust's approach is to minimise exposure to risk that impacts on patient safety and the quality of our services. However, the Trust accepts and encourages an increased degree of risk relating to innovation, providing the innovation is consistent with the achievement of patient safety and quality improvements.

Risks are highlighted via incidents, including serious incidents, complaints, concerns, safeguarding issues, claims and other queries. The Quality Assurance Committee receives quarterly reports on incidents, infection prevention and control, safeguarding, service user experience (including complaints) and clinical audit. Staff are actively encouraged to report all incidents and near misses to enable the Trust to learn from such events and improve service user safety.

Training has been put in place to support risk owners in updating their risks and support is available on an ongoing basis.

The Trust has commissioned a review of its systems processes, capacity and capability around risk to support ongoing improvement and the outcome of this review is due for receipt through our Back to Good monitoring structure, Audit and Risk Committee and Board in June 2022.

3.7.4.2 Board Assurance Framework (BAF)

Assurance is provided to the Audit and Risk Committee every quarter that risks are being addressed and actions completed through updates to the Corporate Risk Register and Board Assurance Framework.

The BAF is a document outlining the Trust's strategic aims and objectives and which details principal risks which may inhibit delivery of those objectives. The BAF is used to monitor the levels of assurance received at Board and in committees regarding the robustness of the Trust's system of internal controls and whether or not the risks are being effectively managed.

The BAF was reviewed at each Audit and Risk Committee meeting and each Board committee also received and reviewed the element of the BAF relevant to their remit. The Board received the BAF on a quarterly basis which was informed by the committee reviews.

A clear link between papers and the BAF is required on each report to demonstrate how they provide assurance to the Board and its committees that risks are being managed and mitigated and support and training has been provided to report authors to support their understanding around the level of detail required generally in the Board reporting structures.

At the start of 2021/22 financial year, the Trust had nine BAF risks to the delivery of the strategic objectives. A further risk was added during the year 'risk that engagement with systems partners is ineffective or lacking; caused by weaknesses in partnership relationships or supporting governance arrangements; resulting in a poorer quality of services, missed opportunities and potential costs' and is monitored by the Board.

A separate COVID-19 risk register is maintained with reporting through the Command structure and the Quality Assurance Committee and to Board.

The Trust is compliant with its CQC registration and will be declaring compliance against Provider licence risk requirements.

The trust has published on its website a register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. Work is underway to call in declarations of interest below Board level with this process expected to complete by the end of Q2 2022/23.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. A new appointment has been made for a Human Rights lead and the EDI and Human Rights teams strengthened in 2021/22.

The trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust Board has approved the 'Green Plan' as part of its sustainability strategy and commitment to this agenda.

3.7.4.3 Public stakeholder involvement in managing risks

The Trust works to continuously improve its approach to engaging service users, carers, governors and partners to learn from individuals' experiences and enable continuous quality improvements in all areas of our business this has included particularly effective partnerships with organisations such as Flourish to broaden engagement with our communities.

Service users, carers, governors and partners engage in the Trust's governance structures and actively take part in groups across the organisation to contribute to planning and service improvement.

The number of service user and carer networks, co-led by service users and carers, continues to develop, enabling services to improve their care in line with service user and carer experience feedback.

Staff networks were strengthened significantly in 2021/22 providing invaluable insight in a wide range of areas.

Partnership working has continued through the Sheffield Accountable Care Partnership (ACP), NHS Sheffield Clinical Commissioning Group, Primary Care Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield City Council.

As a Foundation Trust we have public members and a council of Governors. The overall role of the Council of Governors is to assist the Trust in the drive to raise standards by providing services of the highest possible quality that meet the needs of the people of Sheffield. The Council of Governors receives updates on the Trust's compliance against regulations and standards and helps plan and steer the Trust and assists in setting priorities for improvements and changes. There is a Governance Development Programme in place which in 2021/22 included workshops on

- Integrated Care Systems
- human rights
- raising the profile of carers
- service user engagement and experience
- engagement
- clinical and social care strategy
- Rainbow badge training, and

In addition to this Chair drop in sessions were established and governor observation of Board sub committees was introduced.

He Council of Governors were also provided with externally supported consultants provided two Governor development workshops around induction, roles and responsibilities, holding the Board to account, the Health and Social Care Bill and the Trusts Strategy.

3.7.4.4 Quality governance arrangements

A ‘Back to Good’ programme has been in place throughout the year and was developed to identify the must-do and should-do actions arising from the CQC inspection. These have been monitored monthly through a Back to Good Board and reported to Quality Assurance Committee and Board.

During the year, governance arrangements across the organisation were in place to monitor progress against quality improvement actions following CQC inspections. Senior leaders have engaged with regional NHS colleagues and the CQC to report on improvement.

The Well-Led development programme agreed in 2020 was incorporated into the ‘Back to Good’ programme in 2021 and continued to be reflected in the Board Development Programme.

There has been significant focus on senior leadership activity with a comprehensive Board development programme, a governor development programme, non-executive director development programme, executive development programme and leadership programmes in place and being implemented across the organisation.

Additional activity has included a listening programme of service visits by both the executive team as a whole and Board members (in pairs of one non-executive and one executive member) with actions captured and followed up with the teams visited. This supports triangulation of reports and information received at Committee and Board.

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service level. During 2021/22 a performance framework has been in place, with continuing development of the Integrated Performance and Quality report. This is reporting at board committees and also to the Board. The schedule of meetings for the year ensures all data can progress from the point of availability to reporting upwards via the necessary groups. This quality assurance step ensures the quality of data received. Service performance reviews have taken place regularly, chaired by the Director Finance and attended by the Chief Executive, engaging all members of the executive leadership to positively challenge performance in clinical and corporate services across the organisation.

In 2021 a number of internal controls led to the Director of Nursing sharing serious concerns with the CQC regarding the quality of care at Firshill Rise Assessment and Treatment Service. This led to a number of actions to improve the service but following an unannounced visit by the CQC (although this was expected by the organisation), this resulted in the service being rated as inadequate and a condition and a requirement to stop new admissions until a number of conditions

were met.

A number of learning events were undertaken to understand the root causes of the findings of the report. One of the outcomes of these learning events was that the Trust made the decision to support the safe transfer of the service users in the unit with the support of system partners and then take the opportunity to redesign the model of care with an emphasis on a strengthened community offer. The unit remains closed while the system agrees a new model of care.

Progress has been made in services previously inspected by CQC and rated as inadequate:

- In May 2021 the CQC carried out a follow up inspection of the acute wards and psychiatric intensive care unit, mental health wards for older people, and crisis and health-based places of safety, due to these being rated inadequate at the previous inspection. At this inspection, two services (mental health wards for older people, and crisis and health-based places of safety), improved their rating to requires improvement.
- At this time the acute wards and psychiatric intensive care unit remained rated inadequate because further improvement was required however in December 2021, a follow up CQC visit took place with the report published in February 2022 and an improved rating for these services from inadequate to requires improvement.
- The well-led question was also inspected as part of this due to this previously having been rated inadequate and was re-rated as requires improvement.

In February 2022 the CQC confirmed that the Trust had made significant improvements in the areas highlighted in the previous Section 29A enforcement notice and this enforcement notice was closed.

These improvements led to an overall rating for the Trust of Requires Improvement and a national and regional decision to move from SOF4 to SOF3.

3.7.4.5. Information governance and data security

We have a range of information governance policies which provide a framework covering the creation, use, safe handling and storage of all records and information. The management and monitoring of information risks is the responsibility of the Trust's Senior Information Risk Owner (SIRO) and information risks and incidents are reviewed through the Data and Information Governance Group which is accountable to the Audit and Risk Committee.

Following our 2020/21 Data Security and Protection Toolkit (DPST) submission, a plan was agreed with NHS Digital to address those areas identified as requiring

improvement but the requirement to submit the outcome was subsequently dropped so our attainment level is recorded as 'Approaching Standards'.

The Trust continues to work to implement further improvements to enhance our performance against DPST requirements. An Information Security Group meets monthly and is focussed on the requirements of the toolkit to support the organisation to be 'audit ready' in all areas. A phishing exercise was undertaken by internal audit which identified fragilities in the organisation's IT security and as a result changes were made to strengthen our arrangements. This continues to be an area of focus.

Information governance training is included as part of the core training for new starters and all staff are required to undertake annual information governance training. Other specific training sessions have been provided to staff.

Information governance and data security incidents and risks are recorded and reported through the Trust's risk management processes.

During 2021/22 four incidents were reported to the ICO. One related to a service writing to a service user at the wrong address; one related to an allegation by a service user that an external interpreter had shared their information inappropriately (although this was not verified); one occurred when a temporary member of staff shared information about a service user who was known to them; and one related to out of date details being used resulting in a former carer of a service user being contacted. In each of these cases processes were reviewed and updated where appropriate and the ICO has taken no further action. These are reflected on the risk register and the Electronic Patient Record project will be a significant contributor to mitigating the risks with other safeguards also in place.

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

The Trust has a robust committee governance structure which was refreshed during 2020/21.

The following committees report into the Board:

- Audit and Risk Committee
- Finance and Performance Committee
- Quality Assurance Committee
- People Committee
- Mental Health Legislation Committee (newly established in 2021)
- Remuneration and Nominations Committee

Terms of Reference for all committees have been approved by the Board, and are undergoing regular annual review processes, alongside the reviews of effectiveness for the committees.

The Trust continued to review its operational efficiency metrics throughout the year, as described earlier through the Integrated Performance and Quality Report and Performance Framework.

The organisation has reviewed and continues to review its leadership at various levels as shown by the introduction of the Director of Strategy post. An internal leadership development programme was launched in February 2022 aiming to bring current and future leaders together to challenge their thinking, learn and connect.

Financial sign-off of budgets is undertaken by directors and is performance managed by the respective executive directors. Budget managers are provided with monthly budget reports for their areas of responsibility to assist them in undertaking this role. Performance management reviews involve business partners from within the finance directorate to ensure leaders at all levels are properly supported.

Improvement in triangulation of data has taken place across the Board sub committees with escalation taking place between committees and Board members placed on a range of committees to support cross fertilisation in discussion and around challenge. There has been an improvement in our recovery plans and continuous improvement around monitoring with a more systematic approach to challenge and improvement in place.

As part of well led improvement, finance reviews by NHSE/I continued to take place with CQC/NHSE/I oversight of our Quality Improvement journey continued throughout the year which provided an opportunity for extended challenge and verification resulting in the Trust moving from SOF 4 to SOF 3 at the end of the financial year.

3.7.6. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports and I met with internal and external audits periodically (planned) throughout the year. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and its assurance committees as described in this statement, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Committees provide ‘Alert, Advise, Assure’ reports, alongside the minutes, after each meeting on the significant matters for consideration, these may include issues of specific interest, but will also include control issues or areas where there are gaps in assurance.

The Audit and Risk Assurance Committee provides assurance to the Board

through objective review and monitoring of the Trust's internal control mechanism, such as financial systems, financial information, compliance with the law, governance processes and emergency planning among others. It monitors the effectiveness of the systems in place for the management of risk and governance, and delivery of the Board Assurance Framework. The committee is also responsible for ensuring the integrity and security of Trust data.

The Quality Assurance Committee provides assurance to the Board of Directors on the quality of care and treatment across the Trust by ensuring there are efficient and effective systems for quality assessment, improvement and assurance that service users and carer perspectives are at the centre of the Trust's quality assurance framework.

The Finance and Performance Committee provides assurance to the Board of Directors on the management of the Trust's finances and financial risks, and in relation to performance matters which have developed through the year, as well as progress against transformation projects.

The People Committee provides assurance to the Board of Directors on the human resource structures, systems and processes that support employees in the delivery of high quality, safe patient care and to ensure the Trust meets its legal and regulatory duties in relation to its employees.

The Mental Health Legislation Committee provides assurance to the Board of Directors on statutory and regulatory compliance in respect of Mental Health and Human Rights legislation.

The Remuneration and Nomination Committee makes determination of the composition, balance, skill mix and succession planning of the Board, as well as advising on appropriate remuneration and terms and conditions of service of the Chief Executive, executive directors and directors.

The Non-Executive Directors sit on more than one committee to increase integrated discussions on quality and resource assurance with issues escalated between committees and the Board kept informed through the Alert, Assure and Advise (AAA) reports. The integrated approach is also provided through the Integrated Performance and Quality Report (IPQR) received at Committees and Board.

Our 'Back to Good' programme provides assurance focussed on or related to areas identified for improvement through our CQC report. There is a programme board in place which activity monitors progress and provides regular reports to our assurance committees and directly to the Board. The Quality Oversight Board led by regional partners and attended by CQC, provides oversight of our 'Back to Good' journey.

The clinical audit programme also supports my review of the effectiveness of

internal control. A full internal review of each clinical audit is undertaken with actions identified to address any identified risks and to improve quality of care.

The role of the assurance committees in maintaining and reviewing the Trust's systems of internal control are described above.

The internal audit programme overseen at the Audit, Risk and Compliance Committee provides a further mechanism for supporting this. 360 Assurance, our internal auditors, identify high, medium and low priority recommendations within their audit reports, which are monitored in an internal audit recommendations tracker and reviewed frequently both internal by the Executive Team and with our auditors.

In 2021/22 performance in our in-year audits improved with the in-year position moving from limited to significant assurance. The Board Assurance Framework and Corporate Risk audit remained 'moderate' although it was recognised work to continue to embed these had been made.

The following reports were received with Limited Assurance

- Procurement
- Waiting List Data Quality and Management with one high risk finding identified
- Quality of Performance Development Reviews (PDRs) with one high risk finding identified – note this report is from the 2020/21 audit programme.

The following reports were received with Significant Assurance

- Incident Management
- General Ledger and Financial Reporting Arrangements
- Strategic Governance
- Policy Management
- Transformation and Project Management
- Health and Wellbeing
- Payroll

At the time of writing testing was in progress for the 2021/22 reports for Safeguarding Adults and Children; and Recruitment reviews. The Health and Safety audit was also ongoing with the final draft awaiting sign off.

There have been some delays with implementing some of the recommendations during the financial year (predominantly low or medium risks) and as a result of this the overall opinion remained 'moderate'. However, I recognise this is an area which requires improvement and I am assured systems to address and improve are being put in place to improve the position in 2022/23.

The Head of Internal Audit (HOIA) provides me with an opinion based on an

assessment of the design and operation of the underpinning assurance framework and supporting processes and an assessment of the individual opinions arising from risk-based audit assignments contained within the internal audit risk-based plan that have been reported throughout the year. The assessment has taken into account the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

The Head of Internal Audit Opinion is based on three elements:

- The design and operation of the BAF and strategic risk management arrangements
- The outcome of individual audit reports
- The extent to which the Trust has responded to audit recommendations.

Head of Internal Audit Opinion

I am providing an opinion of **moderate assurance** that there is a generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.

Whilst I have concluded an overall moderate assurance, we recognise that the Trust has continued on its improvement journey and the CQC inspections demonstrate that, although there is still work to do, the Trust is on a positive trajectory.

In providing our opinion we consider the three areas outlined below:

Strategic risk management: moderate assurance

Our opinion considers strategic risk management arrangements over the course of 2021/22. Across the year we have identified a number of findings in relation to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and the Trust agreed actions to strengthen arrangements, including updating and refining the BAF and strengthening the controls for extending BAF/CRR action due dates. Our review of the BAF which was presented to Board in March 2022 confirms steps have been taken to improve the BAF. However the Trust recognises it is a work in progress – work has been done to improve the content, but this is continuing. The Trust feels that discussions have improved and are becoming more focused on managing the Trust's risks. It is important that the improvements continue into 2022/23 and the Trust can demonstrate these are embedding to ensure the BAF is a robust tool the Trust can use to manage its strategic risks.

Internal Audit plan outturn: significant assurance

We are providing significant assurance for this segment. It should be noted that there have been three limited assurance opinions issued during the year (for the Quality of PDRs, Procurement and Waiting List Data Quality and Management audits).

Follow up of Internal Audit actions: moderate assurance

Whilst we acknowledge the external factors which may impact on the Trust's ability to respond to internal audit actions (eg Covid and the CQC), progress has been slow throughout the year, in particular the first follow up rate is low (46%). The Trust's overall implementation rate for actions in 2021/22 is 72%. This just falls within the 'moderate assurance' category for follow up. The Trust's ability to implement agreed actions has been raised in the previous four Head of Internal Audit Opinions.

This opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated.

Conclusion

In my opinion, notwithstanding issues noted in this report there has been substantial progress in addressing the previous significant internal control issues that were identified during 2019/20, with progress made in a number of services previously rated as inadequate. In February 2022 the CQC recognised the significant improvements made in the areas highlighted in the previous Section 29A notice and the enforcement notice was closed.

I recognise there were significant internal control weaknesses identified in the early part of this financial year given the concerns raised about the Assessment and Treatment Service (ATS), Firshill Rise with the following condition placed upon us:

- The registered provider must not admit any service user to the Assessment and Treatment Service (ATS), Firshill Rise, without the prior written agreement of the CQC

Having identified the issues at Firshill Rise, we recognised the opportunity to modernise the service with greater community focus. This requires system support the approach to which is being led by the Trust. The unit will remain closed until that modernisation programme is completed.

The Trust was put under System Oversight Framework segment 4 (SOF4) with a Recovery Support Programme put in place in August 2021. This has been enormously helpful in a range of areas. The improvements made in the year led to a move in our overall rating from the CQC from Inadequate to Requires Improvement and a national and regional decision to move from SOF4 to SOF3 in March 2022 with recovery support no longer required.

We have had a number of significant assurance internal audit reports which provides assurance around our improving systems and controls; and whilst we had a small number of reports with limited assurance only two contained high risk recommendations.

In summary areas of progress across the year include

- Stable executive leadership team and operational leadership arrangements with the right skills and expertise
- Robust Board development plan alongside executive development, non-executive development, governor development and staff leadership programmes
- Embedding of the revised governance structure that was introduced in 2020/21 with assurance reporting to the Board of Directors via a new Alert, Assure Advise (AAA) report from Committee Chairs to Board placing the previous significant assurance reports.
- Increased reporting and scrutiny of the BAF with challenge at committee level
- Embedding of the Performance Framework and the performance

management reviews

- The work of the Back to Good Board ensuring that improvement actions are completed in time and escalating if appropriate.
- We have retained external support in our development work throughout the year which will continue into 2022/23 and has been of significant benefit
- Support has continued to be provided to report authors to improve the quality of reports received at Committees and Board with further work planned in the coming year
- Triangulation of data and performance information with Board and Executive visits and through cross reporting from the Board sub committees has improved across the board
- Work has been identified to support our continuing proramme of improvement
- Movement of our overall CQC rating from Inadequate to Requires Improvement and movement in the following services/areas from inadequate to requires improvement
    - Mental health wards for older people
    - Crisis and health-based places of safety
    - Acute wards for adults of working age and psychiatric intensive care unit
    - Well Led
- Previous section 29A enforcement notice closed
- Movement of the organisation from SOF segment 4 to SOF segment 3 with recovery support no longer required

I am assured around the work in place to address areas of weaknesses in control noted by our Internal Auditors and acknowledgement from them of the improvements made in continuing to demonstrate we remain on a positive and demonstrable trajectory of improvement.

In conclusion whilst significant internal control weaknesses existed in 2021/22, these have been addressed, with significant progress recognised by the CQC in addressing the previous internal control issues identified in 2019/20. To the best of my knowledge, no further significant internal control issues over and above those identified in this report, have been identified within 2021/22.

Signed……..

Chief Executive Date: 22 June 2022