Sheffield Health and Social Care NHS Foundation Trust

Board of Directors – Public

Date:	26 May 2021	**Item Ref:**	19a

TITLE OF PAPER	**Annual Governance Statement**
TO BE PRESENTED BY	David Walsh, Director of Corporate Governance
ACTION REQUIRED	For approval

OUTCOME	To confirm the Annual Governance Statement, including its addition to the Annual Report, separately included within the agenda for this meeting.
TIMETABLE FOR DECISION	26 May 2021
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports covering Risk Management Directorate Risk Registers Risk Management Strategy Trust Strategy Corporate Risk Register Care Network and Directorate Risk Registers
STRATEGIC AIM: STRATEGIC OBJECTIVE:	All
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Provider Licence Annual Governance Statement NHS Foundation Trust Code of Governance
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	The Annual Governance Statement is a mandated requirement for completion.
CONSIDERATION OF LEGAL ISSUES	Breach of SHSC Constitution Standing Orders Breach of NHS Improvement's Governance regulations and Provider Licence.

Author of Report	David Walsh
Designation	Director of Corporate Governance
Date of Report	18 May 2021

Annual Governance Statement

1. Purpose

For approval	For assurance	For collective decision	To seek input from	To report progress	For information	Other (please state)
X						

2. Summary

The Audit and Risk Committee has twice reviewed the Annual Governance Statement (AGS) in its previous two meetings. The final AGS is attached for Board approval.

The AGS is submitted as part of the year-end reporting mandated by NHSE/I. The draft included as an appendix conforms with the template provided by NHSE/I. Much of the material within it is centrally dictated. A good Annual Governance Statement should comply with the template while being clearly recognisable is relating to the organisation to which it relates. It is felt this has been achieved in this statement.

In summary, the AGS concludes with an opinion that there have been significant control gaps during 2020/21. This is consistent with the opinion given in last year's statement and arises from the fact that the actions taken to address matters arising from the CQC inspection in early 2020 have progressed very well, but were nonetheless present or partially present during the last financial year.

Mitigation detailing the various improvements the organisation has made during the year is detailed in the document and in the conclusion.

3 Next Steps

Following approval, the AGS will be submitted and published.

4 Required Actions

Board is asked to approve the AGS.

5 Monitoring Arrangements

N/A

6 Contact Details

David Walsh, Director of Corporate Governance (Board Secretary)
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Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation 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 Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Health and Social Care NHS Foundation 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 Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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. There have been significant changes to the Executive Team during 2020-21.

We commenced the year with a separate Deputy Chief Executive role, with the individual also being specified as Gold Commander in response to the Covid-19 incident. The post remained in place until September 2020.

Out Executive Director of Nursing and Professions post was later expanded to also include the responsibilities of the Chief Operating Officer (and renamed Executive Director of Nursing, Professions and Operations). This postholder took on Gold Commander responsibility in relation to the Covid-19 incident following the departure of the Deputy Chief Executive.

Our Director of HR role, previously a non-voting role on the Board of Directors, was replaced in-year with an Executive Director of People. This is a voting role, assuming the allocation freed up by the absorption of the Chief Operating Officer role as described above.

The posts of Executive Director of Finance, IMST & Performance, the Executive Medical Director and the Director of Corporate Governance (Board Secretary), a non-voting Board role, have remained in place throughout 2020-21.

From December, we added additional expertise and senior-level capacity to the Executive leadership team, to deliver our strategy development and manage issues in estates with the appointment of a Director of Special Projects (Strategy).

Despite the significant changes we have made during the year and the necessity to utilise secondments and acting-up arrangements to achieve this while we underwent this transition, we ended 2020/21 with all members of the Executive leadership team, with the exception of the Director Special Projects (Strategy), under permanent contracts.

Given the organisation's regulatory status, an Improvement Director, appointed by NHSE/I, has been in place for most of 2020/21. There have been two different individuals occupying this role after the initial appointee joined the Executive leadership team and became Executive Director of Nursing, Professions and Operations.

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, placements 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.

Staff Training

Staff training and development needs with regard 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, infection control etc). More specific training is provided, dependent upon the individual's job role and/or work location, and includes incident reporting and investigation, 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).

Following improvements arising from the CQC inspection of five core service and the well-led domain early in 2020, improvements were made to the governance systems to ensure greater compliance with appropriate training by staff. Overall compliance with mandatory training was at 90.5% by 31 March 2021. Of the 27 subject areas:

- Six exceeded 95% compliance
- A further five exceeded 90% compliance
- A further nine exceeded 85% compliance
- A further four exceeded 80% compliance

Of the three subjects that were below 80% compliance, training had been suspended for four months of the year arising from Covid-19, and training had recommenced in smaller numbers with enhanced PPE. This area remains under fortnightly review as part of the Trust's improvement dashboard, developed in response to areas requiring urgent action following the CQC inspection.

The risk and control framework

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 has been refreshed and is due for consideration by the Audit and Risk Committee and Trust Board in April-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 5 x 5 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 one directorate or care network are considered for entry on to the Corporate Risk Register. Risks are recorded on an electronic risk management database (Ulysses Risk Management System), which is separated into teams and directorates/care networks. 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/care network and team level. Each directorate/care network has a risk register lead responsible for managing and maintaining their risk register. The Corporate Risk Register is administered by the Director of Corporate Governance (Board Secretary).

Risks on the Corporate Risk Register (CRR) are monitored by Executive Directors and have been reported to Board and its committees approximately quarterly during 2020/21 (the approximation arising from changes to the timing of Board meetings mid-way through the year and committee meetings during the final quarter of the year). The new Risk Management Strategy increases this frequency to every meeting.

As at 31 March 2021, there were 20 risks on the Corporate Risk Register. The two highest risks both had a score of 16 based on a perceived severity and likelihood of 4. They were:

- Risk that we are unable to provide sufficient additional nursing associate placement capacity to meet demand (Risk 4409)
- Risk that instability of the patient records system could result in loss of information and risk patient safety.

Both risks were being closely managed on the Ulysses system.

The latter risk is one of three safety-related risks on the CRR at the 31 March in relation to Information Management Systems and Technology (IMST). Both areas (safety and IMST) receive additional scrutiny through the Quality Assurance Committee and Finance and Performance Committee. Other risks to have featured throughout the year related to the impact of the EU exit, including a risk on the supply of medicated and Falsified Medicines Directive.

All risks on the CRR have a defined 'monitoring group' (assurance committee), enabling committees to quickly identify those for which they are responsible.

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 upon the circumstances/situation facing the Trust. This was undertaken at a Board Development session in February 2021 and confirmed at a public Board meeting in March 2021. The outcome is included in the new Risk Management Strategy. 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, provided 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.

An internal audit of the governance and risk management commenced in March 2021 having been delayed by considerable revisions the organisation has made to its governance structure (approved by Board in March 2021). The outcome of the review has not been confirmed. However, initial feedback has contributed to the development of the Risk Management Strategy. As part of the governance structure, we have created a Risk Oversight Group (reporting to the Audit and Risk Committee) which will aim to improve compliance around the strategy itself.

Assurance is provided to the Audit & Risk Committee every quarter that risks are being addressed and actions completed via amendments to the Corporate Risk Register and Board Assurance Framework (BAF).

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 approximately quarterly (see earlier explanation around approximation) by the Audit & Risk Committee. Each Board committee also received the element of the BAF relevant to their remit. Following Committee reviews, the BAF was received by the Trust Board.

A clear link between papers and the BAF is required on each report to demonstrate how they provide assurance to Board and its committees that risks are being managed and mitigated.

At the start of the 2020/21 financial year, seven BAF risks to delivery of strategic objectives, though following review by committees this was extended to nine. This has included a BAF risk focused on 'Getting Through Covid Safely'. This was monitored by the Quality Assurance Committee and Board throughout the year.

In addition, a separate Covid Risk Register was developed in April 2021. This was maintained on a weekly basis by the Silver Command operating in response to the pandemic, and reported to Gold Command, and its content included in reports to Quality Assurance Committee and Board. Consideration was given to absorbing the risk register into the Corporate Risk Register during the year, but it was decided that this in itself would create a risk around the change of focus.

The foundation trust was not fully compliant with the registration of the Care Quality Commission throughout the whole of 2020/21, arising from a Section 29a notice having been issued in respect of urgent actions required. These were completed by the end of May 2020 and the notice was subsequently set down. Also as a result of the findings of the CQC inspection, we were unable to confirm compliance against Provider License conditions G6(3) and FT4 for 2019/20 and the same will apply for 2020/21 as the improvement programme did not commence until after the financial year was underway. We were able to confirm compliance against Provider License Condition CoS7.

The foundation trust has published on its website an up-to-date 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.

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

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

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Board is due to revisit sustainability as part of its Board Development programme in June 2021.

It is an organisational ambition of the Trust to continuously improve our approach to engaging service users, carers, governors and partners, both voluntary and statutory, to learn from individuals' experiences and enable continuous quality improvements in all areas of our business.

Such public voice representatives are members of the governance structures of the Trust 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, has continued to develop, enabling services to improve their care in line with service user and carer experience and feedback. This has also been taken into account as part of the revision of the governance structure approved by Board in March 2021.

Our partnership working has continued to through the Sheffield Accountable Care Partnership (ACP), NHS Sheffield Clinical Commissioning Group, Primary Care Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and the Local Authority. The regional Integrated Care System (ICS) has consolidated the joint working with stakeholders across the locality through the development of a joint vision and associated work priorities, aiming to improve the health and wellbeing of our collective population.

As a foundation trust, SHSC has 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. Governors are also members of key governance meetings where they can represent the interests of the local community, service users and carers and make sure that the Trust does what it says it will do.

During the year, governance arrangements were in place within clinical operations to monitor progress against required quality improvements following CQC inspections. Senior leaders have engaged with regional NHS colleagues and the CQC to report on improvement.

Early in the financial year, a Back to Good programme was developed to identify the various must-do and should-do actions arising from the CQC inspection. These have been monitored monthly through a Back to Good Board, and reported upwards to Quality Assurance Committee and Board.

Separately, a Well-Led Development Plan (WLDP) was agreed in May 2020 and has been reported through to Board, with Executive sponsors across a range of actions relating to the Well-Led areas requiring improvement. With some crossover between this and the Back to Good programme, the WLDP has placed particular focus on senior leadership activity. An 18-month Board Development programme commenced during the year as well as a Governor Development programme and NED development programme. The Executive Development programme was delayed while the membership of the executive leadership team was revised, but this is now underway. Additional activity has included a 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).

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

The Trust has a robust committee governance structure, which was refreshed following a significant review as part of the WLDP. All assurance committees were consulted on initial proposals and received a series of reports culminating in the approval of a structure beneath committees for each, approved by the committees themselves in January or February 2021. This was then supported at the public Board in meeting in March 2021, when the establishment of an additional new committee, Mental Health Legislation Committee, was also agreed.

The following now report into Board:

- The Audit and Risk Committee
- The Finance and Performance Committee
- The Quality Assurance Committee
- The People Committee
- The Mental Health Legislation Committee
- The Remuneration and Nominations Committee.

A final stage of the refresh will be the review and renewal of terms of reference for all of the above, which it is proposed to complete by the end of May 2021.

The Trust has continued to review a number of operational efficiency metrics throughout the year, as described earlier through the new Integrated Performance and Quality Report and new performance framework. Quality Improvement remains a key focus and the organisation has engaged with the Royal College of Psychiatrists on a partnership piece of work to develop this further. This work took place in Quarter 4 of 2020/21 and will be progressed in the early part of 2021/22.

The organisation has reviewed and continues to review its leadership at various levels. In addition to the significant changes at Executive leadership level, a new operational structure has been introduced with two care networks each led by a triumvirate of Head of Service, Head of Nursing and Clinical Director. A new Director of Quality began in post early in 2021 and has commenced a restructure in that area, and a new Director of Operations began in March 2021. Within some non-clinical services, reviews of responsibilities are also underway.

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, which commenced in February, involve business partners from within the Finance directorate to ensure leaders at all levels are properly supported.

Information governance

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 and monitored through the Data and Information Governance Group which is accountable to the Audit and Risk Committee.

After successfully meeting the required standards of the Data Security and Protection Toolkit, following completion of a work plan, during 2019/20, the Trust has continued to develop work in this area during 2020/21. An Information Security Group meets every six weeks and is focused on the requirements of the Toolkit to reach a place of all areas being 'audit ready'. An "phishing exercise" was undertaken by internal audit which identified fragilities in the organisation's IT security. Changes were made as a result, although a subsequent exercise has identified that further work is still required. Information Governance training is included as part of the core training for new starters and other training sessions have been provided for staff. Information Governance is also covered in the Trust's local induction checklist for all new staff.

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

In May 2020 we suffered an incident where a large number of documents were deleted from our main patient information system. Two other similar incidents on a smaller scale followed in subsequent months. The vast majority of the documents were restored or recreated and we implemented a variety of additional safeguards and notification processes to guard against future recurrences. We notified the Information Commissioners Office of the incidents and they have undertaken an investigation, the outcome of which is currently awaited.

Data quality and governance

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service level. During 2020/21, a new performance framework was approved, and the Integrated Performance and Quality Report was developed. Since the end of 2020, this has been reported through sub-committees to Board. The schedule of meetings for the year has been revised to ensure 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 been revived with a new regime commencing in February 2021, chaired by the Chief Executive and engaging all members of the executive leadership to positively challenge performance.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and its various committees as described in this document, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

At every committee meeting, members consider matters that have been deemed to be of significant issue to refer to the Board. These may include matters of specific interest, but will also include control issues or areas where there are gaps in assurance. At every Board meeting, the significant issues are reported and considered. Since March 2021, a new approach to this has been trailed where the significant issues were consolidated into a single report with the intention that this would aid triangulation and assist with identifying areas of required focus. This process is still being further developed.

This report is in addition to the minutes received from each of those committees. For 2020/21, each committee will also be asked to undertake self-assessment prior to reporting upwards alongside their annual reports.

The Audit & Risk Committee provides assurance to the Board of Directors through objective review and monitoring of the Trust's internal control mechanisms, 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 provided across the Trust by ensuring there are efficient and effective systems for quality assessment, improvement and assurance and that service user and carer perspectives are at the centre of the Trust's quality assurance framework.

The Finance & 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 transformational 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 Remuneration and Nomination Committee makes determination on 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 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. This 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; and
- The extent to which the Trust has responded to audit recommendations.

The Head of Internal Audit Opinion for 2020/21 stated:

*"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, there are areas for development identified in each of the three segments of my Opinion and the Internal Audit Plan outturn element is concluded with limited assurance. The Trust has had a significant improvement programme in place throughout the year but given this has been in development, I need to reflect the issues identified in my Opinion which is provided for the period 2020/21.

"In providing our Opinion we consider the three areas outlined below:

"Board Assurance Framework and strategic risk management: moderate assurance
The Trust has been progressing a significant programme to strengthen governance arrangements during 2020/21 and has developed the Back to Good Board to respond to the CQC findings issued in April 2020, alongside dealing with the impact of Covid. The Trust has invested significantly in the programme which is progressing and we anticipate that these changes will have a positive impact on 2021/22. The Trust made good progress to develop the BAF early in the year but there is some further development required to strengthen arrangements for the operation and maintenance of the BAF.

"Internal Audit Plan outturn: limited assurance
The Trust developed the Internal Audit Plan to support development in areas where there were known issues. However, a key theme arising from our work this year is around governance. The Mental Health Act/Mental Capacity Act audit identified two high risks in relation to governance, plus governance issues were identified in the staff engagement and physical health reviews which were assigned limited assurance opinions. During 2020/21, the Trust has been refreshing its governance structures; the Trust is taking forward actions agreed in relation to governance alongside embedding its new arrangements.

"Follow-up of Internal Audit actions: moderate assurance
The Trust has made progress in the final weeks of the year to get to a reasonable position on follow up, however, progress has been slow throughout the year and despite extending implementation dates by four months at the outset of the pandemic, many actions have not been completed within the agreed dates. There are also some historical actions (i.e. due pre-2020/21) which the Trust needs to address."

Managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, are a further source for assurance. The Board Assurance Framework itself is also a source in relation to the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Reports from the Board of Directors and the Board Committees
- Reports from External Audit
- Reports from Internal Audit
- External assessments by the CQC, including Mental Health Act Commissioners
- Full registration with the CQC across all locations
- Clinical Audit
- Service User Surveys
- The Staff Survey
- Data Security and Protection Toolkit.

Conclusion

In my opinion, significant internal control issues identified during 2019-20 continued to persist into the period of 2020-21, largely due to the scale of work required to address these matters.

We have made huge progress in addressing these issues, a challenge which has been made all the more difficult by them coinciding with the Covid-19 incident and the enormous impact this has had on all NHS providers. Nonetheless, progress has been made including:

- Significant changes to the executive leadership team and operational leadership arrangements;
- Introduction of a new governance structure including groups below committees and the assurance committee arrangements themselves;
- Development of an Integrated Performance and Quality Report, including consideration escalation arrangements to ensure data has been subject to appropriate scrutiny and quality control;
- Development of a new Risk Management Strategy (implemented for 2021/22) to address pre-existing compliance issues, including the creation of the Risk Oversight Group to oversee this directly;
- A Well-Led Development Plan, including work around Board Development, NED Development and Governor Development, in addition to upcoming work around Executive Development;
- The introduction of a Performance Framework and performance management reviews;
- The work overseen by the Back to Good Board to address ‘must do’ and ‘should do’ areas of improvement as identified by the CQC.

Signed: ……..…… Date: …….

Jan Ditheridge
Chief Executive