Board of Directors - Public meeting

SUMMARY REPORT	Meeting Date:	28 June 2023
	Agenda Item:	4

Report Title:	**Annual Governance Statement and statements of compliance and self-certification**	
Author(s):	Deborah Lawrenson, Director of Corporate Governance	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Board of Directors Council of Governance Audit and Risk Committee
	Date:	28 May 2023 (Board of Directors 22 June 2023 (Council of Governors) 27 June 2023 (Audit and Risk Committee)
Key Points recommendations to or previously agreed at:	The Board of Directors and the Audit and Risk Committee have received the draft Annual Governance Statements and draft declarations of compliance and self-certification in April and May. The declaration of compliance was shared with the Council of Governors on 22 June 2023 the Governors have been asked to confirm their agreement with the statement in respect of support provided to them to fulfil their statutory obligations. A verbal update from that discussion will be provided at the meeting together with any final comments from Audit and Risk Committee. The Annual Governance Statement has been finalised following receipt of the Head of Internal Audit Opinion with other minor amendments made and highlighted.	

Summary of key points in report
Foundation Trusts are currently required to make an annual declaration in relation to compliance with Provider Licence conditions G6(3), FT4 and CoS7. This will change for reporting arrangements in 2023/24. The attached assessment recommends a declaration of compliance against each of the above licence conditions for 2022/23 following receipt at Council of Governors and Audit and Risk Committee. Updates are highlighted since last received at Board of Directors are highlighted in the compliance

statement.

The updated documents are received for final approval at the Public Board of Directors pending any feedback from Council of Governors in respect of support provided to it in discharging its duties, and from the Audit and Risk Committee.

- The Annual Governance Statement (which is part of the Annual Report 2022-23) is attached at **appendix 1** - **for approval**
- Declaration of compliance and self – certification with the provider licence 2022/23 – **appendix 2 – for approval**

Recommendation for the Council of Governors to consider:							
Consider for Action		**Approval**	✓	**Assurance**	✓	**Information**	✓

The Board of Directors is asked to receive and approve:

- The Annual Governance Statement
- The compliance with provider licence statement and the self-certification

Please identify which strategic priorities will be impacted by this report:				
Recover Services and Improve Efficiency	*Yes*	✓	*No*	
Continuous Quality Improvement	*Yes*	✓	*No*	
Transformation – Changing things that will make a difference	*Yes*	✓	*No*	
Partnerships – working together to make a bigger impact	*Yes*	✓	*No*	

Is this report relevant to compliance with any key standards?					**State specific standard**
Care Quality Commission	*Yes*	✓	*No*		**Health and Social Care Act 2022** **Code of Governance 2022** **Annual Reporting Manual 2022/23** **GAM 2022/23**
Data Security Protection Toolkit	*Yes*		*No*		

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, Engagement and Experience	*Yes*	✓	*No*		**Reflected as required**
Financial (revenue &capital)	*Yes*	✓	*No*		
OD/Workforce	*Yes*	✓	*No*		
Equality, Diversity & Inclusion	*Yes*	✓	*No*		
Legal	*Yes*	✓	*No*		
Environmental sustainability	*Yes*	✓	*No*		

Appendix 1 - Annual Governance Statement 2022/23

3.7 Annual Governance Statement

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 2023 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, Operations and Professions, Executive Director of Finance, IMST and Performance, Executive Medical Director, Executive Director of People, Director of Strategy (non-voting) and the Director of Corporate Governance (Board Secretary non-voting) have remained in place throughout 2022/23.

The Executive Director of Nursing, Operations and Professions was in post until February 2023 and was on secondment to NHS England during January 2023. From January and for the remainder of the financial year the role was covered by her deputies as interim Executive Director of Nursing and Professions and interim Director of Operations and Transformation (non-voting). At the end of the financial year substantive recruitment was underway.

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. 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 87.96% as at 02/05/2023

Of the 29 subject areas on the main Trust matrix

- 1 exceeded 95% compliance
- 13 exceeded 90% compliance
- 2 exceeded 85% compliance
- 3 exceeded 80% compliance
- 10 were below 80% - and have recovery plans in place.

Mandatory training is kept under continuous review with floor to senior level reporting and monitoring in place. Individuals and managers receive reminders throughout the year, individuals can see their own data, and managers are 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:

Operational learning mechanisms

- Fundamental standard visits for inpatient services
- Culture and Quality visits for all other clinical services
- Blue light notices for safety critical alerts into teams
- Significant event analysis reports, to support teams to reflect on incidents and draw wider learning.
- Learning drawn from complaints and concerns
- Learning from our engagement leads – “You said, we did”
- Bitesize safeguarding online open sessions
- Lessons Learnt Staff Bulletin (Quarterly)
- Care Opinion and Friends/Family Test
- Mortality Reviews and Structured Judgement Reviews
- Complaints thematic review
- Claims thematic review
- Quality Improvement Forum
- Safeguarding supervision (group)
- Service based development forums

Governance

- Daily Incident Huddle (where all incidents across SHSC are reviewed and follow up agreed)
- Themes of the month report from the incident huddle, shared across SHSC teams
- Prevention of Future Death notices, learning from coroners court hearings
- Serious Incident Reports
- Section 42 enquiries (safeguarding investigation)
- Weekly investigation panel to review all investigations and reports, supporting timely delivery, providing critique and challenge to draw out clear learning and improvement
- Clinical Quality and Safety Group
- Safeguarding Assurance Group
- Least Restrictive Practice Oversight Group
- Commissioned External reviews to improve safety and encourage innovation
- Quality Assurance Committee meetings and Flash Reports for the Board of Directors
- Team and clinical directorate governance meeting reports and events
- 48hr reports leading to Significant Event Analysis Reports with reflective learning
- Clinical Executive Panel (monthly review with directorates of patients whose needs are not being well met by the system)

Strategic /board oversight

- Trust review and response to national reports e.g. Ockenden Report
- Board development learning e.g. Ockenden and Edenfield

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 the Board of Directors in May 2021 and will be refreshed and updated for approval in 2023. 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 are considered to affect more than one directorate (which may be below 12) 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 at which confirm and challenge takes place on controls, assurances, gaps and actions, and the CRR is received at each public Board of Directors meeting.

As at 31 March 2023, there were 24 risks on the Corporate Risk Register the table below outlines those scoring 15 or above at that time and the mitigations in place to address them:

Highest risks as at 31 March 2023	**Mitigations**
Risk related to failure to deliver the required level of Cost Improvement Plan (CIP) for 2022/23. New in March 2023 (16)	• CIP programme board and working groups • Transformation projects programme board and benefits realisation monitoring and oversight • Performance Management Framework • Business planning systems and processes including Executive

	oversight • Part of routing reporting to board, its committees and to Integrated Care Board and NHS England
Risk to capacity and morale of staff, related to the Local Authority (LA) serving notice of intention to withdraw delegated social work and social care functions and associated LA workforce. (16)	• Joint support structures and leadership in place with the local authority • Governance in place led by the LA with participation from the Trust • Planning and implementation group • Communication with staff affected and support in place Work is underway to de-escalate this risk and to reframe it around safe transfer of cases as the functions have now moved to the LA
Risk related to demand for Gender Identity Service greatly outweighing the resource/capacity of the service resulting in high numbers waiting and lengthy waits (16)	• Project steering group in place • Additional investment in place • Developing links with primary care projects to support them to take the lead in diagnostics and support on the pathway • Service line working within NHSE guidelines and service specifications. • Sharing of best practice • Recruitment
Risks related to ligature anchor points – two separate risks (clinical and environmental/estates) (both scoring15)	• Policies and standard operating procedures (SOPs) • Risk assessments • Health and safety checks on inpatient environments and heat maps to identify areas of greater risks • Programme of work to remove ligature points and address blind spots and associated bed commissioning arrangements in place whilst the work is completed. • Clinical risk training • CQC MHA oversight through visits reports and action plans • MH Legislation committee oversight • Nurse alarm systems • Contemporaneous record keeping
Risk related to demand for the Sheffield Adult Autism and Neurodevelopmental	• Recover plan with board committee oversight

Service (SAANS) greatly outweighing the resource and capacity of the service resulting in high numbers waiting and lengthy waits. (15)	• Engagement with PLACE on resource requirements and development of pathways • Review of clinical processes • Governance meetings • Engagement with primary care to ensure safe management of those on the waiting list • Recruitment
Risk related to service users being unable to 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; and in the absence of an assessment, the level of need and risk presented by service users not being quantified and potentially escalating without timely intervention (15)	• Referral triaging processes • Attendance of nurse consultant at daily crisis huddles to report on exceptions to support triaging within 24 hours • Availability of a range of assessment mechanisms • Crisis support communication with those waiting for assessment. • Targeted recruitment • Flow processes • Recovery plan monitored by Quality Assurance Committee
Risk of 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 (15)	• Out of area reduction programme reporting through board committees • Out of area bed approval processes • Flow co-ordination processes • Revised clinical modelling • Daily operational and clinical leadership oversight • Daily crisis and acute care huddles • Weekly meetings to support discharge of those who are clinically ready • Processes in place to ensure quality of care provided by out of area providers

The Board of Directors 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 facing the Trust. The updated risk appetite will be reflected in the review of the Risk Management Strategy and reflected in the Board Assurance Framework (BAF) and Corporate Risk Register.

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. A more systematic approach to training will be put in place in 2023/24.

In 2022/23 the Trust commissioned a review of its systems processes, capacity and capability around risk to support ongoing improvement. This identified areas of good practice and areas for improvement which are being taken forward and monitored at Audit and Risk Committee and Board. Section 3.7.6 outlines detail on the internal audit on risk which provided a split assurance.

Work is taking place as a system and through the collaborative to develop board assurance frameworks and risk registers which will be reflected where appropriate back into our own documents.

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 BAF.

The BAF outlines the Trust's strategic aims and objectives and details principal risks which may inhibit delivery of those objectives. It is used to monitor the levels of assurance received at Board of Directors 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 following receipt at relevant Board of Directors committees and was received for assurance at public board meetings.

All of the Board of Directors and committee reports are required to demonstrate links with the BAF and detail on key risks and how these are being managed.

The 2022/23 BAF identified eight strategic risks. During the year movement took place on risk descriptors to better reflect the current position and there was separation of some risks at Quality Assurance Committee and Finance and Performance Committee to support more focussed monitoring.

The Trust is compliant with its CQC registration and will be declaring compliance against Provider licence risk requirements. The Trust ended the financial year 2021/22 with a move from System Oversight Framework (SOF) segment 4 to SOF segment 3, this was

retained in 2022/23, however the Trust ended the financial year 2022/23 with a move to system monitoring, from regional oversight in recognition of the improvements demonstrated through the year.

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.

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. Reporting around Human Rights and Equality Diversity and Inclusion have been strengthened in 2022/23 and detailed board development sessions held.

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 and ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Board of Directors 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 and significant engagement has taken place to support developed of new Carer's Strategy.

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 and the Board of Directors held a joint development session with the Lived Experience Group during the year.

Staff networks continued to be strengthened during the year providing invaluable insight in a wide range of areas.

Partnership working has continued through the South Yorkshire Integrated Care Board, Sheffield Health Care Partnership, South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative. The Trust's Chief Executive is the lead CEO for the Mental Health, Learning Disability Autism Provider Collaborative.

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 have been asked for views on topics such as updated strategic priorities, annual operating plan and quality account priorities. Governors have participated in system governance change sessions with colleagues from other organisations.

A Governor's Development Programme was in place in 2022/23 with detail on activities outlined in section 3.1.28.4.

In addition to this Chair drop in sessions continued and Governor observation of Board sub committees was made available for Governors.

3.7.4.4 Quality governance arrangements

Over 2022/23 we have continued to improve the quality governance arrangements within SHSC to ensure that the essential quality and safety standards required are met by the services we deliver.

We have strengthened our approach to audit and assurance of some of the key standards of care we deliver through the implementation of the Tendable clinical audit platform across all our bed-based services. The audits have been customised to measure our compliance with our policy standards across a range of areas including restrictive practice, physical health and infection prevention and control and service user experience.

Internal audit assessed our incident management system with "significant assurance" and safeguarding processes were assessed with "limited assurance", resulting in a small number of actions aligned to updating personal information in our electronic patient record.

Learning from a range of governance and assurance processes informs our Quarterly Learning Report and learning hub which is a fully accessible compendium of incident details and learning outcomes. A monthly learning bulletin is circulated to all staff and shared via the learning hub.

We have a range of regular visiting programmes within SHSC which enable us to review the quality and safety of services delivered, hear from the staff that work within them and understand the experiences of service users receiving care from them.

Culture and Quality Visits

Any service that delivers patient care can have a closed culture. All services have been assessed for risk of closed culture based on the criteria identified within the work

completed by CQC on closed cultures and then prioritised based on risk profile. During 2022, all but one area identified as 'high risk' received a Culture and Quality visit.

Fundamental Standards of Care (FSC) Visits

Initially introduced in October 2021 the visits were designed to measure the extent to which the standards of care set out within key SHSC Policies and CQC regulatory requirements are delivered within inpatient settings. This programme of visits is an annual activity that reports to Quality Assurance Committee.

Board Visits

The principles for board visits are to:

Listen – directly service users, carers and to staff in services/teams to hear their views and experiences. In 2022/23 the visits returned to visits on site.

Ask – questions and see the visit as an opportunity to learn more about the service, for example, good practice for sharing and any key issues of concern.

Assure – the information from the visit will support assurance at Board and service level.

In late 2021/22 we reviewed the visit approach and proposed a new methodology which enabled us to better triangulate some of the issues identified through our performance and quality reporting. In 2022/23 we completed 28 Board visits to a range of services across SHSC consisting of bed based, community and rehabilitation provision and corporate areas.

Directorate Performance Reviews

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service level through a performance framework.

Directorate Performance Reviews take place quarterly, 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.

A number of services have maintained or received accreditation demonstrating our ambition to seek external validation to deliver the best care we can (Forest close, Crisis Resolution Home and Treatment, Specialist Psychology, IAPT)

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 July 2022 Data Security and Protection Toolkit (DSPT) submission, a plan was agreed with NHS Digital to ensure an overall outcome of achieved standards by 30th June 2023.

The Trust continues to work to implement further improvements to enhance our performance against DSPT 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.

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 2022/23 one incident was reported to the Information Commissioners Office (IOC). The incident was reviewed and the ICO decided that no further action was necessary.

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

The Trust has a robust committee governance structure in place with the following committees reporting into the Board of Directors:

- Audit and Risk Committee
- Finance and Performance Committee
- Quality Assurance Committee
- People Committee
- Mental Health Legislation Committee
- Remuneration and Nomination Committee

Terms of Reference for all committees have been approved by the Board of Directors, reviews of effectiveness undertaken and annual reports from the committees for 2021/22 received at Board of Directors during the year. Work is well underway on the annual reports from committees for 2022/23.

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 and new KPIs are due for discussion and approval through the committees and Board or Directors early in 2023/24.

The organisation has reviewed and continues to review its leadership at various levels. An internal leadership development programme was launched in February 2022 aiming to bring current and future leaders together to challenge their thinking and learning. This will continue in 2023/24.

Financial sign-off of budgets and performance management arrangements are in place reporting up to the executive team. 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 continued to take place across the Board sub committees with escalation taking place between committees and evidenced through our Alert, Advise Assure (AAA) reports to the Board of Directors.

Board members have participated on a range of committees to support cross fertilisation in discussion and around challenge. Recovery plans are received and monitored at the appropriate committees with clear evidence of confirm and challenge taking place.

During 2022/23 we have continued to submit returns to the CQC in relation to the conditions on registration at Firshill Conditions, confirming that the unit remains paused. An application to vary conditions at Firshill has been approved and conditions 2 – 7 removed resulting in the issuing of a new registration certificate. Condition 1 remains in place, which outlines the need for CQC authorisation should a request to admit a service user to the service be required. The net effect of these changes is that the site is registered without restriction as a community base but with a condition limiting potential inpatient admission.

In June 2023 we outlined at the Health Overview and Scrutiny Sub-Committee at the City Council, our partnership proposals to improve care for people with Learning Disabilities and Autism who need specialist support due to more complex needs at the. Alongside our Integrated Care Board colleagues, we described options for an accessible, flexible and appropriately intensive community model of care, with an enhanced multi-disciplinary team able to support people to live at home in their communities.

The Committee could see that we had actively involved service users, their families, experts by experience, and local communities in planning how we work together to care for people with Learning Disabilities and Autism with more complex needs. They were supportive of us continuing to engage widely in this way as we further develop plans for new models of care and services for people with Learning Disabilities and Autism.

As part of Well-Led improvement, finance reviews by NHSE continued to take place with CQC/NHSE 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 System Oversight Framework (SOF) segment 4 to SOF segment 3 at the end of the 2022/23 financial year and we have ended the current financial year, 2023/24, with a move to local system oversight which we welcome.

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 auditors 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' (AAA) 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 Committee provides assurance to the Board of Directors 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, and 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 of Directors, 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 are kept informed through the AAA reports which is supported by the

integrated approach provided through the Integrated Performance and Quality Report (IPQR) received at Committees and Board of Directors.

Our 'Back to Good' programme has continued to provide assurance focussed on or related to areas identified for improvement through our CQC report. There is a programme board in place which actively monitors progress and provides regular reports to our assurance committees and directly to the Board of Directors. The Quality Oversight Board led by regional partners and attended by CQC, provides oversight of our 'Back to Good' journey and the Trust has been commended for significant improvements made during the year.

The clinical audit programme also supports my review of the effectiveness of internal control. This is received and approved at the Quality Assurance Committee.

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 and Risk 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 internally by the Executive Team and with our auditors.

The following reports were received with Limited Assurance:

- Grievances and Disciplinaries
- Health and Safety reporting (including Central Alerting System (CAS) alerts) – one high priority finding.
- Embedding robust safeguarding practice within clinical services – one high priority finding (prior year audit).
- Recruitment – one high priority finding (prior year audit).
- Estates: Health Technical Memoranda (HTMs) – one high priority finding (prior year audit).

The following reports were received with Moderate Assurance

- Data Security Standards (NHS Digital rating)

The following reports were received with Significant Assurance:

- Complaints
- Infection prevention and control

The following reports were received with split Significant/Limited assurance:

- Strategic risk management
- Cost Improvement programme

In summary, areas of progress across the year include an overall stable executive leadership team and operational leadership arrangements with the right skills and expertise:

- Robust Board of Directors development plan (which has included external support) alongside executive development, non-executive development, governor development and staff leadership programmes
- Well established Alert, Assure Advise (AAA) reports from Committee Chairs to Board of Directors supporting focussed discussion on key areas of concern.
- AAA reporting has been introduced from Tier II groups (groups that report into our board-sub committees) to the board sub-committees providing annual reports on effectiveness.
- The BAF for 2022/23 has undergone significant input from board members in its development and refinement – the document and the assurance provided by it receive confirm and challenge at the Board sub committees.
- A risk oversight group was established in year providing additional rigour and confirm and challenge.
- Improved processes and outcome for closure of Internal and External Audit actions.
- Continuing to embed the Performance Framework and the performance management reviews which include outcome of Well-Led self-assessments
- The work of the Back to Good Board ensuring that improvement actions are completed in time and escalating if appropriate.
- Continuing programme of Quality Improvement with the Board of Directors having received development sessions and regular reports on progress.
- 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 of Directors 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 and will be strengthened further in 2023/24 through a refreshed board visits programme.
- Policy Governance arrangements remain strong with reporting through to board sub committees as appropriate.
- Work has taken place to identify and track action plans and third-party reports and their reporting route. This has been supported by the Tier II annual reports from the sub committees reporting into the board sub committees and reporting on this is expected to be strengthened as a result in 2023/24.
- Whilst there were recognised significant internal control weaknesses identified in the early part of the previous financial year, given the concerns raised about the Assessment and Treatment Service (ATS) at Firshill Rise

the previous Section 29A enforcement notice has been closed, the unit remains closed and the Health Overview and Scrutiny committee has been updated on, and has supported planned next steps in respect of plans for delivery of community services provision.

- Our overall CQC rating has moved from Inadequate overall to Requires Improvement. Our current CQC ratings are found here: https://www.cqc.org.uk/provider/TAH
- Movement of the organisation from System Oversight Framework (SOF) segment rating 4 to SOF segment 3 at end of the previous financial year and to system oversight at the end of the financial year 2022/23
- The Board of Directors has delivered a comprehensive Board self-assessment on Well-Led which has been recognised and commended by NHSE who supported confirm and challenge around the findings. The Board received a paper in March detailing the work and next steps for monitoring of key areas of development.
- Whilst we have been able to demonstrate improving systems and controls in a number of areas and have received an overall opinion from Internal Audit of significant assurance, we received a number of limited internal audit assurance reports this year, however out of these there were only four high priority recommendations.

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 **significant assurance** that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

In providing my opinion three main areas are considered:

- Board Assurance Framework (BAF)
- individual assignments
- follow up of actions.

I am providing significant assurance for the BAF.

I am providing moderate assurance for the outturn of individual audit assignments. We have issued a high proportion of limited assurance opinions in 2022/23 and four reports contain high risk findings. This is a higher proportion than we would expect, although all were areas directed by the Trust. It should be noted that the Strategic Risk Management review was partially limited due to risk training, risk escalation, risk appetite and analysis of the risk register.

The 2022/23 plan was heavily weighted towards risk-based reviews at the Trust's request to support its improvement journey. We are providing a moderate assurance opinion on the basis that the Trust directed the plan to known areas for development, but the Audit and Risk Committee should recognise the risk focused nature of the plan and reflect that the core coverage was minimised in doing so, with fewer than normal core reviews in the plan. In agreeing the 2023/24 plan, we suggest a specific review is undertaken of core coverage, in particular the exceptions from the plan (section A2), to ensure the Audit and Risk Committee is sufficiently assured about these areas from other sources.

I am providing significant assurance for the follow up of actions. The position, as at 31 March 2023, demonstrates a first follow up implementation rate of 81% and an overall implementation rate of 98%. This is a significant improvement on previous years' performance.

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 and the substantial progress made in addressing the previous significant internal control issues I am assured we have good internal controls in place whilst recognising there is always more work to do. 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.

To the best of my knowledge, no further significant internal control issues over and above those identified in this report, have been identified within 2022/23.

Insert signature

Jan Ditheridge
Chief Executive
Date: xxxx

Appendix 2

Sheffield Health and Social Care NHS Foundation Trust Self-certification against Provider Licence Conditions 2022-23

- Yellow highlights are changes since the documents were received at the April ARC
- Blue highlights are additional changes since they were received at the May Board of Directors

Details of Condition	**General condition G6(3) – Systems for compliance with licence conditions and related obligations** 1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS 2. Without prejudice the generality of paragraph 1, the steps the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence, and (b) regular review of whether those processes and systems have been implemented and of their effectiveness. 3. Not later than two months from the end of the financial year, the Licensee shall prepare a certificate to the effect that, following a review of the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied as the case may be that, in the

	financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this condition.
This means	This means a provider is required to have in place effective systems and processes to ensure compliance, identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.
Assurance	• Governance infrastructure • Strategy defined and reviewed objectives and suite of supporting strategies in place and monitored. • BAF risks reviewed regularly • Board and Committees (Audit & Risk, Finance & Performance, Quality Assurance, People, Remuneration, and Mental Health Legislation) • Tier II committees in place and reporting requlary into the Tier I board sub-committees – all have produced self-effectiveness reviews and annual reports • Trust's Risk Management Strategy and risk management processes – positively reviewed through external risk management review (NHSE supported) – with some improvements identified which are being followed up and overseen at Audit and Risk Committee. The Risk Management Strategy will be updated by the end of Q2 in 2023/24. • Risk Oversight Group established in year which has improved rigour around confirm and challenge on the corporate risk register. • Risk Internal Audit split opinion significant for Risk Oversight Group and limited around risk registers • Significant progress made in year with the development of the Board Assurance Framework • Incident management processes and procedures • Speaking Up processes – new FTSU strategy approved March 2023 and Board self-assessment completed. • Service User Engagement Groups and carer engagement groups • Community engagement groups and project working with leaders in Sheffield aligned to race equity. • Wide ranging opportunities to learn from good practice through reporting, groups, forums, visits, events and feedback – with learning reported through reports to committees and board. • Quality Improvement Framework • Back to Good programme • Quality Account • Alert, Advise, Assure (AAA) reports from board sub-committees to board and from groups reporting into the board sub-committees The Trust regularly reviews these processes and systems and their effectiveness. This has included a range of internal audit reports and management reviews of systems and processes.

Evidence	• Annual report and Accounts • Annual Governance Statement • Head of Internal Audit Opinion • Corporate Risk Register • Board Assurance Framework • Risk Management Internal Audit Report • External Risk Review report • Quality Account
Assessment	The organisation has continued to make significant improvements during 2022/23 to address issues highlighted by the CQC inspection undertaken in early 2020. In May 2021 the CQC carried out follow up inspections for the areas previously rated as inadequate - mental health wards for older people, crisis and health-based places of safety and moved these to 'requires improvement'. The Well Led element was also re-visited at this time and moved from 'inadequate' to 'requires improvement'. The acute wards and psychiatric intensive care unit were inspected but remained rated as 'inadequate' as further improvement was required. Following re-inspection in December 2021 they were re-rated as 'requires improvement'. In August 2021 the CQC re-rated the Trust overall from 'inadequate' to 'requires improvement' In February 2022 the CQC confirmed the Trust had made significant improvements in the areas highlighted in the previous Section 29A enforcement notice and this enforcement notice was closed. In March 2022 NHS England and NHS Improvement formally notified the Trust of its transition from system Operating Framework (SOF) Category 4 (formerly 'Special Measures) to Category 3. This was in recognition of the progress made against Quality and the further work around sustained delivery of improvements. Board well led-assessment undertaken in year with positive external assessment by NHSE/I. External risk review undertaken with positive feedback received generally on systems and processes in place and monitoring of improvement actions taking place at Audit and Risk Committee. During 2022/23 we have continued to submit returns to the CQC in relation to the conditions on registration at Firshill Conditions, confirming that the unit remains paused. An application to vary conditions at Firshill has been approved and conditions 2 – 7 removed resulting in the issuing of a new registration certificate. Condition 1 remains in place, which outlines the need for CQC

	authorisation should a request to admit a service user to the service be required. The net effect of these changes is that the site is registered without restriction as a community base but with a condition limiting potential inpatient admission. In June 2023 we outlined at the Health Overview and Scrutiny Sub-Committee at the City Council our partnership proposals to improve care for people with Learning Disabilities and Autism who need specialist support due to more complex needs at the. Alongside our Integrated Care Board colleagues, we described options for an accessible, flexible and appropriately intensive community model of care, with an enhanced multi-disciplinary team able to support people to live at home in their communities. The Committee could see that we had actively involved service users, their families, experts by experience, and local communities in planning how we work together to care for people with Learning Disabilities and Autism with more complex needs. They were supportive of us continuing to engage widely in this way as we further develop plans for new models of care and services for people with Learning Disabilities and Autism. 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 and we have ended the current financial year with a move to local system oversight from March 2023.
Self-certification	**Compliance status: Confirmed**

Details of Condition	**FT4: NHS Foundation Trust Conditions governance arrangements** 1. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services in the NHS. 2. Without prejudice to the generality of paragraph 1 and to the generality of General Condition 5, the Licensee shall: (a) have regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time; and (b) comply with the following paragraphs of this Condition. 3. The Licensee shall establish and implement: (a) effective board and committee structures; (b) clear responsibilities for its Board, its committees reporting to the Board and for staff reporting to the Board and those committees; and (c) clear reporting lines and accountabilities throughout its organisation. 4. The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensees' duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability as a going concern) (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) to generate and monitor delivery of business plans

	(including any change to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) to ensure compliance with all applicable legal requirements. 5. The systems and/or processes referred to above include, but are not restricted to, systems and/or processes that ensure: (a) sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care; (d) the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care; (e) that the Licensee including the Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) there is a clear accountability for quality of care throughout the Licensee's organisation including, but not restricted to, systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. 6. The Licensee shall ensure the existence and effective operation of systems to ensure it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence 5. 7. The Licensee shall publish within three months of the end of the financial year: (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks.
This means	This means Providers should review whether their governance systems meet the standards and objectives in this Condition. There is not a standard / set model, but any compliant approach would involve

	effective Board and Committee structures, reporting lines and performance and risk management systems.
Assurance	• Governance infrastructure and arrangements • Board and Committees (including reviews of planners and terms of reference) • Data Quality process and review • Recruitment process for Board and Executive positions – skills and experience reviewed through Remuneration Committee. Board Remuneration committee and the Governors Nomination and Remuneration Committee have roles in competence of Board (Executive and Non-Executive respectively). • Board stories and visits to sites by board members support triangulation of data • Business planning processes • Business Planning Group • Incident management processes and procedures • Appraisal process for Board Members and Executive Directors • CQC inspection process and outcomes • Review meetings with CQC • Review meetings with NHS Improvement • Trust's Risk Management Strategy and risk management processes
Evidence	• Annual Board Compliance Statements • Annual Operational Plan • Annual Report and Accounts • Annual Governance Statement • Annual Quality Report • Head of Internal Audit Opinion • Trust Constitution and Standing Orders – will be updated in 2023/24 to reflect the new Code of Governance and addendum for Governors changes • Standing Financial Instructions and Scheme of Delegation will be updated as required to meet system changes required in 2023/24. • Terms of Reference for Board Committees • 'Back to Good' Board – which will develop in 2023/24 to focus on Continuous Quality Improvement • Management arrangements • Integrated Performance report • Performance framework including performance management reviews • Board Assurance Framework • 'Alert, Assure, Advise' reports from Committee Chairs to Board • Allocate Health Roster and Safe Care • Fit and Proper Persons Requirement processes

	• A stable executive leadership team and operational leadership arrangements with the right skills and expertise have been in place in 2022/23 and recruitment is underway for replacement executive roles in 2023/24 with the next Chief Executive due to join in August. *Included because this is a statement of compliance for the next financial year (2023/24)* • Robust Board development plan alongside executive, non-executive, and staff leadership programmes • Appraisal process for Board Members and Executive Directors • Robust responsible officer arrangements for medical staff • Induction arrangements in place for all staff including board members. • Board development plan • Range of leadership and development programmes in place for staff across the organisation • Induction arrangements in place for Governors and training and development provided across the year, including via NHS Providers and including system sessions for Governors on changes to their role as a result of new governance changes which came into force in 2022/23 around 'duty of collaboration' and responsibilities around wider engagement • Programme in place for reporting to the Council of Governors throughout the year ensures appropriate reporting takes place
Assessment	The organisation has continued to make significant improvements during 2022/23 to address issues highlighted by the CQC inspection undertaken in early 2020. In May 2021 the CQC carried out follow up inspections for the areas previously rated as inadequate - mental health wards for older people, crisis and health-based places of safety and moved these to 'requires improvement'. The Well Led element was also re-visited at this time and moved from 'inadequate' to 'requires improvement'. The acute wards and psychiatric intensive care unit were inspected but remained rated as 'inadequate' as further improvement was required. Following re-inspection in December 2021 they were re-rated as 'requires improvement'. In August 2021 the CQC re-rated the Trust overall from 'inadequate' to 'requires improvement' In February 2022 the CQC confirmed the Trust had made significant improvements in the areas highlighted in the previous Section 29A enforcement notice and this enforcement notice was closed. In March 2022 NHS England and NHS Improvement formally notified the Trust of its transition from system Operating Framework (SOF) Category 4 (formerly 'Special Measures) to Category 3. This was in

	recognition of the progress made against Quality and the further work around sustained delivery of improvements. In March 2023 NHS England wrote to the Trust confirming retention of SOF 3 at the current time and progress recognised with a move to system oversight from regional with significant progress made in a number of areas commended.
Self-certification	**Compliance status: Confirmed**

Details of Condition	**CoS7: Availability of Resources** 1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the required resources. 2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the required resources will not be available to the Licensee. 3. The Licensee, not later than two months from the end of each financial year, shall publish a certificate as to the availability of the requires resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: (a) "After making enquiries, the Directors of the Licensee have a reasonable expectation that the Licensee will have the required resources available to it after taking account of distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." (b) "After making enquiries, the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the required resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may case doubt on the ability of the Licensee to provide Commissioner Requested Services." (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the required resources available to it for the period of 12 months referred to in this certificate."
This means	This means that providers designated as providing Commissioner Requested Services will have the required resources to continue to provide those services; for example, management, financial, facilities

	and resources. Commissioner Requested Services are services that: • should continue to be provided locally even if a provider is at risk of failing financially; • there is no alternative provider close enough; • removing them would increase health inequalities; • removing them could make other related services unviable.
Assurance	• Board of Directors and Committees • Board Assurance Framework • Annual Operational Plan • Financial Plan • Business planning arrangements and governance • Annual Accounts • Annual Report prepared on a going concern basis
Evidence	• Going concerns assessment process • External audit opinion • Contracts in place for patient services • Financial reports and updates, including annual accounts and supporting narrative • Finance, capital and cost improvement plans in place , including cash flow forecast • Workforce and activity planning
Assessment	SHSC has been sufficiently resourced to undertake the significant changes detailed while also coping with the residual impact of the Covid-19 and have managed industrial action with no significant impact on services and care. Financial, capital and cost improvement plans are in place and being regularly monitored at committee and board level. The Trust has provisionally approved a deficit plan subject to ongoing planning processes, however the Trust has sufficient cash resources for the period.
Self-certification	**Compliance status: Confirmed**