Proud to care in Sheffield

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Board of Directors

SUMMARY REPORT	Meeting Date:	26 June 2024
	Agenda Item:	3 (ii)

Report Title:	**Annual Governance Statement 2023-24 Final for approval**	
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:**	Executive Management Team, Board of Directors, Audit and Risk Committee
	Date:	Previous drafts have been shared with Executive Management Team, Audit and Risk Committee and Board of Directors (May). Audit and Risk Committee 18 June 2024 Council of Governors 20 June 2024
Key Points recommendations to or previously agreed at:	Feedback has been reflected from Board members on the draft received at the Confidential Board in May 2024. No further feedback was received from Audit and Risk Committee on 18 June and the document was recommended to the Board of Directors for approval.	

Summary of key points in report

The Annual Governance Statement 2023/24 which is part of the Annual Report 2023/24 is being received for approval. There were no comments from the Audit and Risk Committee and KPMG the Trust's external auditors have confirmed it is consistent with the financial statements and complies with Foundation Trust Annual Reporting Manual (the ARM).

The document is being received for information and comment in the public session of the June Council of Governors meeting and a verbal update will be provided on any feedback received.

Appendix 1 – Final version of the Annual Governance Statement 2023/24

Recommendation for the Board/Committee to consider:

Consider for Action		Approval	X	Assurance	X	Information	

The Board of Directors is asked to **receive, take assurance from and approve** the final draft Annual Governance Statement.

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	Yes	X	No	
Deliver Outstanding Care	Yes	X	No	
Great Place to Work	Yes	X	No	
Ensuring our services are inclusive	Yes	X	No	

Is this report relevant to compliance with any key standards?					State specific standard
Care Quality Commission	Yes	X	No		Compliance with the NHS Foundation Trust annual reporting manual 2023/24
IG Governance Toolkit	Yes	X	No		
Any other reporting standards	Yes	X	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	x	No		Covered in relevant sections of the Annual Report and Value for Money report (KPMG)
Financial (revenue &capital)	Yes	x	No		
OD/Workforce	Yes	x	No		
Equality, Diversity & Inclusion	Yes	x	No		
Legal	Yes	x	No		
Environmental Sustainability		x	No		

Appendix 1

2.17 Annual Governance Statement

2.17.1 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.

2.17.2 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 2024 and up to the date of approval of the annual report and accounts.

2.17.3 Capacity to handle risk

Our Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk.

Assurance is gained from a wide range of sources that are systematic, supported by evidence and incorporated within a robust governance process. The Board of Directors achieves this through the work of its assurance committees, by audit and other independent inspection, and by systematic collection and scrutiny of performance data, to evidence the achievement of objectives.

This is delivered through the following governance systems:

- Executive Management Team (EMT) - this group has been formally established and strengthened in the financial year as a formal strategic, operational and performance decision making forum under the leadership of the Chief Executive. EMT executes the planning and delivery of the Trust strategy, operational plans and Trust priorities and these are delivered through the values of the Trust. EMT also supports collective action on the key priorities and in managing risks, providing assurance around governance and overseeing reports prior to their receipt through board assurance committees. This will be supported in 2024/25 through the introduction of an Operational Management Group reporting into EMT and providing oversight on all aspects of our operational delivery.

- Board assurance committees - The Board of Directors and its committees receive and scrutinise the risks to achieving our strategic objectives through the Board Assurance Framework and the Corporate Risk registers. The Audit and Risk Committee has delegated responsibility for monitoring the risk management and assurance systems within the Trust.
- Performance reviews - All operational services have a consistent and established integrated performance and quality review framework that ensures day-to-day performance is reviewed. The Executive team carries out tri-annual performance reviews of all departments and this process has been reviewed and strengthened during the financial year.
- Clear improvement priorities - Priorities have been developed, agreed and are represented in our delivery plans. These priorities will ensure clarity of purpose and that each improvement priority has a defined timeframe, milestones and agreed measurements to ensure we can understand the progress made, outcomes delivered and agreed governance oversight.
- Managing risks to the delivery of safe and effective services - The Board Assurance Framework sets out the Trust’s strategic objectives, the risk to achieving them and the control and assurance mechanisms that have been put in place to manage risks and deliver the objectives. A healthy culture of risk discussion is encouraged at all levels to support effective corporate and clinical risk management with risk registers in place to ensure risks are identified, escalated and managed effectively.
- All members of staff have an important role to play in identifying, assessing and managing risk. To support staff, the Trust engenders a fair and open environment. The Trust’s culture promotes the reporting of all incidents and staff are encouraged to follow alternative feedback mechanisms, including through the Freedom to Speak Up (FTSU) Guardian, the Guardian of Safe Working and/or through the Trust’s FTSU (whistleblowing) policy which was updated during the financial year and reflects national requirements.
- Ensuring the delivery of our plan - We have put in place a range of actions to deliver the strategic priorities and key deliverables against our Annual Operational Plan. The Annual Operational Plan has monitoring arrangements in place explicitly linked with the Board Assurance Framework risks. Progress against the plan is reported to our Executive Management Team, Finance and Performance Committee and received at the Board of Directors on a quarterly basis with a six monthly report received at Council of Governors and engagement with them on priorities. Corrective action is taken where required.
- The internal audit plan includes a yearly review of the Trust’s approach to risk management. The recommendations and learning identified from such reviews are taken forward, to support improvements and the embedding of risk management in the Trust. The Audit and Risk Committee maintains oversight of the internal audit plans and internal audit reports are also received at relevant board committees for assurance and for monitoring delivery of actions.

Leadership arrangements for risk management are detailed in the Trust’s risk management framework which was updated during the financial year. The risk

management framework outlines our approach to risk and the accountability arrangements including the responsibilities of the Board of Directors and its Committees, Executive Directors and all staff.

Over the last year there has been continued commitment to improve corporate and quality governance arrangements. Our focus has been to ensure all parts of our organisation are better aware of the quality, safety and effectiveness of the care we provide and that the right decisions are taken by the right people, at the right time, to maintain and improve quality. This has included development of our approach to the Patient Safety Incident Response Framework (PSIRF).

Work has taken place by the Board of Directors to determine current risk appetite with updated appetite statements captured and reflected on the Board Assurance Framework and the Risk Management Framework. A Risk Oversight Group, reporting to the Audit and Risk committee and the Executive Management Team has been established to strengthen, confirm and challenge around risks on the Corporate Risk register, to support cascading risk appetite statements across the organisation and understanding of requirements and to support development of the review of the Risk Management Framework during the year. The Trust received significant assurance for its risk internal audit.

2.17.4 Risk Management 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 Framework** was refreshed and approved by the Audit and Risk Management Committee and the Board of Directors in November 2023. It describes the Trust's strategic approach to safety and risk management; it follows the principles of good governance and sets out the Trust's governance arrangements for risk, together with defining levels of authority, accountability, responsibility and escalation for risk management.

Risks are graded according to their severity and likelihood of occurrence, using a 5x5 risk grading matrix based upon guidance produced by the former National Patient Safety Agency with controls and actions identified to mitigate risks down to their target score.

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 (CRR). Risks are recorded on an electronic risk management database (Ulysses), which is separated into teams and directorates with risks held at corporate, directorate or team level. All recorded risks have an accountable individual and are reviewed and monitored by the appropriate operational governance group. Each directorate is required to have a risk register lead responsible for managing and maintaining their risk register.

Risks on the CRR are overseen by lead Directors, received, monitored and undergo confirm and challenge through the Risk Oversight Group, Executive Management Team, and Board assurance committees with the CRR received at each public Board of Directors meeting.

The CRR is administered by the Head of Corporate Assurance supported by a Corporate Risk Officer, reporting to the Director of Corporate Governance (Board Secretary).

During 2023/24 work took place to ensure that all risks scoring 12 or above held locally and not yet escalated onto the CRR, were appropriately reviewed and escalated where required. This was supported by a programme of risk management training with teams and individuals.

The table below outlines the highest corporate risks as at 31 March 2024, actions and mitigations in place to address them:

Highest corporate risks as at 31 March 2024	Example of actions completed or underway
Risk of failure to deliver required level of savings for 2023/24	The Board received detailed updates on delivery of savings required and carry forward implications to the new financial year. This is monitored at the Finance and Performance Committee.
Risk of loss of knowledge and expertise in the Digital team impacting on delivery of key projects	An external review has taken place to support planning for our electronic patient record programme which includes resource management planning. This is monitored at the Finance and Performance Committee.
Demand for Gender services outweighing resource and capacity of the service Demand for ADHD services outweighing resource and capacity of the service	The Board has agreed these risks would be amalgamated into an overarching corporate risk around waiting times for specialist services. This is monitored at the Quality Assurance Committee.
Risk service users could ligate using fixed ligature anchor points in inpatient services	The Transformation programme for ward improvements mitigates this with planned final ward moves due to take place early in 2024/25.

The Board of Directors reviews its risk appetite at least annually, aligning it to revised strategic objectives alongside the development of the Board Assurance Framework. Risk appetite is reflected on the CRR and the Board Assurance Framework.

The Trust’s approach is to minimise exposure to risk that impacts on patient safety and the quality of our services. However, it 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 also highlighted via incidents (including serious incidents), service user experience, complaints, concerns, safeguarding issues and claims, with learning lessons reports received at Quality Assurance Committee and Board of Directors.

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 and we have a strong reporting culture.

Work is taking place as a system and through the provider collaborative to develop board assurance frameworks and risk registers which will be reflected into those of the Trust where appropriate.

2.17.5 Board Assurance Framework (BAF)

The BAF is received at assurance committees throughout the year and monitored, overall, at Audit and Risk Committee and Board of Directors.

It outlines risks to delivery of the Trust's strategic aims and priorities. It is used to monitor 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.

All reports received at Board Assurance Committees and the Board of Directors are required to demonstrate links with the BAF and detail on key risks and how these are being mitigated.

The 2023/24 BAF identified thirteen strategic risks. During the year improvements have been made to the framework including the introduction of milestones; more granular detail on levels of assurance and clarity on alignment of gaps with associated actions and owners. The BAF and Risk Management received significant assurance through the internal audit process.

The Trust has published a register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) on the website, 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 continued to be strengthened in 2023/24 and detailed board development sessions have been 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 and an updated Sustainability Strategy was approved in January 2022.

2.17.6 Financial Monitoring oversight arrangements

The Trust financial governance processes have been strengthened during 2023/24 in response to a downturn in financial delivery against out financial plan. We have amended approval requirements for expenditure and revised financial governance and monitoring arrangements to minimise the overspend against plan. Additional controls implemented include increasing Executive oversight and implementing revised performance reviews, ranging from monthly to quarterly depending on performance; financial recovery plan for all overspending teams/services; implemented a vacancy control panel for all posts; reviewed agency usage and controls to reduce usage and comply with price caps and frameworks and increased controls and procedures regarding the use of staff above funded establishment. These revised arrangements began to be established in the second half of the year and will continue subject to quarterly review whilst we work to reduce the deficit.

2.17.7 Oversight of Transformation Programmes

The Trust governs its major transformation programmes through a system of programme boards, and a transformation portfolio board which reports to EMT and the Finance and Performance Committee of the Board of Directors. Each major change programme has an executive level Senior Responsible Owner, and a programme board, which is supported by the Programme Management Office. Each programme provides a monthly highlight or exception report to the transformation portfolio board, at which the SROs account for delivery. There is a system of mutual accountability between executive SROs, chaired by the Director of Strategy. The delivery of the overall transformation portfolio is reported to EMT and the Finance and Performance Committee by the Director of Strategy.

During 2023/24 key issues addressed through this process included:

- **Management of dependencies between the Community Mental Health Team transformation programme and the Primary and Community Mental Health transformation,** related to allocation of staffing across crisis and urgent elements of service provision. This was resolved enabling the Primary and Community Mental Health service to go live in April 2024.
- **Therapeutic Environments programme** adapting its scope and timescales in response to issues encountered with water systems and with changes to the anticipated availability of capital funding. This resulted in revised opening dates for Stanage Ward (opened March 2024), and subsequent delays in works on Burbage and Dovedale 2 wards.
- **Electronic Patient Record (Rio Mental Health EPR system) -** In October 2023 we deployed Rio Mental Health EPR system across 10 services as part of a gradual go live implementation led by a third-party delivery partner, with the second phase intended deployment to include the remaining 64 services. Unfortunately, the implementation encountered significant challenges and we paused the implementation to understand the issues. The Board commissioned an external review to supplement a technical review of the deployment to provide an independent view on lessons learned and ensure these are part of the revised planning for the remediation plan to Tranche 1 services, alongside a comprehensive delivery plan for Tranche 2. Governance

arrangements have been strengthened to put in place a highly structured approach including gateway reviews and key points to ensure progress is sufficiently evaluated throughout the programme to mitigate risks by identifying issues early on. We have revised and increased leadership capacity for the programme, further strengthened Executive level clinical leadership through the establishment of the Clinical Safety Design Executive Board responsible for the clinical alignment and safety aspects of the deployment in line with NHS Standard DCB0160: Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems. The Executive and Board oversight of the Programme Board has increased with fortnightly Executive and monthly Board updates whilst we replan the deployment. A revised plan was approved at the April 2024 Board.

- **Disposal of Fulwood site -** The Trust planned to complete disposal of Fulwood site, our previous headquarters, by December 2023. We continue to work with the purchaser to secure revised planning permission for the site under the advisement of the Local Planning Authority. The Board of Directors has been receiving monthly updates on the progress of the disposal and during 2023/24 following delays in the disposal the Board of Directors agreed changes to the arrangements of disposal.

As we move into 2024/25 the Trust will continue to evaluate the effectiveness of the transformation portfolio board approach and will adapt it to reflect the Integrated Change Framework approach. This may include changes in the composition of the transformation portfolio, as some of our major schemes are completed, and other priorities are added.

2.17.8 Emergency Preparedness Resilience and Response (EPRR)

SHSC have a statutory obligation to ensure that we are a prepared, resilient, and responsive to internal and external critical and major incidents. To achieve this the Trust operates a robust programme to ensure that plans are in place and systems of continuous learning.

In 2023, NHS England revised the core standards that govern EPRR nationally. The standards prior to this had been in place for several years and there was a significant change to the core requirement of an organisation that we had to be assessed on in Quarter 4 of 2023/2024. The assessment against these standards was a pilot across North East, Yorkshire and Humber. On completion of this new assessment process, we were rated as non-complaint, as were all other Trust's and the Integrated Care Board across South Yorkshire.

Following the assessment, an action plan has been put in place that will bring us to compliance over the next two years. The action plan was approved by the SHSC Board of Directors in December 2023, and we are making good progress in improving our position and expect to meet requirements by the autumn of 2025.

As per the requirements of NHS England SHSC have robust governance in place since the changes to the standards, which includes an Accountable Emergency Officer who is a Board Director, a tier 2 EPPR group, which reports quarterly to the Audit and Risk Committee.

SHSC continue to work with local and region partners in preparing for critical incidents, which includes continuous learning and memorandums of understanding to support mutual aid.

2.17.9 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 Sheffield Flourish to broaden engagement with our communities and through a very active programme of coproduction for all strategies, major plans and initiatives.

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 the Patient Safety Incident Framework (PSIRF).

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

Partnership working has continued through the South Yorkshire Integrated Care Board, Sheffield Health Care Partnership and that South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative.

The Trust's Chair took over the lead chair role for the Mental Health, Learning Disability and Autism Provider Collaborative during the year and joined the Board of NHS Providers as a mental health trust chair representative.

As a Foundation Trust we serve the people of Sheffield and beyond and have staff and public members and a broad ranging Council of Governors. The overall role of the Council of Governors is to assist the Trust in its drive to continue to raise standards and to hold our Board of Directors to account on this. The Council of Governors receives updates on the Trust's compliance against regulations and standards and has been asked for views on topics such as updated strategic priorities, planned service changes, annual operating plan; quality account priorities and equality priorities. Governors have also participated in system governance change sessions with colleagues from other organisations.

A Governor's Development Programme was in place throughout the year with detail on activities outlined in section 2.12.11.

In addition to this, Chair drop-in sessions have continued and Governor observation of Board assurance committees was made available for Governors with observers in place for all assurance committees.

2.17.10 Clear responsibilities, roles and systems to support good governance and management

Clarity of roles and responsibilities within our governance arrangements are provided in:

- The Constitution including the Schedule of Matters Reserved by the Board
- Standing Orders, Reservation and Delegation of Powers, incorporated in the Scheme of Delegation and Standing Financial Instructions - reviewed in 2023/24
- The Scheme of Delegation of functions included in the Mental Health Act code of practice - reviewed in 2023/24 with no changes required
- The terms of reference for Board committees and operational committees – reviewed annually
- Our programme and project management arrangements.

There are a number of systems to support good governance including:

- The Insight clinical record system – which is planned to be replaced with an electronic patient record system called RIO
- The Ulysses Risk Management System which enables us to manage and report incidents, record risks and supports our serious incident processes
- The e-rostering system which supports safe staffing in our services
- The patient acuity tool which supports staffing numbers and skill mix to maintain effective care and safe staffing
- Our finance system, Integra
- The Electronic Staff Record (ESR) supports the recording, reporting and control of activities related to the training, learning and development of staff.

2.17.11 Appropriate and accurate information being effectively processed, challenged and acted upon

Our performance metrics and their targets are reviewed and refreshed each year as part of our business planning processes and review of our performance framework. Benchmarking and other external sources of information are used as appropriate and when available. Evidence of information being challenged and acted upon is provided in the minutes of Board and its committees which are available to the public.

The Data and Information Governance Group (which developed into a Digital Assurance Group during the financial year) oversaw the Trust's statutory duties and assured quality in regard to data and information, with oversight of information governance under the remit of the Audit and Risk Committee.

2.17.12 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.

During the course of the year, I have recruited substantively to all vacant roles in the Executive team to support me to meet my duties.

The following substantive appointments were made in 2023/24 as outlined in section 2.4.1. All other members of the Executive Team were substantive prior to the start of the financial year:

Executive	Role	Date commenced
Salli Midgley	Executive Director of Nursing, Professions and Quality	Interim from January 2023 and substantively appointed from June 2023
James Drury	Director of Strategy	Appointed from January 2024
Neil Robertson	Director of Operations	Interim from January 2023 and substantively appointed from February 2024

There is a balance of directors with internally and externally focused roles. Director portfolios are regularly reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust.

The Council of Governors, Trust Board and Executive team are operating in an environment of external change and wider system pressure where risk is constant and at high level. The Board Assurance Framework as referenced earlier in the AGS is updated to reflect this and will continue to develop as system and collaborative risks are finalised.

2.17.13 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 the requirements of their role. 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 are reflected in personal development plans (PDPs) over and above mandatory training requirements.

Overall compliance with mandatory training at the end of March 2024 was 87.63% with nine areas being below 80% compliance.

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.

2.17.14 Quality governance arrangements

During 2023/24 we have continued to strengthen and enhance the quality governance arrangements we have in place. We have aligned these activities to our Quality Management System to help us better understand the quality of care provided at a local level and the risks and assurances we hold at a wider organisational and strategic level.

Following the introduction of our Tendable clinical audit platform in 2022/23 to all bed-based services we have worked with teams to assist them in developing local team governance reporting relating to their compliance. This has helped teams to understand what they are doing well, where practice needs to be improved and to support escalations.

Internal audit assessed our Infection Prevention and Control management with 'significant assurance,' with two low risk actions and one medium risk action identified to strengthen our arrangements.

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 quarterly learning bulletin is circulated to all staff and shared via the learning hub.

Our Freedom to Speak Up approach also enables learning through staff voice and has clinical executive oversight for any issues pertaining to patient care. Following the Letby verdict, this focus remains and the FTSU guardian meets monthly with the clinical executives to ensure concerns are heard and investigated, maintaining anonymity where required.

2.17.15 Culture and Quality Visits

It is recognised that any service that delivers patient care can have a closed culture. All services have been assessed for risk of having a closed culture based on the criteria identified within the work completed by Care Quality Commission (CQC) on closed cultures and then prioritised based on risk profile. Due to sickness absence within the team, our schedule for planned visits has not been achieved, however these have been re-established and during 2023/24 12 visits to services took place.

2.17.16 Fundamental Standards of Care (FSoC) Visits

The FSoC visits take place annually to all bedded services and are designed to measure the extent to which the standards of care set out within key SHSC policies and CQC regulatory requirements are met. The 2023/24 programme of visits took place between October and December 2023. Services are required to develop an action plan to support improvements for the standards they are assessed not to have met. Progress is reviewed through team governance meetings. Services falling below the agreed criteria for the 'Safe' standards receive a further visit prior to the annual assessment.

2.17.17 Board Visits

Board visits provide our Executive and Non-Executive members of Trust Board with the opportunity to visit services, ask questions and listen to feedback to support assurance reporting.

This year we have reviewed the approach we take for Board visits and increased the opportunities that Board members have to engage and gather feedback from Service Users/Carers and from the staff in services being visited. We have also widened the programme to include non-clinical based services. During 2023/24 approximately 50 Board visits took place which included some visits to non-clinical services.

2.17.18 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 are chaired by the Director of Finance and attended by members of the executive leadership team. The review provides the opportunity to positively challenge performance in clinical and corporate services across the organisation and to gather insights regarding elements of the CQC well-led domain.

2.17.19 Learning from Good Practice

We continue to review and develop the variety of mechanisms we have to ensure that good practice and lessons learned are shared across our services. Our Quality Assurance Committee receives quarterly learning reports and twice-yearly Quality Assurance and Quality Improvement reports are received at the Committee and at the Board of Directors to support triangulation and thematic review of learning across the Trust.

Operational learning mechanisms

- Fundamental standard visits for inpatient services - 15 steps challenge accreditation added in 2023/24
- Compliments
- Patient experience feedback including quality of experience surveys, local team level feedback and carer feedback
- Culture and Quality visits for all other clinical services
- Board visits to all clinical and non-clinical teams
- Blue light alerts for safety critical notices into teams
- Incident reviews which 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)
- Mortality Reviews and Structured Judgement Reviews
- Quality Improvement Forum
- Quality Improvement Events E.g. Flow Quality Improvement Collaborative
- Supervision Arrangements (clinical, managerial and safeguarding)
- Service based development forums

Governance arrangements

- Daily Incident Huddle (where all incidents across SHSC are reviewed and follow up agreed). Themes from the month are shared across SHSC teams
- Complaints thematic review
- Claims thematic review
- Prevention of Future Death notices, learning from coroners’ court hearings
- Incident Reporting and Investigation (48hr reports, Significant Event Analysis, Patient Safety Incident Investigations) with a weekly investigation panel that review all investigations and reports, support timely delivery, provide critique and challenge to draw out clear learning and improvement
- Section 42 enquiries (safeguarding investigation)
- We have a range of committees and groups which promote shared learning and oversight of quality and risk including:
    - Quality Assurance Committee
    - Clinical Quality and Safety Group
    - Safeguarding Assurance Group
    - Least Restrictive Practice Oversight Group
- Commissioned external reviews to improve safety and encourage innovation
- Flash reporting to the Board of Directors
- Team and clinical directorate governance meeting reports and events
- 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

- Board development learning

2.17.20 Information governance and data security

We have a suite of Information Governance polices which provide a framework for 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 risk and incidents are monitored on a monthly basis through the Digital Assurance Group which is accountable to the Audit and Risk Committee. During 2023/24 there were 169 incidents reported, of which four were reported to the Information Commissioner. These incidents were reviewed by the ICO and no further action was required.

Following our June 2023 Data Security and Protection Toolkit (DSPT) submission a plan was agreed with NHS England to ensure an overall outcome of 'Standards Met' by 30 June 2024 which is subject to regular monitoring. The Trust continues to work to implement improvements to enhance our performance against the DSPT standards and make preparations for the move to the new Cyber Assessment Framework due for release by NHS England in August 2024.

Information Governance training is mandated for all staff to complete annually, with new starters required to complete this within five days of commencement in post. This training is supplemented with role/department specific training.

Following on from identification of significant backlogs of both Subject Access Requests (SAR) and Freedom of Information (FOI) requests, a recovery plan was implemented in the year with monthly oversight from the Executive Management Team. This included investment in a new case management system, additional temporary resources and end to end process reviews. This resulted in elimination of accumulated backlogs (approx. 1600 requests in total). We informed the Regulator (ICO) of the work being undertaken to address the backlogs and have kept them updated throughout.

2.17.21 Working in partnership and establishment of the Mental Health, Learning Disability and Autism Collaborative

In March 2023 the Board approved the arrangements for the formal establishment of the collaborative supported through a committee in common approach. The terms of reference were updated and re-approved in March 2024.

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

We have 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

The Board of Directors delegates the day-to-day management of the operational activities of the Trust to Chief Executive supported by the Executive Management Team.

Terms of Reference for all committees have been approved by the Board of Directors, reviews of effectiveness undertaken and annual reports from the committees received in 2023/24.

Regular updates have continued to be provided to the board assurance committees and public Board of Directors on operational efficiency metrics throughout the year, as described earlier in this report, through the Integrated Performance and Quality Report and Performance Framework and this has been strengthened through the inclusion of new dashboards.

The organisation has reviewed and continues to review its leadership at various levels. The internal leadership development programme launched in February 2022, which aims to bring current and future leaders together to challenge their thinking and learning, has continued throughout the year with positive feedback received from participants and from the sector. This will continue in 2024/25.

Financial sign-off of budgets and performance management arrangements are in place with oversight at Executive Management Team. Budget managers are provided with monthly budget reports for their areas of responsibility to assist them in undertaking this role. Work has taken place to strengthen our arrangements for planning for 2024/25 and the budgets approved and finalised in April 2024. 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 Assurance committees with escalation and cross referrals taking place between committees and formally captured through a new tracker, and evidenced through our Alert, Advise, Assure (AAA) reports to the Board of Directors. This approach has also been successfully rolled out as a reporting tool from tier two groups into our tier one board assurance committees.

Recovery plans are received and monitored at the appropriate committees with clear evidence of confirm and challenge taking place.

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. 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 model has been positively received through the Clinical Senate and preparations for launch in 2024/25 are underway.

2.17.23 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 and undertake cross referral across committees which has been a positive addition to our governance arrangements.

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 user 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. 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.

In previous years our ‘Back to Good’ programme provided assurance focused on, or related to, areas identified for improvement through our CQC report. This programme closed in August 2023 with monitoring of outstanding actions moving to Board Assurance Committees oversight and via a new Quality Assurance Report received at the Board of Directors.

The Quality Oversight Board led by regional partners and attended by CQC, has provided external oversight of our ‘Back to Good’ journey and the Trust has been commended for significant improvements made during the year and has moved to system oversight.

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.

During the course of the financial year the following internal audit reports were received:

- 2023/24 Data Security and Protection Toolkit – Moderate assurance (issued June 2023)
- 2023/24 Equality, Diversity and Inclusion – Moderate assurance (issued October 2023)
- 2023/24 Risk Management Framework – Significant assurance (issued April 2024)
- 2023/24 Financial ledger – Significant assurance (issued May 2024)
- 2023/24 Workforce data quality – Significant assurance (issued June 2024)
- 2023/24 Clinical Record Keeping – Limited assurance (issued June 2024)
- 2023/24 Capital Planning – significant assurance (January 2024)
- With regard to closure of internal audit actions the Trust ended the year with 87% first follow up and 97% overall follow up compliance on which it has received significant assurance.

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

- Robust Board of Directors development plan in place over recent years and being refreshed in 2024/25 (which has included external support), alongside Executive team development, Non-Executive development; Governor development and staff leadership and management programmes
- Well established Alert, Assure, Advise (AAA) reports from Committee Chairs to Board of Directors supporting focused discussion on key areas of concern and cross referral of issues between committees
- AAA reporting from tier two groups (groups that report into our board-assurance committees) to the board committees providing annual reports on effectiveness
- Updating of the BAF for 2023/24 – the document and the assurance provided by it receive confirm and challenge at the Board assurance committees in advance of Board of Directors
- Established risk oversight group providing additional rigour and confirm and challenge with oversight at new Executive Management Team meetings.
- Continued grip around closure of Internal and External Audit actions in a timely way
- Continued and improving performance management review processes
- Embedding of the work of the Back to Good Board into our business as usual – continued focus on closure of outstanding actions through recovery plan monitoring
- Acceleration in our work around driving Quality Improvement with the Board of Directors having received development sessions and regular reports on progress
- External support has continued during the year in supporting our board development and we have commissioned external support in evaluating our stakeholder engagement with a focus in the new financial year around governance, communications and values into behaviour
- Continuous improvement in the quality of our reporting through board assurance committees and Board of Directors with further work planned in the coming year
- Continued triangulation of data and performance information with board and executive visits and through cross reporting from the board assurance committees. This has improved across the board supported by a refreshed and focused Board of Directors visits programme
- Introduction of strengthened corporate communications and communication through our leadership team with the introduction of the formal Cascade
- Continued focus on Policy Governance arrangements with reporting through to board assurance committees as appropriate
- Capturing of action plans and third party reports through our tier one and tier two annual reporting processes up through to the Board of Directors
- Given the concerns raised about the Assessment and Treatment Service (ATS) at Firshill Rise and the receipt of the previous Section 29A enforcement

notice, this unit was closed to inpatient usage in September 2021. The unit remains closed to inpatient admissions as outlined in the CQC registration. The site functions as a community service provision and the Health Overview and Scrutiny committee has been updated on, supported and planned next steps in respect of plans for the transformation and delivery of community services provision which is moving forward at pace.

- Our overall CQC rating has remained overall as Requires Improvement. Our current CQC ratings are found here: https://www.cqc.org.uk/provider/TAH
- The organisation moved to system oversight at the end of (currently SOF 3) the financial year 2022/23.
- The Board of Directors has monitored delivery of actions identified through the 2022/23 well-led self-assessment and an externally supported well-led review will take place in 2024/25.
- This has been a positive year for the organisation in terms of its internal audit outcomes with the majority of assessments providing moderate or significant assurance.

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.

2.17.24 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.

Strategic risk management and Board Assurance Framework – I am providing an opinion of **significant assurance**.

Internal Audit outturn – I am providing an opinion of **moderate assurance**. We have issued one limited assurance opinion and two moderate assurance opinion reviews this year.

Implementation of Internal Audit actions – I am providing an opinion of **significant assurance**. The final first follow up rate is 87% and the overall follow up rate is 97%.

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, 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 any areas of weaknesses in control noted by our Internal Auditors through internal audit reports, 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 significant internal control issues have been identified within 2023/24.

Insert signature

Salma Yasmeen

Chief Executive