Board of Directors - Public

SUMMARY REPORT	Meeting Date:	22 May 2024
	Agenda Item:	09

Report Title:	**Board Committee Activity Report**	
Author(s):	Amber Wild, Head of Corporate Assurance	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director, Chair of Mental Health Legislation Committee Heather Smith, Non-Executive Director, Chair of Quality Assurance Committee Mark Dundon, Non-Executive Director, Chair of People Committee Owen McLellan, Non-Executive Director, Chair of Finance and Performance Committee Anne Dray, Non-Executive Director, Chair of Audit and Risk Committee	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Quality Assurance Committee People Committee Audit and Risk Committee Finance and Performance Committee Mental Health Legislation Committee
	Date:	As detailed below.
Key Points:	This report highlights key matters, issues, and risks discussed at committees since the last report to the Board in March 2024 to alert, advise and assure the Board.	

Summary of key points in report
Each committee has considered 'significant issues' under three key categories in their Alert, Advise, Assure (AAA) Reports:

Alert – areas which the committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on where significant improvement has been made (positive alerts);

Advise – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments.

Assure – specific areas of assurance received warranting mention to Board or for noting key reports received at an assurance committee.

The areas attracting particular focus are those under the 'red' alert headings on each page of the committee reports.

AAA reports for Board subcommittees are included in this report and attached at Appendix 1. Minutes from board sub committees will be shared with the board via the shared folder and non-confidential minutes are available upon request.

Details of the minutes and AAA report for this report are detailed below:

Quality and Assurance Committee:
AAA report from April and May 2024

People Committee:
AAA report from May 2024

Audit and Risk Committee:
AAA Report from May 2024

Finance and Performance Committee:
AAA reports from April and May 2024

Mental Health Legislation Committee:
None

Minutes from board sub committees will be shared with the board via IBABs and non-confidential minutes are available to the public upon request.

Minutes approved by each committee are presented to Board (available via IBABs/Google drive) to provide assurance that the committees have met in accordance with their terms of reference and to advise Board of business transacted at their meeting.

Recommendation for the Board/Committee to consider:

Consider for Action	**X**	**Approval**		**Assurance**	**X**	**Information**	**X**

To formally note the minutes of the committee meetings being presented to the Board
To receive the 'Alert, Advise, Assure (AAA)' committee activity reports within the appendices for discussion.

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 Fundamental Standards	*Yes*	***X***	*No*		"Good Governance"
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standards?	*Yes*		*No*	***X***	
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*	***X***	Not directly in relation to this report – specific detail within the appendices
Financial (revenue &capital)	*Yes*		*No*	***X***	
Organisational Development/Workforce	*Yes*		*No*	***X***	
Equality, Diversity & Inclusion	*Yes*		*No*	***X***	
Legal	*Yes*		*No*	***X***	
Environmental Sustainability	*Yes*		*No*	***X***	

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Quality Assurance Committee (QAC)	Date:	10 April 2024	Chair:	Heather Smith

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
Integrated Performance and Quality Report (IPQR): Out of Area reduction and Health Based Place of Safety re-purposing increase.	Positive alert: There has been a significant reduction in the number of inappropriate out of area (OOA) bed usage, with only 3 patients currently in inappropriate OOA beds. However, **there is an increased number of breaches in the Health Based Place of Safety (HBPoS), which has spiked to 80% in February 2024. A&E breaches have also peaked at 9 (target 3)**	There has been increased usage of the Health Based Place of Safety as a means of admission. In addition, people have been waiting longer for a bed within the emergency department. Further work is to be conducted around patient flow in this area. Committee were advised that in February, the Trust was required to breach the HBPoS for 2 continuous weeks to accommodate a patient on behalf of NHSE whilst they sourced a medium secure deaf hospital placement. This was escalated with the ICB.	IPQR will continue to report monthly to committee. There is a need to review the appropriateness of the current Recovery Plan about OOA (see later section).	May 2024	All apply

ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
Out of Area Recovery Plan	The committee received an update to the Out of Area recovery plan. It was noted that in terms of patient experience and quality of care the HBPoS is a newer environment however it does not have a multidisciplinary team and the context is ultimately that of a HBPoS, not a	HBPoS is a preferred option by many rather than OOA, however it is only suitable for very short term, and whilst being used as a temporary admission point, it limits the availability to those who may need it for its designated purpose. It was advised that a paper relating to	Committee requested that the following data is provided in a future report: • to show the number of patients that need to use a HBPoS outside of Sheffield due to our unit being re-purposed. • to update the action plan	January 2025	BAF.0024

	ward.	breaches and terminology is being shared with the Executive Management Team and this will be seeking a recommendation on how data is captured and reported and how the HBPoS is used moved forward.	following the audit of experience by the Engagement team • for 2022/23 (and earlier) open actions to be updated and closed where appropriate • to provide narrative around the reasons for breaches • to consider if this becomes a 'flow' recovery plan rather than just being about out of area beds It was noted that Out of Area is also monitored in FPC and as part of the monthly IPQR, therefore a standalone report isn't required to return to QAC until January 2025.		
Recovery Team Allocations Recovery Plan	The committee were advised that with the removal of the Care Programme Approach (CPA) the Trust is moving towards the allocation of named workers. This aligns with phase 3 of the Primary and Community Mental Health Transformation work. Work is taking place to upskill workers who have not traditionally been named workers, which includes eg peer recovery workers, and psychologists. New relationships are being negotiated with GP practices as the result of a disaggregated network (Central), which is having an impact on 150 pre-planned patient movements.	Committee were assured that Phase 3 is progressing. Questions related to the quality of experience and the improvement to care. For example, historically, patients that have been discharged have felt that re-accessing support services is a challenge. There are now weekly huddles between Primary Care Networks, VCSE and CMHT Care groups to mitigate against this. Committee felt that future reporting outlining the outcomes and impact would be beneficial such as a focus on the quality of care for those on the 'green' waiting list, equity issues and VCSE issues.	The recovery plan will continue to report to QAC in January 2025, although with a focus on specific issues rather than the process of programme implementation, which is well underway. It was confirmed that an impact and evaluation of transformation will report to QAC in October, and Recovery Team Allocations data will continue to be reported in the IPQR on a monthly basis.	January 2025	BAF.0024
Learning Disability and Autism Reports	The committee received 2 inaugural reports on Learning Disability and	The committee requested that Learning Disability and Autism is	Committee has requested that the reports return to committee in	October 2024	BAF.0024

	Autism which provided assurance against the quality standards that both areas are working to. The Autism Awareness e-learning is being updated following feedback and level 2 of the Oliver McGowan training will be rolled out.	further separated in the reports noting that not all service users who have autism have a learning disability, and vice versa. Committee were asked to note that NHS England refers to Learning Disability and Autism as a collective. Committee requested further assurance that the reasonable adjustments flag is built into the front page of EPR as this affects a range of service users where care givers and admin need to be sighted on personal adjustments (re: person-centred care). Committee asked for assurance on the developments in the sensory review of environments. It was confirmed that all wards except for Stanage have had a sensory review. A detailed report with recommendations has been fed back and a summary is being presented to the Therapeutic Environments Group.	6 months and provide further assurance on the points raised. They asked that themes and areas for improvement are identified. The future report is to indicate impact measures and present data to committee so assurance can be given about quality improvement.		
PLACE report	The report was shared at March Board of Directors and was presented to QAC for awareness and comment. The report shows a deterioration in scores on PLACE compared to last year and poorer performance when benchmarked against other comparable Trusts. The report considers aspects such as food, cleanliness, and condition of buildings. It also looks at the suitability of our environments for service users with Dementia and Disabilities.	Committee expressed a wish that a collaborative approach to responding to the findings from 2023 takes place with the Fundamental Standards Team and Clinical teams. An action plan is being developed which will be shared at Executive Management Team. Committee requested for updates on the progress of the action plan to be scheduled at QAC prior to presenting to BoD.	A schedule for reporting the PLACE Survey 2023 action plan to QAC is to be determined, with a review of the 2023 action plan taking place in July 2024.	July 2024	BAF.0023 BAF.0024 BAF.0025

	The report has identified key areas and wards for improvement and action plans have been created for each area, which should address the immediate and specific needs of each location.				
Corporate Risk Register	The committee received an updated Corporate Risk Register which noted that work is taking place to review the risks and assess where risks may be amalgamated into more appropriate overarching corporate risks. Information governance risks are being reviewed at Risk Oversight Group and it has been confirmed that a Records Management Group is being established on 17th April.	Work continues to review risks scoring 12 and above on directorate risk registers. A Ulysses extraction report will continue to be conducted monthly to monitor any new, high-scoring risks on the directorate and team registers and to ensure discussion takes place with Executive Leads to determine if these should be considered for escalation onto the CRR and reported through to Risk Oversight and EMT for agreement prior to circulation in the CRR to the assurance committees.	CRR will continue to report monthly to QAC	May 2024	All apply
Internal Audit Action Tracking Report	The committee were advised that there is one remaining open action for Infection Prevention Control audit which is on track for completion by the end of May.	Since the last report, the year-end compliance levels for SHSC have been confirmed as: First follow up rate 87% Overall follow up rate 97%	Internal Audit Action Tracking will continue to report monthly to QAC	May 2024	All apply
Policy Governance Group (PGG) Report	The committee were advised of the policies which were approved for renewal or extension at PGG.	Committee ratified the decisions of the PGG as outlined in the report	Policy Governance Group will continue to report monthly to QAC	May 2024	All apply
Quality Assurance Committee Objectives	The committee reviewed the proposed objectives ahead of inclusion in the committee annual report. which were agreed with the committee and will be included in the annual report ahead of presenting to Audit and Risk Committee.	Committee challenged how report-writers would be prompted to focus on the group objectives. It was advised that the format of the summary templates is being revised with new versions to be rolled out in May.	The committee approved the objectives and they will be included in the committee annual report ahead of presentation to Audit and Risk Committee.	May 2024	All apply
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
Eliminating Mixed Sex Accommodation (EMSA) Declaration of	It was confirmed that the Trust can be assured that it is compliant with the standards for eliminating mixed sex	Sexual safety incidents have been highlighted as a key quality objective for 2024/25 which will aim to provide a	No further action required at this time	Ongoing	BAF.0024

Compliance	accommodation over the last 12 months (reportable compliance requirement). 8 breaches were reported and when reviewed it was found they were not externally reportable breaches.	higher standard than what is required nationally in this EMSA declaration of compliance.			

BAF Risk Descriptions

BAF.0023	There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of Service Users and staff which may result in avoidable spread of infectious diseases.
BAF.0024	There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action.
BAF.0025	There is a risk of failure to effectively deliver essential environmental improvements including the reduction in ligature anchor points in, inpatient settings (the therapeutics environment programme) at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skilled staff to deliver works to timeframe required resulting in more restrictive care and a poor staff and service user experience and unacceptable service user safety risks.
BAF.0029	There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users.

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Quality Assurance Committee (QAC)	Date:	09/05/2024	Chair:	Heather Smith

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
IPQR	There have been continued breaches within the Health Based Place of Safety; access to acute care remains difficult. Challenge remains in the recording of demographic data (essential for us to monitor performance with respect to our equity and inclusion goals). The reduced use of huddles on Birch Avenue has negatively impacted on the reduction of falls. Safer staffing report: there are still periods of time where use of bank and agency staffing on the wards is over 50% of the total. There is a need to focus on retention, as recruitment has been positive.	Management actions to continue. A new dashboard is in place with teams in order to improve data collection with the aim of a 6-month recovery plan. An improvement plan in place to resume the huddles as the positive impact of these is evident. Committee noted the greater transparency now available with respect to data reporting on Safer Staffing.	IPQR will continue to report monthly to committee	June 2024	All BAF Risks
Positive Alert IPQR	Access to community services (eg waiting lists) has improved significantly as a result of service reorganisation/transformation and more responsive intervention.		IPQR will continue to report monthly to committee	June 2024	All BAF Risks

ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk

CMHT Benchmarking Survey	In 2023 the CQC commissioned a Mental Health Survey of 53 Trusts. SHSC scored in the middle of the ratings from service users. The results have already been published.	Action planning is in process to address, in particular, the 2 areas scoring below the average (crisis care access and support for physical health) The action plan will be monitored through Directorate IPQR process.	A date for the action plan to be confirmed to the committee.	June 2024	All BAF risks
Memory Service and Older Adult Mental Health Waiting Times - Recovery plans	There were few improvement updates to report. Waiting times remain a concern. There is continuing impact of the lack of some key data for services given the EPR delay. The pressure on the team was acknowledged due to the data issues and the 7-month absence of data.	The committee showed concern around the action plan and the length of time actions remain unresolved.	Radical transformation is required as current efforts are not yielding consistent results. The Older Adult Transformation programme is now becoming urgent.	January 2025	All BAF risks
Population Health Bi-annual Report	Progress has been made with an increasingly important and cross-cutting theme for the ICS and Trust's strategic priorities. Multiple aspects of deprivation and disadvantage affect many of our service users.	The committee commended the work of the team and recommended that this work is embedded within other programmes rather than being 'stand-alone'. This should act as an accelerator now that the initial scoping work has been done.	The future direction for this work and resource allocation is a Leadership issue and members of the Executive team agreed to consider this.	November 2024	All BAF risks
Quality Account Annual Report	Committee received the draft report and were asked to provide feedback. before the report goes to Board at the end of May. External feedback is also being received.	The committee commended the team for their work and presentation of the document (eg the use of Service Users' artwork). The narrative of the Trust's improvement journey was evident and encouraging.	Future Quality Accounts could incorporate more of a narrative about Value for Money in the finance section, explaining the prioritisation that has to be done.	April 2025	All BAF risks
Clinical Audit Plan - Draft	A new approach is being implemented, identifying clinical audits that fit with strategic priorities and transformation work, to ensure evidence-led work is included. As a result, the clinical audit programme will be flexible.	The committee commended the new approach in moving towards a more evidence-led approach, demonstrating good leadership.	Committee requested that future REIG reports to QAC include an update on decisions taken about the clinical audit programme and the reasons for prioritisation/change.	April 2025	All BAF risks
Internal Audit Action tracking Report	There is one action remaining relating to Infection Prevention and Control due May 2024	The action is on track for completion within the specified date	n/a	June 2024	BAF 0023

Policy Governance Group (PGG) Report	The committee were advised of the policies which were approved for renewal or extension at PGG.	Committee ratified the decisions of the PGG as outlined in the report	Policy Governance Group will continue to report monthly to QAC	June 2024	All apply
Corporate Risk Register	Work is taking place to amalgamate risks around waiting times in specialist services and ligature anchor points. A new risk escalated relating to PROMS outcome measures with a score of 15, linked to the EPR delays has been confirmed at ROG and at EMT. The Interim CDIO has been asked to reflect on this risk in their upcoming review of EPR risks.	The committee received assurance that the risks relating to specialist services are being reviewed by the risk owners. The annual audit strategic risk strategy for the current financial year will look at directorate management of risks and how they are confirming and challenging risks.	CRR will continue to report monthly to QAC	June 2024	All apply
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
CPA Cutover Plan	In order to understand how the new approach (replacing CPA) is being tracked and monitored, the Committee had requested sight of the dashboard. There will be discussions regarding integration of this data into future IPQRs.	The Committee commended the dashboard and were assured that the information available to staff was good quality.	To come back to QAC December 2024	December 2024	All apply
Ligature Anchor Point Annual Report	Work to ensure the removal of the Section 29a warning notice is coming to completion once Maple has moved. However, other fixed ligature anchor points exist around our Estate and work continues to address these, within budget constraints. We are now entering a proactive rather than reactive phase.	Good governance is evident around our LAPs,, with heat maps in place and knowledge around where work is required and planned.	n/a	May 2025	BAF 0025
Q4 Mortality Report	Committee received the latest Mortality report. There have been several structured judgement reviews and identified range of learning. Key learning points have been attained from the annual LeDeR report.	The committee are assured by the Trust's robust mortality process with reviews in place, learning is extracted, with examples of good practice. There is a need to understand how the work has led to a change in practice and closing the loop on sharing of learning in a structured way.	The suggestion for improvement to be considered for the next report.	September 2024	All BAF Risks
Quality and Equality	The panel endorsed the plan on the	The committee acknowledged the	n/a	June 2024	All BAF

impact Assessments	location of the move of Maple and the impact on staff and service users, looking at the gender ratio and the number of beds available.	robust processes in place for the QEIA's and are assured on the level of challenge and discussion evident, with a focus on equality.			Risks
Clinical and Social Care Strategy	The Committee received an update on implementation of the Clinical and Social Care Strategy. 43% of the 140 achievements have been completed with 33% are on track for completion, the remaining 6% have a slight delay. Overall, the programme is rated Amber as a consequence of the delays with clinical outcomes and reporting (consequence of Rio delays).	Assurance of progress was received. The excellent work and evidence of success was highlighted by the committee, indicating good leadership and engagement. The transformational power of this strategy was noted. The principles of co-production listed in the report were praised as exemplary and will be shared at a national level.	Committee questioned if we have done enough to 'tell the story' of this work internally but also externally, as we change the way we approach care.	November 2024	All BAF Risks

BAF Risk Descriptions

BAF.0023	There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of Service Users and staff which may result in avoidable spread of infectious diseases.
BAF.0024	There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action.
BAF.0025	There is a risk of failure to effectively deliver essential environmental improvements including the reduction in ligature anchor points in, inpatient settings (the therapeutics environment programme) at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skilled staff to deliver works to timeframe required resulting in more restrictive care and a poor staff and service user experience and unacceptable service user safety risks.
BAF.0029	There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users.

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: People Committee | **Date:** 07/05/2024 | **Chair:** Mark Dundon

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
Positive Alert People Performance Dashboard - Sickness	Sickness in month has reduced to 5.95%	Reducing sickness levels is a key focus for HR and clinical teams and is now at a 2-year low with the main reduction being within long-term sickness cases.	Will continue to report on sickness levels at each committee. Continue to support being Well at Work and managers with effective staff absence management	Ongoing	BAF.0013 BAF.0014
Positive Alert People Performance Dashboard - Case Work	Number of cases in employee relations has decreased. Although the time to conclude cases did increase recently	The Trust has 1 open Employee Tribunal Case which is in the later stage of an appeal. It was recognised that a lot of work has and continues to take place with managers and their H R Business Partners to reduce casework during a time of significant organisation and transformational change.	Will continue to report on casework levels at each committee. Continue to monitor case length to take action if identifying a significant trend	Ongoing	All apply
Positive Alert Inclusion and Equality Assurance Group Report	Positive progress with the alignment of the equality objectives with the Operational Plan and People Strategy.	The committee asked if the report could provide further assurance and asked that measurable changes showing progress were included.	To provide figures to show the scale of the reasonable adjustments' issues and what percentage of requests have been met.	September 2024	BAF.0020
Mandatory Training	There are 8 subjects below compliance, 6 of which have improved since the last report however, 3 subjects have slightly worsened. Immediate Life Support is now above	The committee raised a concern about the progress since the last report and that some areas appear to be stuck. It was suggested that the data is broken down by service line to indicate hot spots and that the use of E-Rostering		Ongoing	All apply

	target. A new corporate risk (5321) has been created which highlights the controls in place and the actions relating to mandatory training compliance recovery however this is pending approval at Risk Oversight Group. NHS England has created a programme to optimise, rationalise and reform statutory mandatory training with an oversight board that is empowered to make the necessary changes. This national work and changes to the policy framework is welcomed as it will enable us to reduce the amount of time spent on Mandatory Training in a way that we have been unable to achieve before.	can help plan in training time allocations. Work is underway with Estates, Clinical Quality Standards team, and Training to address issues with space availability for training. Additional laptops have been provided at Centre Court but it is acknowledged that there needs to be training areas closer to people's places of work, this is being discussed with IT regarding a digital hub and digital literacy. The committee challenged why SHSC is in tranche 2 of this rollout as there are many staff links between STH and SHSC.			
Supervision	The annual Supervision survey took place between March– April 2024, and had a total of 293 responders, around 11% of the total SHSC workforce. The survey included questions on wellbeing, PDR objectives and career development. 77% of responders reported having supervision monthly or more frequently. However, it is noted that there remains consistent feedback over the 4-year	The committee were advised that the supervision policy was recently updated and advised 1 supervision every 6 weeks as a minimum. This was set by speaking to staff about what they need and it meets the compliance standards for staff with registration requirements to meet. With Manager Self-Service, all managers will have access to the staff	Supervision will continue to be monitored via the People Performance Dashboard and recovery plan at each meeting. Sessions to be held to support ongoing supervision quality and signposting to resources to support.	July 2024	All apply

	period from a small number of staff (2-4%), that they are not receiving any supervision and do not feel able to ask for support. Managers are receiving training and support using the self-service system to record supervision and PDRs, whereby it is anticipated that supervision levels will increase.	they line manage and for which they are responsible for ensuring supervision ESR will have reporting function to show outliers. If supervision is missed it can be recorded on the system as such and the data monitored. The committee asked for attention to be paid to staff awareness of Health and Wellbeing and career opportunities, this is to be further monitored to see what can be done to support this as well as ensuring staff know about the resources that are available to promote these conversations. It was suggested that a drop in "Supervision session" takes place to encourage good practice.			

ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
People Performance Dashboard – Delays within Occupational Health affecting time to hire	The committee received the People Performance dashboard which indicated that the Occupational Health delays to recruitment have improved but are still an issue.	The committee were concerned over the delays and requested to separate the internal and external impacts on time to hire so a clear picture of the impacts within our control can be seen.	Will continue to report on OH Delays and time to hire at each committee. SHSC to continue to monitor the contract with STH and take action where service falls below expectations	Ongoing	BAF.0013
Gender Pay Gap Report	The committee received the Gender Pay Gap Report.	The committee were advised that good progress has been made in general pay and pay quartile with the upper middle pay quartile increasing by 4% in favour of women	The committee challenged the trusts which were chosen for the benchmarking and advised it would provide more assurance if benchmarking against all mental health trusts is provided.	September 2024	All apply

			The committee also asked that more narrative is provided to show what actions have taken place and the lessons learnt, as well as the strategic approach to improving the Gender pay gap position.		
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
Workforce and Recruitment Assurance Group Report	The committee received the Workforce and Recruitment Assurance Group Report	The committee asked if workforce and finance teams are triangulating the financial dependency of the Financial Plan and progress against it. It was advised that there are weekly meetings between Finance, Operational teams and Workforce which discuss workforce utilisation and bank/agency usage. Discussions have also taken place with Staff Side and in Developing as Leaders Programme.	An update report will be shared at September's committee. Finance and People to ensure consistent and joint communications to support objectives of efficient and effective workforce planning	September 2024	All apply
People Plan	The People plan with further timescale and leads was provided for information. quarterly updates will be reported to People Committee on progress	The committee asked for the People plan descriptors to reflect more closely the transformation ambitions of the organisation	To review wording and take on board comments about use of language and clarity on descriptors		

BAF Risk Description:

BAF.0013	There is a risk that the Trust does not have appropriate measures and mechanisms in place to support staff wellbeing resulting in absence continuing to rise, that gaps in health inequalities in the workforce grow and their experience at work is poor with a knock-on impact on service user/patient care.
BAF.0014	There is a risk of failure to undertake effective workforce planning (train, retain and reform) to support recruiting, attracting and retaining staff to meet current and future needs caused by the absence of a long-term workforce plan that considers training requirements, flexible working and development of new roles.
BAF.0020	There is a risk of failure to move our culture sufficiently to address any closed subcultures, behavioural issues and not reflecting and respecting diversity and inclusion, resulting in poor engagement, ineffective leadership and poor staff experience in turn impacting on quality of service user experience.

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: Finance And Performance Committee (FPC) **Date:** 11/04/2024 **Chair:** Owen McLellan

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
Financial Performance Report	The committee received month 11 Finance Performance Report however a meeting was held on 10/04/2024 to advise committee members of month 12's financial position.	The draft position for the year is being submitted as a deficit of £4.9m with a previous planned deficit for this year being £3.3m. This represents an improvement of approximately £600k. There have been improvements in the data for month 12, with a deficit of £0.3m. This is an improvement on run rate however it was anticipated that month 12 would deliver c£0.5m positive. A position for next financial year has not yet been approved by Board therefore monthly deficit targets have not yet been set. Inflation and pay impacts will be evident in month 1, worsening the position at month 12, requiring additional savings to counteract. Grip and control measures are continuing through at least Q1, with some progress being made on weekly KPIs, however, the dashboard is a work in progress. There was an end of year impairment charge of c£4m. This means we're reducing the value of some of the assets we hold in the accounts - mainly Longley centre. This is accounting only and is outside of the numbers we report into system.	Financial Performance Report will continue to report monthly to FPC.	May 2024	All apply

ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
None to report					
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
Corporate Risk Register (CRR)	The committee were advised there are 18 corporate risks and work is taking place to look to amalgamate some risks to create higher level corporate risks. Reviews to update the EPR risks is ongoing and will be completed post April Board of Directors. Risk 5051's risk score has been increased from 16 to 20 given the current position as the required CIP to support achieving the planned deficit position has not been achieved.	Committee were asked to note that the Board Assurance Framework is being reviewed to consider which risks should move over into 2024/25 and this will be discussed in Executive Management Team in April, with slide packs shared to NEDs post meeting ahead of presenting to Board of Directors in May. Work continues to review risks scoring 12 and above on directorate risk registers and a Ulysses extraction report will continue to be conducted monthly to monitor any new, high-scoring risks and to ensure discussion takes place with Executive Leads to determine if these should be considered for escalation onto the CRR.	Ongoing reporting to FPC	May 2024	All apply
Internal Audit Actions Tracking Report	The committee were advised that the confirmed compliance levels in terms of closure of internal audit actions is as follows: • First follow up rate 87% • Overall follow up rate 97% There are 2 open actions for monitoring at Finance and Performance Committee related to the Capital Internal Audit which are not yet due. The committee were alerted previously to action 4.5.4 overseen at ARC related to data security standards as 1 action was impacted by the delayed launch of EPR.	No further assurance required at this time	Ongoing reporting to FPC	May 2024	All apply
Policy Governance	The committee ratified the following policies:	An extension to review date is requested to enable the author to liaise with the Trust's	Ongoing reporting to FPC	May 2024	All apply

Group Report	• Non-NHS Income Policy FIN 001 And approved the extensions to review dates for the following: • Sustainable Procurement Policy FIN 009	Sustainability Officer, to determine whether the focus of this policy needs to change to meet current sustainability legislation/requirements and for the updated policy to be taken through the Sustainable Development Group.			
Specialised Forensic Community Services - Market Engagement Questionnaire	The committee were advised that on 26th March SYB Provider Collaborative released a Market engagement questionnaire (MEQ) for a South Yorkshire and Bassetlaw Specialist Community Forensic Service. This is the first step to the expected Commissioning and tendering process.	It is felt at this point that SHSC are well positioned to lead the service provision with currently successfully providing the only current provision in SY&B. On this basis SHSC is completing the MEQ and declaring interest in providing the service going forward. This does not commit the Trust to anything at this point and is in line with decision made by Trust Board in February. Discussions with other NHS Providers are taking place to access if the service specification can be met with the envelope provided. Response to the questionnaire is required by 26th April 2024.	None required at this time	N/A	All apply

BAF Risk Descriptor:

BAF.0021A	There is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring on-going maintenance, inadequate system monitoring, testing and maintenance, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes
BAF.0021B	There is a risk that adequate arrangements are not in place to sufficiently mitigate increased cyber security and data protection incidents. This has been compounded by low Information Governance mandatory training levels across the Trust, unawareness of Phishing attacks as well as legacy core systems that may not meet current security standards and so remain vulnerable to cyber-attack. An attack may compromise or disable key systems and prevent their operation until we either have confirmation that is safe to do so following the application of software security patches or alternatively the system in its entirety is no longer deemed fit for purpose and removed from active service.
BAF.0022	There is a risk that we fail to deliver the break-even position in the medium term caused by factors including non-delivery of the financial plans, lack of 2 – 5-year financial plans including developed CIP programmes and increased cost pressures resulting in a threat to both our financial sustainability and delivery of our statutory financial duties.
BAF.0026	There is a risk of slippage or failure in projects comprising our transformation plans caused by factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity to deliver within the timeframes agreed or lack of availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.
BAF.0027	There is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirement to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs
BAF.0030	There is a risk of failure to maintain and deliver on the SHSC Green Plan, ensure Trust resilience to climate change and provide a safe environment for staff and service users, in line with statutory duties, national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (80% reduction in emissions by 2030 respectively, and net zero

	carbon by 2040). Failure could lead to poor patient outcomes, worsening of existing health inequalities, poor service delivery, disruption to services, inefficient use of resources and energy/higher operating costs, legal and regulatory action, missed opportunities for innovation, reputational damage, reduced productivity and increased environmental impact. [Statutory duties brought in by the Health & Care Act 2022 s.68 require NHS foundation trusts to have regard to relevant guidance published by NHS England and the need to contribute towards compliance with section 1 of the Climate Change Act 2008 (UK net zero emissions target), section 5 of the Environment Act 2021 (environmental targets) and adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008]

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: Finance And Performance Committee (FPC) **Date:** 09/05/2024 **Chair:** Owen McLellan

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
Transformation Portfolio Report - Electronic Patient Record Programme (EPR)	The committee discussed the Electronic Patient Record Programme, noting that the project is reporting an overall red rating which is forecast to improve to amber in May. PE confirmed that £1.4m revenue has been assumed in the EPR plan in terms of profit and loss. PE explained that there were additional costs in revenue as part of delivery and then there were additional costs due to licensing of Rio which were built into revenue costs.	Following challenge at Board of Directors, the EPR Programme Team will ensure that a quantitive Risk Assessment process is followed which will use data to determine the impact of the risk on timescales and costs, therefore there may be variability potential regarding the figures. This will be trialled for inclusion in the portfolio risk strategy. PE explained there is potential for further delays and cost creep as this is a complex program, however, assured the committee that there is a mindset to challenge to stay within budget.	EPR updates will continue to be reported to FPC on a bi-monthly basis	July 2024	BAF.0021a BAF.0021b BAF.0022 BAF.0026
2024/25 Finance Plan – Value Improvement Programme	The committee received the 2024/25 Finance Plan which included Savings phasing and I&E phrasings within the appendices.	Saving plans are in place and have identified £4.8m out of £7.3m as progressing well, therefore there is confident in the current position. It was noted that there is there is confidence amongst the Executive Management Team (EMT). The Non-Executive Directors (NED) noted that assurance will be received from seeing delivery in the P&L and the weekly measures	The committee requested for P&L Phasing and a Q1 & Q4 bridge to be included in the report to Board of Directors.	May 2024	BAF.0021a BAF.0021b BAF.0022 BAF.0026
Finance report – Month 1	The committee received a verbal update on the Month 1 position.	The Committee were assured that the month 1 position was on plan.	The figures will be identified in the forecast and the calculations will be shared with each ward area so they are kept informed.	June 2024	BAF.0021a BAF.0021b BAF.0022 BAF.0026

			The P&L will be sent to committee members by email, when it is available.		
IPQR	The committee received the IPQR and were advised that the report is being revised with a plan being brought to June's FPC meeting.	It was noted that there had been a cross committee referral from QAC to FPC to note that Neil Robertson and Salli Midgley were working with Phillip Easthope on the IPQR development and how it would report to each committee.	The IPQR plan will be presented to committee in June and iterative improvements will be made along the way.	June 2024	All apply
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
Digital Assurance Group (DAG) AAA	Digital Staff Survey was conducted, which had a high engagement rate but advised that morale within the team is low. A workshop took place with all members of staff in the IT department to look at what needs to improve to make things better and a poll is taking place to monitor the feedback from the workshop. The DAG terms of reference are being reviewed and proposed improvements include: • A separate Information Governance & Cyber group where the Caldicott Guardian and Senior Information Risk Owner have more visibility as accountable roles. • The DAG agenda should be explicitly linked to the Digital Strategy. • DAG members agreed that the group should be able to make decisions in some areas e.g. for projects and for approval of policies before they are sent onward to the Policy Governance Group.	The committee were concerned about the morale within the team and it was advised that Maria Jessop is working with IMST to look at the responses and next steps to improve morale. It was also noted that the Organisational Development Report which is received at People Committee monitors topic such as morale. This is also monitored through the EPQR meetings and a template is to be completed to provide assurance on actions taken around staff survey results. Committee were advised that some of the issues affecting morale are within the remit of the team to improve, such as improving the physical location with noticeboards and re-organising furniture to ensure there are relax and breakout spaces available. It was noted that the group will still meet the governance of Policy Governance Group and that there will continue to be a ratification process in place, separate to what is actioned within DAG.	The group's Terms of Reference are going to be reviewed at the group in May with a revised version being presented to FPC in June.	June 2024	BAF.0021a BAF.0021b
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
There are no matters to assure to Board of Directors					

BAF Risk Descriptor:

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