Board of Directors - Public

SUMMARY REPORT	Meeting Date:	24 July 2024
	Agenda Item:	08

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 May 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 June and July 2024

People Committee:
AAA report from July 2024

Finance and Performance Committee:
AAA reports from June and July 2024

Mental Health Legislation Committee:
AAA report from June 2024

Audit and Risk Committee:
AAA report from June and July 2024

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:	12/06/2024	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	**Waiting lists** continue to be exceptionally high for ADHD and Gender services. System-level solutions are being sought. **Access to crisis services** remains challenging. (12 hour breaches in A&E; repurposing of HBPoS; very high demand for Hospital Liaison team). Some of April's data was an improvement but this is still at a level that impacts on patient experience and there were increased pressures in May, which will be reflected in next month's IPQR. There has been a **rise in falls** in older adults. **Safer staffing**: Endcliffe and Dovedale 2 continue to see high levels of patients that require enhanced observations or engagement due to acuity and individual patient needs, which is causing increased fill rate and working above the Clinical Establishment Review.		The recovery plans for these two service lines are due at QAC next month. Focus will be on patient experience. Actions to address this at local and system level continue. It was noted that at Birch the Safety Huddles were not being actioned as regularly as required and now this has been addressed. The next Safer Staffing review will be conducted in June 2024. Changes to the wards through the improved estates programme are planned for the next two months.	July 2024	**All BAF Risks**

IPQR Positive Alerts	There has been a reduction in the wait times for accessing the Autism service. Significant reduction in waiting times for the Community Mental Health Services due to service transformation Data for older adult services is now appearing in the IPQR from Rio.		n/a	July 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**
Right Care, Right Person police procedure	Committee received an update on the implementation of the new police procedure.	There is regular engagement with the police and increasing response to feedback. No serious incidents have occurred since the new policy began.	Going forward updates will come through the learning lessons reporting via the CQ&S Tier II group.	n/a	**All BAF Risks**
Relationship with the new provider of the Alcohol and Drug Misuse Service	Committee received an update on the relationship with the new provider of Drug and Alcohol/Addiction services	Initial meetings with Humankind have taken place to discuss the route for working together going forward, primarily focusing on the Dual Diagnosis Pathway.	The joint approach to care requires strengthening due to a need to provide good quality care for service users with comorbid substance misuse.	n/a	**All BAF Risks**
Sexual Safety Workplan: 6 Monthly Update	Committee received an update on this area of focus. There is now better reporting from the wards and systems are in place to ensure the safe management of incidents.	Dashboards within the service are now live and the next step is to meet with sexual safety leads for narrative around incidents. The wards now have cultural advocacy workers and an expert by experience involved in all aspects of the workplan. Wider work with communities is in place linking with our Engagement Team to enable an intersectional approach to understanding sexual safety and its effect on vulnerable groups.	There is a need to establish greater consistency of sexual safety workplans across the wards. Future reports to reference this.	September 2024	**BAF.0029 BAF.0024**
Clinical Quality and Safety Group	Committee received the AAA report from this Tier 2 group, who monitor clinical quality and safety.	The AAA report gives assurance that this group is tracking key elements in its brief.	Request for more evaluative judgements about information reviewed by the group, so that	September 2024	**All BAF Risks**

			QAC can take assurance from this eg the reports on the progress, updates and concerns from Woodland View, Maple 2 and Dovedale 2		
Health and Safety Annual Report and Q4 Update	The committee received the H&S annual report prior to the Board of Directors.	QAC approved the report for onward reporting to the Board.	Recommendations made about the summary on the front of the report and the need to highlight key successes this year but also the key concerns that are outstanding.	September 2024	**All BAF Risks**
Acute Inpatient Services - new model of care	Committee received a verbal update on current thinking about development of a new clinical model for our acute inpatient services	The key aims are around embedding national guidance and developing a coherent evidence-based clinical model aligning with other transformational work. There is a need for a stepped approach in order to engage staff and have a single clear narrative showing the framework is clinically led, operationally underpinned and data driven. Work with nursing staff is ongoing to embed the Royal College of Psychiatry Standards. A revision of the out of area reduction work is underway with the Directorate Leadership Team working on an acute and community forum supporting integrated work along pathways. Quality Improvement work is ongoing across all wards incorporating the culture of care standards and Safe to Share work.	The committee acknowledge the ambition of the framework in ensuring a stepped approach is taken as changes take place. This will be monitored through the committee.	October 2024	**All BAF Risks**
Corporate Risk Register	The committee received the updated Corporate Risk Register with 4 risks highlighted relating to the committee.	The committee discussed the de-escalation of the detailed risks and asked for further consideration of the	n/a	July 2024	**All BAF Risks**

		one on waiting lists.			
Policy Governance Group Report	The committee received the monthly report from PGG.	The committee ratified the decisions made by the Policy Governance group on the four policies presented.	n/a	July 2024	**All BAF Risks**
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
Independent Thematic Review	The committee received the action plan.	The tracking, monitoring and governance going forward is through the investigation panel with all actions noted on Ulysses and then monitored through the Clinical Quality & Safety Group (CQ&S).	The committee requested the Independent Thematic review tracking to be highlighted within the CQ&S report going forward	N/A	**BAF.0024**
Patient Safety Report (Learning Lessons including FTSU Update)	Committee received the latest report on Patient Safety.	There is continued engagement in a range of learning across the Trust regarding patient safety incidents. Committee were assured by the work being done to use the new PSIRF and implement change.	The Patient Safety Incident Response Framework (PSIRF) is addressing the thematic review of self-harm as one of the five priorities for this period. An update on this was requested for the next report to Committee.	September 2024	**All BAF Risks**
Complaints Report	Committee heard how procedures have been improved with introduction of a new complaints checklist. Focus this year has been on the quality of complaint responses and on internal Quality Assurance processes.	Committee were assured that we are meeting our statutory duties and noted that the response performance within the agreed timelines has improved since 2022/2023, showing a sustained improvement from the Trust following previous difficulties. Committee noted that the new focus is on improving accessibility and inclusivity of our complaints process, which is in line with our overall strategic aims.		June 2025	**All BAF Risks**
Internal Audits Action Tracking Report	The last remaining action for Infection Prevention and Control has been completed and closed.	There are no actions remaining on the report. Committee were assured that we are managing our action tracking process well.	The clinical record keeping audit came through following paper circulation and will come back to the committee in July.	July 2024	**All BAF Risks**
Safeguarding Assurance Annual Report	Committee received the annual safeguarding report.	Committee were assured that all statutory and legal duties have been met. All actions relating to making safeguarding personal linked to the	The insufficiency of processes in place for pregnant women admitted to inpatient services within the Trust is a focus for the	January 2025	**All BAF Risks**

		toolkit have been completed with training in place and ongoing audits. Full compliance is achieved on level 1 and 2 Safeguarding Adults and Children and PREVENT Training. A recovery plan is in place for level 3 Safeguarding Children training.	current year. The overrepresentation of ethnically diverse service users for safeguarding referrals remains an area of focus. Reporting on these two issues will be done in the next 6 monthly report to Committee.		

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:	10/07/2024	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
IPQR	**Waiting lists –** there is evidence of continued high demand and long waiting lists for Gender Identity and the ADHD part of the SAANS service line.		The recovery plans for the waiting lists to continue to be monitored through the committee (see later).	September 2024
	There is a sharp rise in detained patients AWOL (absent without leave)	This is to be reviewed and discussed in the Mental Health Legislation Operational Group (MHLOG)	A cross committee referral has been made to the Mental Health Legislation Committee (MHLC)	
	There are **high levels of acuity** on our wards, requiring 1:1 observations and leading to significant increases to the agreed establishment.		A new approach being piloted to give autonomy to nurses with the ability to reduce observations whilst considering human rights issues on service users.	
	[To note: this month, information about OOA, HBPoS and breaches in A&E went to Finance and Performance Committee, but next month this will be included in both reports with a focus on user experience			

Medicines Safety Report	There are concerns regarding the persistent issues with **medication management,** that require a leadership approach to address and understand. Centralised Fridge monitoring remains an issue with cost implications with a previous pilot displaying positive benefits on the wards.		The committee have requested the report to come back on a quarterly basis in view of the lack of traction with improvement measures.	October 2024
IPQR Positive Alerts	There has been an increase in the reporting of sexual safety incidents, which the committee took as evidence of a positive impact from the raised profile of this area of work. There are significant reductions in the waiting times for Long Term Neurological Conditions (LTNC). Also, Autism. Improvements in the data quality in respect to older adults is being reported through the IPQR monthly. There has been success in the safety huddles at Birch leading to a reduction in falls. Service users report positive feedback relating to the 111 service with planned further work in place for a formal collection of data.		n/a	September 2024

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**
Board Assurance Framework discussed	The committee received the updated Board Assurance Framework for	The committee discussed the revised BAF risks requested further	Feedback to be actioned within the framework offline prior to	September 2024

	24/25	clarification and revision on areas identified.	receipt at Board, including a request to review the reduction of risk score for risk 0025, which was not agreed by the committee and Risk 0029 which requires some review and rewording. Director Of Nursing, Quality and Professions and the Director of Strategy to discuss and to revise the risk for resolution prior to submission to the Board.	
Corporate Risk Register discussed	The committee received the updated Corporate Risk Register for 24/25	The committee discussed the revised corporate risks and requested further clarification and revision on areas identified within each risk on the wording and risk descriptions.	Feedback to be actioned within the framework offline prior to receipt at Board.	September 2024
Policy Governance Group Report	The committee received the monthly report from PGG.	The committee ratified the decisions made by the Policy Governance group on the one policy and one extension presented.	n/a	September 2024
Internal Audits Action Tracking Report	The committee received the updated report.	The IPC remaining open action dated May is now closed. Limited assurance was received on the Internal Audit on Clinical Record keeping, leading to 6 open actions relating to Care Planning and DRAM with work underway.	n/a	September 2024
Quality Assurance 6 monthly Report	There is evidence of assurance activity taking place. EPR delays continue to have an impact on the development of a QMS.	There have been a good number of Board visits, with completion of the form and feedback to teams taking place. Key themes were extracted to inform this report. Fundamental standard visits have	More work is required to develop the report, to give an overview of Quality. Discussions to take place among the NEDs relating to a potential review of Board visits and how to make best use of them.	January 2025

		been followed up when issues were raised. Culture and Quality visits have not all been carried out due to staffing issues and actions not always re-visited. The 2024 milestones for Patient Safety Incident Reporting Framework (PSIRF) and PSIRP plan is in place with positive compliance levels on training. Work on the identified quality hotspots has been overseen by this group and improvement plans monitored.	More rigorous follow-up of issues raised through the Culture and Quality visits needs to be implemented.	
Research innovation Effectiveness and Improvement Group Annual Report (RIEIG)	The committee received the report as a summary of activity from the Research, Innovation, Effectiveness, and Improvement Group in the period January 2024 – June 2024.	The report outlined a wide range of research and QI activities taking place. There was evidence that the group is monitoring against agreed objectives, although an increased focus on impact was requested as part of the report. .	The committee suggested that, whilst the group is working through objectives, there is also a need to provide assurance for evidence-led practice. It was acknowledged that the number if staff working in the area is small but systems and processes could be led by this group to ensure that eg new Nice guidelines or other best practice ideas are being communicated and implemented. Medical Director to consider this with the group.	January 2025
Quality Assurance Committee Related Key Performance Indicators: Update for 2024/25	The committee received the updated KPIs for 2024/2025	The committee approved the updated key performance indicators for forward reporting through the committee.		June 2025
Gender Services recovery plan	The Committee received a strategic overview of the recovery plan. The national picture is also very challenging.	Work is underway with NHS England to work on a national strategy with a focus on the waiting well initiative incorporating lived experience members.	An update on the outcome of the national team's visit was requested, when available	
ADHD recovery plan	The Committee received a strategic overview of the recovery plan. The	In respect of ADHD service, the medication titration list has been	An update on discussions with the ICB and PLACE about	

	national picture is also very challenging.	worked through with everyone who had been assessed now able to access the required medication. As this backlog is now up to date the ADHD specialist team can begin first assessments in a timely manner.	commissioning and immediate support was requested, once concluded.	
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Quality and Equality Impact Assessments	The committee received the monthly report.	The committee are assured about the robustness of process in place on the QEIA panel and the subsequent decisions.	n/a	September 2024
Infection Prevention and Control Annual Report	The committee received the annual report from the IPC	There has been successful resolution and control of the numerous outbreaks on the wards. Actions from the internal audit have been successfully implemented. There was a good level of assurance in the report.		March 2024
Lived Experience Report	The Committee received the report from the Lived Experience group about their monitoring of the Engagement and Experience strategies.	There is effective codesign and coproduction practices in place with coproduced practices being facilitating with Lived Experience Individuals. The milestones on the Carers strategy are on track with the risks mitigated. Engagement with communities and organisations was commended with acknowledged support on service users placed outside of the city. The committee are assured with the continued evidence of the robust implementation of the strategy.	Further work on recruitment of volunteers and the use of the Friends and Family test are ongoing.	January 2024

BAF Risk Description 2024- 25 BAF pending approval at the July 2024 Board	
Risks monitored at QAC	
BAF risk 0024 (QAC)	**New wording** - Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience, staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action.
BAF risk 0025a (QAC)	Note this risk from the 2023/24 BAF has been closed with refinement to risk 24 and 25B .
BAF risk 0025b (QAC)	There is a risk of failure to deliver 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 skills staff to deliver works to timeframe required resulting in unacceptable service user safety, more restrictive care and a poor staff and service user experience
BAF risk 0029 (QAC)	**New wording** - There is a risk of a delay in people accessing core mental health services through the requirements of 'The Right Care Right Place' caused by issues with models of care, access to beds, flow, crisis care management and contractual issues resulting in poor experience of care and potential harm to service users.

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	People Committee	Date:	09/07/2024	Chair:	Heather Smith (Delegate)

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
People Performance Dashboard - Supervision and Mandatory Training	The committee received the People Performance Dashboard which included data on **Trust wide Supervision and Mandatory Training levels, which remain an issue despite three years of action planning and attention.**	The data for compliance with Supervision targets is not yet at a satisfactory level for all areas. This is a concern given the importance of this activity and the need for it to be 'normalised' as part of effective line management. Mandatory Training figures are above the 80% target for the Trust overall but there are some subjects that have stubbornly remained below this target and some areas where the 80% has not been met.	The committee asked for fresh thinking about how to address this matter as progress has been limited. Neil Robertson to address the issue raised about the reporting and recording system we have in place and the criticism made of this. The committee requested that in future the People Dashboard the report highlights the teams which are not meeting their Mandatory Training targets so committee can be aware of hot spots.	Ongoing

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports and Action Plans	Despite a net increase in ethnically diverse staff in senior roles since 2021 the **clinical disparity ratio remains high**. It was noted that looking at the benchmarking, we are below the median (although on a national level the target of 1.25 is challenging) There has been a **significant rise in the relative likelihood of ethnically diverse staff entering the formal disciplinary process** – benchmarking data suggests we are likely to move from a reasonable position in 2023 to the worst quartile. There are **still issues around disabled staff being able to access reasonable adjustments.**	The committee noted there is a lot of learning that can be extracted from casework, looking at trends and themes of disciplinaries that shouldn't have progressed or there was no case to answer. The committee were advised that the EDI team is focused on the reasonable adjustments and that potential additional funding sources are to be considered to help with workload.	Committee asked for a more dynamic approach to issues of equality. This will continue to report to People Committee through the Inclusion and Equality Assurance Group Reports.	September 2024
POSITIVE ALERT People Performance Dashboard - Bank and Agency usage	There has been a reduction in Agency across all areas over the last 12-18 months. NHS England set a target of zero for off-framework agency usage with a deadline of July 2024.	The reduction is a result of a collaborative approach to review all bank and agency usage and weekly meetings are taking place to look at increasing bank usage to reduce agency requirements as well as how the Trust is utilising its workforce above funded establishment. SHSC achieved the target of zero in December 2023 and this figure has been maintained.	This will continue to be monitored at each People Committee.	Ongoing
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**
People Performance Dashboard - Sickness	Sickness absence has remained high at 6.93% however this is consistent in comparison to this time last year.	The committee were still concerned that 42% of sickness reasons are related to stress, anxiety, and depression. It was confirmed that a deep dive was conducted and a range of improvements are being assessed.	It was requested that narrative on the specific improvements being made to address this sickness category is highlighted in future Wellbeing and Organisational Development	September 2024

			Assurance Group Reports	
People Performance Dashboard – Vacancy rates	There has been an increase in the Vacancy rate which is believed to be due to the remodelling in Learning Disability Teams as posts have been introduced but not filled, therefore it is showing as an approx. 3% increase	The committee challenged if financial rigour is negatively impacting staffing, which it was confirmed that patient and clinical safety is not being compromised, safety first is a priority. All vacancies are being assessed through the Vacancy Control Panel to ensure they have robust rationale and to ensure there are no negative impacts to clinical safety. Any changes to establishments are also reviewed via Quality and Equality Impact Assessments.	It was requested to ensure narrative is included in future reports to indicate that financial rigour is in place but it is not at the detriment to patient and clinical safety.	September 2024
People Performance Dashboard - Turnover	The committee noted that staff turnover is below 12% but in the IPQR that figure is showing as 20% which is due to the TUPE'd staff still showing in the IPQR data.	No further assurance required at this time.	It was requested that the turnover figures are reviewed on the IPQR so accurate figures can be reported.	September 2024
People Plan Q1 Update Report including: • Update on the Nursing Plan 2023/26 • Peer Support Worker Plan • Professional Plan – Allied Health Professionals	The plan is on track and some areas which are part of the People Plan such as wellbeing need to be made into a coherent offer and communicated to staff. It was confirmed that there is also a Doctor Profession Plan which has been to committee previously and Psychological Services Plan which will be finalised by the end of the month.	The committee were advised that there is a plan to assess impact measures at the end of Q2 and revise actions if required, however the plan is on track presently. There are no other profession plans in progress but committee agreed it would be beneficial to have plans in place for areas such as admin and Estates.	This will continue to report to People Committee and will return in November 2024.	November 2024
Wellbeing and Organisational development group report	Committee received the latest update from the newly merged Wellbeing and Organisational Development report.	The Committee were impressed with the range of initiatives being undertaken and the progress being made with the 'We said, we did' messaging. The committee were advised that 41 health and wellbeing champions are in place and the Sexual Safety Charter is now in operation. These will help		

		create an environment to support staff and reduce absence		
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Trainee Doctor Plan and Working lives of Doctors in Training	Trainee-specific (TS) People Strategy and the Trainee Doctor Plan and Working lives of Doctors in Training has been produced between Aug 2023 and Feb 2024 to address the morale, well-being, training quality, workforce development and recruitment and retention issues identified in the GMC National Training Survey 2023 and NHS Staff Survey 2022. The TS People Strategy has been co-produced with trainees and with the support from Medical Workforce Planning Group, Medical Engagement and Recruitment Steering Group and Organisational Development Assurance Group. It overlaps in parts with the Trust's People Strategy and Action Plan and takes into the account the specific issues that medical trainees (junior doctors) face.	On the 25 Apr 2023, NHS Chief Executive wrote to CEOs of all NHS Trusts and ICBs, seeking assurance on improving the working lives of doctors in training. SHSC's Strategy outlines 44 pledges and associated actions to improve the working lives of doctors in training. It goes further than was asked by the NHS CEO, and SHSC was able to reply that the work has already started and to give strong assurance that the Trust will comply with all requests.	The plan is on track and will report back to People Committee alongside the other Professional Plans.	Ongoing
Internal Audit Action Tracking was reviewed	There is 1 open action related to the Equality and Diversity audit monitored at People Committee – evidence has been requested as this has moved past its due date of the 30 June.	The outcome from Data Quality: Workforce Data internal audit is significant assurance with 6 actions, the first of which being due end of July.	The actions will be monitored and updates will be provided at each People Committee	September 2024
Board Assurance Framework (BAF) 2024/25 was reviewed	The BAF register for 2024/25 has been reviewed by BoD and EMT and there were 3 risks presented for comment at People Committee.	The 3 risks were approved by committee with no changes	The BAF will be presented to Audit and Risk Committee in July ahead of Board of Directors for final sign off.	Ongoing
Corporate Risk Register (CRR) was reviewed	There are a total of 14 risks on the corporate risk register one of which is a new risk about mandatory training, to be monitored by People Committee.	New Risk 5321 approved for inclusion in the CRR.	No actions required at this time	Ongoing
Modern Slavery and Human Trafficking statement	The Trust's annual statement was reviewed and agreed.			

BAF Risk Description 2024- 25 BAF pending approval at the July 2024 Board	
Risks monitored at People Committee	
BAF.0013 (PC)	**New wording** – There is a risk that our staff do not feel well supported, caused by a lack of appropriate measures and mechanisms in place to support staff wellbeing resulting in a poor experience for staff, failure to provide a positive working environment and potential for increase in absence and gaps in health inequalities which in turn impacts negatively on service user/patient care.
BAF.0014 (PC)	**New wording** – 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 resulting in failure to deliver a modern fit for purpose workforce.
BAF.0020 (PC)	**New wording** – Risk of failure as an organisation to live by our values caused by not addressing closed cultures poor behaviour issues and lack of respect for equality diversity and inclusion, resulting in poor engagement and communication, ineffective leadership and poor staff experience, in turn impacting on our staff survey results, quality of service user experience and attracting and retaining high quality staff.
BAF 0031 NEW	There is a risk we fail to deliver on national inequalities priorities and our clinical and social care strategy which aims to deliver personalised and trauma informed care, caused by failure to adopt an inequalities based approach to care resulting in poorer access, later presentations and risk of poorer outcomes .
BAF 0032 NEW	There is a risk that our estate does not enable the delivery of our strategic priorities and meet the quality and safety needs of our service users and appropriate working environments for our staff resulting in sub optimal effectiveness, efficiency, experience and quality of care

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Finance And Performance Committee (FPC)	Date:	13/06/2024	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 (M1)	The committee were advised there is £3.363m worth of unpaid receivable invoices with £1.307m of this figure being 91 days + overdue.	The committee were concerned over the bad debts that have been accrued at Sheffield Teaching Hospital and Guiness Partnership and queried if the invoices could be split to help recoup the debt or if there are lessons learnt that can be put into practice. The focus has been on Guiness Partnership and South Yorkshire Housing as their outstanding balance is between £500-600k which they have submitted a dispute which is only £63k in difference. It was advised discussions are taking place with the deputies at the other organisations and they need to agree the principles on recharging inflation. PE explained that there are some challenges with recouping the debt, however assured the committee that they are confident with the invoice process and agreed that escalating issues sooner would help to reduce this volume of debt. PE confirmed that for salary overpayments, there are long term repayment plans in place and if the debt is not repaid it will be administered through a collection agency.	The monthly escalation processes for unpaid invoices at SHSC are also being reviewed and will also be evaluated to ensure there are no unknown risks which need to be escalated. Discussions are taking place with Guiness Partnership and South Yorkshire Housing to request that they pay the outstanding amount of £500-600k and manage the £63k dispute separately	Ongoing	BAF.0022

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**
Submitting Financial Plan to NHS England	NHS England requested all systems to re-submit their Financial Plans, which took place and NHS England have agreed the South Yorkshire system plan of £49m deficit. As a result, there is a £6k change to our deficit.	The committee challenged if the bad debt outlined in the Financial Update can be accrued, the interest income could offset this increase in deficit. The detailed capital plan has been updated and the total figure remains the same, however a few schemes have been pushed back in 2025/26, which has been indicated in the Operational Plan.	No further action required	N/A	BAF.0022
Corporate Risk Register (CRR)	The committee were advised that risk 5051's (*There is a risk of failure to deliver the required level of savings for 2024/25. This includes reducing overspending areas through recovery plans*) risk score has been reduced from 16 to 12 given progress made with development of the Value Improvement plans. This has been agreed by the Executive lead.	There was a challenge regarding reducing the score of risk 5051 however it was agreed that for the risk to remain at 16, there would need to be a likelihood that the target will not be delivered. It was expressed that there are plans embedded in budgets which are delivering to target. The CRR which is received each month is a live document which is reviewed at Risk Oversight Group and Executive Management Group and risk scores may increase and decrease throughout a risk's lifetime.	The committee approved the reduction of the risk score and it will continue to be monitored in the CRR.	Ongoing	All apply
Financial Performance Report (M1)	As part of the Financial Performance Report, the committee noted there are some very large overspends as a percentage of budget.	It was confirmed that these are being tackled in the Value Improvement Programme (VIP) and that these areas were overspend last year so it is anticipated they could overspend this year unless measures and targets are put in place through VIP. PE expressed that a culture of Financial Management is being encouraged across the Trust and that the trajectories against submitted plans are being monitored. NR explained that the overspends also includes staffing over clinical establishment and some over established posts, however there is a plan to reduce the staffing (mainly in Nursing and Healthcare) by 60% and through VIP, looking to	Future reports will contain information against the overspend KPI which outlines each area of overspend and their progress against the target of 60% reduction versus the previous financial year.	July 2024	BAF.0022

		resolve the over establishment of some roles. It was also advised that in the central budgets there is a net line of £700k which offsets the net overspend that is being expected in those areas of overspend. PE advised committee that further consideration on the reporting and narrative is to be considered and will be reflected in future reports.			
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
Finance and Performance Committee Related Key Performance Indicators	The KPIs for FPC were due to be presented at June's committee however were deferred.	This item will be presented alongside the IPQR development plan in July's committee. The work programme has been updated accordingly.	No further action required	July 2024	All apply
Digital Assurance Group Terms of Reference	The proposed terms of reference for Digital Assurance Group were presented which outlined the following: • It is proposed that the group no longer report to Audit & Risk Committee and instead report only to FPC. This is in line with removal of Information Governance and Cyber Security matters from the group's remit. • The group's name is proposed to change to Digital Assurance and Approval Group – with the acronym DAAG. • Raihan Talukdar is to remain chair, with a deputy chair of Simon Barnitt and the group will continue to meet monthly.	The committee were advised that Information Governance and Cyber Security are going to sit within their own group and report directly into Audit and Risk Committee. ARC have been made aware of this and the ToR are due to be presented there. The committee requested that the minutes are captured in the same way as tier 1 groups and that video recordings and transcripts are supplementary. The ToR also needs to state that alert, advise, assure (AAA) reports are going to be provided to FPC and it also needs to indicate that an annual report will be provided to FPC as part of the yearly meeting effectiveness. The committee noted that DAAG would not be approving policies but that policies would go to the group for consultation in line with the SFIs ahead of presenting at Policy Governance Group. The committee also were advised that any decision making that had a financial implication would be done so in accordance with the SFIs or escalated to EMT and Board.	The following amendments are to be made to the terms of reference: • To indicate that written minutes will be done for each meeting alongside the video recording and transcript • To state that AAA reports will be shared to FPC • To state that an annual report will be presented to FPC alongside the yearly meeting effectiveness • To check that the reference to "in accordance with the SFIs" is noted in the section on Capital Approval. The committee asked that the ToR is taken to ARC to ensure they also approve the proposed changes.	July 2024	BAF.0021A BAF.0021B

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 (NEW)	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:	11/07/2024	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
Transformation Portfolio Report	The Learning Disabilities model has been agreed and consultation on the roles is due to commence, with support from Communications team to promote the positions. The necessary Project Management support is in place to ensure implementation.	The committee challenged the potential underspend within the Learning Disability Programme and that as much as this would be beneficial to the Financial Plan, it could put the programme off plan. The committee asked for more assurance on the portfolio items which are running over such as Learning Disabilities (LD) and aspects of the Electronic Patient Record Programme and requested that updated timeframes and narrative on mitigations within these programmes are included in the report. The committee was assured that recruitment within LD is being reviewed in September with posts aiming to be filled by January 2025 It was agreed there were some initial problems with Vacancy Control Panel creating delays to recruitment but a revised process has been launched to ensure it is more responsive and any delays are being escalated to Executives and Directors, with feedback being taken from managers concerning any problems that they experience. The committee noted consultation is taking place within the programmes and that staff feedback is being acted upon, even if it is having a slight impact on the timescale for delivery.	The Transformation Portfolio Report will continue to present at FPC on a bi-monthly basis.	September 2024

Financial Performance Report (M2)	Out of area activity increased significantly in May compared to the levels seen in March and April. YTD cost is on plan but the forecast is £1.419m overspent as the savings from the reduction in the number of spot bed purchases is not expected to happen as quickly as initially planned. The committee were advised that ongoing discussions with Guiness Partnerships are taking place to repay invoices of c.£600k. Sheffield City Council have a debt of c.£450k which is being escalated up to Executive level. Sheffield Teaching Hospital have a long-standing debt of c£300k which is mainly due to building usage therefore is being reviewed with Estates and planned to escalate to Executives.	It was clarified that the month 3 position for out of area bed usage has increased from 9 to 18 as of the end of June 2024. The committee were assured that there will be an immediate short-term plan focused on recovery and a medium-term plan from September 2024 to focus on prevention of out of area usage. Various controls and expectations are in place to support the plan for reduction and a cultural piece of work is taking place to ensure that staff understand that reducing out of area is not a cost saving measure but to ensure that patients get the right care as close to their homes as possible. The committee were assured that weekly meetings are in place to ensure correct escalation processes are in place. It was confirmed that the amount of potential dispute from Guiness Partnership and Sheffield Teaching Hospital is minor therefore doesn't pose a risk. But Sheffield City Council debt is a risk and so has been escalated to Executives and only small amount invoices are being raised to the Council presently. The committee requested that a review of processes is conducted to ensure they are robust which it was confirmed this is being actively challenged in the team and there is a plan for 2024/25 to ensure detailed communications are made to debtors.	It was requested that additional reassurance is included in future papers regarding controls which are in place for debtors.	Ongoing
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Costing Update and National	The 2023/24 National Cost Collection (NCC) is due for submission to NHS England by 2nd August at the latest, therefore the committee	The committee advised they are disappointed by the compliance issues including Older Adult data. The service has been working on the data but there is not	A report is to go back to Executive Management Team which will advise that the	August 2024

Cost Collection (NCC) 2023/24 submission report	was asked to approve delegated sign off to Phillip Easthope so the submission deadline can be met and an update report will be brought to committee in August. For the 2024 National Cost Collection it was the intention of the Costing team to produce a fully compliant submission at patient level detail. However, three issues have arisen that prevents this from happening: • Patient level activity data cannot be accessed from SystemOne for community services costs circa £3m, this is a known issue that has been reported to NHSE as an exception to compliance for numerous years. • Older adult services data cannot be accessed since the move to RIO Electronic Patient Record (EPR) system. Cost associated with these services is circa £10m. • Talking Therapies data is not available in the format required for the NCC from September 2023. A solution has been found so is not expected to be an issue for the submission.	enough confidence that can be externally reported on. In terms of the national returns, we are currently not reporting that on adult older adults due to data quality validation. A discussion took place with NHS England regarding reporting through the implementation of Rio and it was agreed that the primary data set that we report through would be Insight.	National Data Team only accept one data set and the feasibility of manually combining datasets monthly. Presently, reporting is in line with NHS England expectations.	
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Review of Performance Framework including approach to IPQR and Plan	Older Adults moved onto Rio Electronic Patient Record last year and there are still some challenges around being able to report on the data. Work has taken place with the team to understand the specific metrics which can be reported. Development plan has been drafted through engagement sessions with Non-Executive Directors as well as reviewing performance reports from other Trusts and feedback from the Chief Executive. Several milestones and deliverables along with timescales have been included.	The committee challenged that the proposed development plan is still difficult to read and doesn't provide a clear summary therefore further work needs to be done to ensure it is easier to digest and understand. The committee expressed that a review of the KPIs is encouraged to look at what is no longer appropriate and to be considered for removal. It was requested to push the timeframe back for the future development of the IPQR and to include the following in the KPIs: • Out of area	The committee ratified the FPC related KPIs on the understanding that the additional areas are considered and a report on all committee KPIs will present at FPC October 2024.	October 2024

	FPC KPIs have been included and proposed the following key changes:
	• Operational KPIs remain largely the same, pending further updates once the Mental Health Investment Standard is agreed with any associated target changes.
	• Recommendation to add two additional metrics (both national standards):
	  ○ Emergency Department referrals seen within 1 hour by Liaison Psychiatry
	  ○ Eating Disorders: Children and Young People Access & Waiting Time Standard
	• Recommendation to extend data quality maturity index to Community Services Data Set and IAPT Data Set (the other two main dataset returns that relate to the services we provide).
		• Mandated 4 week waits in core community services
		• Same day crisis response.		

Board Assurance Framework (BAF)	There were six FPC related Board Assurance Framework risks to be ratified by committee for 2024/2025 ahead of presenting to Board of Directors.	Each risk was discussed and ratified but it was requested that BAF.0030's risk score is reviewed with the risk leads.	The report will be presented to Board of Directors in July 2024.	July 2024
Corporate Risk Register (CRR)	There are currently 14 risks on the corporate risk register with 4 risks assigned for oversight to Finance and Performance Committee. One new risk has been escalated and it is proposed that a further 5 risks, relating to Electronic Patient Record (EPR), are escalated to the CRR.	An update of the EPR risks was presented to the Risk Oversight Group for discussion at the meeting on 1July, by the EPR team. Following discussion at Risk Oversight Group it was agreed that 5 of the highest scoring risks on the EPR register should be escalated to the Corporate Risk register.	The committee approved the current risk scores, descriptors and ratings and approved the escalation of 5 EPR related risks.	Ongoing

BAF Risk Description 2024- 25 BAF pending approval at the July 2024 Board	
Risks monitored at FPC	
BAF.0021A (FPC)	**New wording** - There is a risk of failure to ensure digital systems are in place to meet current and future business needs, caused by failure to develop and deliver up-to-date modern digital strategy and systems and processes to support its delivery, resulting in poorer clinical safety, quality, efficiency and effectiveness.
BAF.0021B (FPC)	**New wording** – There is a risk of cyber security breach caused by inadequate arrangements for mitigating increasingly sophisticated cyber security threat and attacks and increased data protection incidents resulting in loss of access to business critical systems and potential clinical risk.
BAF.0022 (FPC)	**New wording** - There is a risk we fail to deliver the break-even position in the medium term caused by factors including failure to develop and deliver robust financial plans based on delivery of operational, transformation and efficiency plans resulting in a reduction in our financial sustainability and delivery of our statutory duties.
BAF.0026 (FPC)	**New wording** – There is a risk that we fail to take an evidence led approach to change and improvement caused by a failure to implement our integrated change framework effectively resulting in failure to deliver our strategy, improve outcomes, address inequalities and deliver value, growth and sustainability. Elements which would underpin this are: • Research • Innovation • Capability, capacity and processes • Quality Improvement
BAF.0027 (FPC)	**New wording** – There is a risk of failure to ensure effective stakeholder management and communication with our partners and the wider population and to effectively engage in the complex partnership landscape, resulting in missed opportunities to add value for our service users and to meet population needs that require a partnership approach. This may mean that we miss opportunities to also safeguard the sustainability of the organisation longer term and ultimately may fail to deliver our strategic priorities and operational plan.
BAF risk 0030 (FPC)	**New wording** – There is a risk of failure to maintain and deliver on the SHSC Green Plan, caused by lack of robust plans, capability and capacity to deliver targets required resulting in the potential to lead to poor patient outcomes, worsening of existing health inequalities, poor service delivery, disruption to services, inefficient use of resource and energy/higher operating costs, legal and regulatory action, missed opportunities for innovation, reputational damage, reduced productivity and increased environmental impact.

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Mental Health Legislation Committee**

Date: **5th June 2024**

Chair: **Olayinka Monisola Fadahunsi-Oluwole**

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
Least Restrictive Practice Oversight Group Q4 (LRPOG)	There has been an increase in the number of pregnant service users being admitted over the last 6-8 months which brings complexity and challenge related to not only restrictive practise but to care planning.	This is being included on the Least Restrictive Practice Oversight Group work plan and learning events are being organised alongside engagement with the perinatal service. Committee advised that this is being captured in Safeguarding as well as within restrictive practice. There are wider conversations taking place as we are unable to access the regional specialist perinatal mental health beds who are in our system as we are being informed that our service users are too unwell to access these beds and pose a risk to other patients, which is leading to restrictive interventions and separation from babies. The CQC are also nationally focussing on pregnant service users and it has been requested the CQC review the data sets of pregnant service users in acute wards as they are more likely to experience restrictive interventions.	This will continue to be monitored and reported through the LRPOG's Quarterly Report	September 2024
Least Restrictive Practice Oversight Group Q4 (LRPOG)	Compliance for RESPECT training is below the 80% target and is due to capacity within the training team but also low sign-up rates	The committee were advised that there is an open corporate risk related to this (5220).	This will continue to be monitored and reported through the LRPOG's Quarterly Report	September 2024

	and DNAs due to staffing difficulties.	There is a monthly confirm and challenge meeting to ensure effective use of substantive staff across the rota period, which aims to ensure that staff have the capacity to attend mandatory training sessions.		
Least Restrictive Practice Oversight Group Q4 (LRPOG)	The committee were advised that an action plan to improve working with advocacy and addressing the concerns they have raised, has been developed with the Lead for Restrictive Practice, Senior Matron for acute services and the Advocacy Manager.	This action plan has been included within the group's action log.	This will continue to be monitored and reported through the LRPOG's Quarterly Report	September 2024
Mental Health Legislation Operational Group Q4 (MHLOG)	The use of the Health Based Place of Safety (HBPoS) for its commissioned purpose has fallen and this reduction/pattern of use is of statistical significance. The HBPoS continues to be used on a regular basis as a place of admission. On some occasions, patients have been admitted to the HBPoS for a prolonged time.	The committee challenged the prolonged used of HBPoS, whereby it was confirmed this was for a service user who required a specialist placement due to their disability.	In future reports, more narrative will be provided to assure the committee on as to the specific reasons for prolonged usage.	September 2024
Mental Health Legislation Operational Group Q4 (MHLOG)	Compliance with Section 132/132A, which is the provision of information to patients, has been variable, with Burbage ward's compliance dropping to 70%. Non-compliance, and ability to evidence compliance, of Section 132/132A continues to attract regulatory action. Previously, a Task and Finish Group was established to help improve compliance with Section 132/132A.	The committee requested for more assurance around the actions and timescales for improving compliance of Section 132/132A. The committee were made aware that the attendance at the task and finish group has not great and that members are struggling to attend due to working commitments. One avenue which is being pursued is to provide training as part of the Nursing training within the university. The policy is to be reviewed and needs to provide clear guidance to staff on when the information under Section 132/132A is to be provided. There is a concern over translator availability and access to translated literature/leaflets. It was suggested to liaise with Jo Hardwick who	Committee asked that demonstrable traction is provided in the narrative of future reports to provide clear assurance to committee.	September 2024

		is looking at Population Health data, to establish a starting point for identifying health inequalities. The committee were advised that when information is provided to service users, staff ensure that the service user has understood and comprehends the information which has been discussed.		
Associate Mental Health Act Managers (AMHAMs) Activity Q4 Report	AMHAM numbers are still low at 12 but 3 new applicants are being assessed. There are 5 more which have expressed interest but no application has been received at the time of reporting.	During Q4, the number of appeals that did not proceed to a hearing increased and went outside of the upper control limit. This suggests there may be some change that warrants investigation. A review has been undertaken of these cases and the reasons for not proceeding to a hearing were appropriate. Approximately a third of detention renewals and Community Treatment Order extensions considered by the AMHAMs were not completed prior to the expiry of the current order. This is poor practice and considered by the Mental Health Act Code of Practice as being serious. At present, these are not reported as incidents. The MHA office has been asked to start formally incident reporting these instances so that appropriate managers can review on a case-by-case basis.	This will continue to be monitored and reported through the AMHAM's Quarterly Report.	September 2024

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
Mental Health Legislation Operational Group Q4 (MHLOG)	The Mental Health Legislation Operational Group (MHLOG) recommends that it starts to meet on a 6-weekly basis, as opposed to the currently monthly basis. Membership is also recommended to be reviewed.	It was requested to check the alignment with MHLC and ensure that the revised group dates do not clash with deadline dates for this committee. It was also requested to assess the outcome from the self-assessment for feedback on what could improve the group efficiency.	The committee asked that a proposal of revised dates, updated terms of reference and draft work plan are to be brought back to the September Committee for approval before the meeting schedule is changed.	September 2024

Human Rights Framework Progress Report Q4	The plan for 2024 is on track with over 320 people completing 3.5 hours of Human Rights training via RESPECT Level 3. The committee were advised there is a risk due to Human Rights training being withdrawn from the RESPECT level 3 programme. The committee were advised that there are some staff which have been unable to attend the RESPECT level 3 update and therefore have been unable to access Human Rights Training.	The committee were advised that Human Rights Training is being integrated into RESPECT Level 1 training, which will provide 90 minutes of training. It was also acknowledged that the training is part of the Preceptorship programme and that there would be a cohort of medics and doctors in RESPECT Level 1 training which should aim to raise medical awareness.	The committee asked for feedback from the training to be included in future reporting, which can be obtained through the post RESPECT evaluation forms.	September 2024
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Mental Health Legislation Operational Group Q4 (MHLOG)	Bespoke training is to be designed in respect of the Mental Health Act for Birch Avenue and Woodland View.	Assessment questions as part of mental health legislation mandatory training are to be made more difficult and include where possible questions about lessons learnt.	This will continue to be monitored and reported through the MHLOG Quarterly Report.	September 2024

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Audit and Risk Committee** **Date:** **18th June 2024** **Chair:** **Anne Dray**

KEY ITEMS DISCUSSED AT THE MEETING					
TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)					
Negative alert **Internal Audit Progress Report – Clinical Record Keeping – Limited Assurance**	The Clinical Record Keeping internal audit report was received with limited assurance. The Head of Quality and Safety attended the meeting on behalf of the Executive lead to answer detailed questions.	It was confirmed a pre-discussion had taken place with the Executive lead who commended the helpful report, and actions (which have been agreed) and which confirmed areas of concern the Trust had already identified. The Committee asked about the level of confidence that deadlines for the proposed actions could be met and the rationale for the long- time frames for some of these. It was explained these were due to the need to dovetail with implementation of new systems through the Electronic Patient Record (EPR) work. The Committee asked for assurance Quality Assurance Committee will oversee delivery of actions and it was confirmed the regular Internal Audit progress reporting would be received at the Committee to ensure this takes place as well as through quality assurance reporting and monitoring of the action plan which it was agreed should cover any interim actions to provide assurance on traction given the extended	Cross referral to Quality Assurance Committee – Actions from the Internal Audit on clinical record keeping to have strong oversight at Quality Assurance Committee	From July 2024 – March 2025	**All BAF risks Apply**

		timeframe for delivery of some actions identified in the audit. Assurance was provided a number of actions are already in train with training sessions planned and taking place.			
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF risk**
<u>Positive alert</u> **KMPG External Audit Annual Report including Value for Money**	KMPG Intend to issue an **unqualified opinion** on the financial statements with no significant weaknesses identified regarding the Trust's value for money arrangements for 2023/24. Audit findings: • Results of testing on fraud risk were satisfactory. • No issues identified on sampling of management override of controls. • Fixed assets have been valued and recorded appropriately. • Assumptions used in valuation of land and buildings are considered balanced. • Value for Money – no significant weaknesses identified. Officers from the Finance and Governance teams were thanked for their support, engagement and provision of evidence through the process.	All outstanding matters drafted and shared in advance of the meeting have since been covered off with some testing to be finalised around financial statements which was not of concern. No significant issues identified and Auditors confirmed compliance with the Foundation Trust Foundation Trust Government Financial Reporting Manual FreM and the Annual Trust Reporting Manual ARM requirements. Expecting to issue an unqualified opinion. Work is expected to be completed in time to support submission of the Annual Report & Accounts by the 28 June deadline.	Testing still to complete testing over post close journals and staff numbers, final manager and director review of audit testing and receipt of the final annual report and accounts (and TACs) and the signed management representation letter. A recommendation was raised in the Value for Money (VFM) report in respect to Electronic Patient Record (EPR) that learning be reflected in planning for any major system changes going forward.	By 26/27 June 2024 to support submission on 28 June.	**BAF.0022** **BAF.0026** **BAF.0027**
<u>Positive Alert</u> **Final Head of Internal Audit Opinion; Annual Report and progress update**	The committee received Final Opinion with a summary of internal audit service for 2023/2024. It was confirmed it had been a positive year with significant assurance provided on Strategic Risk Management and the Board Assurance Framework and for the Implementation	Assurance was given there is sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied.	A cross committee referral was made to FPC has been made in respect of their dual responsibility to oversee KPI's aligned to their own committee and performance and a role in overseeing the	May 2025	**All BAF risks apply**

	of Internal Audit Actions which ended the year with a final first follow up rate of 87% and an overall follow up rate of 97% which was a very strong position. The opinion in respect of internal audits was moderate assurance overall. This provides an overall Head of Internal Audit Opinion of Significant assurance.	Since the previous meeting internal audit reports had been received as follows: • The Workforce Data Quality report has been issued with significant assurance. • Clinical Record Keeping – limited assurance see Alert. The remaining audit on Pay Expenditure is complete, but due to a delay in receiving the data it was unable to be finalised in time for the Audit and Risk Committee June meeting and will be reflected in the 2024/25 internal audit reporting.	ongoing work with development of the Integrated Performance and Quality Report (IPQR)		
<u>Positive Alert</u> Quality Account (QA)	The committee received and agreed the report for onward submission and approval at the public Board of Directors in June. The report was commended for its user friendly approach. It was confirmed the Draft Quality Account went to the Quality Assurance Committee in June 2024 and iterations have been received at Board of Directors and Council of Governors. The committee asked for assurance monitoring of actions will take place at Quality Assurance Committee and a cross referral as such was made. The committee noted at the request of the Chief Executive work will take place to synergise the planning for the Quality	Feedback received from South Yorkshire ICB, Sheffield Healthwatch and the Local Authority Health Scrutiny Sub-committee have both provided their feedback, which has been incorporated into this report and it has been positively received. The Council of Governors, South Yorkshire Integrated Care Board (ICB), Sheffield City Council and Sheffield Healthwatch were all consulted as part of the development of the Quality Objectives for 2023/24**.**	It was noted some dates, figures and page numbers are to be checked prior to finalisation in advance of the publishing deadline of 30 June 2024. Support in finalising the document is being provided by Communications. Pending these updates the committee approved the report for onward recommendation to the BoD. Planning to take place across Quality, Governance and Finance teams to co-ordinate the approach to development of the QA and the Annual Report in 2024/25	For receipt at Board 26 June 2024	**BAF 0024** **BAF 0025** **BAF 0029**

	Account and the Annual Account this financial year.				
Positive Alert **Draft Accounts and Analytical Review 2023/24**	The committee received the Draft Annual Accounts noting that the annual accounts are still being reviewed as part of the year end audit and could still change. To date there are no material changes and the reported deficit for 2023/24 remains at £4.932m.	There are no significant changes to main statements and updated analytical review previously brought to the committee in May 2024. Since circulation of the draft, an updated copy has been circulated to members reflecting the changes in 2 areas of the accounts including the South Yorkshire Pension Scheme which showed as a nil asset with liability and assets this year compensating the movements.	A cross committee referral has been made to FPC for the plan for the pension surplus.	January 2025 for planning approach	**BAF.0022** **BAF.0026** **BAF.0027**
Positive Alert **Annual Report including annual governance statement (AGS).**	The committee received the annual report and AGS presented for any final comments prior to presentation to the Board for final approval in June. The AGS will be received for information at the Council of Governors meeting held in public in June and the annual report V4.2 has been shared for information in confidence pending the outcome of the discussion at the Audit and Risk Committee and in advance of final approval at the Board in June.	KPMG confirmed the Annual Report is compliant with the Foundation Trust Annual Reporting (the ARM) requirements and there were no inconsistencies with the accounts.	The committee recommended the Annual Report for approval at the Board of Directors.	26 June 2024	

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
Internal Audit Plan 24/25	The committee received the final internal audit plan for final approval following submission of the draft to the committee in May 2024	There were no amendments from the previous draft version and it was approved.	N/A	N/A	**All BAF risks apply**

Management Letter	The committee received and discussed the draft management letter from the Director of Finance with his recommendation this be approved.	The Director of Finance thanked all teams for their support in the process and staffing and resilience challenges in the Finance team were noted with particular thanks given to Carl Twibey Management Accountant for his work	Received and agreed for onward submission to the Board for Approval.	June 2024	**BAF.0022 BAF.0026 BAF.0027**
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF risk**
Value For Money	KPMG outlined their findings in detail drawing attention to recent work to review EPR arrangements and improvements made to governance arrangements and lessons learned from the first Tranche of the programme.	KPMG confirmed based on their findings they had not identified any significant weaknesses in the Trusts arrangements.	To be published on the website following finalisation.	July 2024	**BAF.0022 BAF.0026 BAF.0027**
Losses and Special Payments Full Year Report for 2023/24	The committee received the report reviewing SHSC's losses and special payments in line with policies governing such payments, following the committee's request to review the level and scope of losses and special payments made by SHSC over the financial year.	It was confirmed there were 66 cases totalling £89,829 for 2023/24 including pharmacy stores losses as one item with a value of £2,000. A number of estates claims had been coded directly to premises costs rather than through the losses and special payments process. It was confirmed employment and public liability claims were covered in a separate line in the accounts and therefore had not been referenced. The Committee asked for assurance recording will take place proactively going forward following learning from the issues outlined in the report and it was confirmed revised processes are in place for ensuring claims are captured and dealt with promptly and appropriately.	The committee approved the report.	N/A	**BAF.0022 BAF.0026 BAF.0027**
360 Internal Audit – Progress Report, Final Head of Internal Audit	The final Head of internal Audit opinion was received further to the interim report submitted to the committee in May 2024.	An opinion of significant assurance is provided, generally there is sound framework of governance, risk management		July 2024	**BAF.0022 BAF.0026 BAF.0027**

Opinion and Annual Report and 2024/25 Internal Audit Plan	The report contains the Final Opinion with a summary of internal audit service for 2023/2024. The committee received the progress report on work undertaken since the last report to the committee in May 2024.	and control designed to meet the organisation's objectives, and controls are generally being applied. An opinion of significant assurance is provided for Strategic risk management and Board Assurance Framework. An opinion of moderate assurance is provided for Internal Audit outturn. An opinion of significant assurance is provided for Implementation of Internal Audit actions with a final first follow up rate is 87% and the overall follow up rate is 97%.			
Monitoring of Internal Audit Actions	The committee received and discussed open audit actions and noted progress made.	For internal audit actions sitting under ARC, 7 of the 8 open actions sit under the strategic risk audit and are not yet due. The remaining action is delayed due to EPR and an agreement with Internal audit on a revised date is pending – it was agreed this should be marked on the document as January 2025. Completion rate is 100% so far in this financial year.	Tracker to be updated with a date of January 2025 for the EPR related action.	July 2024	**All BAF Risks apply**
Monitoring of external audit actions – ISA 260 from 2023/24	The committee received and discussed progress with delivery of actions during 2023/24.	The Director of Finance advised one element related to payroll controls was expected to carry over into the ISA 260 monitoring report for 2024/25 from the audit of 2023/24. There were no recommendations in respect of the Value for Money element of the audit for 2023/24.	Carry over the payroll control issue.	July 2024	**All BAF Risks apply**

BAF Risk Descriptions from the 2023/24 BAF	
BAF.0021A (FPC)	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 (FPC)	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 (FPC)	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 (FPC)	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 (FPC)	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 risk 0024 (QAC)	Risk of failing to meet fundamental standards of care with the regulatory body resulting in avoidable harm and negative impact on service user outcomes and experience staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action. This risk could be associated with the failure to detect closed cultures within clinical teams.
BAF risk 0025a (QAC)	There is a risk to patient safety caused by failing to effectively deliver essential environmental improvements for the reduction of ligature anchor points / improvements in therapeutic space in inpatient settings.
BAF risk 0025b (QAC)	There is a risk of failure to deliver 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 skills staff to deliver works to timeframe required resulting in unacceptable service user safety, more restrictive care and a poor staff and service user experience
BAF risk 0029 (QAC)	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
BAF.0013 (PC)	Risk 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 (PC)	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 (PC)	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: **Audit and Risk Committee** **Date:** **16th July 2024** **Chair:** **Anne Dray**

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
Counter Fraud, Bribery & Corruption Annual Report	The committee received the annual report.	The plan has been delivered in full with 2 minor proactive pieces of work in the finalisation stage. The Counter Fraud Authority (CFA) advise to keep cases open until the Trust's internal enquiries are completed and reported back for closure. A staff-facing counter fraud portal has been developed providing training, guidance and reporting materials. Of the 7 new cases opened 5 have been approved and closed.	A cross committee referral to People Committee has been actioned to periodically receive the data tracker on delayed disciplinary cases for prompt action and follow up. The committee formally recorded the signed off counter fraud standards submission by the CFA revised deadline of 14th June 24.	September 2024	
Governance Report - Modern Slavery and Human Trafficking Statement 2023/24	The committee received the annual governance report including the retrospective modern slavery and human trafficking statement for approval prior to submission to the Board of Directors.	The committee noted minor changes required on the statement including amendments to the wording of identified sections. The committee approved the report subject to completion of the highlighted amendments.	The requested changes to be implemented prior to submission to the Board	July 2024	
Digital Assurance Group	The committee received the AAA report, updated Terms of Reference (ToR's)	The committee are alerted to the proposal to establish a new group with a focus on cyber	The ToR's for the newly formed group to be shared	September 2024	

	and update on the cyber security and Information Governance (IG) group.	security and IG. This group will include the responsible Executives for information: The Senior Information Risk Owner and the Caldicott guardian supported by the Head of Technical Services and the Information Governance manager.	with the Director of Corporate Governance prior to Executive Management Team in August and shared with the committee offline.		
Positive Alert **Post balance sheet changes statement.**	The committee received an update on the post balance sheet and annual accounts.	A small number of minor changes were made to the 2023/24 Annual Accounts after they were presented to the Audit and Risk Committee on 18th June 2024. The final and signed Annual Accounts were submitted to NHS England on 28th June 2024 along with the Annual Report. All changes were reviewed as part of the year end audit. There were no changes to the main statements including the Balance Sheet (Statement of Financial Position) and there were no material changes to the rest of the accounts. The reported deficit for 2023/24 remains unchanged at £4.932m with no significant events post 31st March 24 having a material effect on financial statements. The paper confirmed that at the time of writing there are no significant events which have occurred after 31st March 2024 which would have a material effect on the financial statements. The Director of Finance confirmed this is still the case as at the 16th July 2024.	n/a	n/a	
Positive Alert **360 Assurance Internal Audit Progress Report**	The committee received the updated progress report.	The Trusts first follow up and overall follow-up rate for the year-to-date 24/25 is 100%. Approval was sought to bring the Accounts Receivable audit forward to (Quarter)Q2 in line with work being undertaken throughout South Yorkshire for agreement with Finance.	The committee approved the plan to bring forward the Accounts receivable Audit to Q2.	October 2024	

		Moderate assurance has been issued with respect to the Data Security and Protection Toolkit in line with NHS England's assurance ratings. New global internal audit standards have been published to become effective from Jan 2025. Work underway to align practices and processes to these. System wide work undertaken re discharge management currently in draft report with PLACE.			
Positive Alert **Trust Emergency Preparedness Group**	The committee received the AAA report from the Group	Trajectory is tracked to achieve 60-65% compliance on the core standards by October 2024. Progress is continuing with the NHSE core standards at 40% compliance. Further sign off of key documents will bring overall compliance to 57%. The Trust has responded effectively to the last round of industrial action by the BMA, with no business continuity issues and no reported incidents. Work is being undertaken with NHS England and South Yorkshire ICB to both understand and seek advice on how to meet some of the new requirements that currently are not achievable to Mental Health Trusts.		October 2024	
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
On track to ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF risk**
Monitoring of Internal Audit Actions	The committee received the updated report.	There are currently no high priority actions identified. The remaining open action from the previous year's DPST, delayed due to the implementation of EPR, is pending a revised date of February 2025. We are in a strong position with 100% of quarter one's actions completed.	n/a	July 2025	
`KPMG External Audit Progress Report	The committee received a verbal update on the external audit progress report.	The accounts were submitted on 28 June 24 with no changes to report apart from minor discussions. There is a scheduled debrief between KPMG and the finance team to discuss future improvements on processes for next year. Planning will begin in November 2024	n/a	October 2024	
Single Tender Waivers	There were no reported single tender waivers at the meeting this month	n/a	n/a	October 2024	
Governance Report	The committee received updates on the Council of Governor elections, Fit and Proper Persons Test, Declarations of Interest and received the Terms of Reference for the committee and Tier 2 committees for approval prior to submission to the Board.	Of the 22 available seats for the Governors 12 have been filled through the governor election process. The election processes this year has proved successful with an anticipated 35 governors for this year. Proposed changes to the constitution have been through the Council of Governors (COG) and going for agreement to the Board.	The committee approved the ToRs for submission to the Board subject to the minor changes identified. Cross Committee referral to Quality Assurance Committee and People Committee to refer to the HFMA committee guidelines for Freedom to Speak up	July 2024	

		Continuing work is in place for the Declarations of Interest currently completed with the Governors and with an improved position of staff below Board level compared to last year. Fit and Proper Persons Test has been completed for Board members with the new requirements received and confirmed by the Chair on a demanding process with confirmation of submission by the end of June	oversight and onward reporting.		
Annual Claims and Litigation Reporting advance of Board.	The committee received the annual report for approval prior to submission to the Board of Directors	The mid-year report was received in October and this is the final end of year report with support from primary links at Capsticks. Some additional information is to be added prior to submission to the Board in terms of the cover sheet, clinical liability cases and employment liability cases and confirmation these relate to incidents arising prior to the new financial year. New additional learning workshops have been implemented led by the partner lead at Capsticks with over 20 clinical and corporate staff attending to date.	The committee approved the report for onward submission to the Board subject to the detailed amendments. The committee requested further detail on the trend of claims summarised over the last 2-3 years to be included in the next mid-year report.	July 2024	
Board Assurance Framework	The committee received the Board Assurance Framework 24/25 for approval prior to submission at the Board of Directors.	The committee reviewed and discussed the revised risks submitted to Tier 1 committees in July	The committee approved the report for onward submission to the Board subject to some minor change in the wording of identified risks.	October 2024	

Corporate Risk Register	The committee received the 24/25 corporate risk register for approval prior to submission at the Board of Directors	There have been no changes since the last report and there are continued monthly extraction reports from Ulysees to identify any new risks.	The committee approved the report for onward submission to the Board subject to some minor changes in the wording of identified risks.	October 2024	

Risk Oversight Group	The committee received the AAA report from the Risk Oversight Group.	The latest group meeting discussed the EPR and fire safety risks at length with the changes reflected onto the Corporate Risk Register. Work is underway with the communications team to add support and understanding around risk appetite with the organisation and risk owners.	n/a	October 2024	
Policy Governance Group	The committee received the AAA report from the Policy Governance Group.	The committee were asked to endorse approval of the following policies under the auspices of the ARC, post approval at PGG. 5 policies for ratification • Claims Policy • Policy Framework • Managing Conflicts of Interest in the NHS Policy • Record Management Policy • Remote Working and Mobile Devices Policy 1 extension to review • Waste Management Policy The committee approved the extensions and ratified the policy decisions by PGG.	n/a	October 2024	

BAF Risk Description 2024- 25 BAF pending approval at the July 2024 Board	
Risks monitored at FPC	
BAF.0021A (FPC)	**New wording** - There is a risk of failure to ensure digital systems are in place to meet current and future business needs, caused by failure to develop and deliver up-to-date modern digital strategy and systems and processes to support its delivery, resulting in poorer clinical safety, quality, efficiency and effectiveness.
BAF.0021B (FPC)	**New wording** – There is a risk of cyber security breach caused by inadequate arrangements for mitigating increasingly sophisticated cyber security threat and attacks and increased data protection incidents resulting in loss of access to business critical systems and potential clinical risk.
BAF.0022 (FPC)	**New wording** - There is a risk we fail to deliver the break-even position in the medium term caused by factors including failure to develop and deliver robust financial plans based on delivery of operational, transformation and efficiency plans resulting in a reduction in our financial sustainability and delivery of our statutory duties.
BAF.0026 (FPC)	**New wording** – There is a risk that we fail to take an evidence led approach to change and improvement caused by a failure to implement our integrated change framework effectively resulting in failure to deliver our strategy, improve outcomes, address inequalities and deliver value, growth and sustainability. Elements which would underpin this are: • Research • Innovation • Capability, capacity and processes • Quality Improvement
BAF.0027 (FPC)	**New wording** – There is a risk of failure to ensure effective stakeholder management and communication with our partners and the wider population and to effectively engage in the complex partnership landscape, resulting in missed opportunities to add value for our service users and to meet population needs that require a partnership approach. This may mean that we miss opportunities to also safeguard the sustainability of the organisation longer term and ultimately may fail to deliver our strategic priorities and operational plan.
BAF risk 0030 (FPC)	**New wording** – There is a risk of failure to maintain and deliver on the SHSC Green Plan, caused by lack of robust plans, capability and capacity to deliver targets required resulting in the potential to lead to poor patient outcomes, worsening of existing health inequalities, poor service delivery, disruption to services, inefficient use of resource and energy/higher operating costs, legal and regulatory action, missed opportunities for innovation, reputational damage, reduced productivity and increased environmental impact.
Risks monitored at QAC	
BAF risk 0024 (QAC)	**New wording** - Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience, staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action.
BAF risk 0025a (QAC)	Note this risk from the 2023/24 BAF has been closed with refinement to risk 24 and 25B .
BAF risk 0025b (QAC)	There is a risk of failure to deliver 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 skills staff to deliver works to timeframe required resulting in unacceptable service user safety, more restrictive care and a poor staff and service user experience

BAF risk 0029 (QAC)	**New wording** - There is a risk of a delay in people accessing core mental health services through the requirements of 'The Right Care Right Place' caused by issues with models of care, access to beds, flow, crisis care management and contractual issues resulting in poor experience of care and potential harm to service users.
Risks monitored at People Committee	
BAF.0013 (PC)	**New wording** – There is a risk that our staff do not feel well supported, caused by a lack of appropriate measures and mechanisms in place to support staff wellbeing resulting in a poor experience for staff, failure to provide a positive working environment and potential for increase in absence and gaps in health inequalities which in turn impacts negatively on service user/patient care.
BAF.0014 (PC)	**New wording** – 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 resulting in failure to deliver a modern fit for purpose workforce.
BAF.0020 (PC)	**New wording** – Risk of failure as an organisation to live by our values caused by not addressing closed cultures poor behaviour issues and lack of respect for equality diversity and inclusion, resulting in poor engagement and communication, ineffective leadership and poor staff experience, in turn impacting on our staff survey results, quality of service user experience and attracting and retaining high quality staff.
BAF 0031 NEW	There is a risk we fail to deliver on national inequalities priorities and our clinical and social care strategy which aims to deliver personalised and trauma informed care, caused by failure to adopt an inequalities based approach to care resulting in poorer access, later presentations and risk of poorer outcomes .
BAF 0032 NEW	There is a risk that our estate does not enable the delivery of our strategic priorities and meet the quality and safety needs of our service users and appropriate working environments for our staff resulting in sub optimal effectiveness, efficiency, experience and quality of care