Board of Directors - Public

SUMMARY REPORT	Meeting Date:	25 September 2024
	Agenda Item:	09

Report Title:	**Board Committee Activity Report**	
Author(s):	Amber Wild, Head of Corporate Assurance	
Accountable Director:	Executive leads and the Chairs of the Assurance Committees. Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director, Chair of Mental Health Legislation Committee Heather Smith, Non-Executive Director, Chair of Quality Assurance Committee and Interim 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 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 July 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:

Appendix 1 - Quality and Assurance Committee:
AAA report from September 2024
Annex A Health and Safety Committee AAA

Appendix 2 - People Committee:
AAA report from September 2024

Appendices 3 and 4 - Finance and Performance Committee:
AAA reports from August and September 2024

Appendix 5 - Mental Health Legislation Committee:
AAA report from September 2024

Audit and Risk Committee:
None

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

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 and to receive the 'Alert, Advise, Assure (AAA)' committee activity reports within the appendices for assurance and 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?

Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		***Well Led***
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standards?	*Yes*		*No*	***X***	***Code of Governance***

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***	

Appendix 1 QUALITY ASSURANCE COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Quality Assurance Committee	Date:	11th September 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 No**
Safe2Share Update	The project completes in October 2024 however funding is available only until February 25, which was of concern to the Committee. Training of 47 staff has been completed on the tool with testing taking place in July 2024 on service users and staff. Guide leaflets for service users family members and staff are available on Jarvis.	The work evident in the project is supported by the committee. Consideration has commenced of options for using the coproduced questions after February which may include funding safe2share platform or an internal platform. The evaluation will be critical to support decision making.	A verbal update in October has been requested on the implications for when the funding of the project ends in February 2025	October 2024	All BAF risks
Integrated Performance and Quality Report	Gender Identity Service and ADHD waiting times remain high. Ongoing work to improve the mandated service user demographics shows *no improvement* in the recording of protected characteristics despite	ADHD assessments are to re-commence this month.	n/a	October 2024	BAF 0029

	leadership through operational managers OOA bed usage, inappropriate use of HBPoS: remain challenging. Observations due to acuity and individual need remain high and are the subject of special focus.	Committee received the Home First recovery plan and were assured by the actions presented and the focus on 'hearts and minds'.			
IPQR – **Positive Alert**	The number of women accessing the perinatal service continues on course to exceed the target as it has for the last 4 months with the Trust significantly ahead against regional data. The recovery and improvement rates for Talking therapies has exceeded the target so far this year and remain on target for the coming months. The Health Improvement Team is now sufficiently funded, with an improved position with respect to waiting times and referrals. The waiting list for Long Term Neurological conditions has decreased significantly over the past 9 months as a result of changes in practice and new ways of working implemented through the QI collaborative. Safer staffing on the wards proceeds well. There have been		n/a	October 2024	BAF0029

	no staffing incidents or shifts where staff were below the agreed safer staffing level, with monitoring in place to ensure staffing is used effectively. All shifts are covered by ILS and RESPECT trained staff.				

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 No
Matters Arising – Burbage	The issues relating to Burbage concerning staffing, leadership and patient safety now have an improvement plan in place, supported by the directorate leadership team with work ongoing and updates going to the Executive management Team (EMT)		Updates on this ongoing concern will be considered by Caroline Johnson going forward and reported accordingly	n/a	BAF 0024
Matters Arising – Health Based Place of Safety (HBPOS)	There has been a whistleblowing report to the Quality Care Commission (CQC) in terms of inappropriate usage of the HBPOS	This has been responded to and agreement has been made with the leadership team that they will work towards a 72 hour maximum stay on the HBPoS.	This will continue to be monitored and reported through the Integrated Performance and Quality Report (IPQR)	November 2024	All BAF Risks
Health & Safety Report Q1	Fire doors remain a concern. An external review of the fire doors has been commissioned by the Executive Management Team (EMT) Gaps in the Trust's arrangement for fully trained fire wardens has been identified as an alert.	The committee are assured of the processes currently in place with feedback expected in the next report to the committee. Fortnightly meetings are in place to ensure actions stay on track. Arrangements in place for the relevant training to be completed in October 2024	An update to be provided the next time the report comes to Committee.	December 2024	BAF 0024

Board Assurance Framework (BAF) Q2	The committee received the updated framework with refinement on appetite, cross-referencing of risks and amendments to scoring.	The highlighted changes were approved by the committee	n/a	January 2025	ALL BAF risks
Corporate Risk Register (CRR)	The committee received the register with updates on risk for approval.	The committee approved the detailed changes and recommendations prior to submission to the Board	The register will continue to be submitted to the committee monthly.	October 2024	All BAF risks
Quality Objectives	The committee received an update on progress with the new objectives for 2024-2027	To committee are assured on the initial progress and the plans in place.	The committee requested evaluation and risk to be detailed in the summary sheet going forward	December 2024	All BAF risks
Suicide Prevention in England	The received report outlines the findings from the National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) Annual Report 2024 and the new Suicide Preventions Strategy for England 2023-2028	Work undertaken in the Trust ensures a continued focus on suicide prevention to reduce the risk in service users.	The committee requested an executive summary to draw out the key points and to highlight what is happening within the Trust and in Sheffield for assurance on the broader strategic approach, prior to submission to Board	TBC	All BAF risks
Learning and Safety Report	The number of formal 'Serious' Incident Investigations have decreased aligned to PSIRF whilst broader spectrum learning via Local Learning Reviews and Local Learning Responses are increasing. Low threshold reporting remains at a consistent level.	There is progression into the Patient Safety Incident Response Framework (PSIRF) on coordinating learning responses to aid the dissemination of learning. The committee are assured by the triangulated learning identified across patient safety incident to improve patient and staff experience along with evidence of robust improvement plans in place.	Cultural Differences to be detailed in onward reporting.	December 2024	All BAF risks
Quality and Equality Impact Assessments	The panel robustly assessed the QEIA submitted by the Digital Team as part of value improvement scheme relating to the renewal of the Trust's contract for print services.	There continues to be a robust embedded process in place. **To note:** The committee were concerned to hear about the outstanding	n/a	October 2024	All BAF risks

		21 QEIA's relating to VIP programme proposals. These have not yet come through to panel.			
Independent Desktop Thematic Review of Learning July 2024	The committee received the report.		The committee confirmed previous receipt of the action plan with continued monitoring for recommendation to onward reporting to the BoD.	n/a	No BAF risks
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Impact of RIO implementation on Service Users	The new Electronic patient Record (EPR) system RIO has already led to some improvements in recording. These were outlined to the Committee.	A full benefits review paper is going through various committees, and meeting with older adult services weekly continues to make improvements with further benefits to come going forward. Positive feedback is evident.	n/a	n/a	BAF 0021A
New CQC Assessment Regime	The new framework will assess services against quality statements based on 6 evidence categories. The approach is to socialise all teams to the new assessment regime, quality standards and changes to both peer review processes and a self-assessment approach.	The committee are assured there is a plan in place for socialising and preparing services aligned to the new CQC assessment regime	n/a	n/a	BAF 0024
Mortality Report Q1	There are continued learning opportunities related to unexpected deaths in the community with ongoing improvement actions for communication and documentation.	The committee are assured on the compliance to standards with further clarity and themes to be evidenced in future reporting. 100% of all reported deaths at the Trust were reviewed during	n/a	November 2024	BAF 0024

	The Mortality Review Group are currently focusing on End of Life Care within SJR's	Q1 of 2024/2025. The Trust is complaint with the 2017 National Quality board (NQB) for learning standards.			
Ulysses Audit Platform Implementation	The committee received an update on the expiration of the Tendable contract and the use of the new Ulysses audit module. Further to the ending of the contract with Tenable in July 2024, engagement with audit lead and staff is taking place to improve existing audit sets and to test and implement the Ulysses Audit Module.	With the feedback widely accepted, the committee requested a review of the governance structure within the report in order to ensure that audit practice is improved.	The committee requested an update in 6 months on the progress of the implementation.	March 2024	All BAF Risks

Risks monitored at QAC	
BAF risk 0024 (QAC)	Risk of failing to meet fundamental standards of care with the regulatory body 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 0025b (QAC)	There is a risk of failure to deliver the therapeutic environments 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 impact on service user safety, more restrictive care and a poor staff and service user experience
BAF 0029 (QAC)	There is a risk of a delay in people accessing core mental health services 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
BAF0031 (QAC)	There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services, caused by failure to adopt an inequalities based approach to care resulting in poorer access, later presentations and risk of poorer outcomes.

Appendix 1 Annex A Q1 2024/2025 Health and Safety Committee Alert, Advise, Assure Highlight report

HEALTH AND SAFETY COMMITTEE ALERT, ADVISE, ASSURANCE REPORT	
Committee:	**Health and safety Committee**
Meeting date:	**29th July 2024**
Lead:	**Samantha Crosby, Head of Facilities and Health & Safety**

KEY ITEMS DISCUSSED AT THE MEETING

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

Issue

- **Fire doors**: Due to not receiving full assurance the Health and Safety Committee commissioned further work by the Estates team to clarify the situation. Subsequently the Associate Director of Estates and Facilities has led a review and presented the findings to EMT on 20th June. EMT accepted the proposal to commission an external review of the fire doors. Following completion of the review, in September 2024, a report will be presented to EMT that will outline a clear understanding of the level of risk associated with the fire doors, and the likely costs of addressing the risks.

- **Fire Warden provision**: At the March 2024 Health and Safety Committee that highlighted possible gaps in the Trust's arrangements for fully trained fire wardens at each site at all times of operation. This situation has arisen due to changes in post-pandemic working practices, where blended hybrid working arrangements are more common, resulting in the possibility that nominated fire wardens may be working off-site. The Committee noted the need for all fire wardens to be compliant with training requirements. At the May meeting a verbal update was provided and the Committee commissioned the Fire and Security team to develop a proposed solution so that A) the responsibilities of managers in relation to the provision of fire wardens are communicated and understood. B) Assurance is provided that every Trust site has appropriate fire warden arrangements in place, and C) Assurance is provided that fire wardens are appropriately trained, this is awaiting further information required from the training department in order to move forward. it is anticipated that this work will be completed during October 2024.

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

Issue

- No issues to advise.

ASSURE (Detail here any areas of assurance that the committee has received)

Issue

- The Health Technical Memorandum (HTM) 05-01 Managing Healthcare Fire Safety, boar report (Appendix 2) is information provided for the board as required in the HTM guidance – to be sent to the Trust Board.
- Policies, procedures and documentation available to demonstrate statutory compliance, statistical data from incidents, audits undertaken, and an action plan where limited assurance has been identified.

Appendix 2 Health Technical Memorandum (HTM) 05-01 Managing Healthcare Fire Safety, Board report

Fire Related Category

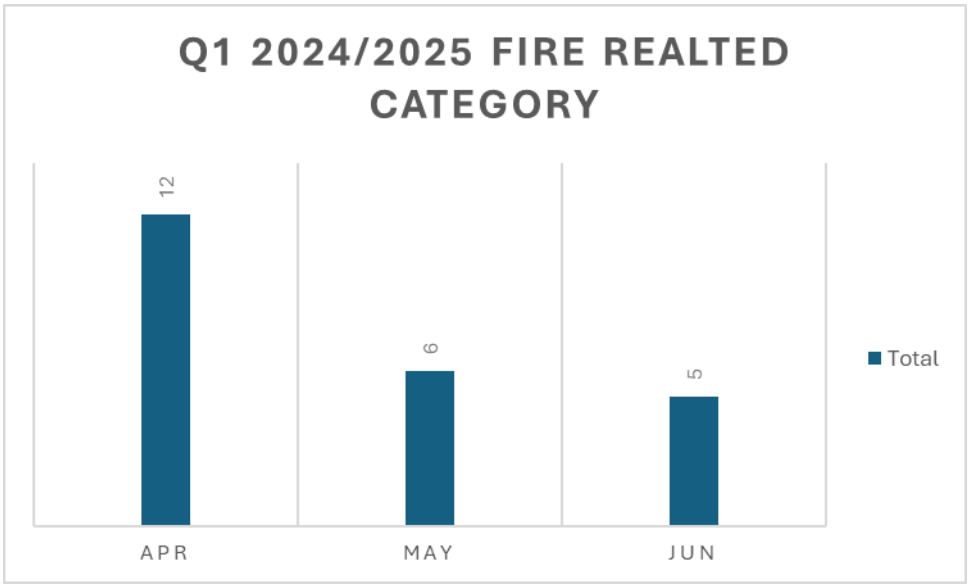
The reporting on “fire related incidents” is as per the requirement of the Health Technical Memorandum 05-01. With additional information on the monitoring on fire risk assessment action plans and specific fire door planned preventative maintenance inspections and remedial actions required on fire doors (specified as actions on Risk 5344).

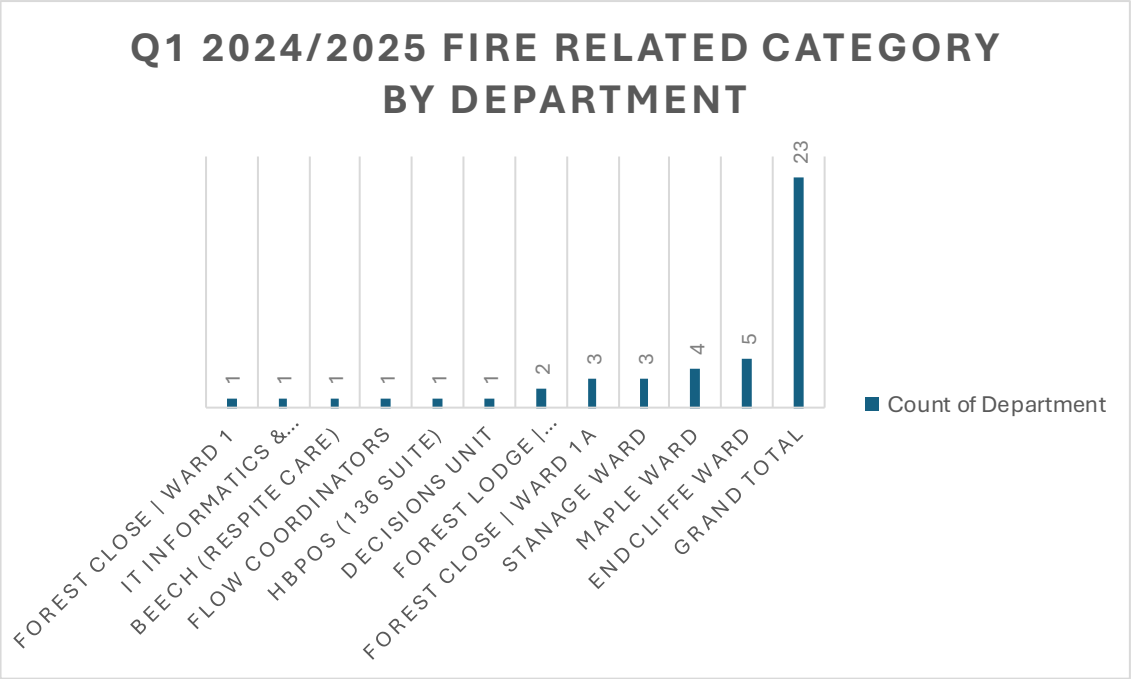
Ulysses classified fire related as events involving:

- Equipment / machinery related
- Smoking related
- Arson / doubtful origin
- Electrical defect
- Flammable substance
- Faulty equipment
- False alarm – good intent
- False alarm – malicious.

The clear benchmark is for no actual fires and no false alarms to take place.

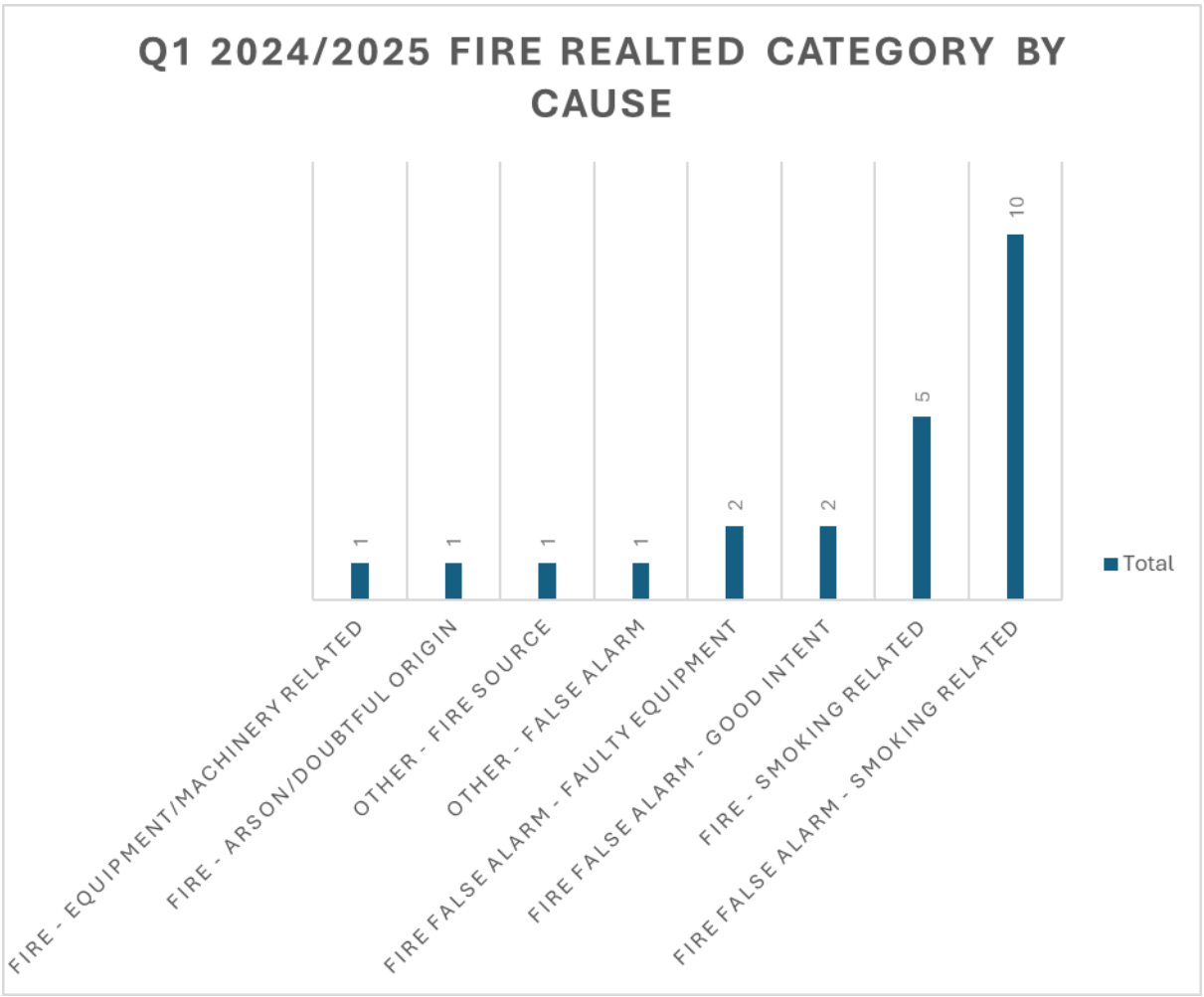
There were a total of 23 events logged within this category Q1 2024/2025, this is a slight increase from Q4 2023/204 which saw 18 events logged.





Q4 2023/2024 had seen Forest Lodge as the top reporter with 3 events whereas this quarter is Endcliffe with 5 events, all were smoking related. With these events clinical colleagues will support the individuals involved with reminder of “smoke free” policy and access to the “quit” team if required.

Number of Fires

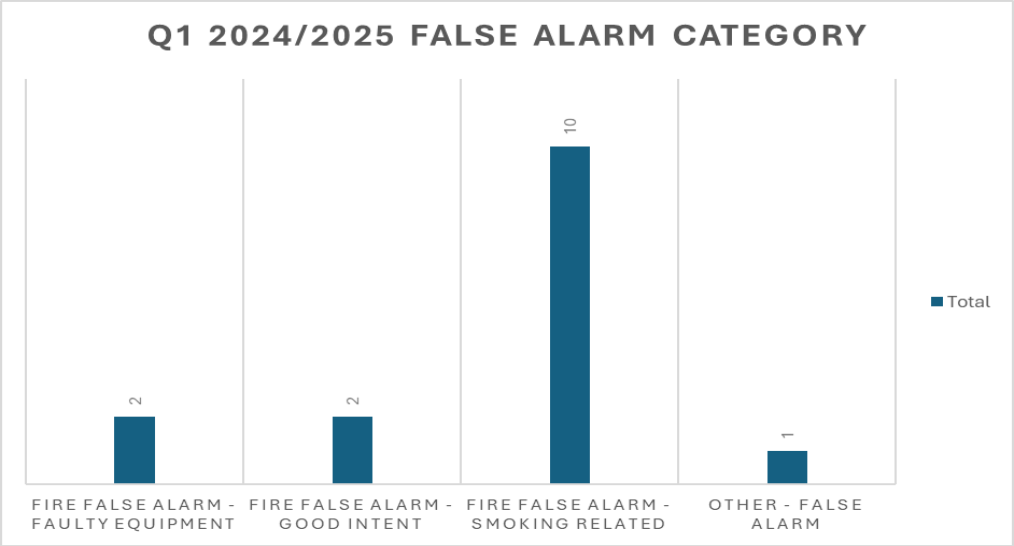


Q1 2024/2025 figures:

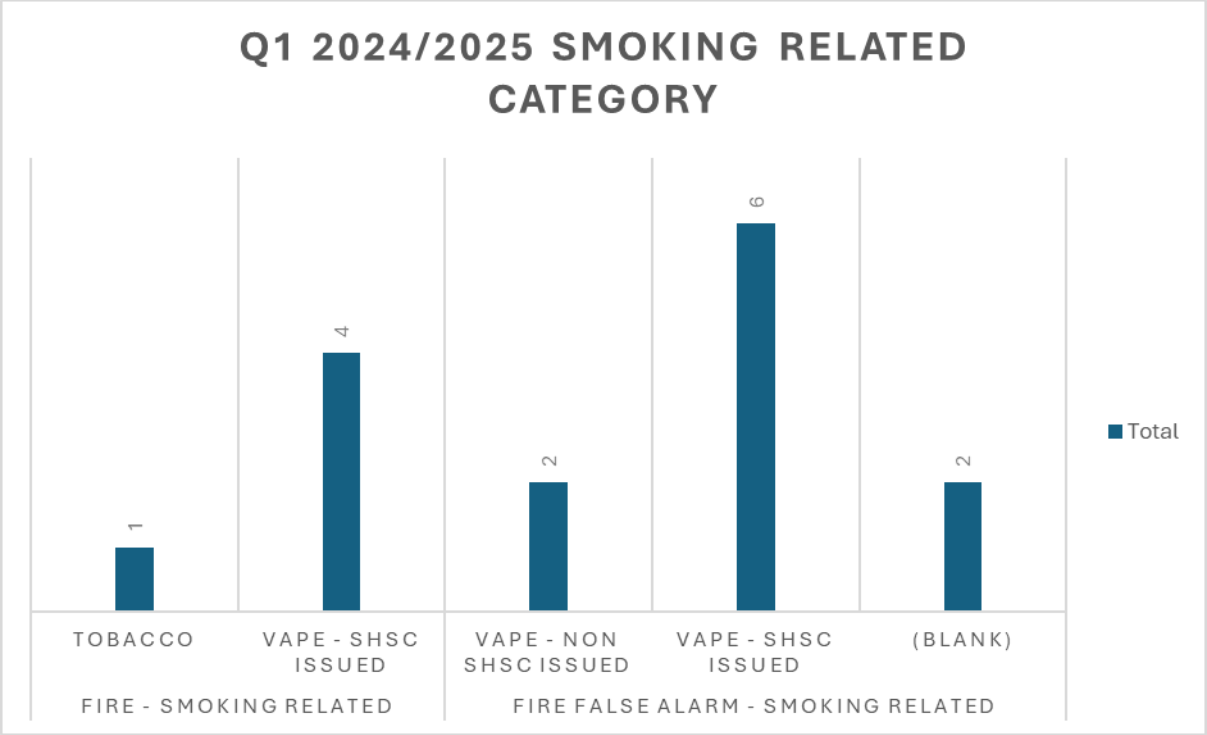
Of the 23 events, 1 was logged as moderate and this is where a patient, within Health Based Place of Safety, set fire to the mattress that was on the floor.

Number of False Alarms

Of the 23 events logged within the incident management system, Ulysses, 15 are logged as false alarm. These events are reviewed by the Fire and security Co-Ordinator and any action required is implemented.



Fifteen events are logged related to smoking these will be followed up by the QUIT team to support individuals who want to stop smoking or vaping, and others will be reminded of the “smoke free” policy.



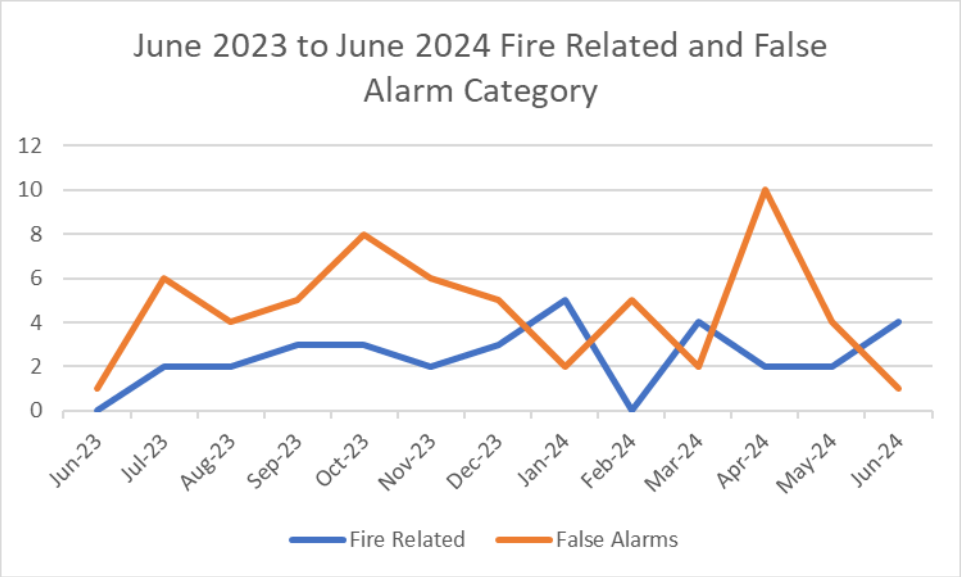
Unwanted Fire Signals

An unwanted fire signal is where the alarm is activated, because of anything other than a real fire, and the local fire and rescue service are mobilised to attend the site.

During Q1 2024/2025 the Fire and Security Co-ordinator has reported that there were two incidents that were false alarms but mobilisation of the fire and rescue service.

The unwanted fire signal aim is 0 occurring, the Fire and security Co-Ordinator follows up fire related incidents to ascertain any learning.

Annual Figures for fire related and false alarms:

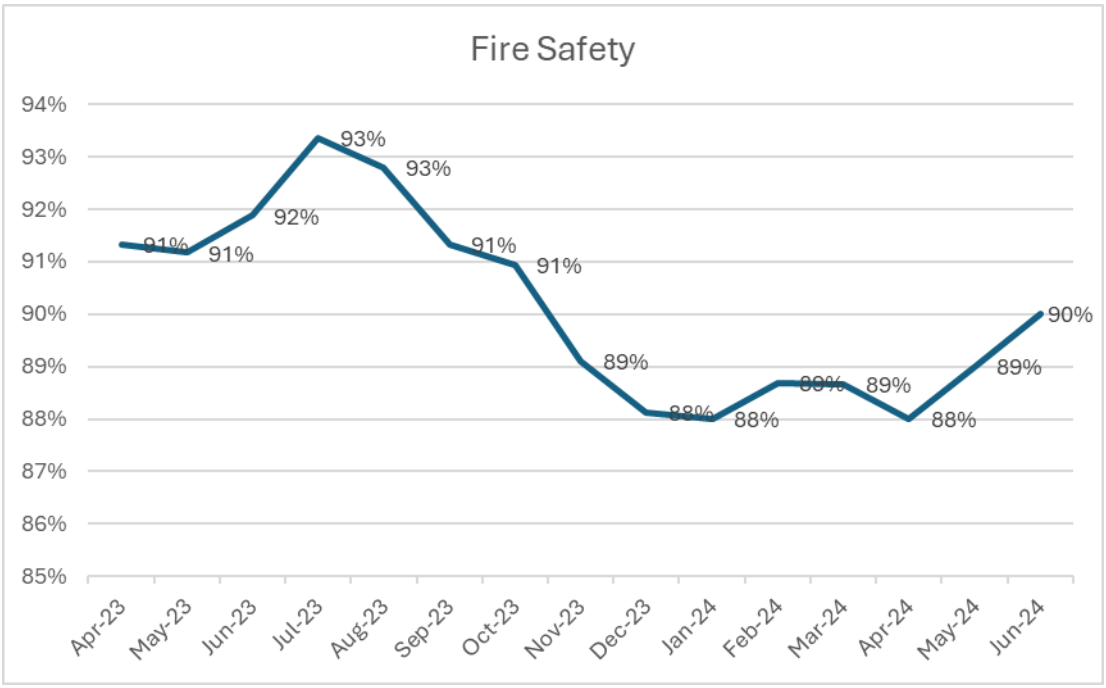


The fire related category remains low in events, the chart above shows a spike in April 2024 of false alarms, 50% were related to Endcliffe Ward of those, four were related to vaping, hence the higher reporting figure.

The categories on Ulysses can be confusing and therefore the Fire safety team will be asked to review these to ascertain if there could be changes that provide clarity or if this is not possible to look at what guidance can be implemented to support staff when identifying which category is applicable.

Mandatory Fire Safety Training

This is mandatory, for all staff, via ESR that is completed online and has remained above the required 80% compliance.



Audits undertaken by fire and rescue service:

The Fire and Rescue Service attended the Longley Centre in April 2024, this was for familiarization of the site.

Fire Risk Assessment Action Plan Monitoring

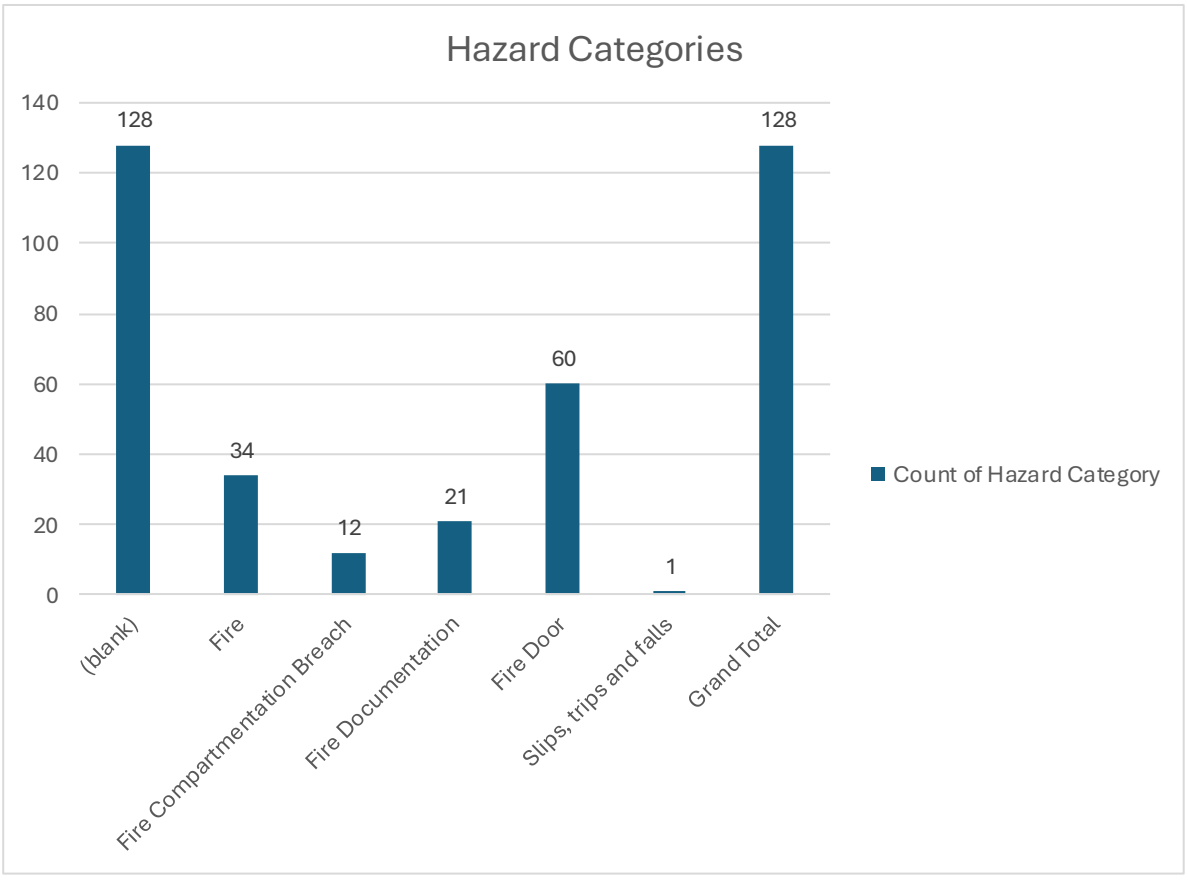
Fire Risk Assessments are conducted by the Fire and security Co-Ordinator and reported via the KPI, that is presented to the Health and Safety Committee.

The actions identified form part of risk reduction and mitigation in relation to fire risk.

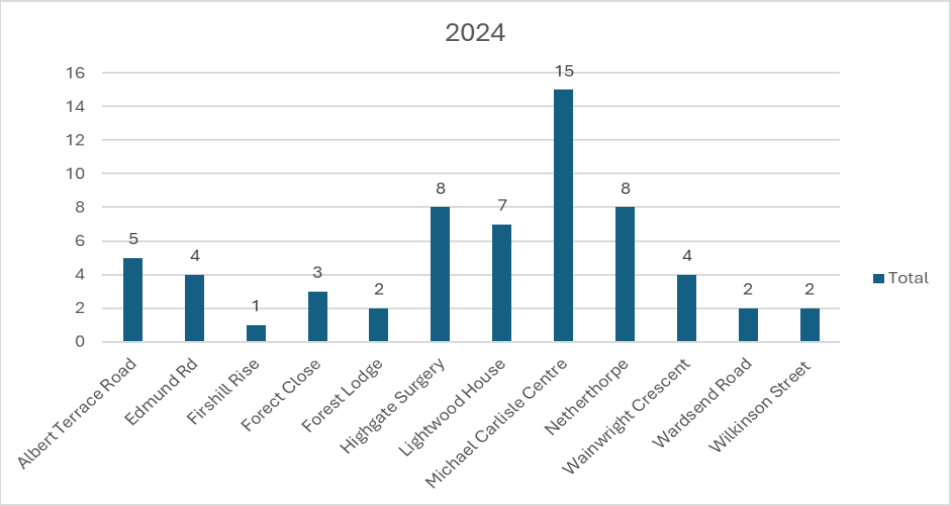
The fire risk assessment remedial action plan was previously updated as it did not facilitate ease of monitoring, following a period of two years this action plan has required another update to reformat and identify duplicated actions and further work is required to close off older actions, this will continue to be reported via the Health and Safety quarterly report.

For example, some of the actions involve undertaking some remedial work and a job number has been logged but currently the Head of Facilities and Health & Safety needs to undertake further detailed analysis of the actions.

The 2021-2023 action plan identified a total of 290 actions identified and of these 128 have no entry in regard of completion yes or no and this requires follow up to ensure they have been completed, they are all rated as low or very low.



Of the actions outstanding, there are 60 related to fire doors and 12 to fire compartmentation breach, therefore it is unlikely that these will be completed until the formal programme regarding the fire doors is completed.



The 2024 action plan is currently still being working through and will continue to be monitored to ensure that actions are closed off in a timely manner. The above chart shows the number of actions assigned to each area at this time, Longley Centre and Grenoside Fire risk assessments will be updated following the implementation of the 12-month review.

In addition, the Fire Risk Assessments are now being conducted every twelve months, and this is to support risk mitigation whist there remain concerns with fire doors compliance with required standards.

Appendix 2 COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	People Committee	Date:	10/09/2024	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
People Performance Dashboard	Sickness remains at 7.1% (an outlier) across the organisation with Stress, Anxiety, and depression being the main cause for absence at 43% of the 7.1%. PDR compliance is at 70%; the target is 80%. Supervision compliance has increased to 65% but remains under target. Mandatory training compliance is above 80% across all directorates but this masks continued under-compliance in some teams and in some subject areas. There is a disproportionate number of ethnically diverse staff in formal processes.	Long term sickness has been highlighted by the ICS and targeted at SHSC as part of the Health and Wellbeing Group: a task and finish group has been established to look at consistently high levels of absence. Supervision and PDR reporting will migrate to Self Service over the next few weeks which is anticipated to improve data recording. The committee were advised that resulting from the right to work audit, some issues were being investigated which have impacted on case work numbers involving ethnically diverse staff. This is being worked through and an update will be included in the next Workforce, Recruitment and Transformation Group Report.	It was requested to report mandatory training figures by directorate to highlight the hot spots and provide clearer assurance to the committee.	November 2024	BAF0020
Positive Alert: Agency Usage	Clinical agency usage has dropped to 9 WTE in July from 87 WTE this time last	The committee noted that agency usage and rates is a focus from an ICS	The ICS benchmark data will be included in future People	November 2024	BAF0014

	year. **Total Bank and Agency** in July 2024 was 139 WTE, compared to 186 WTE in July 2023, a 26% drop. There has been an increase in agency usage in admin and clerical areas from 2.68 to 19.37 WTE but this is due to agency support for the implementation of Rio.	perspective and a dashboard is being created to look at Bank usage across the system. The Committee also noted a new focus on the % of medical shifts covered by agency staff above the capped rate.	Dashboard reports.		
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
People Performance Dashboard	12-month average turnover has increased to 12.3% which is above the People Plan target, this is due to Head Count and whole time equivalent (WTE) dropping over the last 4 months resulting from Vacancy Control Panel measures, value improvement programme, and reviewing the current establishments. Time to hire has dropped from 88 days to 74 days. The target is 60 days. Positive overall recruitment over the last 12 months with 309 new starters and 274 leavers.	Turnover and time to hire will continue to be reported in the People Dashboard. Grip on the People dashboard data and increasing sophistication of the data gives assurance.		November 2024	BAF0014
Health & Safety Group Q1 Update	Following completion of the Fire Doors review, in September 2024, a report will be presented to EMT that will outline a clear understanding of the level of risk associated with the fire doors, and the likely costs of addressing the risks. Assurance was given that fire wardens are appropriately trained, this is awaiting further information from the training department which is anticipated to be completed during October 2024.	The committee were advised that there is mitigation in place for Fire Doors issues whilst awaiting completion of the programme.	Health & Safety Group will continue to report to People Committee quarterly.	January 2025	BAF0025b
Acute & PICU	The committee were advised that work is	The committee raised concerns around	The committee requested that	November	BAF0014

Inpatient Ward Supervision Compliance and Mandatory Training Recovery Plans	ongoing to improve Supervision and Mandatory Training figures.	the Supervision levels and asked if staff are understanding the importance of supervision and that they try to prioritise this alongside their work.	information is included in future reports on training places that are not filled	2024	
Workforce Recruitment and Transformation Assurance Group Report	Workforce plans have not yet been fully completed for all services and it has been recommended that workforce plans are required for vacancy control management. ICS workforce planning event considered NHSE requirements: themes identified included consistency around system wide workforce planning and to ensure it is streamlined. Feedback from the workforce plans so far has indicated a need for sustainability around the use of apprenticeships, other training routes and new roles where funding is time limited.	Committee emphasised their high expectations about the quality of workforce planning in order to maximise transformation opportunities and demonstrate integration of new roles and new ways of working.	Workforce Recruitment and Transformation Assurance Group Report will continue to report to People Committee each quarter	January 2025	BAF0014
Mandatory Training Governance Report	8 subjects remain below target compliance with 3 subjects improved since the last report, 2 subjects remained static, and 3 have deteriorated. A new risk (5321) has been added to the Corporate Risk Register related to training including delivery and facilities There is a national review of Statutory and Mandatory Training and an action plan has been developed based on this review.	The importance of staff being up to date with their mandatory training has been highlighted at the Collective Leadership Group and in the Communications Cascade. A focussed session on Mandatory Training will take place at the Operational Management Group in September.	Mandatory Training Governance Report will continue to report to People Committee each quarter	January 2025	BAF0014
Inclusion and Equality Assurance Group Report	Benchmarking against a wider set of peers provides assurance of positive progress in reduction of the Gender Pay Gap			January 2025	BAF.0020

	The Workforce Race Equality Standard and Workforce Disability Equality Standard were discussed in the Executive Management Team time out on 1st August 2024 and the following priority areas were agreed for the remainder of 2024/2025: • Discrimination • Disabled staff experience, in particular why disabled staff report that the organisation does not value their work • Focus on areas relevant to the diversity of the organisation. **To note:** The data on potential career progression of ethnically diverse staff indicates stalled progress. The experience of Disabled staff in the organisation reflected in staff survey results is poor and current action in progress may not result in change in the short term.	The committee noted that the work on career progression has stalled in terms of disparity ratio, there is more to do to improve including further work on the recruitment process, reputation of the organisation to attract ethnically diverse staff and working with the ICS.	The committee requested that information on reciprocal mentoring is included in future reports.		
Employer's liability claims update	The learning report covers fifteen employers' liability claims, with the incident dates ranging from November 2017 to August 2022. The employers' liability claims primarily involve: • assaults to staff by Service User's • injuries as a result of manual handling • slip/trips • inadequate facility maintenance • inadequate equipment.	Further discussion on learning specifically related to employers' liability cases and actions taken to be scheduled to take place at a future People Committee meeting post receipt of the confidential mid-year report at Audit and Risk Committee and Board of Directors	An update on Employer's liability claims will be added to the work programme once a reporting schedule has been agreed.	Ongoing	BAF0013
Internal Audit Action Tracking	The remaining action for Equality Diversity and Inclusion audit which received 'moderate assurance' has been closed. Internal Audit have advised they have received some evidence from the People	There is one action relating to E Roster which is due by the end of September, this is on track. Overdue actions are being addressed.	Internal Audit Action Tracking will continue to report to People Committee	November 2024	All apply

	Directorate and will work to close the overdue actions by the end of September.				
Board Assurance Framework 2024/25	The BAF has been updated following engagement with Executive leads and receipt at Executive Management Team. There are no new risks or amendments to risk descriptors for People Committee.	The committee reviewed each BAF risk which sits under the People Committee and agreed the updates.	Board Assurance Framework 2024/25 will continue to report to People Committee each quarter.	January 2025	All apply
Corporate Risk Register (CRR)	There are 18 risks on the corporate risk register two of which are monitored by People Committee. It has been agreed at Executive Management Team (EMT) and Risk Oversight Group (RoG), to develop an additional risk for inclusion on the corporate risk register: • Medical recruitment in inpatient services	A detailed discussion on corporate risks has taken place in August and September, at Executive Management Team (EMT) and Risk Oversight Group (RoG), to reflect whether those risks on the register are still relevant and appropriate, and to consider whether there are additional risks for consideration for the corporate risk register. Regarding Medical recruitment in inpatient services, the committee asked that consideration is given to this risk to ensure that it is wider than acute wards. The recommendation will then need to go through RoG and EMT for inclusion on the Corporate Risk Register. The Committee noted and approved all updates to People Committee related risks.	Caroline Parry, Helen Crimlisk and Sarah Bawden are to meet to discuss the proposed scope of the new Medical Recruitment risk, and an update will be presented to a future People Committee	November 2024	All apply
Policy Governance Report	The committee received the report outlining the extensions to review dates which were presented to Policy Governance Group.	The committee agreed the extensions but were clear that the number of extensions are not appropriate. Committee were, however, reassured that work is taking place with the Executives to minimise the number of extensions.	Policy Governance Report will continue to report to each People Committee	November 2024	All apply
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk**
Safe Staffing Report (Clinical Establishment Review progress)	There have been no serious incidents related to staffing levels within acute services and there have been several	It is recommended to approve the clinical review for the next 6 months as there is clear evidence of being able to	Safe Staffing Report (Clinical Establishment Review progress) will report to People Committee	January 2025	BAF.0013 BAF.0014

	good patient safety indicators such as the least restrictive practice work. There is still more work to do on observations and NHSE have launched a project around enhanced observation. Improvements to effective usage of Roster systems took place and new work in line with the establishment reviews.	provide safe staffing levels but there is some further work to do on associated projects.	in January 2025.		

BAF Risks monitored at PC 2024- 2025	
BAF 0013	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	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	Risk of failure as an organisation to live by our values caused by not addressing closed cultures poor behavioural 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.

Appendix 3 COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Finance And Performance Committee	Date:	15/08/2024	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 (M3)	At M3, the year-to-date deficit position of £2.290m is £0.027m worse than planned. The forecast is expected to achieve the planned deficit of £6.514m. Value improvement and recovery plans totalling £8.6m have been developed however the current forecast shows an expected delivery of £6.5m, the main reason for the under-delivery is Out of Area. Work is ongoing to strengthen and implement the plans and identify further opportunities to achieve the planned savings required of £7.3m. The £0.8m shortfall is currently offset with non-recurrent underspends due to vacancies. Capital expenditure at Month 3 is lower than planned but the forecast is to meet the plan for the year. There is still uncertainty around the timing of the Fulwood sale which to be a risk to delivery of the capital programme. Out of area activity increased significantly in May and June compared to the levels seen in March and April, this has been driven by increased demand for inpatient care. The	The committee noted that agency cost has decreased by £0.4m but bank costs have increased by £0.6m, and it was noted that there had been an increase in the use of bank staff, however clinical establishment controls have been put in place to limit this and there has been a reduction. The committee were advised that a revised out of area (OOA) plan has been developed to reduce bed usage to 9 by the end of September and then 3 for the remainder of the year, with 7 patients having been identified for discharge in August. There will be tighter grip and control supported by a 14-point action plan. The committee noted that Guiness Partnership has paid £600k of their aged debt however there has been further deterioration and the overdue figure presently stands at £4.1m. Agreement has been made with Sheffield Teaching Hospital which totals £900k and further conversations will take place to assess why the invoices are outstanding.	It was requested that a cross committee referral from FPC to People Committee (PC) should take place for PC to review the aggregate of bank and agency usage over the last 12 months. The committee requested that the aged debt needs to be broken down to show what is due where and what are the issues and mitigations to provide the committee with further assurance.	September 2024	BAF.0022

	£1.3m overspend (£1.5m including Out of Area Transport) is based on returning to 3 spot Acute Out of Area beds in September. If Out of Area usage continues at the same level as the end of June, then the expected overspend is £3.5-4m. Aged Debt has increased in the last year which is having a negative impact on the Cash position. Most of the older debt is with Sheffield Teaching Hospitals, The Guinness Partnership and South Yorkshire Housing Association. Finance have stepped up additional focus on this area to ensure older disputed debts are paid or escalated to ensure quicker resolution can be found. This work is expected to result in the aged debt reducing in the next few months. The Guinness Partnership outstanding debt issue has been resolved since M3.				

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 No
Financial Performance Report (M4)	The committee were advised that there is a £91k underspent which is slightly better than plan and run rate however there is an ongoing risk around VIP which is showing £6.3m forecast against £7.3m. Therefore, there is a £0.7m residual gap to deliver the forecast outturn. £2.7m overspend in out of area position has slipped from £1.9m.	The committee were assured that there is a revised plan for out of area which is still £1.5m away from plan. The committee were advised that the Trust is not forecasting to recover the original position but to reduce it and any further savings will go into the next financial year.	An update on M4 will be presented to FPC in September.	September 2024	BAF.0022
Business Planning Group Q1 Update including Capital Plan Position	There are significant risks to the delivery of the capital programme this year due to the uncertainty with the capital receipt from the sale of Fulwood House. This will impact over critical programmes focussed on Maple refurbishment, safety improvements and	It was confirmed that several community service developments should proceed in the next financial year pending discussions with the ICB, however larger projects may need to be deferred. Regarding Nursing Home Services, it was felt that it would be	The committee requested that the Capital Plan is revisited considering developments within Leaving Fulwood and EPR, and an update is	September 2024	All apply

	essential estate infrastructure upgrades. Mitigation plans are being finalised for review with the Executive Management Team and the Committee that will define options around a reduced capital programme, brokerage with the ICS, or deferral of income into the next financial year There are significant financial risks associated with Nursing Home services. While cost projections have reduced following a review of staffing levels across both Homes, Birch Avenue services continue to be challenged with a forecast financial deficit of £1m based on month three. SHSC have been successfully awarded a place on the National Pilot programme to test new models of 24/7 care for community mental health services, however the communication of this is currently under embargo until the end of August.	difficult for the commissioning authorities to provide additional funding and it is believed this project may move into year two, however discussions are ongoing. The committee discussed ensuring that the smaller projects continue to make progress so that when funding is available, they can commence work and a paper will be presented to EMT in September which indicates the projects and scenarios.	going to be provided in September.		

ASSURE (Detail here any areas of assurance that the Committee has received)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk No
Corporate Risk Register (CRR)	There are 20 risks on the Corporate Risk Register, 9 of which are assigned for oversight to FPC Following discussion at Board of Directors and Executive Management Team (EMT), consideration is being given to including a Cyber related risk. A detailed risk discussion took place at EMT and work is underway to finalise the risk descriptors and scores, with a revised report to go to EMT early September.	A meeting took place at Organisational Management Group to update them on the changes to the Risk Management Framework and work is underway to ensure staff are supported in time for the internal audit on Strategic Risk Management. EPR risks have been discussed and further work is required on the actions. The PROMs risk is being considered as to how it should be reported and an update will follow in September.	A report will be provided to FPC in September.	September 2024	All apply

	Fire doors risk cannot be revised until to outcome from the independent review results are released.				
Charity Governance - Relationship with Sheffield Hospitals Charity and our involvement in Charity Related Events	Relationships between SHSC and Sheffield Hospitals Charity (SHC) are developing which is a result of concerted efforts by both organisations. It is recommended that the proposed actions are pursued for the remainder of 2024 with a view to achieving mutual benefits. joint SHC/SHSC presentations to SHSC staff to promote the opportunity to apply for funds and to take part in fund raising activities. The Trust is in the process of recruiting an associate director of communications and corporate governance, who will help to coordinate efforts between SHSC and SHC.	The committee supported the proposal and advised further engagement with communications needs to be done to ensure staff across the organisation are aware of the support through SHC.	N/A	N/A	BAF.0022

BAF Risks monitored at FPC 2024- 2025	
BAF.0021A	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	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	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	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	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.0030	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.

Appendix 4 COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Finance And Performance Committee	Date:	12/09/2024	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 – Month 5	M5 position will be reported as £63k adverse to plan. Value Improvement Programme (VIP) delivery including non-recurrent mitigation is forecast at £7.1m and therefore £0.2m risk unmitigated. There is an improvement between month 4 and 5 of £0.5m. Key risks continue to be out of area mitigation plan and demand for out of area which is presently 13 in use with a target of 9 by the end of September, which has been approved by EMT.	Plans to cover the unmitigated £0.2m include committing to stronger internal controls, such as There are 11 inappropriate and 1 appropriate out of area beds in use at the time of the committee. The plan is to reduce this to 9 by the end of the month. 4 of the 11 inappropriate beds are patients which are not Sheffield residents but are still registered with Sheffield GPs.	Discussions are taking place with the ICB to look at the agreement whereby non-Sheffield residents fall under SHSC's care as their registered GP Practice is Sheffield based.	October 2024	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
Electronic Patient Record Update - Rio training for new starters	The highlight report from August was shared with committee. On 4th September, progression through gateway 2 was accepted and stakeholder	The committee raised concerns about the training and support that is available for tranche 1, whereby the committee was advised that this is being reviewed with a clear narrative on what needs to be addressed and by when. The committee were	EPR will continue to update FPC on progress as part of the Transformation Portfolio Reporting	November 2024	BAF.0021 a

	engagement has progressed, however there are still some concerns about all ensuring all stakeholders are able to come to the engagement meetings. All engagement sessions have been scheduled and work is taking place with colleagues to ensure as many people as possible can attend. Considering this, the RAG rating is proposed to move from red to amber.	advised there was good engagement and problem solving at a recent workshop.			
Financial Performance Report (M4) - Over establishment	At an organisation view the Medics pay is the largest driver behind the pay overspend as other professions have partial offsetting vacancies to areas with overspending. The value for Medic pay is adjusted for offsetting income. Work is ongoing to review medical workforce across clinical areas and reduce medical locum expenditure. Enhanced observations are also a key risk for overspending. Delivery against recovery plans is ahead of plan but are forecast to fall short of the full year plan. Discussions around this are still ongoing to understand the final position.	The committee were advised that a medical establishment review process is underway and will be presented to EMT. The review aims to establish the commissioned position and the reasons for the drift. It is presently understood that there is an over establishment of medical staff in Older Adults but there are no temporary staff in this area so discussions are taking place on how to reduce the over establishment. The committee queried if over establishment across the Trust is on track whereby, they were advised that it is with nursing performing well, but the critical areas are in Psychology, AHP and medics.	Over establishment will continue to report as part of the Financial Performance Report	October 2024	BAF.0022
Financial Performance Report (M4) - Debt position	The outstanding aged debt is £3m in month 5 which has reduced from £4.3m since month 4.	Details were provided to the committee on specific debts, progress that has been made and actions being taken.	The Finance team are having fortnightly meetings to escalate any debts that have elapsed 30 days. Debt position will continue to report as part of the Financial Performance Report	October 2024	BAF.0022
Working Capital Review	The committee received the Working Capital Review.	The committee had no recommendations for change and approved the review.	N/A	N/A	All apply

Finance Strategy 2022-2026	The Finance Strategy update was received at committee.	The committee felt that the strategy update was a little too critical in terms of the performance and that it would be encouraged to focus and celebrate on the positives and the challenges that have been overcome as a result of issues in areas outside of the Finance Team's control. The committee sought clarification if the corporate benchmarking referenced in the update had been to committee.. The committee also advised that building the organisation's understanding and capability on finance decisions wider than that of the finance team is critical in ensuring VIP targets are met and strengthens the function of the strategy. The committee recognised the need to work more collaboratively with areas such as the workforce plans as it can assist in the immediate decision making but also relate into the 3-year plan. It was noted that catalogue control is in place but that additional consideration to procurement should be considered in the key priorities.	The strategy was approved for onward presentation to Board of Directors following inclusion of the recommendations. It was assured that corporate benchmarking data should be available in a couple of months and an update has been added to November's meeting.	November 2024	All apply

ASSURE (Detail here any areas of assurance that the Committee has received)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk
Corporate Risk Register (CRR)	The committee received the Corporate Risk Register which sought approval on the updates to risk descriptors and the inclusion of a Cyber Security Risk	The committee approved the recommendations and the inclusion of a Cyber Security Risk.	Corporate Risk Register will continue to report to FPC each meeting.	October 2024	All apply

BAF Risks monitored at FPC 2024- 2025	
BAF.0021A	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 an 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	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	T 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	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	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.0030	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 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.

APPENDIX 5 COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Mental Health Legislation Committee** **Date:** **4th September 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 Q1 (LRPOG)	The Least Restrictive Practice Strategy and workplan are due to come to completion at the end of 2024 and the final 3rd annual report has been completed. Work is underway to develop the new strategy workplan and it should be finalised for presenting to LRPOG in November 2024. People out of city and the quality and safety of the service they receive continues to be of concern. Waits for beds are increasing, leading to patients becoming more unwell as they wait and more likely to be subject to restrictive practices on admission. In addition, waits for discharge packages means that patients stay longer than required. Issues with access to secure transport has been reported this quarter. This can delay admission/transfer and lead to people becoming more unwell or becoming distressed by the wait.	The committee asks for future papers to indicate the number of physical restraints by ethnicity or gender; however, it was confirmed that better presentation of data won't be possible until Rio is in place and more nuanced data is anticipated to be accessible in early 2025. Mechanisms have been put in place to understand the quality and safety experienced by people in out of city beds and work is ongoing to limit out of city bed usage. Transport concerns are being reviewed by Greg Hackney and Greg Hughes to assess how the Trust may provide its own transport.	A cross committee referral to People Committee was requested relating to staff being able to access Respect training. It requested that People Committee provide assurance on what is being done to ensure that staff have protected time to access their training courses. LRPOG will continue to update MHLC via quarterly reporting.	December 2024
Mental Health Legislation Operational Group Q1 (MHLOG)	Assessments of mental capacity of patients to consent to an informal admission continue to not be undertaken consistently. There are	The committee were concerned with the number of patients who were not having their capacity assessed and that these figures	The committee requested for an action to be opened to look at the Second Opinion Appointed Doctors	December 2024

	risks of potentially unlawfully depriving a person of their liberty if such assessments are not done. There continues to be a lack of assurance that assessments of mental capacity to consent to treatment are being completed. The Trust continues to lack assurance in respect of providing information to patients under s132/132A Mental Health Act (MHA). This remains a risk on the Corporate Risk Register. The committee were advised that Second Opinion Appointed Doctor (SOADs) decisions are not always communicated by the responsible clinician. It had been raised by Board of Directors that there was a high number of patients absent without leave, however following a deep dive, it has become apparent that there are 2 ways of recording section 17 leave and different interpretations as to what absent without leave means. Work is underway to rectify these issues. The committee were asked to approve the proposal to change MHLOG meeting schedule to every 6 weeks instead of monthly starting from January 2025, along with approving the updated terms of reference and work plan for the group.	appear to be increasing. Bespoke training is being written for Birch Avenue training staff which will be delivered face to face by Jamie Middleton alongside 6 supervision sessions for the Clinical Manager in respect of this training. A review will then be conducted to assess if additional support is required. It was noted that there are proposed changes to the scheme of delegation which should aim to improve providing information on rights to patients detained under section 132 and section 132a. The task and finish group has been established and even thought attendance has been variable work has progressed. The committee approved the proposal to move MHLOG meetings from monthly to every 6 weeks.	(SOAD) decisions which are supposed to be communicated by the responsible clinician, however, show a marked drop in compliance on Maple and Dovedale wards. It was requested that appendix 1 which relates to absent without leave data is shared with Board members, which was emailed to the Board of Directors facilitator to disseminate. MHLOG will continue to update MHLC via quarterly reporting.	
Associate Mental Health Act Managers (AMHAMs) Activity Q1 Report	The Trust now has 11 AMHAMs, one less than the previous reporting period. Two new AMHAMs have been offered appointments and are currently undergoing onboarding processes. There has been an increase by approx. 40% in the number of AMHAM reviews that did not	The committee were advised that AMHAM numbers remains on the risk register. It was clarified that the reviews are not always been done before the expiry because of both AMHAM and Registered Clinician availability. The committee were assured that a pilot is	An action was opened to review the delays where AMHAM reviews are not actioned before the expiry dates so as to assess any trends and mitigate this risk. The committee were made aware that the closing date on the open	December 2024

	take place prior to the date of the current period's expiry. The main reason for not being able to hold earlier reviews was because of the availability of the patient's Responsible Clinician. Reviews not taking place prior to expiry of the current detention/order is a serious matter as it risks regulatory action against the Trust and giving patients a poorer experience of care. Two patients had to be referred for a Mental Health Review Tribunal as a result of delays in ward staff submitting a patient's application.	being conducted at Northlands to ensure hearings are planned into diaries earlier to avoid delays to hearings. Once the pilot has been concluded, learning will be shared across other wards.	advert on the website has expired so it was requested to review and confirm back to committee that this has been corrected.	
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**
Vision Based Surveillance	The committee received a report on the Vison Based Surveillance position statement which sought to make clear the use of surveillance within SHSC and the reasons for this, in addition to provide a statement about those systems which are not support and rationale for this. Human Rights Officer has conducted a review of the use of CCTV and it has been confirmed that whilst CCTV exists in some of our facilities, it does not record and so is used in a way that respects people's human rights. A pilot on body worn cameras was conducted in 2021 but there wasn't evidence to advise they made an impact on patient safety. The committee were advised that the Trust has been focused on valuing Therapeutic Relationships and how the clinical staff engage with service users, especially those which require periods of observation and engagement, rather than relying on vision-based surveillance.	The committee expressed support of the paper for onward presentation to Board of Directors and advised it was helpful to now have governance around the decision to not use vision-based surveillance. It was commended by committee that SHSC is performing very well regarding this topic and ensuring human rights are being considered.	N/A	N/A

	There has not been a scenario where police reports have been declined due to the lack of footage from body worn cameras.			
Use of Force Annual Report	The Use of Force annual report is a requirement of the Use of Force Act to summarise the Trust's work over the year but it also has aligned with the 3-year end of the strategy. There has been a significant reduction in Restrictive Practice which has been driven by a focus on clinical engagement, therapeutic relationships and working with patients who are distressed. The work recognises the importance of working with communities, service users, carers, and significant others, and as a result, culture change is taking place across the organisation.	The committee commended the team for the vast amount of work that has been invested over the 3-year period and the positive impact on restrictive practice and culture change. The committee asked what should be monitored by the Board of Directors to ensure sustained improvement, which it was confirmed that the following aspects are important rather than focussing on figures: • Engaging with teams to help them drive culture change and deliver on reducing restrictive practice, • Continued working with community such as PMC and SACMH, • Ensuring that human rights and co-production are central do any work in this area, • Continue to work to the governance that has been established.	The committee approved the report for onward presentation to Board of Directors for publication on the Trust website.	N/A
Corporate Risk Register	The committee received an update on the 5 risks which sit under the auspices of MHLC.	• Risk 5124 no proposal to change risk score. • Risk 4513 no proposal to change risk score but need to work with the risk owner to include reference to responsible clinician availability as well as AMHAM availability. • Risk 5026 The committee asked that the risk score is reviewed as potentially could be higher than current score. • Risk 5047 the committee approved this risk being merged within the existing mandatory training risk which sits under People Committee. The risk would still sit under directorate risk registers and assurance will then be provided to MHLC through MHLOG quarterly reporting.	The risk register will be updated and present to Executive Management Team ahead of Board of Directors.	December 2024

		• Risk 5220 the committee approved this risk being merged within the existing mandatory training risk which sits under People Committee. The risk would still sit under directorate risk registers and assurance will then be provided to MHLC through MHLOG quarterly reporting.		
Least Restrictive Practice Oversight Group Q1 (LRPOG) - Seclusion	Maple successfully moved to Dovedale 2 as the final part of the CQC improvement plan for removal of fixed ligature anchor points. Dovedale 2 is working without direct access to a seclusion room. Prior to this, a significant reduction in the use of restrictive practice has been noted along with improved use of de-escalation and record keeping as the ward moved to all male from mixed gender.	The committee commended that there are no seclusion rooms at Micheal Carlisle Centre and a standard operating procedure is being developed.	N/A	December 2024
Mental Health Act Scheme of Delegation	The Scheme of Delegation is an annually reviewed Board approved document which sets out who n the trust is authorised to carry out specific tasks under the Mental Health Act. The committee were asked to approve the proposed changes ahead of presentation to EMT and BoD.	The main change is an expansion of the roles as to who is authorised to provide information to patients under section 132 and section 132a. This will help to raise compliance levels in this area but also increase the diversity of staff who can provide information. The committee approved the proposed changes for onward presentation to Executive Management Team and Board of Directors.	N/A	N/A
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Policy Governance Group	The committee ratified the policies and extensions which had been presented to PGG in August 2024.	Key policies were identified for presenting to MHLC in full following approval at PGG. Mental Health Act Code of Practice Equality and Human Rights NCPS 010 was received at the September meeting and endorsed by the committee, with Blanket Restrictions policy being planned in for review in December 2024.	N/A	December 2024

BAF Risks Related to Mental Health Legislation Committee Discussions	
Number	**Descriptor**
BAF.0024	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.0025b	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.0031	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 .