Public Board of Directors
Item number: 9
Date: 30 July 2025

Confidential/ public paper:	Public
Report Title:	**Board Committee activity reports**
Author(s)	Corporate assurance team
Accountable Director:	Executive leads and the chairs of the assurance committees
Presented by:	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
Vision and values:	The Trust vision is to improve the mental, physical and social wellbeing of the people in our communities. The role of each Committee is to support the Trust Board by ensuring the strategic priorities are met. This ensures that **we keep improving**, whilst we work together so **we are inclusive.**
Purpose and key actions:	This report highlights key matters, issues, and risks discussed at committees since the last report to the Board in May 2025 to alert, advise and assure the Board.
Executive summary:	Each committee has considered issues under three key categories in their alert, advise, assure (AAA) reports. **Alert:** items from the from the meeting that require highlighting positive or negative and how it is being actioned. **Advise:** summary of the agenda items raised, and 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 AAA reports for the Board subcommittees are attached at the **appendices.** Appendix 1 and 2 - **Quality and Assurance Committee** AAA report from June and July 2025 Appendix 3 - **People Committee** AAA report from July 2025 Appendices 4 and 5 - **Finance and Performance Committee** AAA report from June and July 2025 Appendix 6 and 7 - **Audit and Risk Committee**

	AAA report from June and July 2025 Appendix 8 - **Mental Health Legislation Committee** AAA report from June 2025 Minutes from board assurance committees will be shared with the board via iBABs and non-confidential minutes are available to the public upon request

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	**X**	*No*		
Deliver Outstanding Care	*Yes*	**X**	*No*		
Great Place to Work	*Yes*	**X**	*No*		
Reduce inequalities	*Yes*	**X**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
• Well-Led Development plan that effective governance systems are in place to assess, monitor and improve the quality and safety of services. • Supporting principles within the Code of Governance for NHS provider Trusts (April 2023) issued by NHS England to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public, through effective flow of information between the committees and the Board.	
Board Assurance Framework (BAF) and corporate risk/s:	The committees have oversight of all BAF and corporate risks. Different committees offer assurance on a range of these including the management of associated risks.
Any background papers/ items previously considered:	Reports highlighted in the alert, advise assure reports have been received at all the assurance committees: • Quality Assurance Committee • People Committee • Finance and Performance Committee • Audit and Risk Committee • Mental Health Legislation Committee
Recommendation:	The Board of Directors are asked to: • **formally note the minutes** of the committee meetings being presented to the Board • **receive the alert, advise, assure** (AAA) committee activity reports within the appendices for **assurance** and **discussion**.

Alert Advise Assure
Quality Assurance Committee 11 June 2025

Alert:

IPQR

- There has been a deteriorating position with the recording of protected characteristics noting that the issue could be related to the recent implementation of Rio. However, in the areas where the pilot project has been implemented, good levels of improvement and engagement can be seen.

Positive Alert:

IPQR

- Out of area care is meeting its trajectory however there is only small headroom. It is anticipated that the Home First programme will help ensure this remains on track
- Staffing levels have stabilised at Forest Lodge with unfilled shifts reducing and being monitored on a weekly basis.
- Waiting lists in a number of specialist services continue to be in an improved position.

Advise:

Locally unreviewed incidents update

- As of 2 June 2025, there were 320 unreviewed incidents across SHSC (reduced from 416 on 19 May 2025).
- The committee received assurance that the situation is improving and noted that by September 2025 the remedial action will be completed.
- An update will come back to the committee in October 2025 to include an SPC chart. This will enable the committee to gain full assurance that the issue has been dealt with.

Patient Learning and Safety Report

- Developments reflect a proactive and structured approach to learning and improvement, with a clear focus on translating insights into measurable safety outcomes.
- The committee noted that learning from deaths is to be further reflected in this report prior to submission to Board of Directors. The committee asked that the papers clearly shows that mortality and learning are in separate reports.
- The committee raised concern about having one person involved in the reviews and debriefs can create a single point of failure and were advised that more work is needed to embed a safety culture and immediate learning and actions.

Clinical Quality and Safety Group

- The committee received a new style report from this group, noting that the group is in transition in terms of governance and assurance.
- The committee agreed that more assurance on the actions needs to be provided in future reports.
- The committee requested that a matters arising is added to a future QAC which would relate to “post incident debrief” and would look at incidents of restrictive practice and self-harm.

Medicines Safety Report -limited assurance

- The committee are not assured there is clear evidence that demonstrates if progress is being made in medication management
- There have been further incidents in missing medication.
- The committee asked there is a focus on the strategic issues and what has been done around them to provide assurance on improvements in future reporting.

Recovery Plan for Sheffield memory Service -limited assurance

- The predicted trajectory for the waiting list total for the end of April was 856 the waiting list as of April 25 is 774. The service is ahead of proposed target by 82.
- The committee acknowledged time is needed to enact the plan, whilst there is lack of evidence of pace.
- The committee requested a review of the quality measures for the memory service recovery plan to ensure the transitional phase maintains high standards.
- The committee noted that Memory service and OACMHT recovery plans were not highlighted on the front sheet of the IPQR as areas for concern. This will be addressed prior to submission to Board.

Older Adult Community Mental Health (OACMHT) Waiting times

- The team caseload has followed a reducing trend between February 2024 and January 2025. However, due to medic sickness / cover needed in other areas, the medic waiting list has subsequently increased.
- The committee requested the development of a plan to review the medical model in the older adult CMHT and consider the use of other professions for initial assessments, and report back at the next scheduled review.

Home First Programme

- The committee received the bimonthly update noting whilst progress against the Out of Area (OOA) trajectory is being made, the last few weeks we have not seen the same level of progress.

Assure:

Oxygen Supply Review Update

- The incident highlighted systemic gaps in oxygen prescribing, supply management, and emergency access across the Trust and the committee are assured that corrective actions are underway to prevent recurrence and improve patient safety.
- An audit has been suggested to be built into the clinical room audits and that a report goes through Senior Leadership Team, therefore it was agreed there is no need to report back to QAC unless there are any matters which need alerting to this committee.

Mortality Report Q4 and Annual

- During 2024/25, SHSC was fully compliant with the 2017 National Quality Board (NQB) standards for learning from deaths.
- The committee were assured that the Trust is compliant with national standards, and that benchmarking data is included.
- It was requested that before the report goes to Board of Directors that the conversation regarding Learning Disability deaths and inequalities-based approach is further drawn out in the paper.
- A report which is being prepared on the new framework for patient safety and inequalities will be presented to the Clinical Quality and Safety Group in July. To be shared as matters arising by September 2025.

Quality Equality Impact Assessments (QEIA)

- The QEIA panel have considered one scheme relating to workforce wellbeing electronic patient record system replacement.
- The committee are assured the process continues to be robust.

Safeguarding Assurance Group

- The committee receive the annual report indicating Sheffield Health and Social Care NHS Foundation Trust (SHSC) continues to meet its statutory safeguarding

responsibilities under the Care Act 2014, Children Act 2004 and associated national frameworks.
- The Trust remains non-compliant with safeguarding children level 3 training; however, a task and finish group has been established.

Policy Governance Group Report
- The committee received the monthly report from the group and **ratified** and **approved** the decisions of the meeting on 27th May 2025 on 3 policies.

Complaints Annual Report
- The committee are assured of the improvements being made with significant changes over the last few years, more focus on communication will offer increased assurance in future reporting

Risks reviewed: All risks reviewed by risk owners and approved by the committee.
- Risk **5001** review of the new wording – **Approved**
- Risk **5438** alerted to a review of the wording in response to an incident at Forest Lodge, to come back to the committee once the review is complete

Approved by:

Heather Smith, Committee Chair, Non-Executive Director

Date:

Alert Advise Assure
Quality Assurance Committee
Date: 9 July 2025

Alert:

Integrated Performance and Quality Report (IPQR)

- The recording of protected characteristics has **deteriorated** when used as a Trust wide average. The committee are concerned on the effect of this on the work on inequalities. The targeted improvement work underway with volunteer teams is proving to be effective, but there appears to be a lack of pace in rolling this out.
- Out of Area (OOA) and HomeFirst targets remain off-trajectory. Key drivers have been identified and the committee acknowledge the volume of work underway to address this. A report with further updates will be presented to the committee in September 2025.
- The committee **continue to monitor** issues such as referrals to Community Mental Health Teams (CMHT) and the waiting times for Eating Disorders, Sheffield autism and neurodevelopmental service (SAANs) and Gender Identity Service, along with the 111-response rate. There are signs of improvement but insufficient to remove them from areas of concern.

Quality and Equality Impact Assessments (QEIA)

- The committee noted there have been no panel meetings since the last report in June 2025.The committee raised concern over this and the Chief Operating Officer is going to look into this due to the number of value improvement programmes (VIP) waiting for review.

Advise:

Quality Assurance Report

- There have been sustained improvements in care quality, informed by triangulated evidence from Fundamental Standards of Care (FSoC) visits, Board engagement, service user feedback, and regulatory input from the Care Quality Commission (CQC).
- Progress with the embedding of the Quality Management System (QMS) and transitioning to the Ulysses audit platform is ongoing but not yet complete.
- **Concern remains** around the standards of clinical documentation, risk assessment, and care planning, however work is ongoing to address these issues.
- The committee asked for future reporting to use an Alert Advise Assure format to enable evaluative judgements to be discussed.
- The committee challenged how up-to-date the format of our clinical audits are eg FSoC. These will be reviewed. The next report will focus on the culture of care and community visits and there will also be an update on the FSoC review.

Enhanced Support Update (formerly Hotspot Report)

- The CQC unannounced inspection in May 2025 yielded broadly positive feedback; however, record keeping and medication management remain concerns.
- A Safeguarding concern raised on 11/06/25 regarding environment and care was found to be unsubstantiated and based on outdated evidence.
- It is proposed the enhanced support is stood down on Burbage Ward and Woodland View. The committee were assured that this was based on satisfaction of 'exit' criteria from the Enhanced Support process.
- The committee are encouraged by the robust and rigorous process in place which is positively impacting the quality of care and evidently further supporting staff.

Tier II Research, Innovation, Effectiveness, and Improvement Group (RIEIG) Report - including progress against strategy

- Most objectives within the strategy are being met and are being integrated into business as usual.
- Challenge remains around resources for clinical academic positions.
- The committee asked for more focus on improved communication and collaboration across the Trust to prevent silo working and missing out on the sharing of good practice.
- The committee requested that, in future there was consideration of how research projects are prioritised and **linked to the Trust's strategic priorities.**
- The committee asked for an increased focus on the diversity of the research champions' network.

Tier II Lived Experience Group Report

- Significant progress has been made in strengthening engagement across inpatient and community services, with over 240 service users supported by cultural advocacy workers and more than 40 community service visits conducted. Good practice is evident here.
- The development of the new Communications and Engagement Strategy is underway, due to launch in September 2025
- To the disappointment of the Committee, feedback collection has had a period of low priority/impact. There is the need for a shift in how teams work with feedback. The engagement team has a clear plan to support teams in this area.
- The committee asked for closer working between the engagement team and the Quality Assurance team to ensure that feedback and engagement is a stronger element of our understanding of the quality of our provision.
- The committee asked for more focus on engagement with OOA patients and families in the next report.
- The committee commended the ambition demonstrated in this area of work.

Integrated Performance and Quality Report (IPQR)

- The committee requested a detailed paragraph as matters arising in September on the Homeless Assessment and Support Team (HAST) and the implications of the end of Changing Futures funding and how the trust is mitigating this issue.
- Following an intensive support plan unreviewed incidents has fallen significantly over the recent months.
- Changes in observation practices on Endcliffe Ward have resulted in less clinical need for observations and a twilight shift has been used to support minimal use of restrictive practice and in the event of incidents.
- The committee have requested a thorough review of the recovery plans to ensure the right areas of concern are monitored; this review will be completed for September 2025.
- It was requested that progress against national key performance indicators (KPI's) and specific data quality issues be drawn out and highlighted in the IPQR report summary going forward.

Gender Identity Services Recovery Plan

- National demand has significantly increased exceeding available resources. Recruitment is underway to fulfil the required positions.
- The committee challenged how the reduction in average wait times to assessment for the Gender Identity Service can be achieved given the current referral rates.

SAANS and ADHD Recovery Plan

- To enable to Trust to meet commissioned service demands an action plan on short- and medium-term initiatives has been developed with the Executive Management Team (EMT), Directorate leadership team and Integrated Care Board (ICB)
- The committee requested future reports to include the 'average wait time to assessment' figure as there was a lack of consistency in consecutive reports of the data being used for comparison.

Assure:

Board Assurance Framework (BAF) 2025-2026

- The development of the BAF risk descriptions and score has taken place by the Board of Directors aligned to the refreshed Trust strategy, following discussions at the executive management team and Trust Board development sessions in June 2025.
- There are five BAF risks for monitoring by the Quality Assurance Committee – four risks have updated risk descriptions and scoring, and there is one new risk.
- The committee requested for all risks to be formatted in the same way to include the details and cause of the risk so actions can be clarified.

Internal audit open actions tracker

- The current percentage rate as of 26 June 2025 for completion of actions currently stands at 86% for both overall implementation rate and first follow-up rate.

Policy Governance Group (PGG) Report

- The committee **ratified** and **approved** the decisions of the Policy Governance Group in June 2025 including 5 policies and 4 extension requests

Staying Safe from Suicide - Best Practice Guidance for Safety assessment

- The committee received the report outlining the key focus points of the newly released 'Staying safe from suicide - Best practice guidance for safety.
- Work is being undertaken across the Trust to ensure the new guidance is reflected across the Trust.
- The guidance, as part of the personalised assessment of risk project, has been based on the 5P principles which fits within the current project and the Trust are ahead of the curve nationally
- The committee are assured on the good work ongoing and the positive progress which is evident. The work was commended.

Risks reviewed:

The committee **agreed** the revised risk description for risk 5438 for approval at the Board of Directors in July 2025.

The committee requested review of the wording of risks 4576 to ensure clarity and alignment with the corporate risk approach and to review the narrative of all risks to ensure it is clear what the risk links to.

Additional information:

The chair and Executive Lead to discuss when and how the clinical audit programme will come to the committee going forward.

Approved by: Heather Smith

	Date	11 July 2025

Alert Advise Assure

People Committee 8 July 2025

Alert:

Sickness

- Sickness remains a cause for concern. Whilst the May data has seen an improvement to 5.9%, this does not meet our target of 5.1%. In addition, committee recommended that this target should be more challenging, to match the local ICB target of 4.8% or the national target of 4% and to take account of public sector ranges of 3-4%.

Mandatory training

- Moving and handling level 2 sessions have not been able to run since December 2024 as the previous lead retired. The compliance rate is now low which presents a risk. An interim trainer has now been identified, and training is planned to restart in July.
- The committee requested that a recovery plan for Moving and Handling level 2 training is brought to People Committee for consideration in September and a discussion will take place at Executive Management Team to assess if providing level one training would be a sufficient mitigation in the interim.

Action plans in response to the Staff Survey results

- Only 12 out of 20 required actions plans have been received since the Staff Survey 2024.The deadline for returning these was 30 April 2025. This has been escalated to operational colleagues.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports and Action Plans

- The number of ethnically diverse staff into senior roles remains a concern. There has been a net decrease.
- In 2025 the percentage of disabled staff in clinical roles at Band 8c and above compared to the workforce overall has not improved and has worsened to minus 13%.
- The committee requested a recovery action plan to be shared with committee.

Positive alerts

Time to hire

- The time to hire parameters have changed nationally, and a local review of data has taken place, which has reduced our calculation of our time to hire to 48.61 days from 97 days previously. The new national target is 60 days.

Employee relation cases

- There has been a positive reduction in cases moving to formal processes between April and May. Average case length remains within target, however there are several cases which exceed this. There are focussed efforts on these cases to progress to conclusion. Proactive work is in progress to improve both process and staff/manager experience of the disciplinary process.

Supervision and PDR

- There has been a significant improvement in supervision and PDR compliance. At the time of the committee meeting, supervision was at 72.67% and PDR at 74.23% with further improvements anticipated. The target is 80%.

Advise:

Letter from NHS England on NHS job evaluation

- The Trust is on track with the implementation of the new nursing and midwifery role profiles and a job evaluation scheme is in place, involving appropriate representation including staff side. An update will come to a future committee.

Acute & PICU Inpatient Ward Supervision Recovery Plan

- The current compliance level for acute and community supervision is 77%, which is the highest it has been since reporting began.
- The committed requested to see triangulation between supervision, PDR, annual leave, and sickness to assess if we can evidence the correlation between supervision and lower sickness rates.

Assure:

- Workplace Wellbeing Annual Report showed there are positive outcomes from the work done by the team and a proactive approach to continuing to strengthen the offer to staff.
- The committee acknowledged the positive outcome of the NHS Senior leadership visit (Education agreement) and the work that is planned to grow the Library and Knowledge service.
- The committee praised the early completion of the actions within the Fair to Refer Report and noted that the Trust is compliant with the requirements.

Risks reviewed:

- The committee approve the revised risk descriptor of BAF 0013 and increased score of 16
- The committee approved the revised risk descriptors for BAF 0014 and BAF 0020 noting the risk scores remain unchanged.
- The committee approved the inclusion of the new risk BAF 0028 (racism) with a score of 16 and discussed the need to focus on this more explicitly in future meetings.
- Risk 5409 relating to medical staffing and recruitment challenges continues to be managed with further active recruitment and one action is overdue for review. No changes to the scoring currently. Committee requested clearer reporting on this in the data dashboard.
- Risk 5358 has been updated to reflect the detailed violence and aggression plan in place and one action is overdue for review. No changes to the scoring currently.
- Risk 5321 remains the same whilst the national mandatory training review is underway to look at how training will be delivered. No changes to the scoring currently.

Feedback to Trust Board:

There was no additional feedback to the Board other than indicated in the alert and advise section of this report.

Approved by:		
Heather Smith, Chair and Non-Executive Director	**Date:**	13/07/2025

Alert Advise Assure
Finance and Performance Committee
Date: 12 June 2025

Alert:

Financial Performance Report (M2)
The committee were advised of a £400k overspend at month two, primarily due to the value improvement programme (VIP) which was noted to have an adverse variance of £450k.

The committee noted the update to VIP plans and clinical teams working to 20 June deadline for a comprehensive update. The quarter one position will be a critical milestone to understand forecast delivery and take any mitigation to ensure delivery of plan.

The committee were assured that there will be implementation of weekly monitoring conversations with executive colleagues to track performance against the VIP plans and resolve issues in real-time. It was also noted that during June, out of area has been challenging and that an enhanced recovery team has been established which aims to encourage medics to liaise with out of area providers and challenge long lengths of stay.

The committee raised concerns about the cumulative effect of VIP plans on the Trust and the potential impact on staffing.

The committee understood that the impact of VIP can impact not only financially but on morale, resulting in potential grievances and subsequently create delays to projects therefore it is important to consider the quality and people impacts.

Advise:

Developing our approach to performance improvement
The committee welcomed the approach and recommended it for onward presenting at Board of Directors as well as ensuring it is widely socialised and engaged with a variety of audiences. The committee were advised that the final framework will come back to committee in August 2025 and it will include national benchmarking in the performance improvement framework and set clear timelines for implementation.

Estates Strategy 2021-2026 Draft
The committee received the draft estates strategy and were advised that more work is to take place to develop the strategy before it returns to FPC ahead of presenting to Board of Directors.

Assure:

Annual Review of Performance Framework including Finance and Performance related Key Performance Indicators
The committee approved the framework and key performance indicators outlined in the report.

Risks reviewed:

- All corporate risks have been reviewed in accordance with the review frequency outlined in the risk management framework.
- A new risk (5462) in relation to a risk that the Rio optimisation phase does not deliver the expected benefits has been added to the risk register with a risk score of 4 x 3 =

12 (severity x likelihood). • The committee approved the amendments in the report for onward presentation to Board of Directors.		
Additional information: • N/A		
Approved by:		
Owen McLellan	**Date**	19/05/2025

Alert Advise Assure
Finance and Performance Committee
Date: 10 July 2025

Alert:

Financial Performance Report (M2)

- The year-to-date deficit is £387k higher than planned, this is a result of Value Improvement Plans (VIPs) being behind plan by £450k.
- Work is ongoing in June to ensure more plans are signed off and have plans in place to deliver within this financial year. The forecast of achieving the plan is on the basis that the VIP requirement of £8m is achieved.
- There is a year-to-date underspend on capital, we have been informed that our bid for safety schemes has been approved, and we are going to receive £1.2m of funding rather than the £0.8m included in the plan, this is the reason for the additional spend on the forecast.
- ICB funding for out of area beds ended in March 2025 with focus on Better Care Fund discharge funding being focussed on staffing to enable discharge into the community.
- In 2023/24 Medics pay was highlighted as the largest driver, with approval of additional medical budget within the 2025/26 planning and reduction in some costs there is a small underspend of £6k for Month 2. The forecast is based on several medical vacancies continuing due to it being difficult to recruit, work is also continuing where there is still Medical overspends as part of recovery plans within the Value Improvement Programme.
- The committee were concerned that at this point in the financial year, there are £5.9m worth of schemes that are yet to develop as plans with QEIAs also to be completed. The committee were assured that although the trajectory for completion is off track, significant work has been done to offset this in terms of non-recurrent underspend. Structures and processes have been embedded which will allow delivery of the plans which have been signed off and QEIA meetings will take place fortnightly instead of weekly to work through the backlog.

Advise:

Sustainable Development Group (SDG) AAA Report

- SDG members have been set an action to update the Green Plan Action Plan to ensure all action are SMART by 31st May 2025. We are still lacking ownership for actions under Low Carbon Care and Adaptation focus area (total 13% action have no owner). There remains to be significant gaps in actions start (56% of actions) and end dates (60% of actions).
- There is a funding risk to implement SHSC Heat Decarbonisation Plan (HDP) due to withdrawal of Public Sector Decarbonisation Schmoe (PSDS) grant funding. Further funding opportunities continued to be explored.
- The committee requested to see the action plan and milestones around achieving carbon net zero in the next report to committee.

Assure:

Annual update: Sheffield Hospitals Charity (SHC)

- There has been positive progress in strengthening the relationship between the Trust and SHC which has resulted in income to the organisation with improving inclusivity being a driving factor in the successful bids.
- SHC will have several time-limited strategic funding calls throughout the year. We will encourage colleagues to make high quality bids for these opportunities. The next one will open in June and will be focused on Reducing Health Inequalities.
- The committee expressed that communication regarding how to access funding should be shared wider across the organisation.

Risks reviewed:

- The development of the Board Assurance Framework risk descriptions and scores have taken place by the Board of Directors aligned to the refreshed Trust strategy, following discussions at the executive management team and Trust Board development sessions in June 2025.
- The committee asked for the Board Assurance Framework and corporate risks to align to one another with narrative on what is the cause for each risk to be further drawn out.
- The committee queried if the gender service corporate risk should also report into FPC as well as Quality Assurance Committee, which will be discussed with action owners.

Additional information:

N/A

Approved by:

Owen McLellan	**Date**	23/07/2025

Alert Advise Assure
Audit and Risk Committee
Date: 16 June 2025

Alert:

None

Advise:

Draft External Audit Reports – ISA260 and Annual Auditors Report

- The intention is to issue an **unqualified opinion** on the financial statements and the external auditors have identified no significant weaknesses regarding the Trust's value for money arrangements for 2024/25.
- The committee are content with the overall position of the Trust and are assured where issues are identified they are being addressed with insight on capabilities.
- The Annual Report 2024/25 is compliant with Annual Reporting Manual (ARM)requirements and areas subject to audit with no inconsistencies with the Accounts identified.

Draft Management Letter of Representation

- The committee **approved** the report for onward submission to the Board of Directors in accordance with standards, subject to the additional noted narrative and final wording on the Health and Safety Executive (HSE) matter.

Final draft Annual Report including final accounts and analytical review and final annual governance statement.

- Changes made to the final accounts through the audit process include reclassification of operating expenses and corrections to related party disclosures.
- Comments will be made in the final accounts, if necessary, should the sale of Fulwood not proceed.
- The committee **approved** the annual report for recommendation to the Board of Directors for final ratification.

Quality Account

- The committee received the final version of the quality account noting feedback from Sheffield Integrated Care Board (SY ICB), Healthwatch Sheffield and Sheffield Health and Well-being Scrutiny Committee has been considered.
- There is an error noted on the document relating to the job title of an individual at the SY ICB this will be corrected prior to publication.
- The committee **approved** the final version for onward recommendation to the Board of Directors pending the update as noted.

Assure:

Internal Audit Plan

- There are no significant changes to the final plan since presenting the draft to the committee in May 2025
- The committee **approved** the final internal audit plan 2025/2026 for onward recommendation to the Board of Directors

Internal Audit Progress Report 24/25 and 25/26

- Significant Assurance has been issued on the Performance Management Framework, Patient Safety Incident Response (PSIRF) framework and absence management Audits. Work is ongoing around observations and engagement.

- The committee are **assured** that the issues raised are being considered and, where necessary, addressed by the Trust.

Final Head of Internal Audit Opinion and Annual Report

- An opinion of **significant assurance** is provided noting there is generally a sound framework of governance, risk management and control designed to meet the objectives of the system under review and controls are generally being applied consistently.

Risks reviewed:
None

Additional information:
None

Approved by: Anne Dray, Non-executive director and committee Chair.

	Date	6 July 2025

Alert Advise Assure
Audit and Risk Committee
Date: 14 July 2025

Alert: No alerts

None

Advise:

Internal Audit Progress Report

- Data Security and Protection Toolkit (DSPT) audit report has been provided with a low-risk assurance and high confidence opinion in-line with NHS England methodology.
- The terms of reference for the Fit and Proper Persons Test, Safeguarding and Duty of Candour audit reviews have been agreed with work commencing on audits in July 2025. Audits taking place in August 2025 will be the Safeguarding review.
- The follow up rate for internal audit actions stands at 100% for quarter 1 and the committee are assured of progress.

Internal Audit Action Tracking Report

- Summaries of the remaining open actions from 2024-2025 were received noting the overall first follow up rate is 86%.
- Absence management, Patient Safety Incident Response Framework (PSIRF) and performance management framework all received significant assurance.
- The committee requested full audits to be made available for members on iBabs and a process to strengthen the management of oversight of reports.
- The committee flagged that the monitoring of internal audit actions for the Divisional Risk Management report overseen by ARC has only one named person responsible. This will be reviewed.
- A review of all deadline dates for audit actions will ensure in year improvements can be achieved rather than a deadline date. .

Counter Fraud Bribery and Corruption Annual Report

- 10 new referrals of suspected fraud, bribery, and corruption have been received, and it was confirmed SHSC had a return on investment of £1.91 for every pound spent, compared to the NHS average of £1.06.
- The committee were updated on ongoing investigations, including a workforce issue which has resulted in overpayment of salary.
- Counter Fraud Functional Standards were presented with an overall green and 4 ambers are currently being addressed.
- Due to increased investigation demand the number of reactive days was increased within the 2025/6 plan agreed by the Exec Director of Finance.
- The committee are concerned regarding the lack of engagement with training. This will be addressed with the relevant team(s) and support will be sought from the executive managers to aid improvement.

Annual Report and Accounts Planning Process

- Improvement areas in the planning process have been identified with emphasis on planning and clear accountabilities.
- Learning and reflections will be incorporated into the process for next year so it is more efficient and streamlined. Updates on the timetable will come to the committee in October 2025.

Single Tender Waivers

- 3 waivers were reported in this cycle associated with estates and the Good Governance Institute (GGI)
- The committee are assured on the robust processes in place with no concerns noted.

Risk Management Framework

- The committee received the updated document for comment and feedback prior to submission to the BoD.

Information Governance, Cyber Security & Artificial Intelligence Group

- The committee noted the good progress on subject access requests (SAR's) despite previous challenges.
- Improvement work has taken place on cyber security and communications on artificial intelligence (AI) around obligations of staff to ensure there are good quality control measures in place.
- The committee raised concern over external cyber-attacks, the poor response previously on a test of phishing emails and the need to maintain a focus on training and exercising. The Committee also discussed the use of data protection impact assessments.

SIRO and Caldicott Guardian Annual Report

- The committee approved the request to stand down the single annual report as it now comes through regular reporting to the committee

Assure:

External Audit Progress Report

- The final accounts were submitted on time and will be shared with members offline once available

Governance Report

- The committee received the current iteration of the governance report covering declarations of interest, fit and proper person test compliance, governor elections, and the upcoming annual members meeting.

Policy Governance Group

- The committee approved and **ratified** the decisions of the group in relation to the Accessing Legal Advice Policy.

Risk Oversight Group (ROG)

- The committee received the group report detailing work that has taken place to review the Corporate Risk Register (CRR), the risk management framework and Board Assurance Framework (BAF) for information and assurance and the group continue to use the monthly extraction reports from Ulysses for risk monitoring.

Risks reviewed:

BAF 0021b risk description reviewed and approved emphasising the importance of ensuring that actions taken will effectively close the gap between current and target scores for each risk.

CRR 5461 narrative of the risk to be reviewed.

The committee agreed to the revised risk description **5438** and for the 2 new strategic risks **5461** and **5351**

Additional information:

None

Approved by: Anne Dray, Non-executive director and committee Chair.

	Date	23 July 25

Alert Advise Assure

Mental Health Legislation Committee (MHLC)

4 June 2025

Alert:

Non-compliance with tribunal reports

- There has been non-compliance with tribunal reports in respect of legal directions being issued by HM Court and Tribunal Service.
- The committee were advised that any non-compliance with tribunal reports is being incident reported, with a central log to monitor themes. The committee noted the importance of incident reporting for non-compliance orders to ensure proper logging and escalation through relevant line managers. Actions were taken by members of the committee to communicate the important importance and ownership of complying with the reports. A focussed update on this area will be presented in the September committee.

Mental Health Act mandatory training

- The Trust continues to be non-compliant with Mental Health Act (MHA) mandatory training. As a mental health provider with responsibilities under the MHA, this is likely to attract regulatory interest.
- Commissioners have recently indicated that to be compliant with mental capacity related legislation, compliance must be 90% or more. This position is at variance to the compliance target of 80% understood by the Trust. Clarification is being sought from Commissioners.
- The non-compliance with Mental Health Act mandatory training is monitored by a corporate risk which reports through People Committee.
- It was requested that future reports include the training trajectory and recovery action plan.

Health Based Place of Safety (HBPoS) for non-section 136 related activity

- The committee challenged the use of Health Based Place of Safety (HBPoS) for non-section 136 related activity noting that there is a risk to the organisation. The committee were given assurance that the third regional suite is often kept available for its intended purpose, and there is an escalation process in place to Executive level where a service user's admission exceeds the timeframe. It was agreed that MHLC should oversee the improvement trajectory and so a report on HBPoS is to come back to the September committee.

Peer support worker funding

- The committee highlighted funding issues for peer support workers on inpatient wards, noting that ward budgets do not allow for their inclusion. The potential inclusion of peer support workers in the staffing model for the new female ward could provide an opportunity to test their effectiveness. It was noted that metrics and evaluation of parameters will be put in place to evaluate the effectiveness of various components in the new female ward.

RESPECT Training

- Compliance remains below the 80% target due to staff non-attendance and limited training capacity. Although improvements have been made, this continues to pose a risk ensuring sufficient trained staff are on duty. This is reflected in Corporate Risk 5220.
- The committee noted there is a legal requirement as to what goes into the RESPECT training hence it spans 4 days, however it was requested to consider if elements can be done on Teams.

Advise:

Associate Mental Health Act Managers (AMHAMs)

- Two new AMHAMs have recently completed their training and have started to shadow hearings
- Concerns were highlighted regarding the quality of social circumstances reports for tribunals, noting that feedback from AMHAMs often lacked specific details.
- The committee discussed the need for AMHAMs to provide more specific feedback to improve the quality of reports and ensure continuous improvement. Work is underway with AMHAMs to ensure they provide specific narrative feedback when scoring reports poorly.
- The committee recommended a sampling method to obtain feedback from not only the AMHAMs but also clinicians and patients rather than AMHAMs providing feedback on each patient.

Completion of consent and treatment forms

- The committee noted the improvements in the percentage of consent and treatment forms being completed and that the number of incidents related to section 17 leave has fallen.

Levels of seclusion

- Q4 has had the lowest use of seclusion since recording began with 68 days without seclusion in PICU.

Least Restrictive Practice Oversight Group (LRPOG) delayed workstream actions

- Six actions are currently delayed, including improvements to digital infrastructure, environmental reviews, and embedding peer support roles. These delays are primarily due to staffing constraints and funding limitations.

Mental Health Bill – Briefing

- The bill continues to progress through the parliamentary process. There are no current scheduled dates for future stages, however, typically the bill will enter the committee stage around 4 weeks after the first reading.
- There are significant human rights concerns with the upcoming mental health bill, noting that it may not address racial disparities or comply with international human rights standards. Careful monitoring of the bill's impact will be undertaken. However, its final form and implementation timeline are still uncertain.

Assure:

Utilisation of Maple Ward as a Seclusion Unit

- The committee were advised that whilst initial plans were drawn up for a stand

along seclusion room on Maple Ward, this was never finalised, operationalised nor utilised and other ways have been found to manage patients using least restrictive practices. It was confirmed there are no associated risks or new actions that need to be considered.
Risks reviewed: There are no board assurance framework risks and 2 corporate risks to discussion at this committee: • Risk 5026 relating to Deprivation of Liberty Safeguards (DOLS) framework has no change to the score of 12. The risk continues and there are occasions still arising when service users are deprived of their liberty with no lawful authority (via DOLS process). • Risk 5124 relating to compliance with s132/132A Mental Health Act has no change to the score of 12. Incident data is currently being reviewed to establish frequency of non-compliance, and the risk score will be reviewed when the data analysis has been completed. • The committee asked for a review of the actions for risks 5026 and 5124 to ensure they are sufficient to achieve the target scores and consider if the target scores are realistic
Feedback to Trust Board: There was one cross-committee referrals from MHLC: • To People Committee The committee raised concerns over the increase in the required level of Mental Health Act training and asked that a cross-committee referral to People Committee takes place.
Approved by Chair and date: Olayinka Monisola Fadahunsi-Oluwole 04/06/2025