Public Board of Directors
Item number: 9
Date: 24 September 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 July 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 - **Quality and Assurance Committee** AAA report from September 2025 Appendix 2 - **People Committee** AAA report from September 2025 Appendices 3 and 4 - **Finance and Performance Committee** AAA report from August and September 2025

	Appendix 5– **Mental Health Legislation Committee** AAA report from September 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 • 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
Date:10 September 2025

Alert:

- No new risks to alert to Board from this meeting. We continue to monitor issues such as OOA, waiting lists in some specialist services and recording of protected characteristics. Work is ongoing in all these areas with signs of progress being made.

Advise:

Homeless Assessment and Support Team (HAST) Update:

- The Committee requested an update following the ending of the Changing Futures additional funding for this service.
- A review of the HAST service, led by Sheffield ICS, has developed a consensus for the focus of the service, highlighting the high regard the service is held in by partner agencies.
- Key actions and areas of focus have been identified including investment to stabilise current services through Sheffield Integrated Care Service funding.
- The committee were pleased to hear the creative and productive solution in place including collaborative arrangements with other teams within the Trust eg AOT.

Learning Disabilities (LD) Service Change – update.

- The model has been reviewed incorporating pilot results and feedback from LD carers and Sheffield Voice. Collaborative working continues with Sheffield Voice and also now includes Mencap.
- A service which is responsive and flexible to accommodate people outside a 9-5 service is envisaged and this is fully supported by the Integrated Care Bord (ICB) and a representative from Mencap will be joining the LD board.
- The committee were optimistic around the likely outcomes following the service changes. The ongoing work is insightful, focussing on service user experience, outcome measures and the more effective use of the staffing resource available.

2025/2026 Q1 Health and Safety Committee Alert, Advise and Assure Highlight Report

- Relevant policies, procedures, compliance meetings, protocols, and documentation is available to demonstrate statutory compliance with legislative requirements and outlines actions where non-compliance issues are evident. In addition to this there is the health and safety action plan that further demonstrates that SHSC effectively identifies gaps and is working towards resolving these.
- The committee noted that whilst risks associated with fire doors will begin to decrease at the end of 2025, as doors are replaced, it was requested that the BAF risk is reviewed, with future reports to include a projection for the decline of this high risk.

Annual Report – Suicide Prevention England 2025 -report received

- During the period August 2024 to August 2025 there were 25 suspected suicides in SHSC. Of the 25 deaths zero were reported in inpatient settings, which is a significant change.
- Workstreams and processes are in place which aim to reduce suicides in Autism and ADHD, and include green light working, autism specialist trained staff, and a model for new female ward being planned with ASD specialisms in mind and specific skill mix model to support this.
- The new Personalised Assessment of Risk work is ongoing to replace the DRAM assessment. The document is based on the 5Ps formulation approach and has been designed in collaboration with NCISH, Culture of Care and other NHS Trusts

supporting Culture of Care with the projects.

- The committee acknowledge the work ongoing in addition to what is happening nationally and the evidence of positive partnerships in place locally.

Learning Into Action Plan: Response to Nottinghamshire NHS Foundation Trust Review

- The staff engagement events have identified many recommendations, some of these can feed into ongoing workstreams however there are several actions that need clarity on how to deliver and who can action these.
- There will be monthly meetings to govern the action plan, however there is a risk that this will duplicate with other governance structures that some of the actions sit under – creating duplication of reporting or actions not being reported on through the right streams of work.
- The committee can advise the Board that we have the requisite response and action plan in place, as required by NHSE. To note that many of the recommendations in the Nottinghamshire review aligned with our current improvement work, indicating that we have a grip on what needs to be done going forwards.

Forest Lodge Improvement Update

- The South Yorkshire Provider Collaborative undertook an Annual Quality Review (AQR) (July 2025) the draft report was received 19 August 2025, and it outlined 55 recommendations, some of which must be completed before the service can reopen to admissions and exit enhanced monitoring. Recommendations made triangulated with our own assessment of the issues.
- Since February 2025, a weekly Improvement Group, chaired by the Executive Director of Nursing, Professions and Quality, has overseen the delivery of a robust and responsive improvement programme.
- The committee are assured patient quality and safety is improving as a result of the robust plan in place.

Bi-annual Population Health and Inequalities Update

- The governance process for health inequalities has been reviewed to streamline and reduce volume of reports and potential duplication. Reporting will align with both health inequalities statement and annual report timelines.
- An annual re-assessment has taken place. The results show improvements across all four domains
- The committee are assured by the progress of the current work indicating a positive start. Impact will take time, it was acknowledged. There is more work to be done but there are plans in place that include working collaboratively with others across the city.
- The committee **recommended** the Annual Statement on health inequalities for onward **approval** at the Board of Directors

Integrated Performance and Quality Report

- The committee received the new version of the IPQR, produced following engagement and feedback from stakeholders across the Trust including a Task and Finish group. Intended to provide a more holistic, integrated, and strategically aligned understanding and assurance of the Trust's performance and the details of action that is being taken to improve. An AAA-style front sheet will be produced in future months which will aid the committee's discussions and assurance process.

Protected Characteristics Recovery Plan

- Positive impact is demonstrated through quality improvement work with the small number of teams in the pilot. The new change methodology is having impact but the next step is scale and spread of improvement.
- The implementation of RIO does not assist with the protected characteristics data improvement as only 2 metrics migrate over from the Spine.
- Work is underway to ensure we have sight of data for teams who do not use Rio but use SystemOne and Iaptus.
- Lessons learned support the wider programme of work to improve data collection across the Trust. The committee commended the evident impact so far whilst recognising the need for the engagement of teams not currently in the pilot and a trajectory for improvement across all teams.

Board Assurance Framework (BAF) Q2

- The committee received the revised BAF risks 2025-2026 which have been aligned to the refreshed Trust strategy and were approved by the Board of Directors in July 2025.
- Risk descriptions have been updated to ensure consistency with the recommended format of as per the risk management framework and following an internal audit action assurances are now identified as positive or negative.
- The committee **noted** the updates to the BAF prior to submission to the Board of Directors.

Home First Programme

- The committee received the bi-monthly report and acknowledged the hard work of all the teams and are waiting in anticipation for the evidence-based results and changes.
- Alert: staffing requirement to support the implementation of gatekeeping in September
- Acute Wards Standards: Good progress made, though implementation delayed to early September.
- HTT & Flow Service Model: Focus on gatekeeping; resource needs identified.
- CMHT Referral Criteria: Defined with GPs and Primary Care Sheffield to ensure timely, appropriate referrals.
- Length of Stay (60+ Days): MADE events to start 1st October, targeting complex and MOJ patients to support discharge.
- Risks are being managed by the Programme Board

Assure:

Mortality Report Q1

- During quarter 1 2025/26, SHSC was fully compliant with the 2017 National Quality Board (NQB) standards for learning from deaths. 63 deaths (2 of which were learning disability deaths) were incident reported and reviewed via mortality processes.
- The committee discussed the recent LeDeR national findings and the increase of mortality in ethnically diverse patients. We will undertake further analysis of our data to understand actions which are required. Plans are in place to undertake structured judgement reviews of deaths of people from ethnically diverse backgrounds. In the absence of better demographic data, this approach was commended.

Patient Learning and Safety Report Q1

- High levels of incident reporting have been sustained, with most incidents resulting in low or no harm. Improvement work is aligned to the five patient safety priorities: unexpected deaths, self-harm, medication errors, restrictive practice, and falls, with measurable progress in each area.
- Risks are evident across multiple data sources and are identified for sustained attention including risk assessment, substance misuse, discharge and transfer safety, domestic abuse enquiry process and digital integration gaps.
- The committee congratulated the strong triangulation evident in the report and are assured the right processes are in place. Learning has been extracted and acted upon (quality improvement processes) and this has changed practice because of the work being done. A notable example is the reduction in incidents of self harm.

Quality and Equality Impact Assessment (QEIA) Alert, Advise, Assure report

- The panel has convened more frequently than usual in July and August to respond in a timely manner to proposals being presented as part of the Value Improvement Programme, so as not to prevent the timely delivery of the Trust's financial plan.
- A total of eighteen schemes were considered, all of which were associated with value improvement schemes, 2 schemes weren't supported, and further work is to be undertaken, and 16 schemes were supported.
- The committee are assured the processes are robust.

Infection Prevention & Control (IPC) Quality Assurance Committee Annual Report (2024-25)

- The overall picture is one of continued progress against the established framework for evaluating the effectiveness of infection prevention and control measures across the Trust.

- Following the implementation of improvement plans both areas received a good rating resulting in 30 areas within the annual programme achieving a rating of 90% or above. Significant progress has been made during 2024/25 to how SHSC records and manages healthcare associated infections (HCAIs), working in collaboration with the pharmacy and clinical teams to identify infections, improve microbiology sampling and antibiotic prescribing.
- The committee noted the well managed service, with improvements evident year on year.
- The **committee** approved the IPC annual report 2024-2025.

Policy Governance Group Report

- The committee received the updates from the group noting there were no policies reviewed in July 2025.
- In August 2025 2 policies were presented for ratification and 2 policy extensions for approval. The committee **ratified** and **approved** the decision of the group

Safe Staffing Report (Clinical Establishment Review progress)

- The committee received the report post People Committee for information. Assurance was received and accepted.

Implications of the Penny Dash Review

- The Penny Dash review, published in July 2025, sets out nine major recommendations to improve patient safety and quality across the NHS, highlighting significant issues with duplication, fragmented oversight, and limited impact from existing national bodies.
- These changes mean adapting governance structures, improving data capability, and preparing for new regulatory expectations. As a Trust there is already progression in these areas through our partnership with the Good Governance Institute (GGI), the development of a revised Integrated Performance and Quality Report (IPQR) and strengthening patient voice.
- Next steps include presenting the new governance framework to EMT in October 2025, finalising the revised IPQR, and implementing Care opinion in October 2025.
- The committee are assured that we are in a good position to respond to the recommendations of the Dash Review, many of which we had anticipated and had been acting on.

Risks reviewed:

- The committee **noted** the updates provided on all corporate risks and **approved** the revised risk description for 5438 for onward recommendation to the Board of Directors (BoD.

Additional information:

- None

Approved by: Heather Smith, Non-Executive Director and Committee Chair

	Date	13 September 2025

Alert Advise Assure
People Committee
9 September 2025

Alert

Sickness

- Sickness remains a cause for concern. In-month sickness has only decreased slightly from 6.9% to 6.75%. Target is reduction of trust wide in-month sickness by 2% (to 4.75%) by March 2026.
- A sickness action recovery plan has been developed, and implementation began 05/08/2025. Additional support is being provided to services to manage sickness via weekly meetings. The committee received limited assurance about the plan and it was acknowledged that more work needs to be done (especially around knowledge of HR processes and tracking of these).

Acute & PICU Inpatient Ward Supervision Recovery Plan

- There continues to be recording issues linked to ESR due to visibility issues for managers. Workforce is working on restructuring the hierarchy to fully resolve this issue. The committee expressed disappointment at the extent to which systems-issues are sometimes a barrier to progress.
- At the time of the meeting, Burbage is at 60% and Dovedale 2 and Endcliffe are at 80% compliance but this is not reflected in the data.
- The committee noted that senior managers have implemented a rota to release staff for supervision during periods of high acuity, emphasising the importance of supervision for staff wellbeing, especially following incidents of aggression and violence.

Positive alerts

Time to hire

- Average time to hire from April to July is 55 days which is below the target of 60 days

Employee relation cases

- There are 18 formal employee relation cases open, with an average case length of 4.5 weeks, which is within KPI targets.

Safe Staffing Report (Clinical Establishment Review progress)

- The trust is operating within safe staffing levels without excessive use of temporary staff, except in specific high-acuity areas.
- Improvements have taken place in rostering and reducing agency use (now down to zero), particularly for Health Care Support Workers.
- A reduction in observations has led to a reduction in the use of staff above establishment and, by implication, less restrictive care.
- It was noted that the inclusion of multidisciplinary mix in the safe staffing review is not yet possible and an update will be reported when it becomes

feasible within the next year.

Mandatory training

- There has been improvement with 3 additional mandatory training subjects reaching the target percentage:
    - Mental Health Act – 83.47%
    - Resuscitation Level 3 (ILS) 84.52%
    - Rapid Tranquilisation 86.51%

Advise

Supervision and PDR

- Trust wide supervision compliance has recovered to 73.5% following a significant reduction seen when recording was moved to ESR in Jan 2025. However, this is still just short of the target of 80%.
- PDR compliance improved significantly in June and again in July. The seasonal PDR window was extended to 31 July 2025. However, only 83.5% of staff had a PDR recorded meaning that, despite the extension, we did not achieve the target of 90%.
- All areas are recording supervision and PDRs on Manager Self Service; however, some areas have dropped in compliance over the last couple of weeks.

Mandatory training and recovery plan

- Mandatory training Compliance is at 89.7% across the organisation and consistently above the 80% target for all directorates. We are below target for 8 subjects, but this is an improving position eg Moving and Handling (a trainer has now been appointed).
- A recovery plan is in place and will report by exception to the committee.

People Plan Update Report including updates on all professional plans

- The committee noted that the People Plan is broadly on track and noted the need to align future strategy with the forthcoming NHS 10-year workforce plan and management standards. This would guide the development of the people strategy refresh and a target operating management model which is being developed for HR and OD teams nationally.

Medical Workforce Planning Update

- An update was presented and the committee recognised the persistent recruitment and retention issues and the need to reconcile establishment and financial data
- Committee noted the innovative work underway to address some of the medical workforce staffing issues.

Health & Safety Committee Report Update Q1

- The report was received and more data requested on the Violence and Aggression reduction workstream in future reports.

July People Pulse Results

- 368 responses received, equating to 13% of SHSC staff based on current headcount. In 2024, we received 427 responses.
- Our overall engagement score is 6.59, remaining static when compared with July 2024.

Inclusion and Equality Assurance Group Report

- The committee noted the lack of progress in ethnically diverse staff in senior roles and noted that work needs to be done, building on current action and future plans, to embed a comprehensive talent management and progression system.
- The committee discussed the need for more interim impact measures to track progress which will be included in future reports.

Assure

Internal Audit Action Tracking Report

- The current percentage rate as of 29 August 2025 for completion of actions currently stands at:
  - 100% for first follow-up rate for medium and high-risk actions.
  - 90% follow up rate for overall implementation for all risks.
- 08 Absence Management 2024-25
  - Received on 9 June 2025 with significant assurance.
  - There are seven open actions (three medium, four low).
  - Two are on track for completion by their due date at the end of September 2025.
  - The remaining five are due for completion at the end of December 2025.
- 03 Fit and Proper Persons Test 2025-26:
  - The terms of reference have been finalised.
  - The fieldwork for this audit has taken place August 2025.

Risks reviewed:

- The committee reviewed the revised Board Assurance Framework and noted the addition of risk BAF 0028 which relates to anti racism.
- The committee noted that medical staffing was discussed at the committee which related to risk 5409. It was requested to look at what needs to be done for the risk score to reduce.
- The committee also acknowledged that a report relating to risk 5358 needs to be included in a future agenda so this can be monitored more closely by the committee.
- The committee challenged that the risk score for 5321 hasn't changed when there has been improvement in 3 subjects so asked that this is discussed with risk owners to see what needs to happen for the risk score to reduce.

Feedback to Trust Board:

A cross-committee referral to FPC was made to review the issue of digital systems affecting the ability to log supervision.

Approved by:

Heather Smith, Chair and Non-Executive Director	**Date:**	15/09/2025

Alert Advise Assure
Finance and Performance Committee
Date: 14 August 2025

Alert:

Month 3 financial performance report

- The year to date deficit has been reported on plan, indicating existing pressures can be mitigated.
- The underlying variance was reported at £0.8m behind plan with value improvement plans (VIP) being behind plan at £750k.
- Work is ongoing to sign off plans during July and it is anticipated there will be at least £8m worth of plans at this stage. There is confidence that the £8m VIP requirement can be met.
- Out of area in June was at 32 for Acute Spot and PICU at the start of the month and increased to 35 by the end of the month. There was also 2 discharge to assess beds being used. These numbers were higher than the planned trajectory of 27.7 for June and therefore there was an overspend in month of £0.2m which has superseded the underspend from April & May. The year-to-date position for Acute & PICU is now an overspend of £0.06m
- A capital bid for safety schemes was approved, resulting in £1.2m in funding rather than the £0.8m previously included in the plan.

Advise:

Petty cash usage

- The committee received a report outlining the petty cash usage across the Trust which indicated £20k in floats across 30 locations.
- The policies relating to petty cash have been recently updated.
- The committee were assured that there is an annual review of petty cash and that Phillip Easthope reviews card purchase spends as part of the non-pay spend checks.

Costing Update and National Cost Collection (NCC) 2024-25 submission report

- The committee received the submission report and asked for an update with comparisons and benchmarking to be presented to committee.

Assure:

Digital Assurance and Approval Group Report

- The Trust is utilising Microsoft Teams as it is a lot more stable that other telephony options. Skype cut off will be in October 2025, however the Telephone replacement project is at risk of not completing by the cutoff date which would increase cyber risk.
- There is a governance group with a focus on artificial intelligence which considers the uses and risks.
- Bit locker has been removed with no compromise to security and Zscaler has been rolled out as a secure VPN for all users.
- All software is being reviewed to ensure that it is robust and up to date as well as ensuring all staff have in date information governance training.

Business Planning Group Report

- With the contract for the sale of Fulwood House now terminated we need to confirm the impact on the capital programme for the year. The plan defines which projects

will be impacted by the loss of the £5.95 million, and updates on this are reported separately to the Committee.
- Expected increased funding of £130,000 to stabilise the HAST service has now been confirmed by South Yorkshire ICB.
- There has been a delay in finalising plans for the development of the planned transitions service for young adults due to a difference of view about what is required and what is feasible within the funding envelope. There has been a review with Executive and Place leads and options for the way forward are being finalised which will support decision making regarding the way forward.
- The mobilisation of the expanded community eating disorders service across South Yorkshire has commenced. Proposals for the future eating disorders inpatient services are being developed and reviewed by the Provider Collaborative and SHSC continues to shape the plans for the way forward.

Risks reviewed:

- The corporate risk register was reviewed and it was noted that risks need to include more information on the "caused by" and actions. It was advised that the risks continue to be reviewed with risk owners and that the next report will include more of the requested data.

Additional information:

N/A

Approved by:

Owen McLellan	**Date**	14/08/2025

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

Alert:

Financial performance report (M4)

- At month 4, the year-to-date deficit has been reported on plan with zero variance. The underlying variance was £1.6m behind plan at month 4. This is mainly due to the pay award pressure £0.6m, Value Improvement Plan (VIP) underachievement £0.6m and reduction in underspending areas against plan £0.5m. Due to an increase in Acute & PICU out of area numbers in June & July there is an overspend of £0.2m against trajectory.
- There is confidence that the £8m VIP requirement can still be met and that further mitigations can be found to offset other pressures therefore income has been rephased in order to report on plan year to date, work is ongoing to ensure plans are signed off and the full target is achieved in year. The forecast is in line with plan on the basis that the £8m VIP requirement, unrealised mitigations to offset other pressures and Out of Area trajectory will be met.
- Out of area is overspending in the first 4 months due to Acute & PICU usage being above trajectory in June and July. Usage in July was at 33 for Acute & PICU spot at the start of the month and reduced to 23 by the end of the month, on top of this, 5 discharge to assess (D2A) beds were being used. The trajectory for July was 24 so the actual numbers exceeded for the whole month, resulting in an overspend in month of £0.14m.
- The year-to-date position for Acute & PICU is now an overspend of £0.2m, the forecast for future months assumed the planned trajectory will be achieved which goes from an average of 23 in August to 5 in March 2026.
- Outstanding debt has been reduced to £2.2m at the end of July, this is mainly due to a debtor paying the remaining of prior year invoices. The Finance Team continues with increased debt recovery action to ensure older disputed debts are paid or escalated to ensure quicker resolution can be found.

Maple ward improvements overspend

- The committee challenged the overspend at Maple ward of £300-350k noting a business case was previously approved through FPC for Maple ward improvement works.
- The committee were advised that the full contingency has been used, with part of the money being invested at Dovedale 2, which was felt it should have had its own business case. JD explained that had this money not been invested at Dovedale 2, there would have been sufficient budget for the Maple works.
- The committee requested for a paper to come back to FPC to provide assurance that the project is on time and budget.
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Positive alert:

Out of area improvement

- The committee were advised that the out of area target for August was 23 and there was an average of 22 in use, therefore meeting trajectory. The committee noted that M5 shows £2.1m in improvement there is still work to do to cover the under-delivery period during June and July 2025.
- There is tighter grip and control such as weekly leadership meetings in areas to limit overspend.

- The committee were informed that over the next few weeks, one of the Home First intervention will go live which relates to home treatment and patient flow. This will aim to drive and deliver the downward trajectory in out of area.
- The Home First programme is helping to drive the reduction and there has been support from the local authority and ICB.
- Winter plans and escalation plans are being developed with bi-weekly patient flow meetings taking place with medical leaders and wards to monitor any challenges as they arise.

Advise:

Improvement and change report

- The PCMH Closure Report was conditionally approved by the Improvement and Change Board, acknowledging it accurately reflected the programme up to March, though further developments have since emerged. Key concerns include incomplete benefits realisation, unresolved issues with medical staffing and waiting lists, impacts on CMHTs, and the need for a clear position statement to guide future planning. A formal post-implementation review will be conducted, and communications will highlight both the programme's achievements and areas still requiring attention.
- There has been a two-week delay to the Maple Ward and Dovedale 2 improvements, affecting the Home First Programme's Out of Area trajectory and requiring close oversight. A £130,000 overspend on Maple Ward due to added de-escalation and sensory rooms will be managed within existing capital plans, while the staffing model for the to be renamed Dovedale 2 requires further development before Executive review. A detailed recruitment and mobilisation timeline is needed to align with build progress.
- Gleadless and Heeley Neighbourhood Mental Health Pilot Progress has been made across estates, finance, and digital delivery, but differing views on the clinical and operational models are creating tensions between partners. To resolve this, a workshop with SHSC and partner organisations is scheduled for early September. The aim is to agree on shared principles to guide the future service design.
- The committee raised concerns about the tension between partners in the Gleadless and Heely project asking that more information on this and the impact is included in the next update. SM suggested that this is addressed in the Board report.

Assure:

Improving digital maturity

- There has been an improvement in our scores from 1.77 to 2.02 and the Trust has improved in five out of seven pillars, placing the Trust within the main group of mental health organisations in the region, with further improvements expected in the next assessment cycle, particularly after decommissioning legacy systems.
- The committee requested for more detail on the governance and assurance processes for the self-assessment, including peer review and audit mechanisms prior to presentation at Board of Directors in September.
- The team were encouraged to aim for top quartile performance in digital maturity and highlighted the importance of empowering staff to engage with digital systems, suggesting a plan to improve digital literacy and engagement.

Annual review of national treasury management policy

- The policy was received and approved with no changes

Working capital review

- The review was received and approved with no changes

Estates and Facilities oversight committee report

- The committee received an update on the last quarter and asked that the Longley Meadows lease risk is reviewed to assess if this is a risk or an issue.

Risks reviewed:

- The committee received the Board Assurance Framework noting the updated risk descriptions and the inclusion of references to whether assurances are positive or negative. This has been identified as an internal audit action for completion by the end

of September 2025.

- All milestones and actions for all risks have been updated.
- There have been no changes to the summary or scoring for BAF0026, BAF0027, and BAF0032.
- BAF0022 has no change in risk score noting that current underlying cost pressure of circa £2m and VIP shortfall of c£2.2m pressure mean risk remains the same at this point.
- BAF0023 has a revised plan and timescales which include additional funding agreed for the optimisation work by the Trust Board.
- BAF0030 escalation process have been completed with significant progress made on the summary position.
- There are 19 risks in total on the corporate risk register, with 3 risks monitored by FPC.
- The committee questioned the categorisation of a new risk (4757) under reducing inequalities, which it was agreed to review its classification with the risk lead.

Additional information:

There was one cross-committee referrals to People Committee which asked them to have a discussion on the medical recruitment pipeline and development routes for trainees.

Approved by:

Owen McLellan	**Date**	16/09/2025

Alert Advise Assure
Mental Health Legislation Committee (MHLC)
3 September 2025

Alert:

Mental Health Legislation Operational Group Q1 (MHLOG)

- There continues to be occasions when the Mental Health Review Tribunal has issued legal directions because the Trust has not carried out a task it is required to do. This attracts risks of legal sanctions from the Tribunal and leaves the Trust vulnerable to a regulatory intervention. It also has an impact on patients' experience of care and may impact on the Trust's reputation. New practice standards are being produced and escalations created to prevent re-occurrences and clear expectations have been set out.
- Clarification has been obtained from Commissioners that mandatory training in respect of mental capacity and deprivation of liberty safeguards must be 90% or more to be deemed compliant. Mandatory training remains on the corporate risk register, overseen by people directorate. The training department are reminding individuals when they are not compliant.
- Data in respect of compliance with s132/132A (provision of information to patients) is currently limited due to the roll out of Rio. This issue has been escalated to the Digital team for resolution to be found.
- The Health Based Place of Safety (HBPoS) continues to be closed on occasions. This is being reported on through IPQR. The regional suite is not repurposed. Closures are escalated to executive team when this occurs. The main reason for closure is because there is no bed available after a person has been assessed at the HBPoS having been detained under s136. This is reported on through the Home First programme.

Least Restrictive Practice Oversight Group Q1 (LRPOG)

- There has been a rise in seclusion incidents on Endcliffe Ward compared to the previous quarter. This has been recognised and responded to via action plans resulting in reductions in July and projected further decreases in August.
- Long-Term Segregation (LTS) was used for a particular individual as the least restrictive option, supported by the clinical team, Deputy Director of Nursing, and Respect Team, and reported to the CQC. The LTS period has now concluded.
- The Director of Nursing requested a recovery plan for Respect Training compliance among Bank staff, which had been consistently low. The plan was reviewed at LRPOG in August, with several actions already completed and showing positive impact resulting in a 6% improvement. This will remain under close scrutiny by the Restrictive Practice Lead and Training Lead.

Advise:

Associate Mental Health Act Managers (AMHAMs) Activity Q1 Report

- There has been an increase in the proportion of detentions/CTOs which were not reviewed by the AMHAMs prior to the order expiry date. Whilst within statistical process limits, the number of occurrences should be zero.
- The most frequently cited reason for such delays is the availability of Responsible Clinicians (RC). RCs have been reminded by the MD of the importance of making themselves available in a timely manner and ensuring relevant cover arrangements.
- There continues to be a low number of AMHAMs in post however a new AMHAM has been appointed and onboarding process underway. There is no national guideline for the number of AMHAMs required.
- Executive Management Team (EMT) has approved a 2.5% uplift to the hourly rate of remuneration for the AMHAMs, dated back to 1 April 2025. The committee were advised that this does not require further approval and will be enacted.
- The committee requested that more monitoring and measuring the diversity demographic among AMHAM recruitment is included in future reporting

<u>Mental Health Act Scheme of Delegation</u>

- The proposed changes in the paper were approved for onward presentation at Board of Directors in September 2025.

<u>Least restrictive practice (use of force) plan - Annual Report</u>

- The report was received and approved for onward presentation at Board of Directors in September 2025.

Assure:

<u>Human Rights Framework Progress Report Q1</u>

- Human Rights training, provided in RESPECT training focusses on blanket restrictions and human rights. The focus and nature of training will be kept under review in light of learner experience, feedback and service needs identified.
- 34 newly trained active Practice Leads over 2024/2025 (currently 69 practice leads in total)
- Key initiatives included the patient rights leaflet and collaboration with SACMHA, PMC, and Flourish.
- The Human Rights Officer role has been repositioned to the Quality Directorate from the Medical Directorate.
- The committee suggested increasing internal communication about human rights achievements,

Risks reviewed:

- The 2025-2026 BAF risk descriptions and scores have been aligned to the refreshed Trust strategy, following discussions at the executive management team and Trust Board development sessions in June and July 2025.
- Work is underway to update BAF risks so that the risk descriptions are consistent and meet the recommended format.
- There are no specific risks for this committee, however a number do align to the committee therefore there may be cross references relating to updates and mitigations.

- Corporate risks 5026, 5124, and 5351 were discussed and it was requested to change the wording on risk 5351 to reflect that there is a responsible clinician.
- The committee discussed the persistent high risk associated with DOLS, noting that it is largely outside the trust's control due to national legislative delays, and agreed to review actions to better reflect the committee's remit.

Feedback to Trust Board:

There was one cross-committee referrals from MHLC:

- To People Committee: The committee discussed the importance of peer support workers, agreeing that funding and establishment issues should be addressed as a cross-committee referral to the People Committee.

Approved by Chair and date: Olayinka Monisola Fadahunsi-Oluwole 16/09/2025