Board of Directors (Open)

SUMMARY REPORT	Meeting Date:	26 January 2022
	Agenda Item:	18

Report Title:	**Committee Activity**	
Author(s):	Amber Wild, Corporate Assurance Officer	
Accountable Director:	Susan Rudd, Director of Corporate Governance Olayinka Monisola Fadahunsi-Oluwole, Chair of Mental Health Legislation Committee Heather Smith, Non-Executive Director, Chair of People Committee, and Interim Chair Quality Assurance Committee Richard Mills, 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:**	N/A
	Date:	N/A
Key Points:	The purpose of this report is to highlight key matters, issues, and risks discussed at committees. These are to advise, assure and alert; and each committee report is attached as an appendix to this summary report. Reports are attached for Quality and Assurance Committee (QAC), Finance and Performance Committee (FPC), People Committee (PC) and Mental Health Legislation Committee (MHLC). Audit and Risk Committee (ARC) will provide a verbal update from their meeting on the 18 January 2022. Minutes approved by committee are presented to Board to provide assurance that the committees have met in accordance with their terms of reference and to advise Board of business transacted at their meeting.	

Summary of key points in report
Each committee has considered 'significant issues' under three key categories: **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. **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.

The summary reports have been completed by the Chairs and they are attached to this report. The areas attracting particular focus are those under the 'red' alert headings on each page of the committee reports.

Minutes are not presented to Board until they have been approved by the reporting committee. The minutes available are from the November and December meetings for Quality Assurance Committe; the November meeting for People Committee; the October meeting for Audit and Risk Committee; and the September meeting for Mental Health Legislation Committee.

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,
To receive the 'Alert, Assure, Advice' committee activity reports within the appendices.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good Continuous Improvement	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		"Good Governance"
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standards?	*Yes*		*No*	***X***	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety 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***	

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Finance and Performance Committee** **Date:** **9 January 2022** **Chair:** **Richard Mills**

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
New Electronic Patient Record	Received EPR Contract and schedules	Received and discussed contract and schedules and outstanding issues	Approved proceeding to contract signature with Contractor for the EPR system based on the SHSC and Legal review of the main contract and all schedules, subject to finalisation of the outstanding clauses. **Recommend to Board**	January 2022
	EPR Deployment Services – Intention to Award Approval	Received report on the EPR deployment partner tender report	Approved Contractor as the preferred bidder and give approval for SHSC to issue an intention to award notice to that effect	January 2022
Relocation of Trust HQ	Received revised Full Business Case (FBC)	Following the identification of a further HQ site in early December, followed by the staff group consultation, the preferred option is to consolidate the remaining circa 250 corporate staff onto one site.	FBC approved and support progression of the lease agreements for new locations. **Recommend to Board**	January 2022
Ligature Anchor Points	Recieved Phase 3 Full Business Case (FBC)	Articulates the capital and revenue requirements to complete the remainder of the LAP Reduction Programme in response to CQC Section 29a warning notice	Approved the capital and revenue requirements identified in Phase 3 business case and support the continued progression of the ligature anchor point programme implementation.	January 2022

			Recommend to Board	
Integrated Performance & Quality Report for the Period ending October 2021	Received November IPQR report prior to submission to Board, with revised performance format. Reviewed areas of 'Good Performance' and 'Performance concern'	Noted ongoing special cause for concern in demand and waiting lists, particularly in SPA/EWS and Recovery Teams. Noted Recovery Plans also received by QAC	Further updates to be received in March and sychronised with receipt of Recovery Plan at QAC. Format to be simplified wherever appropriate cognisant required governance arrangements	March 2022
Cost Improvement Programmes	CIP Update and Future Plans	Received update on progress and plans for 22022/23	Noted non-recurrent nature of 2021/22 achievement, subsequent impact on next year's target and shortfall for 2022/23. Need for further plans identified.	March 2022
2022/23 Financial Plan	Update on progress	Noted receipt of financial planning guidance is still awaited. Concern over timescales and impact on Financial Plan raised.	Concerns to be escalated to Board	January 2022
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**
Transformation Portfolio Report	Noted progress with Transformation Programmes	Received updates	Noted	January 2022
BAF / CRR	BAF and CRR to be reviewed to reflect risks identified in meeting	Noted no significant change	None	January 2022

ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Contract Monitoring Report	To provide an update on SHSC's Income Contracts exceeding £200k	Noted ratings	Noted issues with Buckwood View and Birch Avenue contracts	March 2022
Finance Report for the Period ending November 2021	Received routine report of monthly Finance position	Routine reporting of financial performance.	Receive monthly report	February 2022
Operational Plan Report – Q2 2021/22	Noted update and recommendations	Received assurance over impact of latest plan guidance	Noted potential for further development	April 2022
Standing Orders and Standing Financial Instructions Breaches	Received report on compliance against current Standing Orders and Standing Financial Instructions from December 2020 to December 2021	Reviewed report in line with the terms of reference to gain assurance over the implementation and effectiveness of controls for minimising and mitigating breaches to Standing Orders and Standing Financial Instructions.	Noted	January 2022

2021/22 RM/jch

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Mental Health Legislation Committee** **Date:** **15 December 2021** **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
Section 136 delays	The overall capacity issue of having only two places of safety remains. Moving an individual out of a health-based place of safety can be a problem because of capacity. It is a complex and long-standing situation, but progress is gradually being made.	There are plans to improve the Trust's bed position. The beds have been purchased and progress is being made to reduce flow rates which will help to free space in the health-based place of safety. An action plan is being formed around the review of Standard Operating Procedures in places of safety, and the issue of assessment timelines. The actions are there but it is about how assurance is extracted and reported on.	Summary of key risks would be helpful in future reports. It would be useful to know if there is a plan in place for Quarter 3 and improvement targets for specific actions so that Non-Executive Directors can report to Board effectively.	March 2022
Availability of Section 12 doctors. The responsibility to find Section 12 doctors other than within the Trust lies with the local authority.	The availability and supply of a second doctor external to the Trust is the issue under discussion and is causing delays. There are regional staffing issues reflected nationally.	Assurance can be had over the Trust's Section 12 doctors. The Section 12 App must be utilised to ensure that access to other doctors is swift. Internal staffing has improved.	Engagement piece required between SHSC and the local authority	March 2022

CQC actions relating to seclusion reviews.	Independent reviews must be conducted by a senior doctor that has not looked after the patient. Groupings of doctors have been organised to ensure that a doctor can be allocated within the required timeframe. If a doctor cannot be allocated this is escalated to clinical directors. There is now an extra clinical director review for patients that have been in seclusion for longer than 48 hours.	An education programme has been implemented to ensure junior doctors have been educated on the importance to complete reviews in a timely manner. Senior doctors have supported with this.	To be included in the Back to Good Programme. Review through the risk management process.	March 2022
Resolution of a procurement arrangement with a provider that does not use mechanical restraint	The Trust stopped the use of a particular provider because of the use of mechanical restraint.	A pre-approved range of providers that meet the Restraint Reduction Network Standards are being utilised. There are providers in place, but a substantive contract is being sought. There are no identified risks with the interim providers.	The aim is to finalise a contract that would be regularly reviewed. The Trust should ensure that its own check and balance is in place to avoid reliance on the existing procurement framework. Start and end date of transport contract to be confirmed with Director of Operations and Transformation.	March 2022
Liberty protection safeguard implementation	There is still no Code of Practice for Liberty Protection Safeguards, and there are no regulations and operational National Guidance.	Committee received the report for assurance and information.	There will be a MHLOG meeting in January 2022 to specifically address Liberty Protection Safeguards.	March 2022

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
Least Restrictive Practice Conference	Evaluation from the Least Restrictive Practice conference received positive feedback.	A recording will shortly be available to view on Jarvis. A highlight was the Lived Experience of the Carer session.	For noting	N/A
MHLC Human Rights Workplan.	The Trust are working in partnership with the British Institute for Human Rights in the first year of development and rollout of a human rights training programme.	Collaboration with the Least Restrictive Practice Oversight Group (LRPG). Involvement in the Least Restrictive Practice seminar in November 2021, working on policy development within Task and Finish Groups, and promoting the Trust's commitment to human rights. Day to day advice on human rights is available to teams across the Trust as issues arise.	Training to be incorporated into the Electronic Staff Record (ESR) training. Priority given to teams that are more likely to use restrictive practice. Specialist training will be implemented to target individual wards.	March 2022 for update

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

Issue	Committee Update	Assurance Received	Action	Timescale
Use of Force Implementation Plan	New guidance on the Use of Force Act 2018 has been released. National implementation timescales have not been given. Updates to the SHSC policy will be completed in December 2021, ensuring compliance as soon as possible.	Dataset Version 5 is already within the Use of Force Act 2018 and the Trust is compliant.	An assurance report will be provided to the next Committee meeting outlining evidence such as policy and the RESPECT Training. The risk highlighted relates to the timely completion of work with Service Users and families.	March 2022
Annual Work Plan	Committee received the workplan for information.		Clarity on where the Associate Mental Health Act Managers (AMHAMs) sits on the plan	March 2022

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **People Committee** **Date:** **11 January 2022** **Chair:** **Heather Smith**

KEY ITEMS DISCUSSED AT THE MEETING				
TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
People data – Sickness levels Turnover rate	Sickness levels continue to rise as does the turnover rate which colleagues are monitoring. Performance against Model Hospital data is poor.	Lack of assurance of impact of actions in terms of sickness and turnover.	Colleagues are monitoring this data on a monthly basis. Committee requested sickness data to be presented as COVID and non-COVID.	IPQR produced monthly. Data received at Committee each meeting (bi-monthly).
Covid vaccinations	There remains a number of patient-facing staff who have declined the Covid vaccination and a number of patient-facing staff who haven't yet declared their Covid vaccination status. Some services are particularly at risk e.g. Maple Ward.	Vaccination report and figures received during the meeting shows that at present 42 patient-facing staff have declined the Covid vaccination and a further 50 patient-facing staff have yet to declare their Covid vaccination status. Committee is assured that colleagues are working to improve the position.	People Directorate and Clinical Operations colleagues are working with staff and line managers tin a number of ways to encourage patient-facing staff to take-up the Covid vaccination.	On-going. To be reported at March meeting.

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**
Data quality has improved which is encouraging	Supervision data is now more accurate and continues to improve. Vacancy rate data is now more accurate.	Data contained in the IPQR received by Committee.	Monitored monthly via the IPQR	Data received at Committee each meeting (bi-monthly).
Nursing vacancy position improving	The number of nurses is increasing steadily.	Recruitment reports describes a positive position for our nursing figures.	Committee will continue to receive an up-to-date position regarding our nurses.	Data received at Committee each meeting (bi-monthly).
Violence and aggression towards staff	There is a plan in place for work on violence and aggression.	Health and Safety manager taking the lead on this matter. Fuller assurance to be received in terms of data when the next H&S report is received at Committee.	Committee will continue to receive an up-to-date position	July 2022 meeting
Equality and inclusion	Report received from the Inclusion and Equality Group.	There is a positive increase in the work related to equality and inclusion. Coherent work underway via a cross-Trust initiative and further work expected to develop the impact measures.	Gannt chart to be received by Committee in March. Next full report due to Committee in May, to include impact measures.	As timetabled to be received by Committee
Workforce planning	The Workforce Planning Transformation Group Report advised that a forward plan / trajectories for workforce planning is being developed.	Committee were assured that a forward plan is being developed.	Next report to Committee in May.	
	Positive news re apprenticeships and fulfilling our nursing placement capacity.			

Board Assurance Framework and Corporate Risk Register	Risk 0014 – Retention & Recruitment. Committee are mindful of the progress made (particularly with regards to recruitment) but recommended holding off reducing the risk rating at this time.	More sustainable assurances are required and more assurances required regarding work being done to address retention.	Next Recruitment and Retention Report to have a retention focus.	Committee to review this rating again at the March meeting, although the next R&R Group report isn't expected until May.
	Recommendation to improve ease of review of the BAF and CRR		Committee recommended highlighting (or note on the front sheet) any changes since the last report to improve ease of review – noting that there are numerous reports to review across a number of Committees. Committee would also like to see an improvement trajectory for the BAF/CRR – e.g. if we did x,y,z how would this affect the rating?	Director of Corporate Governance to review the process.

ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Recruitment and retention	A cross-Trust effort to develop a coherent plan is having impact.	Assured via the Recruitment and Retention Group report.	Next report to Committee in May.	As timetabled to be received by Committee
Casework	Average casework length is decreasing and the number of ethnically diverse staff involved in formal cases is decreasing.	Assured via the casework data received a part of the Just and Learning Report.		
Supervision data	The performance data indicated that the take-up of regular Supervisions is around 72% which is encouraging and moving in the right direction to reach our 80% target.			

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Quality Assurance Committee** **Date:** **12 January 2022** **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
Threat to the delivery of the Back to Good Programme – new risk	Impact of Covid19 and the Omicron variant poses a risk relating to the delivery of the Back to Good Programme. Recommendation to escalate to the CRR received and approved.	Assurance that this risk has been escalated to the CRR.	Add risk to CRR.	Complete
SPA/EWS & Recovery Service waiting times	SPA/EWS & Recovery Service waiting times remain an issue.	Partial assurance received. Transformation plans underway.	Committee will continue to focus on the issue and the emergence of the Recovery Strategy.	Ongoing
IPQR: Birch Avenue (Quality Risks Update) – new risk reported	Concerns raised about quality of care. Covid19 outbreak. No families and carers given Care Giver Status and so have been unable to visit.	Identified early and action plans reported.	Quality visit to identify risks and workstream. CCG involvement secured. Action Plan and Impact Measures to be reported at February 2022 QAC meeting.	Update requested for February 2022

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
Back to Good Programme	B2G Programme continues to be tracked and subject to scrutiny.	Report received.	Broader snapshot of the outstanding CQC actions to be provided at February 2022 meeting to give further assurance of overall quality. Timing of report to QAC adjusted to improve quality of data presented to	February 2022/Ongoing

			Committee.	
Complaints process	Considerable progress made with the development of the process. Focus of Committee to shift to learning from complaints, rather than being given assurance that an adequate process is in place.	Assurance received that robust process is in place. Partial assurance received on monitoring arrangements.	Training scheduled for end of March 2022. Data to be presented at February 2022 QAC meeting via Learning Report and the Patient Experience Report to give full assurance (to include monitoring arrangements).	February 2022
Culture and Quality (Fundamental Standards of Care)	Progress reports on Culture and Quality pilots received and noted. More detail requested on monitoring and communication to Committee.	Report received.	Indicators that trigger a full Quality and Culture Visit to a team to be identified.	February 2022
IPQR: GDC and SAANs waiting lists	Recovery Plan was received. Monitoring continues. Committee recognises issues with contractual and commissioning route that needs to be pursued.	Assurance received that the issue would continue to be monitored via the IPQR.	To be included within the IPQR going forward, not a standalone item.	February 2022
IPQR: SPS waiting lists	Recovery Plan was received. Committee recognises the good progress made.	Assurance received – further assurance necessary regarding Service User input.	Report to Committee encapsulating SPS Service User input regarding the changes that have been made.	Future report to QAC from Salli Midgley - date TBC
Equality and Inclusion	Committee received an update from IAPT. Work is linked to National development.	Work will form part of Trust's response to overall Improvement Framework, the Patient and Carer Race Equality Framework (PCREF).	PCREF programme will be brought to QAC – date TBC.	Ongoing
Service User Engagement and Experience strategy	Committee received an update to the strategy development	Assurance received that the work is in progress and the appropriate amount of consultation/co-production is underway or planned.	Strategy to be brought to Committee once completed	To be timetabled into work plan for Committee
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
IPQR	Positive progress is being made on key issues identified within the IPQR and numerous services such as Restrictive Practice,	Report received.	To continue to address improvement in the services where this improvement has not yet been seen.	Standing item/Ongoing

	Inpatient Length of Stay, and Management of Incident Reviews.			

Sheffield Health and Social Care NHS Foundation Trust

Audit & Risk Committee (ARC)

ARC 19.01.22
Item 03

Notes of the Audit & Risk Committee meeting held on Tuesday 19 October 2021 at 1pm.
Format: Microsoft Teams Meeting

Present: Mrs. Anne Dray, Non-Executive Director, Chair: Audit & Risk Committee
Mrs. Sandie Keene, Non-Executive Director, Chair: Quality Assurance Committee
Mr. Richard Mills, Non-Executive Director, Chair: Finance & Performance Committee

In Attendance: Mr. Phillip Easthope, Executive Director of Finance
Ms. Beverly Murphy, Executive Director of Nursing, Professions & Operations
Mr. Rashpal Khangura, Director, KPMG
Ms. Leanne Hawkes, Director, 360 Assurance
Ms. Lianne Richards, Client Manager, 360 Assurance
Mr. Chris Taylor, NHS Anti-Crime Specialist, 360 Assurance
Mr. Matt White, Deputy Director of Finance
Mr. David Walsh, Director of Corporate Governance/Board Secretary
Mr. Terry Geraghty, Emergency Planning Officer (Item ARC2021/10/115)
Ms. Sharon Mays, SHSC Chair (Observer)
Ms. Amber Wild, Corporate Assurance Manager (Observer)
Mrs. Jeanine Hall, Executive Assistant (Minutes)

Apologies:

Min Ref	Item	Action
Agree Meeting Behaviours As the meeting was to be held via MS Teams arrangements, the Chair reaffirmed meeting etiquette to ensure that agenda items received the appropriate level of discussion and consideration, and that members could contribute to the discussion/ask questions as necessary.		
ARC2021/10/0102	**Welcome & Apologies for Absence** The Chair welcomed members to the meeting, noting that no apologies had been received. She also advised that Mr. Steven Hible, Council of Governors member, has been nominated to observe future meetings of the Audit & Risk Committee by the Council and will be provided with the relevant papers and log in details as appropriate.	
ARC2021/10/0103	**Declaration of Conflicts of Interests** No declarations were received.	
ARC2021/10/0104	**Notes of the meeting held on 20 July 2021** The notes of the meeting held on 20 July 2021 were approved as a correct record and would be received at the next Public Board of Directors meeting for information.	
ARC2021/10/0105	**Matters Arising & Action Log** Members reviewed and amended the action log accordingly, and updates on the outstanding actions were recorded. i. <u>Annual Review of Committee Effectiveness 2020/21 – Cross Referencing Between Committees</u> As agreed, discussed further at the Board of Directors and agreement that the use of the 3 A's Report (Assure; Alert; Advise) completed by each committee for	

	the Board would provide an indication of whether there is cross over of issues between committees for the benefit of Board members. There is also a specific agenda item on today's agenda regarding the Annual Review of Committee Effectiveness and Objectives. **Action considered complete.** ii. <u>2021/22 Board Assurance Framework – Consistency of Scoring Key Controls etc</u> Noted that further discussion is scheduled at Board Development Sessions in November and December.	
ARC2021/ 10/0106	**Board Assurance Framework 2021/22** The Committee received the report from Mr. Walsh for assurance. The report indicates changes made since its last receipt by ARC and Mr. Walsh noted a further issue for consideration by members which has been identified because of the early work being undertaken to formalise the 2021/22 Head of Internal Audit Opinion Statement relating to potential gaps or weaknesses. The first area relates to the development of the BAF risk against the new strategic priority in respect of Partnerships. He advised that work is ongoing to address this and that in the absence of a further ARC meeting prior to receipt by Board, and to avoid any further delay in finalising this element, that this updated BAF risk is received direct at Board for consideration. The second area relates to oversight of the BAF across the whole range of Board committees and a perceived weakness in the first part of this year. Confirmed that arrangements have been strengthened to ensure this is addressed. Changes to scoring have been identified in section 1.4 and the committee are asked to agree the proposed changes and the process update. Ms. Keene noted discussion at recent Quality Assurance Committee regarding the background to the target risk score for BAF25. Mr. Walsh confirmed that this was reviewed post QAC and advised that it is believed to be an error when updating the risk. It has subsequently been revised back down to 6 and that this would be reported to the next QAC meeting for completeness. Following conversation regarding the consistency of presentation between the BAF and CRR, while noting there is a fundamental reason for the information being presented in the way it is within each of the documents, Mr. Walsh felt consideration could be given to the information being represented in a more consistent way between the two documents. Mr. Walsh confirmed that while ARC oversee the whole of the BAF process, they do not have oversight on any specific BAF risk. However, oversight of the new partnership risk needs to be addressed. It was agreed that this was a decision for the Board of Directors and would be taken to the scheduled Board BAF discussion for resolution. The committee noted receipt of the BAF, the intention to have further Board level discussions regarding the BAF and the assurances it provides and noted the intention to determine oversight of the new partnership risk at the Board.	DW
ARC2021/ 10/0107	**Corporate Risk Register 2021/22** The Committee received the report from Mr. Walsh for assurance. The Chair noted the four specific risks on the CRR under the oversight of ARC (4483; 4480; 4376 and 4375). Agreed that risks 4376 and 4375 would be discussed under separate agenda item ARC2021/10/0116 Escalation & Update Report from the Digital Information Governance Group.	

	Noted that although risk 4483 has controls in place, it is not yet at its target risk score and there are no actions listed. She asked that this risk be reviewed to determine whether there is a gap in planned actions. Mr. Easthope advised that this risk related to the recent phishing audits and the resulting number of low-risk outstanding actions. He agreed to review the population of the CRR to ensure it presented an accurate reflection of the current position and mirrored the information submitted through Pentana. It was confirmed that information on the CRR is presented by highest risk first to focus attention on those priority areas, however, it was agreed that consideration would be given to the presentation of this information at committee level to make it more accessible. In terms of static risks and potential for concern, it was agreed that while no month-on-month change should not be a concern, no change across the year should be an element of concern and reviewed. This is a key area identified for further consideration to ensure that appropriate support is given to managers populating the CRR to ensure there is clarity on actions impacting likelihood or reduced severity and to what extent and then managing this through the process. Acknowledged that this is the part of the well-led journey and improving our understanding and driving ownership lower down the organisation. NED members reiterated the need for a future Board discussion regarding the BAF and CRR; the processes surrounding these documents at committee level and the static nature of some of our risks as well as our expectations of trajectory and pace of change. The Chair welcomed the oversight from the other Board committees into this discussion and in preparation for the Board discussion, made a further ask of each committee to consider how the Board needs to look at this and make it work better for us. In terms of training and improving the information on the CRR, Mr. Walsh advised that a series of workshops are being arranged for people responsible for corporate risks over the next month. Mr. Walsh also noted the addition of a new risk 4727, which falls under the remit of QAC. This risk is in specific response to the CQC inspection report relating to the omission of a safeguarding risk.	PE
ARC2021/ 10/0108	**Policy Governance Summary** The Committee received the report for review and, on the recommendation of PGG and explanation from Mr. Walsh regarding ongoing discussions regarding proposed claims management arrangements, confirmed extension to review date for the Claims Policy.	
ARC2021/ 10/0109	**Mid-Year Review Against Committee Objectives/Line of Sight of Action Plans (Audit & Risk Committee)** Members agreed that these two agenda items could be discussed together. Mr. Walsh provided a brief overview of progress against committee objectives and the three specific key action areas, noting • Better sight of improvement action plan activity across services and under all Board committee areas of responsibility – confirmed there is now a plan in place and an update on progress will be received at January's ARC with a view to a full mapping exercise completed alongside other year-end activity in May 2022. • Head of Internal Audit Opinion and areas requiring improvement in the	

	coming months – agreed as area of biggest risk. • Arrangements to ensure oversight of Clinical Audit – proposed way forward presented within the paper. Ms Keene confirmed that action was already being taken to ensure the appropriate reports are received back into QAC in respect of furthering these actions. She also noted that within the tier 2 groups reporting into QAC was the Research, Innovation, Effectiveness & Improvement Group. It is well within the remit of that group to oversee clinical audit programmes and discussions are taking place in this respect. Members welcomed the update on these workstreams, particularly in respect of clarifying clinical audit oversight arrangements, noting that further discussion regarding the completion of follow up actions will be discussed under item ARC2021/10/0112. **The Committee received and agreed the assessment of progress against objectives.**	
ARC2021/ 10/0110	**Annual Review of Committee Effectiveness & Objectives** The Committee received this report from Mr. Walsh for assurance. Mr. Walsh noted an amendment to paragraph 1.5 (3rd bullet point) of this paper which should read Improving Clinical Audit Oversight. He advised that the report provides a summary of ARC activities for the year 2020/21 setting out how it has met its terms of reference and key priorities and as part of ARC's overseeing role, provides as an appendix the annual reports from other Board committees. Members noted these reports and approved for receipt at Board to provide assurance regarding committee processes over the last year in respect of their terms of reference. It was agreed that on this occasion while this process was late being completed, it would in future be linked to the work around the Annual Governance Statement. Mr. Walsh agreed to add a note in this report regarding the intention to incorporate Mental Health Legislative Committee in next year's process, following its recent establishment. **The committee formally received the report confirming compliance against terms of reference and approved for affirmation to the Board of Directors.**	
ARC2021/ 10/0111	**Line of Sight of Action Plans – Audit & Risk Committee** Item ARC2021/10/0110 refers.	
ARC2021/ 10/0112	**360 Assurance Progress Report** The Committee received the report from Ms. Richards for assurance. It was confirmed that three reports have been issued since the last report and that work continues with key Trust officers to plan and agree terms of reference for each of the outstanding audits. Ms. Richards advised that a significant amount of work is currently underway to ensure the completion of the plan stays on track and that the team are meeting regularly with Mr. Easthope to discuss any issues and keep under review. Ms. Richards advised that the timescales for annual Data Security Protection Toolkit audit have now been confirmed nationally and this requires an amendment to current plan to enable this audit to be undertaken in Q1 2022/23.	

	This amendment to plan will require the committee's agreement. Follow-up completion rate currently stands at 43% which falls within the Limited Assurance rating. Work continues with the Trust to improve this position and regular updates are provided to the Executive Team. She advised that the following audits have been completed: Policy Management – Significant Assurance PDRs – Limited Assurance. A number of issues were identified which are being followed up and the Trust is working to strengthen PDR arrangements. Payroll – Significant Assurance. A joint audit with Sheffield Teaching Hospitals and Sheffield Children's Hospital in respect of core payroll controls. No specific actions identified for SHSC. With respect to the Head of Internal Audit Opinion stage 1 memorandum, she advised that at this stage the main findings are in respect of the partnership objective and recording of the relevant risks on the BAF, which has been discussed earlier and is being addressed: issues around the People Committee and issues in respect of strengthening the BAF content. All these areas will be followed up as the year progresses to inform the final HoIAO statement. Members noted the low completion of follow up actions, with a number of aged actions still outstanding which is a persistent issue for the Trust. Mr. Easthope confirmed that this is a regular discussion topic at the Executive Team Meetings to ensure appropriate ownership and oversight, and there is a collective and individual acceptance that progress to date is not acceptable. A number of actions are being followed up to address the situation and discuss with 360 Assurance to ensure actions are completed and evidenced to enable actions to be closed. While acknowledging the current position, Mr. Walsh advised that he believed there was more ownership of this position within SHSC and that there are plans in place to focus and get it back on track. In response to a question regarding the deliverability of this year's plan, given the current position, Ms. Richards and Ms Hawkes confirmed that while there has been some slippage, they were confident that the plan will still be delivered and that any further slippage concerns will be raised at an early stage. With respect to the action plan agreed as a result of the limited assurance on the recent PDR audit, it was agreed to request that the People Committee consider the robustness of that plan. It was also suggested that a narrative was needed in respect of the aged outstanding actions to ensure clarity on the status. Ms. Richards agreed to include the historical narrative regarding these actions to provide an understanding. It was confirmed that there is a process in place to ensure committees receive the relevant audit reports and that this should include oversight of audit outcomes and progress of actions, including those aged outstanding actions. Mr. Walsh and Mr. Easthope agreed to review all aged actions prior to the new process being established and identify for committee oversight as necessary, in liaison with 360 Assurance.	DW

	The Committee noted concerns regarding the completion of actions in a timely manner and agreed that this should be brought to the Board's attention. The deferral of the DSPT audit into Q1 2022/23 in line with national timelines was approved.	
ARC2021/ 10/0113	**360 Assurance Counter Fraud, Bribery & Corruption Report** The committee received this report from Mr. Taylor for assurance. Mr. Taylor advised that in addition to the formal work programme, the Trust has been required to submit information to NHS Counter Fraud Authority as part of two national exercises looking at Purchase Orders vs non-Purchase Order spend and Covid related public procurement notices. He also confirmed that a fraud risk scoring exercise has recently been completed to respond to the new requirements around the assessment and management of fraud risks, the results of which will be issued shortly in the form of a risk briefing for the Trust's awareness. Noted that the Trust's counter fraud champion was identified as the Deputy Director of Finance and the Chair agreed to discuss further with Matt White at a forthcoming meeting. **The committee noted receipt of this report and were duly assured by its content.**	
ARC2021/ 10/0114	**KPMG External Audit Progress Report** The Committee received the report from Mr. Khangura for assurance. Mr. Khangura advised that the report provides an overview of the initial areas from their risk assessment as part of the 2021/22 audit plan, excluding the standard audit risks of management override of controls and fraudulent revenue recognition. In terms of the financial statement element of the audit, the transaction relating to the disposal of Fulwood; introduction of IFRS16 and new disclosures on fair pay in the remuneration report have all been identified as areas for further consideration. Further work and discussions with key staff are already taking place to inform the final plan in respect of these areas. With respect to the VFM element, the CQC inspection activity and progress as well as the underlying financial position and medium-term financial planning implications have been identified for follow up. Mr. Khangura confirmed that the full audit plan would be received at January's ARC meeting. Ms. Murphy welcomed the work around the underlying financial position and the planning implications. She felt that understanding this position is key to the success of our transformation programmes and informing any decision on how to use resources differently. **The Committee noted the position and were assured by the report.**	
ARC2021/ 10/0115	**Emergency Preparedness, Resilience & Response Assurance Framework Update** The Committee received this quarterly assurance report from Ms. Murphy. Confirmation was provided that a full declaration of compliance was received at the September Board of Directors and the report received by members today builds on that compliance statement. Three standards have been identified where partial compliance is being reported:	

	mass casualty; data protection and security toolkit and FFP3 access and the report confirms workstreams in place to move to full compliance over time. Ms. Murphy noted that while progress made in respect of our on-call framework has been good, starting from a very low base, she felt the time was right to stand back and review processes by the end of this calendar year to ensure the right level of support is available on the rota to ensure our services are safe and well supported. This review and timeline were welcomed by Members. It was also noted that an improvement plan is in place, progress against which is reported into ARC on a quarterly basis, including the identification of any new risks and actions. Members welcomed this report and the significant degree of assurance it provides. An assurance was also provided that the learning from the recent pandemic is being incorporated into future work plans to better prepare for any future emergency; as well as an overview of the steps being taken to meet anticipated winter pressures across the range of our services. **The Chair confirmed the Committee's assurance in the key areas of this report and noted this would be reported up to Board.**	
ARC2021/ 10/0116	**Digital Information Governance Group – Escalation & Update Report** The Committee noted receipt of this report for assurance. Mr. Easthope confirmed that the report provides elements of assurance in respect of digital information governance as well as identifying areas where further assurance has been requested by the Digital Information Governance Group. He highlighted a number of key workstreams currently being pursued by DIGG. He noted that risks had been escalated to the CRR, noting that risk 4376 relating to storage of records at President Park, has been a long-standing issue for DIGG relating to concern about the specific location of records at President Park and ease of access to these records. Progress on review of this risk has been slow but there is now an action plan in place about more security in that area as well as incorporating consideration of the long-term future of that storage for the Trust. On a similar theme, risk 4375 relates to the storage of records at Fulwood House. There is a residual issue around some historic finance and workforce records. Following escalation, and discussion at the Executive Team Meeting, there is now a plan in place to pick this up over the new few weeks as part of the Leaving Fulwood Programme to ensure a forward policy is in place. The report highlights where there has been a lack of assurance in respect of a cluster of patient confidentiality breaches within a particular service. Work is now being undertaken to understand trends, incident commentary, identify key learning points and ensure appropriate training is put in place and reinforced. Noted for awareness that the incidents of Insight document loss have reduced with ongoing mitigation having a positive impact. Mr. Easthope also advised that he felt DIGG was now embedding in its remit while still acknowledging that there is much to do. Members welcomed the increasing level of transparency of information governance issues but stressed the need for pace in the consideration being	

	given to the options to manage and address the records risks. There was general acknowledgement that the transformation programmes currently being delivered have implications for our IT systems which require careful management as well as ensuring a Digital Strategy that is fit for purpose is in place. Discussions continue with key IMST officers and others regarding prioritisation etc to ensure this is managed appropriately and safely. Following concerns being raised by NED members regarding the potential for further issues to arise as a result of the Leaving Fulwood Project, Mr. Easthope advised that time and effort is being spent to ensure that all areas are being addressed as part of the programme plan and it is being managed, but that there will always be unforeseen issues arising. Mr. Mills questioned whether given the possible level of risk associated with the issues in this report, and the quarterly cycle of ARC meetings, whether consideration needed to be given to whether assurance updates/progress reports should be provided into an alternative forum. Mr. Easthope noted that they key separation is information governance through ARC and digital/technology through Finance & Performance Committee. He acknowledged that alongside this, we need to ensure that the risks are surfacing and being managed as part of the key transformation programmes. In this respect we have the Transformation Board and other mechanisms in place for that oversight which report into FPC and other groups onto Board. He added that if we ensure the appropriate Digital Strategy oversight is in place for technological implementation there are not many of the IG issues that can be fixed month by month. It was agreed that quarterly escalation reports would continue into ARC, but that if necessary Mr. Easthope would provide updates on specific issues following each of the DIGG meetings. **The Chair confirmed that the Committee had received this report for advice**.	
ARC2021/ 10/0117	**2022 Schedule of Meeting Dates – Audit & Risk Committee** The committee formally approved the schedule of meeting dates for 2022, noting that the May date may be subject to change following receipt of the final year-end timetable.	
ARC2021/ 10/0118	**Single Tender Waivers** a. <u>Process Assurance</u> As agreed at the last meeting, Mr. Easthope confirmed that he had received the arrangements in place for the consideration and approval of single tender waivers. He noted that the Procurement Department have recently reinforced the correct process to all officers, hence the higher number of waivers being received over recent meetings. Following the last meeting he sent an appropriate communication to remind key departments of the correct policy and to communicate the concerns raised by ARC members regarding the level and nature of waivers currently being received. He assured members that the policy is clear, is now being applied correctly and that key areas of learning are being applied. The report received by members notes a number of areas of concern and common themes which are all being followed up through the relevant groups. In terms of measuring improvements, it was suggested that the level of	

	inappropriate use within this report will provide a good indication. b. Waivers Received Since Last Meeting. The Committee noted the detail of all single tender waivers approved since their last meeting, received for information.	
ARC2021/ 10/0119	**Any Other Business** a. Private Discussion with Auditors Agreed that a discussion between the Non-Executive Director members and the Auditors would be arranged prior to the next meeting. b. 2022/23 Plan Confirmed that arrangements are being made for the 2022/23 audit planning meeting.	
ARC2021/ 10/0120	**Meeting Evaluation & Confirmation of:** a. Meeting Effectiveness Agreed that the meeting had been effective with a number of substantive items on the agenda. b. Significant issues report to the Board of Directors Alert • Board Assurance Framework 2021/22 • Corporate Risk Register 2021/22 • 360 Assurance Progress Report – Follow Up of Actions & Aged Actions Advise • KPMG Progress Report – Initial Areas from Risk Assessment 2021/22 Plan • Digital Information Governance Group – Escalation & Update Report Assure • Emergency Preparedness Resilience & Response Assurance Framework Update Changes in level of assurance Agreed that changes in level of assurance were explored during the meeting and that a Board conversation regarding the BAF would be a continued area of focus. Agreed actions To be monitored via Committee Action Log Review of Committee Timetable/Work Programme Noted	

Date and time of next meeting: 18 January 2022 @ 2.30 p.m.
Apologies to: Jeanine Hall, PA to Chief Executive & Executive Director of Finance
Tel 2716716; email Jeanine.hall@shsc.nhs.uk

AD/jch/approved AD

Sheffield Health and Social Care NHS Foundation Trust

Mental Health Legislation Committee (MHLC)

CONFIRMED Minutes of the Mental Health Legislation Committee held on Tuesday 8 September 2021 at 12 Noon. Members accessed via Microsoft Teams Meeting.

Present:
(Members) Mike Potts, Trust Chair (Chair)
Olayinka Fadahunsi-Oluwole, Non-Executive Director
Dr Mike Hunter, Executive Medical Director
Sandie Keene, Non-Executive Director
Salli Midgley, Director of Quality

In Attendance: Lorena Cain, Nurse Consultant for Restrictive Practice
Hester Litten, Interim Head of Safeguarding
Jamie Middleton, Head of Mental Health Legislation
Dr Jonathan Mitchell, Associate Clinical Director for Rehabilitation and Specialist Services
Sharon Sims, PA to Chair and Director of Corporate Governance (Minutes)

Apologies: David Walsh, Director of Corporate Governance

Min Ref	Item	Action
MHLC21/09/024	**Introduction and Welcome** The Chair welcomed everyone to the meeting and noted that Jamie Middleton was in attendance in his new role as Lead for Mental Health Legislation.	
MHLC21/09/025	**Apologies and confirmation of quoracy** Apologies were received and the meeting was quorate.	
MHLC21/09/026	**Declarations of interest** Salli Midgley reported that she was a Trustee of the Restraint Reduction Network.	
MHLC21/09/027	**Minutes of the meeting held on 8 June 2021** The minutes of the meeting held on 8 June 2021 were agreed as an accurate record.	
MHLC21/09/028	**Matters Arising and Action Log:** <u>MHLC21/06/016(i) Mental Health Legislation Report Q4</u> The Trust response to the White Paper had been collated but not submitted. This came to light following the action to share the formal response with the Committee. Dr Mike Hunter attributed this to changes in personnel. He reported that the Committee had been sighted on the Trust response at its inaugural meeting in April 2021. Jamie Middleton advised that the Approved Mental Health Professionals had collated a response which had been submitted on their behalf by the Local Authority. <u>MHLC21/04/004 Introduction of Mental Health Legislation refers</u> Assurance to the Committee of a robust process to monitor the 3-month rule and update of the audit. Action Log Update.	SM/JM

MHLC21/06/17 Mental Health Legislation Q4 Report refers
Sandie Keene asked if the improvement plan that Jamie Middleton was leading on in relation to the recording of S135/6 had developed. Jamie Middleton advised that he had referenced this in his Quarter 1 report. Dr Jonathan Mitchell added that this also linked to an IT issue in relation to the source of data as this is currently collated manually.

Care Quality Commission (CQC) Matters
Dr Mike Hunter reported that the Trust was inspected in May 2021 and the outcome of the inspection was that the Trust had improved its rating from Inadequate to Requires Improvement. He noted that there was a "must do" action in relation to policy compliance with the Mental Health Act. He reminded Committee that they had been sighted on Annexe B of the Code of Practice and there had been agreement to progress the action plan. Dr Mike Hunter reported that this plan would be subsumed in the Trust's overall CQC action plan and monitored through the Back to Good Board, Quality Assurance Committee, and the Board. It would also feed into this committee for any Mental Health Legislation issues.

The Chair acknowledged the Trust's improved CQC rating in its ambition of getting back to "Good" and the work to date to get to get to this position.

MHLC21/09/029 **Mental Health Legislation Operational Group**

a Terms of Reference
Committee received the Terms of Reference for the Mental Health Legislation Operational Group (MHLOG) for approval.

The Chair referenced the section on Standing Orders and Standing Financial Instructions and asked if there was clarity on the Scheme of Delegation. He also asked if the reference to advocacy services under membership related to service user representatives. Jamie Middleton advised that a manager from the advocacy services attended in their capacity as an independent mental capacity and mental health advocate.

Salli Midgley noted that people with lived experience could apply for roles where there was reference to service user representation on groups and committees, and that a job description had been developed to clarify the roles and that they would be remunerated accordingly.

Dr Jonathan Mitchell noted a change in representation from Learning Disabilities Services, and that whilst the new service model is developed an interim Clinical Lead/Matron would attend MHLOG.

The Chair referenced the Terms of Reference and noted that the notes from MHLOG should be shared with Committee. Salli Midgley agreed to check this requirement with Charis Consulting as it was not in alignment with other committees.

Committee received and approved the MHLOG Terms of Reference. Clarity on presentation of notes from MHLOG to Committee SM

b Workplan
Committee received the plan for information. Jamie Middleton reported that this was work in progress and would align with Key Performance Indicators and the Human Rights Act.

Committee received the MHLOG work plan for information.

c Mental Health Legislation Q1 Report

Committee received the report for assurance and information.

Jamie Middleton reported on the key highlights from the quarter. He noted that there had been two Care Quality Commission Mental Health Act visits to Maple and Burbage Wards, they had identified several areas that required attention, and an action plan to address them had been submitted and would be monitored through MHLOG.

Key Highlights:

- Low rates for Mental Capacity Assessments for informal admissions (43%). The Flow Co-ordinators have been reminded that there is a need to complete an assessment. Jamie Middleton advised that he had revised the MHL training and would add this to the schedule.

- Serious incidents attributed to the unlawful administration of medicines without consent. Committee received reassurance that staff had been advised of the requirements under the Mental Health Act and additional training given were appropriate.

- Low use of Section 4, Sections 5.2 and 5.4 (urgent/emergency admission)

- Health Based Place of Safety (HBPoS), an area of concern related to the timeliness of assessment, only 40% of patients assessed within the 3-hour target. Reasons could be attributed to the patient being unwell, sleeping or no Section 12 Doctor. Other issues include data quality in relation to recording, staffing shortages and concerns that the bed is being used for acute admissions, which whilst ensuring patient safety, blocks the bed and has a knock-on effect for Accident and Emergency and Out of Area.

- Incident Reports recorded as invalid detentions, attributed to missing or errors of the paperwork; additional training given were appropriate.

Sandie Keene noted that whilst there was transparency on several issues, including Place of Safety, Deprivation of Liberty Safeguards (DOLS), invalid detentions and medications, she noted gaps and asked how they were being prioritised and whether there were action plans that Committee needed be monitoring.

Olayinka Fadahunsi-Oluwole noted her concerns regarding the high number of agency staff and asked if there were plans to recruit substantively.

Dr Jonathan Mitchell reported that operationally this was important and noted there had been challenges in relation to the accuracy of information, which emphasised the need to ensure that systems were in place to meet the standards.

Jamie Middleton reported that updates in relation to the Health Based Place of Safety (HBPoS) are being reported into MHLOG. Monitoring of DOLS applications in respect of residents at the residential units which SHSC has contracts with continues. A significant number are being deprived of liberty but have no legal order in place.

However, legally SHSC has fulfilled its legal obligations and the responsibility for the DOLS assessments and authorisations are with the Local Authority, not the Trust. Jamie noted this is the picture reflected nationally and why DOLS is to end in 2022.

Jamie advised that from a legal perspective the Trust could not intervene and advise NHS Sheffield Clinical Commissioning Group (NHSSCCG) of the applications made by the Local Authority for residents deprived of their liberty.

Medicines errors are being addressed with a rolling training programme to ensure new staff are captured. Jamie had also reviewed the training and would enhance it in some areas. Jamie agreed to discuss this with MHLOG, as remaining lawful was the fundamental priority, and that some areas required a review of their practice.

Neil Robertson reported that HBPoS had new leadership and had moved under the Crisis service line, the decision making for the use of Section 136 had been reviewed and new operating procedures were being drafted, and a more robust data set was also in development. He believed there were challenges in relation to detentions and noted that there were also issues in relation to the reduction in beds during the estates work, which were being addressed through the procurement of additional out of area beds.

In relation to the use of agency staff, Neil Robertson advised that agency staff would be used to cover the wards and the substantive staff would be moved across to cover the HBPoS. He noted that a report on recruitment was on the agenda for the next People Committee.

Dr Mike Hunter reported that he would ask the Clinical Directors to work with Jamie Middleton on the concerns related to the unlawful administration of medicines so they could be explained in future reporting. He added the Quality Assurance Committee (QAC) receive quarterly reports on Medicines Safety and Medicines Management from the Chief Pharmacist and suggested the Chief Pharmacist is asked about lawful handling of medicines under the Mental Health Act in QAC.

Sandie Keene was pleased to see that the quality agenda was starting to impact and used the reading of rights as an example. She asked if data was collated on the length of time it took to find a bed for someone detained in HBPoS and if there had been improvements. She asked if quality indicators could be included in reporting.

Salli Midgley was mindful this was a new committee and that the work in MHLOG will feed in, she reassured Sandie Keene that the issues were being discussed. She noted that there was a gap in the co-production of the report and would like to see Clinical Directorates and the Mental Health Legislation Team work together to develop the report. She added that the clinical membership of MHLOG was also under review, which aligned to the findings of the 360 Assurance Audit report. Salli Midgley was also mindful that there needed to be collaboration across several areas, and used the issues raised in relation to medicines as an example.

Chair
SM
JM

Committee received the report and noted limited assurance in relation to the action plans and priorities.
Number of areas to alert to the Board
Development of the Key Performance Indicators (KPIs) to present to Committee in December 2021

MHLC21/09/030 **Least Restrictive Practice Groups (LRPG)**

a Terms of Reference
Committee received the Terms of Reference for LRPG for information.

Lorena Cain reported that LRPG had been newly formed, and that the

Reducing Restricted Practice Operational Group reported into it.

The Terms of Reference were received at the inaugural meeting in July 2021 and there were gaps in membership including the appointment of a service user as co-chair.

Sandie Keene asked for clarity on the different levels for the groups. Salli Midgley reported that the groups were different the monthly group focused on clinical and operational issues, and implementation of Safewards, whilst the quarterly Oversight Group was focused on delivery and implementation of the strategy. Salli Midgley believed that once Committee becomes established some elements could be stood down. Lorena added that there was co-production in the Operational Group and a strengthening of the leadership and ownership.

Dr Mike Hunter asked if there was professional representation from Learning Disability Service in either group. It was confirmed that there was representation on both groups.

Committee received and approved the Terms of Reference

b Workplan

Committee received the Workplan for LRPG for information.

Lorena Cain reported that the workplan aligned with the Strategy and covered a three-year period. The Project Management Office (PMO) are focused on developing the priorities and the quality improvement agenda.

c Least Restrictive Practice Q1 Report

Committee received the report for information.

Lorena Cain reported on the key highlights:

- Approval of the Least Restricted Practice Strategy, which was to be launched at an event on 9 November 2021.
- Consultation on the statutory guidance on the Use of Force Act, which was submitted. The feedback will influence the work programme in relation to policies, training, practice, and data/record keeping.
- Progress on the clinical model (Safe wards) in collaboration with Clinical Directorates.
- Involvement in the National Restraint Programme (Burbage and Stanage wards).
- Two members of staff on the Post Graduate Certificate Course for Reducing Restricting Practice.
- Strengthening the connection with Advocacy, several issues in relation to knowledge and guidance require further work.
- Review the plans of the Task and Finish Groups to ensure they are co-produced, and in the frame of Human Rights.
- Review of all policies and a focus on training and implementation plans.

- Risks include data, and there is work on-going to focus on team level reporting.
- Limited capacity of the Respect Training Team to deliver at team level.
- Daily huddles to review incidents and take necessary actions.

MHLC21/09/031 **Horizon Scanning Report**

Committee received the report for information.

Jamie Middleton reported that the consultation for the Mental Health Act review had closed, the Government will continue to review the Act, no dates have been released and will be subject to parliamentary time and spending review.

Jamie Middleton advised that there had been recent prominent court cases elsewhere in the country regarding delays in taking concerns to the Court of Protection, and about sexual activity and mental capacity.

The Chair asked if the Board needed to be alerted on the cases. Jamie Middleton believed they did not, as these were still live.

Sandie Keene asked if there was senior level oversight on complex cases. Jamie Middleton advised that there was an escalation process to the Director of Operations and Transformation, Director of Quality through to the Director of Corporate Governance. The Court of Protection work had moved under Corporate Governance but he needed to have an oversight as clinical staff would seek his advice and examples can be used for training purposes.

Committee received the report and noted the content.

Neil Robertson left the meeting

MHLC21/09/032 **Liberty Protection Safeguards (LPS)**

Committee received the report for assurance and information.

Jamie Middleton reported that it was a difficult position, and at the behest of the Department of Health and Social Care (DHSC) involved other NHS Trusts and providers, and the Local Authorities.

He reported that there was a potential risk, in that the implementation date is scheduled for April 2022, but to date no Code of Practice had been published but was expected during Winter 2021, which would leave a very short time.

A meeting with 360 Assurance was held to discuss the report and they reported that everyone was in a similar situation, they did however advise that a hub model had been discussed, which the Local Authority were not aware of. He was also mindful that NHS England had recently submitted bids for LPS leads.

Sandie Keene was concerned that not all parties were engaging in discussions. She asked if there was opportunity to draft business cases for additional resources in preparedness. Jamie Middleton believed Board needed to be alerted that there may be requests at short notice, and his main concern related to the Approved Mental Capacity Professional (AMCPs) role and the unclear expectations on provision for either Trust or hub level.

Dr Mike Hunter advised that there would need to be clarity on the requirements

and inhibitors.

Committee received and noted the content of the report.

Salli Midgley left the meeting

MHLC21/09/033 **Corporate Risk Register**

Committee received the report for approval.

Dr Mike Hunter asked Committee to approve the risk which related to the connectivity of wi-fi. He reported that MHLOG had reviewed and scored the risk above the threshold and therefore escalated it to Committee for inclusion on the Corporate Risk Register.

Committee received the report and approved the new risk for inclusion on the CRR.

MHLC21/09/034 **Meeting Evaluation**

Annual Work Plan

Committee received the workplan for information.

Significant Issues to report to Board.

Alert

Mental Health Legislation Q1 Report – gaps in assurance (CQC visits, Medicines incidents, non-compliance with legislation and data gaps) which MHLOG are addressing.

Least Restrictive Practice Groups (LRPG) Q1 Report - gaps in data and concerns with the delivery of Respect and Human Rights Training.

Liberty Protection Standards – delays and impact

Advise

Launch of the Least Restricted Practice Strategy

Assurance

Horizon Scanning

Changes in level of assurance (BAF)

Committee agreed there was no change in level of assurance.

MHLC21/09/035 **Any Other Business**

Chair of MHLC

The Chair reported that this had been his last meeting and that Olayinka Fadahunsi-Oluwole would take over as chair of committee. Sandie Keene thanked the Chair, Mike Potts and noted that he had identified the gap and been pivotal in establishing MHLC. She also wished him well in his retirement.

Council of Governor Observer

The Chair reported that a Governor had been assigned to Committee and would be observing the meetings, in their capacity as holding the Non-Executive Directors to account.

Date and Time of Next Meeting: Wednesday 15 December 2021 from 11:30am to 1:30pm
Meeting Format: MS Teams

Apologies To: Sharon Sims, PA to the Chair and Director of Corporate Governance
Sharon.sims@shsc.nhs.uk

ITEM 3a, 11-01-21
CONFIRMED 11-01-22

Sheffield Health and Social Care NHS Foundation Trust

People Committee

Minutes of the People Committee meeting held on Tuesday 9th November 2021, via teleconference

Members Present:	
Heather Smith	Non-Executive Director (voting) (HS) and Chair of Committee (the Chair)
Anne Dray	Non-Executive Director (voting (AD)
Richard Mills	Non-Executive Director (voting) (RM)
Caroline Parry	Executive Director of People (voting) (CP)
Susan Rudd	Interim Director of Corporate Governance (SR)
Apologies:	
Simon Barnitt	Head of Nursing for Rehab and Specialist Services (SBar)
Fleur Blakeman	NHSEI Intensive Support Director (FB)
Emma Highfield	Head of Nursing for Older Adults and Acute Inpatient Services (EH)
Beverley Murphy	Executive Director of Nursing, Professions & Operations (voting) (BM)
In Attendance:	
Sarah Bawden	Deputy Director of People (SBaw)
Deborah Cundey	Interim Head of Performance (DC) (for item 5)
Karen Dickinson	Head of Workforce Development and Training (KD)
Liz Friend	Trust Governor (LF) observing the meeting
Wendy Fowler	Freedom to Speak Up Guardian (WF) (for item 1)
Sally Hockey	HR Business Partner (SH) observing the meeting
Liz Johnson	Head of Equality and Inclusion (LJ)
Pat Keeling	Director of Special Projects / Strategy (PK)
Pranav Mahajan	Physician Associate (PM) observing the meeting
Sharon Mays	Trust Chair (SM) observing the meeting
Victoria Racher	Workforce Systems Manager (VR) (for item 5)
Neil Robertson	Director of Clinical Operations and Transformation (NR)
Dean Royles	NHS Consultant, Yorkshire and Humber (DR) observing the meeting
Jason Rowlands	Director of Performance (JR) (for item 11)
Amber Wild	Corporate Governance Manager (AW) supporting Susan Rudd
Helen Walsh	PA to Executive Director of People (minutes) (HW)

Welcome and Apologies

The Chair, Ms Heather Smith welcomed members to the meeting and introductions were provided for those observing the meeting – Sharon Mays, Pranav Mahajan, Liz Friend, Sally Hockey and Dean Royles.
The Chair also welcomed Richard Mills, Non-Executive Director and Vice-Chair of our Trust Board and Susan Rudd, Interim Director of Corporate Governance as new regular members of People Committee.
The Chair also noted that a Head of Nursing would be a regular member of Committee – on rotation; either Simon Barnitt or Emma Highfield.

Apologies were received from:
Fleur Blakeman, NHSEI Intensive Support Director (FB) and Beverley Murphy Executive Director of Nursing, Professions & Operations. It was noted that Neil Robertson, Director of Clinical Operations and Transformation will be attending People Committee on behalf of Beverley Murphy going forward.

The Chair explained that, following a directive from the CQC a couple of years ago, new governance arrangements were put in place via the introduction and development of six Assurance Groups [tier 2] that correspond to the strategic themes of our People Strategy. [tier 3 comprises of a number of Engagement Groups that include our Staff Network Groups and Joint Consultative Forum]. This has ensured that the leadership of Committee agendas is distributed between the Chairs of the Assurance Groups who each bring a report as timetabled, in order for Committee members to enact assurance on a variety of key issues, that are ultimately reported to our Trust Board via the significant issues report.

However, the Inclusion and Equality Assurance Group is providing its first report to Committee today, and the Organisational Design & Development Assurance Group, and the Survey Steering Group, are yet to be convened due to reorganisation of the OD Team.

The Chair added that Committee agendas are also structured as such to provide an update on the Risk element of each strategic theme, as set out in our Trust Board Assurance Framework (BAF).

Min Ref	Item	Action
1/11/21	**Staff Voice** The Chair welcomed Wendy Fowler, Freedom to Speak Up Guardian to the meeting. • As highlighted in her briefing paper, the FTSU Guardian has recently undertaken beneficial discussions with staff on Dovedale 2 to discuss their concerns, including the impact of not being able to recruit to key roles. • Following a query from Mr Mills, Ms Fowler explained that her key role is to talk with the individuals concerned but also to signpost to other areas of assistance such as the People Directorate. Ms Fowler also directs relevant concerns down the mediation route which, if successful, mitigates the need for a formal process. • Following a query from Mrs Dray, Ms Fowler responded that she deals with a combination of concerns – some staff go directly to the FTSU Guardian because they don't know where else to turn first and others contact the FTSU Guardian if they feel that other Trust processes are failing for whatever reason. Ms Fowler has regular meetings with Sandie Keene, Non-Executive Director lead for FTSU. Mr Mills said he would speak to SK to establish how the other Non-Executive Directors can assist with key areas of concern. • Following a query from Ms Parry, Ms Fowler responded that she has experienced a mixed response from managers who have concerns raised with them, and often, Ms Fowler's role is about managing expectations of the individual who has thought long and hard before raising a concern to then receive a less than reciprocal response from the manager. • Reviewing the impact measures provided in Ms Fowler's briefing paper, the Chair summarised that the impact of the initiatives put in place by the FTSU Guardian has been variable but there has been some improvement. The Chair also observed that the most common concerns raised are related to cultures that have developed. • Ms Fowler added that a positive step forward will be the introduction of FTSU leads within each team / area to help champion Speaking Up and change culture. This would, of course, increase the number of concerns received, which must be perceived as a positive step forward rather than a negative one. The Chair thanked Ms Fowler for speaking to Committee today and looked forward to receiving another update at a future meeting to highlight in particular any shifts, positive or negative, and any barriers faced. **ACTION – Mr Mills to speak to Sandie Keene (FTSU NED) to establish how the other Non-Executive Directors can assist with key areas of concern.** **ACTION – Ms Fowler to note that her next briefing report to Committee should highlight in particular any shifts, positive or negative, and any barriers faced.**	RM WF
2/11/21	**Declaration of interests** No declarations of interest were made.	
3a/11/21	**Minutes of the meeting held on 7th September 2021** The minutes of the meeting held on 7th September 2021 were agreed as an accurate record.	

3b/11/21	**Matters arising / Action Log** The Chair confirmed that all actions contained in the minutes are recorded in the Action Log. A briefing paper on each of the following matters arising were received by Committee and the following was noted.	
	i. Assurance re training needs outside of mandatory training At the September meeting, Committee members received an update on Workforce Transformation. One of the items highlighted was the centralised training budget – risk associated with progression and implementation of agreed business case. To mitigate against the identified risks a proposal has been made to reduce the scope of the centralised budget to all staff / majority staff subjects and to use a top slice approach – a decision is still pending. Ms Dickinson added that there has been some progress since the briefing report was written. The budget for centralised training [taken from localised training budgets] is still less than we hoped (£127k) but we are now in a position to begin to implement the centralised training budget. The amounts remaining in localised training budgets will still be used for training but can't be released for centralised training. Ms Dickinson is working with Finance to move the available funds into a centralised training budget, and will identify the training subjects that the centralised budget will pay for. Committee were pleased to note some progress with the centralised training budget but requested analysis of equity of access to training and a risk analysis in order to monitor the impact of the budget being smaller than anticipated. **ACTION – Ms Dickinson to include, in the next Workforce Planning and Transformation Group report to Committee in January 2022, analysis of equity of access to training and a risk analysis in order to monitor the impact of the budget being smaller than anticipated.**	KD
	ii. Alert re Information Governance Training The Data and Security Protection Toolkit standards require us to achieve 95% compliance in Information Governance training at one point in the year, with the next submission in June 2022. Our current compliance level is set at 80% in line with all other mandatory training subjects. The Digital Information Governance Group (DIGG) made a recommendation that IG compliance is increased to 95% to meet the required standard and for the window for completion for new starters be changed from 90 days to 5 days. The Workforce Planning and Transformation Group supported this proposal at their meeting on 12th October 2021. People Committee members endorsed this decision.	
	iii. Casework length (RAG rated) Following a query from Mr Mills, Mrs Bawden confirmed that 'casework' refers to People Directorate processes: disciplinaries; grievances and capability when they are at formal stages.; and Unacceptable Behaviour where cases fall into a formal stage – but doesn't include sickness cases. Committee were pleased to note that increased scrutiny of cases and the appointment of a HR Business Partner to support unblocking and completion of cases is having an impact on our casework data. In the past 4 weeks, 11 cases have been closed. The Chair noted that the percentage of ethnically diverse staff who are involved in cases is disproportionately higher than the percentage of ethnically diverse staff at our Trust and asked that colleagues continue to work to address the disparity. The Chair also requested an improvement trajectory for future reporting to Committee. **ACTION – Committee to receive an improvement trajectory in the next briefing to Committee.**	SBaw

	iv. Briefing on rest spaces in our buildings Committee were pleased to note that there has been a review of rest areas for staff and actions have been identified to improve the position. Mr Mills commended the work undertaken to create new rest spaces at Dovedale 2. Following a suggestion from the Chair, Ms Keeling confirmed that we will be informing staff about the positive improvements that have been and are being made.	
	v. Apprentice Staff Network Group Following a query from Mrs Dray, Mrs Bawden reported that Stephanie Allen pursued the setting up of a Staff Network Group for Apprentices but hasn't received much interest for it. Ms Bawden added that SA will establish the reasons why and perhaps market it differently to make it more appealing, or perhaps widen the membership beyond apprentices, or make it an annual event as suggested by the Chair. Mrs Dray was disappointed to hear that there hadn't been much take-up and welcomed a different approach because a dedicated group such as this could be helpful for staff who are going through training processes and will also help us understand what works well and what doesn't work well which will ultimately inform our retention plans.	
	vi. Assurance re external contracts **ACTION Bfwd – Mrs Dray and Mr Walsh to determine what would be the most appropriate forum to receive assurances on external contracts such as Occupational Health and Payroll. 09-11-21 Mrs Dray agreed to speak to Susan Rudd our new Interim Director of Corporate Governance.**	AD SR
People Strategy – overview and update bi-annual review		
4/11/21	Ms Parry presented this item and the following was noted. Committee acknowledged receipt of the bi-annual review report which seeks to provide an overall assessment of progress against the People Strategy over the past 6 months, and our aims to: 1. Prioritise health and wellbeing to support staff to feel healthy, happy and well at work 2. Recruit and retain the right staff with the right skills 3. Deliver workforce transformation to meet service needs both now and in the future 4. Collective, inclusive and compassionate leadership across the whole organisation with equal opportunity for growth and development. Committee were pleased to note that progress is being made against each of the aims with the embedding of the Assurance Groups that report to Committee. Nurse recruitment and retention continues to be an area of concern. Incentive packages for nurse vacancies and international recruitment options are being considered. The development of our Leadership Framework will be supported by external experts working with an internal Co-design Team of 10-12 of our leaders from a cross-section of our Trust at different stages in their journey – to June 2022. Continued roll-out will be led by internal staff (Head of Leadership and OD and the Co-design Team). KPIs have not been fully achieved, despite efforts and initiatives in place to make improvements. Sickness absence, in particular, is already showing an increase ahead of the Winter season which is traditionally high for sickness. There are also concerns regarding data quality and reporting, increasing vacancy rates, and agency spend. Actions are in place to address these areas which will be tracked through the Assurance Groups, with oversight at the People Committee. Following a query from Mrs Dray about health and wellbeing interventions, Mrs Bawden confirmed that the Staff Health and Wellbeing Group will undertake a deep dive into hotspot areas and evaluate the effectiveness of our interventions (Trust-wide and as part of the ICS workstreams).	

	Workshops have taken place with Staff Side colleagues, to enhance partnership working and support the review of our Recognition Agreement. Plans are in place for further sessions with Staff Side and managers working towards a positive employee relations climate and in support of the principles of a Just and Learning culture. Twelve new mediators have been appointed to support early resolution of cases. Further to a query regarding Exit Interviews, Ms Parry confirmed that a Qualtrics Survey is now used to capture data from Exit Interviews which has improved the response rate and will enable reporting to Committee in due course via the Recruitment and Retention Group. The People Plan and KPIs are to be reviewed to ensure they are reflective of the current position and have sufficient focus on priorities and be presented to Committee in March 2022 alongside a refreshed People Strategy. Following a query from Mrs Dray, Ms Parry also agreed to include data benchmarked against the Model Hospital. **ACTION – Ms Parry to present the refreshed People Strategy, People Plan and KPIs to Committee in March 2022, with data benchmarked against the Model Hospital.**	CP
Performance Monitoring		
5/11/21	Ms Racher and Mrs Cundey attended the meeting for these items and the following was noted. **a. Integrated Performance and Quality Report** Committee acknowledged receipt of the IPQR for information, to ensure Committee members are fully sighted on Trust-wide aspects of the report as well as Workforce. The Chair highlighted that the demand for services has increased at all access points; community waiting times are very high; and there are estate issues at St Georges which is having an impact on quality, which will consequently have an impact on our staff. **ACTION – The Chair asked for commentary to be appended to the IPQR similar to, or the same as, the commentary that goes to Quality Committee.** **b. HR Performance Dashboard** Committee acknowledged receipt of the report. Ms Racher presented this item and the following was noted. • Following an earlier query from Mr Mills it was acknowledged that the reasons for an increase in turnover of staff is due a. admin and clerical staff group (Aug and Sept 21) and b. in Sept 2021, 51 additional clinical services staff were recruited and 36 left the Trust within the same period. Aside from these two areas our Trust's turnover rate is favourable compared to the national average. Mrs Cundey confirmed that she will be working with the Workforce Information Team to clearly define how our turnover is reported, as it can be cut a number of ways. • Ms Racher confirmed that long term absence indicates a downward trajectory and short term absence indicates an upward trajectory. • 36% of the absences in Aug and Sept 2021 relate to Anxiety, stress and depression 13% relate to musculoskeletal issues and 11% relate to infectious diseases. • The staff group with the highest rate of sickness absence in Aug and Sept 2021 was 'Estates and Ancillary' staff followed closely by 'additional clinical services' staff. Ms Keeling reminded colleagues that it is important to note that the Estates and Ancillary staff group covers a wide range of roles Trust-wide, not just Estates. • The Chair summarised that Committee were pleased to note that the data concerning Supervision, PDRs and essential training compliance is generally on track but Committee remains concerned about the accuracy of workforce data particularly around vacancies. The Chair requested that colleagues add 'time to recruit' data to the next report, continue to establish more accurate vacancy data, and to provide comparators alongside all our data next time where possible.	DC

	ACTION – The Chair requested that colleagues add 'time to recruit' data to the next report, continue to establish more accurate vacancy data, and to provide comparators alongside all of our Trust data where possible.	DC, VR
	c. Staff vaccinations Mr Robertson reported that Clinical Operations and the Workforce Information Team are running the Flu Campaign and are also responsible for rolling out the Pfizer booster covid vaccination to staff. Previously the majority of staff vaccinations were provided by other local Trusts. As at the end of last week the flu vaccination rate was 45% of all our staff. This equates to 100 people more than last year, at this point in the campaign. Vaccinators will be administering the flu vaccine at the sites of targeted teams. As at the end of last week the Covid booster vaccination rate was 33% of all our staff. Mr Mills thanked the vaccination team for their efforts and commended the excellent operation of the vaccination hub at Fulwood. Following a query from Mr Mills, Mr Robertson confirmed that we are focussing on covid vaccinations of care home staff and staff who come into contact with care homes and will have more information about the proposal for mandatory vaccines of all health and social care staff at the next meeting. Following a query from Ms Johnson, it was agreed to include Bank staff and ethnically diverse staff in the data next time.	
	ACTION – Mr Robertson to provide an update on vaccinations at the next meeting in January and include data re Bank staff and ethnically diverse staff.	NR, VR
People Strategy theme: Health and Wellbeing		
	Report from the Staff Health and Wellbeing Group A report from the Staff Health and Wellbeing Group is due to Committee in March 2022, followed by July 2022 and November 2022. This does not preclude urgent items being presented, as necessary, to meetings in January, May, September if agreed with the Chair.	
People Strategy theme: Recruitment and Retention		
6/11/21	**Report from the Recruitment and Retention Group** Mrs Bawden presented this item and the following was noted. Committee acknowledged receipt of the report which seeks to provide assurance on recruitment activity and seeks approval to review the deliverables set out in the delivery plan in 2020, considering the emerging national priorities and combining deliverable actions to create best opportunities to deliver change. Key actions and challenges – - Continue to work on improving our data to enable more accurate reporting, particularly related to retention / leavers. - Continue to work on our KPIs in order to measure impact more accurately. - Undertake international recruitment (supported by NHSEI and NHS Providers). Certain countries engage in training for mental health nurses and STH have a successful tried and tested international recruitment programme that we can take learning from. - Engage in UK wide recruitment fairs (4 planned for early 2022). - Working with the ICS on retention strategies. - Implement a rapid improvement plan for nursing recruitment to RMN Band 5 and 6 and other hard to recruit professions. - Focus on the retention of medical staff following feedback from Medical Staffing Committee.	

	- Support the Flex for the Future retention programme. - Review the overall position for all professions to ensure that we focus on good recruitment and retention strategies across all groups. - Ensure actions to reduce the disparity ratio are supported. - Embedding of our Staff Network Groups into the governance structure are now taking shape and beneficially feeding into the Assurance Groups. Following queries from Mr Mills and Mrs Dray, the Chair requested that a further update on recruitment plans international and local be presented at the next meeting in January, to also include a review of the wording of our job descriptions to make them more appealing in line with other organisations. Mr Robertson stated that he is in favour of pursuing international recruitment as long as we market ourselves effectively, and added that it is important to learn from Trusts where international recruitment hasn't worked so well and be cautious against comparing our Trust with acute Trusts such as STH. The Chair summarised by thanking colleagues for the work undertaken so far in respect of a fresh approach to recruitment and retention which, she recognised, is quite challenging and looked forward to receiving an update in January. **ACTION – A further update on recruitment plans international and local be presented at the next meeting in January, to include comparators with other similar mental health organisations, and a review of the wording of our nurse job descriptions.** <u>Additional hours to cover nurse vacancies</u> Mr Robertson confirmed that the number of additional hours worked is comparable with our vacancy data, however an additional piece of work is being undertaken to establish what proportion of additional hours are being covered by Bank, Agency and substantive staff. **ACTION – Mr Robertson to provide data next time of the additional hours worked by Bank, Agency and substantive staff to cover nurse vacancies.**	SBaw NR
	BAF RISK – Recruitment and Retention. There is a risk that we fail to attract and retain staff due to competition, reputation issues and the healthcare context, and do not find ways to present a sufficiently attractive, flexible offer of employment, resulting in a negative impact on the quality of the workforce and negative indicators for quality of care. Mrs Bawden confirmed that the risk increase that was applied last time still reflects where we are currently and recommended reviewing it again in January, following receipt of the next report from the Recruitment and Retention Group.	
Break		
	Committee members observed a 10 minute break.	
People Strategy theme: OD, Leadership and Talent		
	Following reorganisation of the Organisational Development Team, it is proposed that a report from the Organisational Design and Development Group is due to Committee in March 2022, followed by July 2022 and November 2022. This does not preclude urgent items being presented, as necessary, to meetings in January, May, September if agreed with the Chair.	
7/11/21	**Pulse Survey** Committee acknowledged receipt of the report, produced by Sally Hockey, HR Business Partner, that sets out the background to our first People Pulse Survey, describes its purpose, how we have adopted it and the results and actions arising from the survey. Ms Parry reported that our Trust opted for the quarterly survey, the first of which took place in July 2021. The results from the July survey, are taken from 623 responses, this equates to	

	21% of all staff, which is a promising start compared to other Trusts. Areas of action have been identified, and actions are in place to respond to the feedback. This has been communicated via the Leaders call and at the Joint Consultative Forum. Teams are being asked to discuss the results locally to understand what the feedback means for them. Mr Mills welcomed receipt of the report but requested more detail to understand what the results are telling us. The Chair agreed and requested analysis at a future meeting and comparators against the Staff Survey results. The Chair summarised that there are areas of concern to escalate to Board with regards to the Pulse Survey that indicate we aren't yet making the progress desired e.g. the percentage recommending our Trust as a great place to work.	
	ACTION – The Chair requested analysis at a future meeting and comparators against the Staff Survey results and other organisations. Likely March 2022. **POST MEETING NOTE: The Chair later requested that reports on the Pulse Survey and Staff Survey alternate at each meeting of Committee.**	CP, SH CP, SH
	ACTION – The Trust Chair, Ms Mays asked to see a full copy of the Pulse Survey report [questions and results], for information.	CP
People Strategy theme: Inclusion and Equality		
8/11/21	**Report from the Inclusion and Equality** Committee acknowledged receipt of the report which seeks to provide assurance that our organisation is responding to the statutory duties of the Equality Act 2010, and provides an overview of progress of the Inclusion and Equality Group - a high-level EDI review and an update on Big Conversation. Ms Johnson presented this item and the following was noted. • The first meeting of the Inclusion and Equality group took place on Tuesday the 2nd of December. The terms of reference of this new group had been agreed and presented to People Committee earlier this year. • The main focus of the first I&E Group meeting was to consider the function and purpose of the group. *To promote and ensure that Inclusion and Equality are embedded in all that we do within our organisation. The group will drive forward development of an inclusive, fair, and diverse organisation across organisational functions and oversee a strategic approach to equality legislation and relevant health and social care policy.* • It had been agreed that the Chair of the group will be the Director of Clinical Operations and Transformation (Neil Robertson) to reflect the cross organisational function role of the group. Following a query from Mrs Dray, Ms Johnson confirmed that there is a link with the I&E Group and some service-related elements such as one of our organisation's quality objectives. Further discussion is required with the Director of Quality to consider reporting to Quality Committee [and/or associated tier 2 groups], as well as People Committee [workforce objectives]. There are also a number of data elements to consider, relating to ethnicity, for inclusion in our IPQR. • A clear link has been agreed with the Chairs of the Staff Network Groups – they will send one representative to each meeting. A similar link to the Service User Engagement Group was discussed and this will be followed up with the Director of Quality. It was suggested that it may be useful to have an external member (as is the case with Quality Committee) and this will be discussed at the next I&E Group meeting. • The Chair welcomed the report and was pleased to see the progress being made in this area and the increasing involvement of our Staff Network Groups in our decision-making and direction, which will be monitored and reported on at future meetings. The Chair also requested that future reports from the I&E Group show the groups key deliverables and actions. **ACTION – Ms Johnson and Mr Robertson to include key deliverables and actions in the next report to People Committee.**	LJ, NR

09/11/21	**Interim Gender Pay Gap Report** Committee acknowledged receipt of the report which seeks to assure Committee of the reasons for our organisational pay gap that are within the control of the organisation; that progress against actions are identified; and, in relation to our benchmark with other similar organisations, that our pay gaps are not significantly different from those in similar NHS organisations. Ms Johnson presented this item and the following was noted. • There is a statutory duty to publish Gender Pay Gap data annually, for public sector organisations this is set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. • Our Gender Pay Gap for 2020 was reported to People Committee and Board in March 2021. Board requested that they are provided with an update before the next due publication date (March 2022). This paper is being presented to People Committee to consider before Board. • The paper reviews the reasons for our organisations pay gap, explores benchmarks against other similar organisations and highlights progress in areas that are under the control of the organisation, including against the action identified in the report to Board in March 2021. • The interim Gender Pay Gap report indicates that overall, our GPG is low and, in the two areas where there is a significant pay gap, the gap is reducing. It also indicates that we are not outliers against other NHS organisations in this regard. • The Flex for the Future National Programme that we are part of will be beneficial in assisting staff to move into more senior roles. • Following a query from Mrs Dray, Ms Johnson responded that more female consultants were encouraged to apply for Clinical Excellence Awards, but there has also been 3 female consultants leave the Trust. So, although the pay gap for this staff group is decreasing there is a still a way to go. Plans are afoot nationally to improve the distribution of CEAs.	
10/11/21	**Annual Equality and Human Rights Report** Committee acknowledged receipt of the report which seeks to assure Committee that our organisation is responding to the statutory duties of the Equality Act 2010. • Following brief discussion Committee noted that the Annual Equality and Human Rights Report is ready for submission, and, although our disparity ratio is a significant issue, there has been progress, and greater clarity in other areas. • Ms Johnson proposed to provide the monitoring dashboard to Committee on a regular basis in order to demonstrate progress in a digestible format. Following a suggestion from Mrs Dray, Ms Johnson confirmed that a report is provided to the Mental Health Legislation Committee that outlines the impact measures of the initiatives deployed since the pandemic. • Committee suggested that the report be presented to the Quality Committee. Mr Robertson agreed to contact Beverley Murphy and Salli Midgely for the QC agenda. • The Chair and Mr Mills thanked Ms Johnson for an excellent report. • The report will be presented to our November Trust Board. **ACTION – Mr Robertson to contact Beverley Murphy and Salli Midgley to add the Annual Equality and Human Rights Report to the Quality Committee agenda.**	NR

BAF RISK – OD, Leadership and Talent. There is a risk that we fail to effectively support the development of a new approach to leadership and culture and/or align this leadership approach with organisational design, resulting in low staff morale, poor service and indicators of the quality of care.

Mrs Bawden confirmed that the risk rating should remain as is for now but suggested adding to the controls, mitigation and assurances columns to reflect the positive work being undertaken in respect of equality, diversity and inclusion.

ACTION – SBaw agreed to arrange to update the BAF risk to reflect the positive work being undertaken in respect of equality, diversity and inclusion.

People Strategy theme: Workforce Transformation		
	Report from the Workforce Planning and Transformation Group A report from the Workforce Planning and Transformation Group is due to Committee in January 2022, followed by May 2022 and September 2022. This does not preclude urgent items being presented, as necessary, to meetings in March, July, November if agreed with the Chair.	
11/11/21	**NHS priorities and planning guidance Q3-Q4 – draft updated workforce return** Committee acknowledged receipt of the report that seeks to assure Committee that the Trust is working to the NHSE/I priorities and guidance for Q3-Q4 (H2) and to also seek approval on the Trust's updated workforce plan submission. Key points noted – 1. **NHSE/I Guidance:** Updated planning guidance for Q3-Q4 (H2) has been issued. This requires the Trust to submit updated financial and workforce plan forecasts for H2. 2. **No material changes:** The full guidance has been reviewed by Business Planning Group and there are no new requirements or material changes that impact on our Plan and our priorities for this year. 3. **Financial plan forecasts:** There are no new financial challenges arising from the H2 guidance. 4. **Workforce plan forecasts:** Changes from our original submission regarding planned expansion in Q3 and Q4 are reflected in the updated submission. 5. **Workforce plan submission:** The submission requirements for H2 are significantly different to the May submission and two submissions aren't readily comparable. 6. **No new risks:** The Board Assurance Framework reports on known risks arising from workforce recruitment and ensuring a breakeven position. There are no new risks arising from the NHSE/I Guidance for H2 or the submissions. Following brief discussion Committee endorsed the forecasts outlined in the report. However, it was acknowledged that our aspirations in terms of workforce planning will be hampered by the risks and challenges with recruitment and retention.	
BAF RISK – Workforce Transformation. There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs, resulting in a disjointed approach and a disengaged workforce (industrial relation issues, sickness absence and poor retention, staff survey indicators). Next report from the Workforce Planning and Transformation Group timetabled for January 2022.		
Governance		
12/11/21	**Joint Consultative Forum verbal briefing** Ms Parry provided the following highlights from the last meeting of JCF that took place on 29th September 2021 – • Progress has been made to reduce our average case length with support of Staff Side and they are supportive of engaging with staff to promote initiatives arising from the Pulse Survey results. • The electronic system for booking flu vaccinations has improved ease of access. • Staff Side are assisting with conversations that may involve redeployment of unvaccinated staff working in our care homes (national deadline for vaccinations for frontline staff is 11th November 2021). • Reassurance received about the consultation process regarding the relocation of our Trust headquarters.	

13/11/21	**People Directorate Policies** Ms Wild, Corporate Governance Manager reported on the following on behalf of Susan Rudd, Interim Director of Corporate Governance and the following was noted. **Assurance document from Policy Governance Group** The Policy Governance Group met on 27th September 2021 and 25th October 2021, and the following recommendations made to Committee -	
	a. People Directorate Policies for ratification Committee members ratified the following policies, as approved by the Policy Governance Group – Dress Code, Uniform and Appearance Policy HR 024 – Interim Review Lone Worker Policy HR 042 Agile Working Policy – New Policy	
	b. People Directorate Policies – extension requests for ratification Committee members ratified the following extension requests as approved by the Policy Governance Group – Retirement Policy HR 005 – Extension Employment and Deployment for Short-Term Cover Policy HR 014 – Extension Redundancy Policy HR 002 – Extension Control of Substances Hazardous to Health Policy HR 016 – Extension Stress Management at Work Policy HR 006 – Extension *Study and Study Leave Policy HR 007 – Extension *An extension to the expiry date of the Trust Study Leave Policy until 31st March 2022 was granted by the Policy Governance Group 25th October 2021. The current policy is fit for purpose to support the local level process currently in place but will need updating, before the end of March, to reflect a centralised approach and clarify scope and process for identifying and agreeing learning and development needs.	
	c. People Directorate Policies status Ms Wild asked Committee members to note, for information, the People Directorate policies due to expire in quarter 3, as identified in the Master Policies Register. <u>Use of mobile phones whilst providing direct care</u> Following a recent observation by a staff member, People Directorate and Clinical Operations colleagues do not condone the use of mobile phones by staff whilst undertaking enhanced observations of dementia patients, and is in breach of Trust policy.	
14/11/21	**Board Assurance Framework and Corporate Risk Register** Ms Wild reported that risk No. 4165 (lack of compliance with RIDDOR) has been moved from the People Committee BAF to the Quality Committee BAF, and that risk No. 4749 (unable to meet training needs) has been added as a new risk and will need reviewing based on information gathered at this meeting.	
15/11/21	**Confirmation of Significant Issues to report to our Board of Directors** Committee members noted the following significant issues to report to Board. **TO ALERT** (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently) • Committee remains concerned about the accuracy of workforce data particularly around vacancies.	

- Our data, generally, is presenting significant cause for concern, particularly around sickness absence which is rising (now nearly 7%).
- The turnover rate remains high and our vacancy rate is also increasing. Committee noted that this will have significant impact on quality of care and our staff experience.
- Committee requested an update on the latest actions on recruitment and retention to be reported at its next meeting in January 2022.
- There are areas of concern with regards to the Pulse Survey that indicate we aren't yet making the progress desired e.g. the % recommending our Trust as a great place to work.

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

- Committee were pleased to note that the data concerning Supervision, PDRs and essential training compliance is generally on track.
- Progress is being made with the actions that form the People Strategy Delivery Plan although the lack of impact on KPIs is a cause for concern.
- Committee noted that the Strategy will be refreshed in the new year and be presented to Committee in March 2022.
- Committee noted a delay with actions related to leadership and culture due to the reorganisation of the Organisational Development Team. However, Committee noted that interim solutions are in place to ensure, for example, that the Staff Engagement work continues and that work has begun to develop a Co-Design Team to take forward the externally facilitated Leadership Programme.
- Committee were pleased to receive positive reports on our handling of casework, with the majority of cases now being closed in a more timely manner.
- Committee wished to advise the Board that our Trust currently has two live Employment Tribunals.
- Following a request from Committee, there has been a review of rest areas for staff and actions have been identified to improve this position.
- The interim Gender Pay Gap report indicates that overall, our GPG is low and, in the two areas where there is a significant pay gap, the gap is reducing.
- The Annual Equality and Human Rights Report is ready for submission, and, although our disparity ratio is a significant issue, there has been progress, and greater clarity in other areas.
- Committee were pleased to note some progress with the centralised training budget but requested a risk analysis in order to monitor the impact of the budget being smaller than anticipated.

ASSURE (areas of assurance that Committee has received)

- Committee were assured that the new Tier 2 and Tier 3 Governance structures are beginning to have impact.
- A report was received from the Recruitment and Retention Group relating to the pro-active approach being taken regarding flexible working which should in turn have a positive impact on retention data.
- The report from the Inclusion and Equality Group shows the increasing involvement of our Staff Network Groups in our decision-making and direction, which will be monitored and reported on at future meetings.
- The new recruitment system TRAC is bedding in which will be able to provide us with KPI data in order to establish any trends, themes and areas for improvement.
- There is a plan to consult staff at Fulwood House about the detail of the relocation of our Trust Headquarters. Committee requested that the Equality Quality Impact Assessment be carried out as soon as possible.

Any other Business		
16/11/21	**To note any other business within the scope of the Committee's Terms of Reference**	
	a. <u>Independent inquiry affecting healthcare settings</u> Committee acknowledged that Government have initiated an independent review into the incidents at a Trust in South East Kent and relevant colleagues agreed to check our policies in terms of third parties working on Trust premises, including DBS checks. **ACTION – SBaw to arrange for the Advisory Team to check our policies regarding third parties who work on Trust premises.** **b. <u>360 Assurance Audit of Quality of Personal Development Reviews</u>** The Chair informed Committee that via 360 Assurance an audit of the quality of personal development reviews has been undertaken. The audit highlighted a number of concerns resulting in only limited assurance being enacted. Ms Parry acknowledged that this would fall under the remit of the Head of Leadership and OD (once in post) and agreed in the interim to present a briefing to the next meeting of Committee. **ACTION – Ms Parry and Mrs Bawden to arrange for a briefing to be submitted to the January meeting to provide assurance that the recommendations from 360 Assurance are being actioned and followed up.** **c. <u>New headquarters and Leaving Fulwood Plan</u>** Ms Keeling presented this item. Committee acknowledged receipt of the report that seeks to provide assurance about the timeline, high level relocation plan and communication plan. Ms Keeling confirmed that consultation with staff in their teams will be to discuss which of the three locations each team will be relocated at, followed by individual consultation should it be required. Mr Mills welcomed the approach taken by the Leaving Fulwood Project Team which has been more than five years in the planning. Mr Mills asked Ms Keeling to consider adding into the proposal to staff the travel times in relation to other forms of transport. Ms Parry noted that the Staff Network Group Chairs appreciated the opportunity for early contribution at one of their meetings recently. Committee welcomed the plan to consult staff at Fulwood House about the detail of the relocation of our Trust Headquarters. Committee requested that the Equality Quality Impact Assessment be carried out as soon as possible. No further business was noted.	SBaw CP SBaw
17/11/21	**Evaluation / Annual Planner**	
	a. Determine meeting effectiveness Committee members reflected positively on the meeting by indicating a score out of 10 in the MS Teams Chat. Mrs Dray observed that the item on 'freedom to speak up' would have been better placed with its own item on the agenda. The Chair recognised and appreciated how hard everyone is working despite the challenges and thanked colleagues and report writers for their input and continued efforts.	
	b. Key agenda items for the January 2022 meeting of Committee Committee received the Work Programme / Annual Planner for information. The Chair reiterated the request from Committee to provide a further update on recruitment and retention at the January meeting. Anyone who is unable to meet the deadline for papers should let the Chair know in advance.	

HS CHECKED 15-12-21

CONFIRMED 11-01-22

Date and time of next meeting:

Tuesday 11th January 2022, 2:00pm – 4:30pm, via teleconference

Apologies to: Helen Walsh, PA to Executive Director of People

Helen.Walsh@shsc.nhs.uk

Quality Assurance Committee

CONFIRMED Minutes of the Quality Assurance Committee held on Wednesday 8 December 2021 at 10am. Members accessed via Microsoft Teams Meeting.

Present: (Members)
Sandie Keene, Non Executive Director (Chair)
Olayinka Fadahunsi-Oluwole, Non Executive Director
Dr Mike Hunter, Executive Medical Director
Beverley Murphy, Executive Director of Nursing, Professions and Operations
Heather Smith, Non Executive Director
Prof Brendan Stone, Associate Non Executive Director

In Attendance:
Abiola Allinson, Chief Pharmacist (item 11)
Tania Baxter, Head of Clinical Governance
Sue Barnitt, Head of Care Standards
Deb Cundy, Interim Head of Performance (Item 08)
Adele Eckhardt, Lead for Care Standards (Item 15)
Emma Highfield, Head of Nursing (Item 12a/b)
Dr Michelle Horspool, Deputy Director of Research (Item 16)
Amanda Jones, Lead for Allied Health Professions
Riann Parr, Ward Manager, Dovedale 2 Ward (Item 12a)
Dr Jonathan Mitchell, Clinical Director
Maggie Sherlock, NHS Sheffield Clinical Commissioning Group (NHSSCCG)
Amber Wild, Corporate Assurance Manager
Dr Linda Wilkinson, Head of Psychological Services
Chris Wood, Associate Clinical Director
Sharon Sims, PA to Chair and Director of Corporate Governance (Minutes)
Franky O'Brine, Corporate Governance Officer, (Observer)

Apologies: Susan Rudd, Salli Midgley Chris Digman and Simon Barnitt, Dani Hydes, Neil Robertson,

Minute Ref	Item	Action
QAC21/12/204	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies. She reported that the Committee's administration was in transition and that Franky O'Brine from the Corporate Governance Team was in attendance as an observer.	
QAC21/12/205	**Declarations of Interest** No declarations were received.	
QAC21/12/206	**Minutes of the meeting held on 10 November 2021** The minutes of the meeting held on 10 November 2021 were agreed as an accurate record.	
QAC21/12/207	**Matters Arising** No matters arising to note.	

QAC21/12/208	**Action Log** Committee received the action log for information. QAC21/10/178 Task and Finish Group Nursing Medication ……. refers Dr Jonathan Mitchell asked for clarity on this action. The Chair reported that Committee had requested an update focused on the increase in medicines incidents in Rehabilitation Services. QAC21/10/192 IPQR refers Amendment: Restricted Practice - further work on compliance with Health and Social Care standards.	
QAC21/12/209	Beverley Murphy reported that Sandie Keene was leaving the Trust and that this was her last meeting as Chair of the Quality Assurance Committee. She thanked her for her service to the Trust and across the Health and Social Care network and added that she would be missed, and that she had been focused on quality and improvement for the people of Sheffield. Sandie thanked Beverley for her kind words and added that she was sad to be leaving, she noted that Committee had gone from strength to strength and that there had been improvement in the quality of reporting. Sandie advised that the recruitment of a new Non-Executive Director had commenced, and that Heather Smith had agreed to act as interim Chair of the Committee.	
QAC21/12/210	**Quality Account Progress** Tania Baxter reported that Committee receive a quarterly update on the progress against the quality objectives, which was one element of the Quality Account, and that Council of Governors would also receive an update in February 2022. She noted the date for submission of the Quality Account had not been published but expected this to be June 2022. Consultation with partners would include; the Lived Experience Co-Production Assurance Group, Sunrise, NHS Sheffield Clinical Commissioning Group (NHSSCCG), Local Authority and Healthwatch. Beverley Murphy asked if Committee could receive assurance that work to meet the priorities had progressed. Tania reported that workstreams had been assigned to each area and there were data sets to support each objective and that work had been co-produced. The Equality and Inclusion Group had been established and the work on restricted practice work had moved at pace with the launch of the Restricted Practice Strategy. Committee would receive this update in the next quarterly report. **Committee received an update and were assured that the timetable for consultation would align to the submission date for the Quality Account.**	
QAC21/12/211	**Back to Good Programme Board** Committee received the report for assurance Sue Barnitt reported on the key highlights. She noted that the themes for the outstanding actions and key risks included; staffing levels, ligature anchor points, IMST, mandatory training, supervision and agency staff training, environmental issues on and adherence to the Duty of Candour. The risks related to training and supervision and Emma Highfield reported that there had been a lot of work in this area, she used Stanage Ward as an example	

	and noted that they had developed a board which was populated with staff supervision and training sessions. She was aware there had been challenges in relation to releasing staff for mandatory training and attributed this to staff absence during the pandemic and recruitment issues. She advised that Neil Robertson, Director of Operations and Transformation and herself were undertaking a review of the recruitment process and the need to create multi disciplinary teams. Beverley Murphy reported that from a mitigation perspective the Quality Team had introduced a daily huddle to review incidents and escalated any that required further action. They were able to identify where Duty of Candour had not been met and support the team, further work is required to help teams understand this and have the confidence to act when an incident occurs. Heather Smith referenced the three areas that were off trajectory and in particular the Acute wards and asked if Committee should be concerned and whether there was any indication of their position and when they would be achieved. Dr Mike Hunter noted that the comments would be fed into the report for the Board Workshop in December 2021. In relation to the Section 29A for the Acute Ward he noted there were a number of environmental risks, the most significant of which related to ligature anchor points. The mitigations that had been put in place had not been successful and therefore needed a different approach. Emma reported that there had been a change in practice, with daily safety huddles and increased engagement, she added that service users were feeding back that things were different. Emma in response to a question on safeguarding reported that this was high on the agenda and noted the increase in training and reporting. Sue added that the fundamental standards of care visits had also give opportunity to test staff knowledge. Mike advised that the question to be considered is whether the improvements met the required threshold. Beverly Murphy assured Committee that she met regularly with the Matrons and Ward Managers as part of their development and had also visited the wards. She reported that there had been significant investment in the leadership to develop their teams and was confident that the threshold had been met. She added that if the Care Quality Commission (CQC) find lapses they would be followed up and teams supported. Sue added that there was further developmental work with the teams on what a good rating would look like. *Committee were informed that the CQC were on site, and inspecting a number of in-patient wards* **Committee received the report and noted the updates and the areas requiring further development.**	
QAC21/12/212	**Integrated Performance and Quality Report** Members received the report for assurance. Beverley Murphy reported that the format for highlighting changes had been revised. The key highlights to note included an increase in restraints at Birch Avenue, and ongoing concerns with CPA compliance in the Community Teams, whilst there had been recovery plans focused on this, one of the teams had been in decline and required further investigation. The Board had been sighted on the waiting times at Emotional Wellbeing Service (EWS) and Single Point of Access (SPA), and a new model had been shared with	

	the team in November 2021, improvements are expected going forward. Improvements to note included the access to IAPT and a reduction in restricted practice on Stanage Ward. The Committee referenced the report and supported the revised format. Olayinka Fadahunsi-Oluwole referenced the increase in restricted practice for rapid tranquilisation and asked if this was attributed to staffing shortages. Beverley Murphy advised that reduction in seclusion was a positive step and that the appropriate increased use of medication (rapid tranquilisation) to realign chemical imbalance in the brain meant that the patient could be cared for in a calmer environment. Dr Mike Hunter confirmed that the Trust benchmarked low in relation to rapid tranquilisation. Emma added that service users are also being asked for feedback back on this change in practice and noted that one service user had said that having medication was preferable to being secluded, staff feedback is also positive in that a situation is de-escalated quickly and with a calmer approach. The Chair referenced the waiting times in Eating Disorders and asked if this was under review. She also noted the demand trajectory was increasing and asked if this was above trajectory and outside of tolerance levels. Beverley Murphy referenced Pg 36 of the report which reported on anticipated demand. Deb Cundey thanked Committee for their feedback, she would be looking at the trajectories of the recovery plans in the next quarter to feed into the summary. She assured Committee that the detail was explored at clinical service line level. **Committee received the report, noted the content and future development.** a) <u>Rapid Improvement Plan – Dovedale 2</u> Committee received the report for assurance. Emma Highfield reported that as Head of Nursing she routinely received information from different sources, she had become curious when she triangulated information for Dovedale 2 and had arranged to speak with Greg Hackney and Ward Manager Riann Parr. Emma noted that Riann had taken ownership and had prepared an improvement plan. The Chair noted that the report had been useful and addressed both culture and practice issues. Heather Smith welcomed the approach that had been taken, and the support that Riann had received. She asked how change would be evaluated, and what the triggers and aims were. Emma advised that there would be continued monitoring of incident forms and noted that any change in staffing concerns was a good measure, as well as feedback from the Freedom To Speak Up Guardian and reviewing the training and supervision records. Emma believed that staff morale was also an indicator and that it was important to speak with them. Riann added that there was an open culture on the ward for sharing things and that feedback from the team meetings had identified a number of themes to work on. Dr Mike Hunter advised that the environment is also clinically challenging for staff as this client group may have experienced abuse, trauma or neglect. Beverley Murphy reported that she had visited the ward recently and their	

	feedback triangulated with Emma's findings and that the team would be supported through their transition. **Committee received the report and were assured that an action plan had been developed.** **Committee to receive quarterly updates.** b) <u>Birch Avenue – Risks to Quality</u> Committee received the report for assurance. Emma Highfield reported that a number of risks had been identified at Birch Avenue Nursing Home, some of which related to the environment. Birch Avenue is a 40 bedded facility, which had been reduced to 28 beds following guidance during the pandemic. The team are impacted by the number of vacancies (11.6 WTE), and Emma had concerns in relation to capacity when beds are reopened. There have been challenges in recruiting to the unit, the rolling recruitment campaign required a refresh. Emma noted that the unit was not Multi Disciplinary and had no Occupational Therapy or Psychology input. They receive a small amount of Physiotherapy intervention, which is not enough to sustain the mobility of patients. Two new leaders had been appointed, and they would require time and developmental support Concerns had also been raised in relation to staff attitude and she noted that morale was very low. When reviewed, care planning, documentation and risk assessment were all found to be inconsistent and therefore further concerns in relation to engagement with families and carers. The number of reportable incidents attributed to restricted practice had increased, and the unit will be a priority for training. Emma acknowledged there was a lot of work and was keen to collate feedback and utilise the G1 Ward model. Dr Jonathan Michell believed it was important to understand how other nursing homes operated and how they access community resources. Emma added that Birch Avenue and Woodland View were managed differently and that the Trust were only contracted to provide the staff. Historically the Ward Managers had not been included in the Trust's leadership programmes. Beverley Murphy advised Committee that restricted practice in a Nursing Home could constitute to hands on support if a patient was in cognitive decline, she believed this could be attributed to the increase in reportable incidents. She noted that there needed to be a focus on care planning and engagement with families and carers. In relation to the unit not being multi disciplinary, Beverley reminded the Committee that this service was commissioned differently and therefore further consideration was needed in relation to whether it aligned with the Trust's Clinical and Social Care Strategy. **Committee received the report and were assured that the unit was under review and would be supported by a development plan.** **Committee to receive an update in January 2022.**	
QAC21/12/213	**Learning Disability (LD) and Autism Transformation Progress** Committee received the report for assurance. Dr Jonathan Mitchell reported that the LD Programme Board reported into the Transformation Board, and is supported by a Programme Manager, he noted a risk in relation to continuity and cover for maternity leave from January 2022.	

	Firshill Rise would remain closed to admissions whilst the work on the model is progressed, he noted that the key focus would be to look at the purpose and function of an Assessment and Treatment Service (ATS), and that community provision would also be considered. A recommendation would be available for Committee in February 2022. Jonathan was mindful there were pressures to progress and advised that the external clinical expert had suggested a timeline that allowed for co-production, and proper engagement and consultation with service users. He advised that he was also speaking with external partners including Primary Care. Heather Smith referenced the communications plan in the report and believed this model was a good example of culture change, which could be developed wider into the Trust. She also suggested strengthening the objectives, deliverables and desired outcomes with the addition of a descriptor of the vision. Dr Mike Hunter reported that whilst the scoping work is progressed, the Board are required to have a strategic discussion in relation to future provision of an ATS and the alignment with Learning Disability Services. Beverley Murphy added that Claire Lea had also facilitated a learning event following the findings by Care Quality Commission inspection, and that her report would feed into this work. **Committee received the report and were assured of the progress.** **Committee to receive a recommendation in February 2022.** **Strategic discussion by the Board to be scheduled.**	B/Forwarc MH
QAC21/12/214	**Infection, Prevention and Control (IPC) (Q2)** Committee received the report Katie Grayson reported on the key highlights for the quarter, to note: • Training compliance was 92% against a target of 80% • No cases of MRSA/MSSA/EColi Bacteraemia • Two outbreaks of Covid affecting three patients on G1 Ward and six staff at Fitzwilliam Centre. • Environmental cleanliness scores above 90% The implementation of the new Cleanliness Standards had progressed well, and staff had received training. Work was progressing to ensure that the Charter is displayed on every site. Reporting against the Standards will be included in the IPC quarterly reports. The Chair referenced tables 2 and 5 in the report and noted that there were a number of red areas on the improvement plans and asked if Committee should be concerned. Katie reported that she was not concerned at this stage (Q2) and assured Committee there was a robust monitoring process, and that additional support was given to any team. Heather Smith referenced the action related to mattresses and asked if there had been any progress. Katie reported that there was a programme of monthly monitoring and that the supplier does an annual audit, she noted that a number of mattresses had been replaced. **Committee received the report and were assured** Beverley Murphy reported that Katie Grayson would be leaving the Trust and had	

	secured a national role. She thanked Katie and noted that the Trust had benefited from her knowledge and expertise, she also thanked her for her support during the pandemic. The Chair on behalf of the Committee wished Katie well in her new role.	
QAC21/12/215	**Patient and Carer Experience (Q2)** Committee received the report for assurance. Sue Barnitt reported that more information had been collated for this quarter, to ensure a broad overview of experience. The next report would include an overview of themes and actions following visits. She noted the challenge of ensuring that the report was meaningful and that focused discussions on themes at the Service User Experience Group feed into Committee reporting. Prof Brendan Stone believed there was further work on the learning from complaints. He also believed that complaints that are no upheld should be examined for any learning to drive improvement. He was surprised to learn that only two stories from Care Opinion had resulted in change. He noted that lack of communication had been a theme from a number of sources. He asked if there was a process for the selection of service users' stories at Board. Sue advised that the Experience and Engagement Officers were reviewing Care Opinion feedback and working with teams to look at ways of increasing this. Sue also reported that Best Practice Workshops had taken place and one had focused on service user and carer feedback and looked at ways of increasing this. In relation to stories at Board, Beverley Murphy reported that there had not been a process and that going forward she would be ensuring all teams had opportunity to select a service user to share their story at Board, and for them to be supported, she would also like representation from the team. Dr Jonathan Mitchell reported that the Best Practice Workshop had been a forum to share information and noted that a number of teams had established focus groups and undertook surveys and had evidence of the collation of feedback and the influences on changes in practice. Some teams believed this was more beneficial than Friends and Family Test and Care Opinion. There is further work on how this could be synthesised and included in future reporting. **Committee received the report and were assured of progress and the development of future reporting.** **Committee to monitor the Complaints Improvement Plan**	SB
QAC21/12/216	**Medicines Safety (Q2) inc Task and Finish Group – Nursing Medication Administration Improvement Work** Committee Received the report for assurance Abiola Allinson reported on the key highlights for the quarter, to note: • Reduction in overall medicines incidents • Medication management – highest incidents related to temperature excursions and management of controlled drugs • Medication Administration – highest incidents related to prescribing errors The outcome from the Task and Finish Group had included the development of the Competency Framework to be launched in January 2022 and Plans for Observed Practice and implementation of the EBMED Programme. Further work to be undertaken with Estates on the environment, and work to improve culture and behaviours and good quality reporting.	

	The Chair suggested the inclusion of the trajectories to identify the impact on the improvements. She asked if Committee should be concerned with the high number of unaccounted controlled drugs. Abiola advised that new controls paperwork had been introduced and the Pharmacists were working more directly with wards to ensure timely submission of reporting. He expected to see improvements during Quarter 3. Beverley Murphy asked to meet with Abiola to discuss the controlled drugs discrepancies and agree any further actions. **Committee received the report and noted the progress in the quality of the report and were assured of the progress of the Task and Finish Group. Focused discussion on the Controlled Drugs incidents**	BM/AA
QAC21/12/217	**Physical Health – Progress Report** Committee received the report for assurance. Sue Barnitt reported on the key highlights. She noted there had been delays with Tendable (formally Perfect Ward) in relation to the uploading of the Physical Health Audit and meeting the training compliance for MUST, Nutrition and Hydration and NEWS2 training. She advised that all the Task and Finish Groups had been established and were working through their action plans, in addition huddles to support the wards with physical health issues were taking place. Heather Smith asked if the standard of good had been defined. Sue advised that the Physical Health Strategy was scheduled for a refresh in January 2022 which would result in a revised implementation plan and vision for the future. Dr Mike Hunter asked when the Physical Health Audit would be available. Sue was confident it would be available by the end of December 2021. **Committee received the report and were assured of the progress**	
QAC21/12/218	**Improving Sexual Safety – Annual Report** Committee received the report for assurance Kate Oldfield reported on the key highlights. She noted that work had progressed on the programme of change to improve sexual safety and deliver on the Strategy underpinned by the National Standards and Care Quality Commission guidelines. Forest Close as an example, had implemented a change programme supported by the Quality Improvement Facilitator. The clinical leadership team are engaged and committed to learning from staff and service user feedback, with a focus on capability as a key enabler. Kate advised that the work on Forest Close has enabled the development of a strategy which can be rolled out across adult acute in-patient wards. She noted that success is dependent on ensuring the conditions were right for change, which included the culture of the leadership team to work cohesively with staff to understand their capabilities and development needs. There would also need to be a focus on prevention and learning from incidents. Prof Brendan Stone referenced the trauma and attachment training and asked how it aligned with the programme of work. Kate reported that it had been delivered to staff at Michael Carlisle Centre and would be delivered to staff at Longley Centre in due course. The training is focused on understanding some of the traumas service users or even staff may have experienced or been challenged by to ensure they have a knowledge base to work from. Beverley added that this also aligned to being trauma informed within the Clinical and Social Care Strategy.	

	Dr Linda Wilkinson reported that staff were being support through this change process, she added that a lot of service users had experience of sexual trauma as children or adults and that the training was also important for staff, to help them manage their own emotions whilst having challenging conversations. Dr Mike Hunter reported that the term "trauma informed" had, had its profile raised nationally and that experts by experience and service users were concerned that it would become a label, without looking into the detail. **Committee received the report and were assurance of the progress.**	
QAC21/12/219	**Board Visits** Committee received an update on the Board visits Adele Eckhardt reported that the administration of the visits had transferred to the Quality Directorate and that visits to all services had been scheduled upto 31 March 2022. A small number had been cancelled and notification had been received in advance. The visit template had also been revised and the initial feedback had been positive. The reporting to Board had been realigned and Board would receive the Quarter 3 report in February 2022, this report would include details of the progress and the "You Said, We Did". **Committee received the update and were assured of the progress toco-ordinate the visits.**	
QAC21/12/220	**Research, Innovation and Effectiveness Strategy** Committee received the report for information Dr Michelle Horspool reported that the strategy had been progressed following initial discussion at the Board in November 2021 and developed as an enabler to the Clinical and Social Care Strategy, it also aligned with the Trust's ambition to be evidence led. The consultation to date had included a number of engagement events and involved both professions and service users and the themes had been detailed in the report. The report also outlined the developing aims, underlying principles and key priorities. Committee are asked to consider the consultation and progress to date and contribute, and to think about the future development and whether they are the right ones to support the ambition of being research active and evidence led and to receive feedback on the aims and priorities and how they aligned the strategic priorities. The next steps are to present a further draft to Committee in January 2022 and the recommendation to Board for approval in January 2022. Prof Brendan Stone referenced the summary and noted that a number of service users had not been aware the Trust was engaged in research and therefore there was a need to raise its profile and articulate the meaning of evidence led. He noted there had been co-production in the development of the strategy and that service users and carers had said they wanted to think about what was important and be involved in future research, which he was pleased to see. Michelle advised that service users were wanted to be more informed and engaged and the expert by	

	experience in the team was supporting this agenda and are exploring developing a service user research group. Beverley Murphy believed the strategy could be used in recruitment campaigns to promote the Trust as a research active organisation and the contribution staff had on a day to day basis. Michelle advised that the consultation had focused on what was needed to be more engaged with research, to embed evidence led practice, and think about what teams needed to achieve to deliver the strategy. Dr Mike Hunter added that there was also a need to have a multi disciplinary approach. The Chair noted that the strategy was research focused and asked for clarity on the elements of innovation and effectiveness. Michelle acknowledged there was further work to do in these areas and would need to be considered in the implementation plan and framework for effectiveness. **Committee received the update on the strategy and supported its further development.**	
QAC21/12/221	**Policy Governance Group** Committee received the report for assurance and approval. Amber Wild reported that the following items had been through governance process and Committee were asked to approve the recommendations. • Use of Force Policy, formally the Violence and Aggression Policy • Case for Need: Complex Needs Committee also received the master spreadsheet, Amber advised that there had been further develop on the Transition of Young People from CAMHS to Adult Mental Health Services Protocol (Red rating) **Committee received the report and approved the recommendations.**	
QAC21/12/222	**Emerging Quality risks** Beverley Murphy reported that Length of Stay (LOS) on adult acute wards had increased and triggered on the IPQR, further work was required to understand the increase, she noted that delays in transfer/care were attributing and that further discussion may be necessary with the Local Authority and Commissioners.	
QAC21/12/223	a) <u>Annual Work Plan</u> Committee received the workplan for information. b) <u>Significant issues to report to the Board of Directors (Alert, Assure & Advise)</u> The Chair reported that she would populate the template for the Board report. c) <u>Changes in level of assurance (Board Assurance Framework)</u> Committee agreed there had been no changes in level of assurance. **d)** Meeting Effectiveness	

Date and time of the next meeting: Wednesday 12 January 2022, 10am to 12:30pm

Format: MS Teams *Apologies to Francesca O'Brine, Corporate Governance Officer Francesca.O'Brine@shsc.nhs.uk*

Quality Assurance Committee

CONFIRMED Minutes of the Quality Assurance Committee held on Wednesday 10 November 2021 at 10am. Members accessed via Microsoft Teams Meeting.

Present: (Members)
Sandie Keene, Non Executive Director (Chair)
Olayinka Fadahunsi-Oluwole, Non Executive Director
Dr Mike Hunter, Executive Medical Director
Salli Midgley, Director of Quality
Beverley Murphy, Executive Director of Nursing, Professions and Operations
Heather Smith, Non Executive Director
Prof Brendan Stone, Associate Non Executive Director

In Attendance:
Tania Baxter, Head of Clinical Governance
Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services
Sue Barnitt, Head of Care Standards
Nick Bell, Head of Research & Development (Item 13)
Sam Crosby, Head of Health & Safety (Item 9)
Deb Cundy, Interim Head of Performance (Item 12)
Emma Highfield, Head of Nursing (Item 12a)
Dani Hydes, NHS CCG
Amanda Jones, Lead for Allied Health Professions
Vin Lewi, Patient Safety Specialist (Item 10a/b)
Sharon Mays, Trust Chair (Observer)
Dr Jonathan Mitchell, Clinical Director
Neil Robertson, Director of Operations and Transformation
Susan Rudd, Interim Director of Corporate Governance
Maggie Sherlock, NHS Sheffield Clinical Commissioning Group (NHSSCCG)
Amber Wild, Corporate Assurance Manager
Chris Wood, Associate Clinical Director
Sharon Sims, PA to Chair and Director of Corporate Governance (Minutes)

Apologies: Chris Digman, Governor

Minute Ref	Item	Action
QAC21/10/191	**Welcome & Apologies** The Chair welcomed everyone to the meeting. She noted that Sharon Mays, the new Trust Chair would be observing Committee and that Susan Rudd had joined the Trust as Interim Director of Corporate Governance.	
QAC21/10/192	**Declarations of Interest** No declarations were received.	
QAC21/10/193	**Minutes of the meeting held on 13 October 2021** The minutes of the meeting held on 13 October 2021 were agreed as an accurate record.	

QAC21/10/194	**Matters Arising** a) <u>Board Assurance Framework - Review of risk target score for BAF0025</u> Salli Midgley reported that the risk appetite had been adjusted in error and had been returned to its original score. The action was complete.	
QAC21/10/195	**Action Log** Beverley Murphy reported that the Committee Administrator would work with the action owners to ensure the narrative and dates were correct.	
QAC21/10/191	**Back to Good Implementation Plan** Committee received the slide deck for assurance. Sally Midgley reported on the key highlights: Year 2 Overview - A total of 142 actions from 55 regulatory breaches. The delivery group met monthly to monitor and report on the actions. A revised template ensures robust reporting identifying risks to delivery and exceptions. Dr Mike Hunter reported that the position for October 2021 was off trajectory and that only one action had been completed. Sally Midgley advised that the descriptions on a number of actions had been amended. She used supervision as an example in that, whilst supervision had been reported on, the target had not been achieved and that services had asked for an extension to allow time to achieve the target. She believed the action should have been closed and a new action created and advised that further discussion of all the actions would take place at the Back to Good Programme Board. She added that services were also keen to progress actions beyond regulatory standard to achieve good or outstanding practice. Dr Mike Hunter noted the need to ensure that from a Back to Good perspective the need to close the regulatory actions. The Chair welcomed the approach to review the outstanding actions as there had been concerns that they had not met the regulatory requirements. Beverley Murphy referenced the Estates actions and noted that the estates work on Burbage Ward was scheduled for completion in May 2022 and that a concern had been raised in relation to the site plan and the location of a de-escalation room, and risk is it was used as a seclusion room. She noted it would be discussed at the next Back to Good Programme Board. Heather Smith referenced Slide 12 – Improvement Measurement and believed that Committee needed to see impact measures to gain the assurance. She also referenced the Firshill Rise Slide and noted the need for timescales for resolution of the review and service model. She also noted that increase in safeguarding reporting and whether this was a concern from a workforce perspective. Beverley Murphy advised that the Firshill Rise improvement programme had been formalised and the Project Initiation Document (PID) would report through Transformation Board to Finance & Performance, and back to Committee and the Board in January 2022. Salli Midgley noted that the Safeguarding report was on the agenda and Hester Litten could answer questions on the concerns raised. **Committee received the update and were assured of progress of the regulatory actions.**	

QAC21/10/192	**Quality Objectives 2021/22 – Q2 Report** Members received the report for assurance. Tania Baxter reported the key highlights: Three quality objectives; reduction in seclusion and restraint, access to community services for BAME groups and embedding co-production. The report highlighted the progress to date during the quarter within Year 1 and the key deliverables for the next quarter. The anticipated risks had been included in the report, she noted that there was further work from an IMST perspective in relation to capturing BAME data. She added that this would feed into the newly established Equality and Inclusion Group and that she would attend their next meeting to give them an overview of the Quality Objectives. The Chair asked if the rating of moderate assurance still applied. Tania Baxter confirmed it did and that there was further work to complete before year end, she would expect significant assurance at the end of Quarter 3. Prof Brendan Stone asked how the learning was systematically shared and in particular with the Lived Experience and Co-production Assurance Group (LECAG). Tania Baxter advised that each objective had its own workstream with the aim of sharing learning across the Trust. As an example, there had been a session to raise awareness at the Restricted Practice Conference. She agreed to include a summary of the workstreams in future reporting and would liaise with the chair of LECAG. Beverley Murphy noted that there was triangulation, the Restricted Practice Conference organised by Salli Midgley and Lorena Cain had been well attended and staff and service users had engaged. The day covered a range of topics, including external speakers and an update on the Restricted Practice Strategy. Stanage Ward shared their experience of implementation and reported a 60% reduction. She added that co-production was starting to have an impact in relation to cultural change. Dr Mike Hunter referenced the objective related to BAME groups access to community services and asked how it would capture the broad range of services, including IAPT and Primary Care Mental Health, which are nationally services with low access rates. Tania Baxter advised that Clinical Operations were focused on this and working with IMST to define community services and what was achievable in Year 1. Heather Smith believed a conversation between the chairs of committees on the priorities for data governance was necessary. The Chair asked where IMST priorities discussed. Dr Mike Hunter reported added that Phillip Easthope chaired the Digital Strategy Group (DSG) which reported into Finance & Performance Committee (FPC), and he as Caldicott Guardian chaired the Data and Information Governance Group (DIG) which reported to Audit & Risk Committee. He advised that IMST priorities are taken through DSG, whilst DIG are focused on the confidentiality of data. ` The Chair was mindful that a lot of projects referenced IMST input and asked if executive team and services were sighted on the IMST priorities and assured of the triangulation and if there was an articulation. Dr Mike Hunter advised that the sub committee level could be articulated, the challenge is how the quality	

	priorities fit into the digital priorities and connectivity with the integrated planning group and business planning processes. The Chair asked if this piece of work could be commissioned and suggested that people priorities are included. Beverley Murphy added that there was a risk in relation to the new Electronic Patient Record (EPR) System and the fragility of the current system. FPC will receive an update and recommendations on the next steps. **Committee received the report and noted moderate assurance.** **Update on workstreams to be included in future reporting** **Report detailing the IMST Priorities linked to quality (other committees)**	TB BM/MH
QAC21/10/193	**Fundamental Standards visits/ Culture Quality Visits** Committee received the slide deck for assurance Sue Barnitt reported the key highlights. The visits were established for assurance and adherence to the 29A Warning Notice and to create a service baseline. A number of visits had taken place and the tool had been shared with the Nurses Council and they had, had the opportunity to benchmark themselves. Whilst the task had taken a significant amount of time and resource, it had delivered some positive outcomes and the teams had settled into the programme of visits and had engaged. Sue Barnitt on reflection believed that due to the size of the task it would have benefited from Project Management Office (PMO) support. The report included a number of issues that had been raised during the visits, and included; access to shared bathrooms and garden areas, key belts, fire procedures and environmental concerns. The next steps included feeding into "Perfect Ward", developing the quality visits to include culture, improving quality and safety information and increasing service user involvement. Beverley Murphy, in relation to gaining assurance asked where the actions would followed up. Sue Barnitt advised that there was a completed audit for each visit and a framework which could be shared and would feed into Back to Good Programme Board. Each team had a quality improvement lead with responsibility for ensuring the actions were delivered and embedded. The Chair asked if there was a schedule for visits to give Committee assurance that all service areas would be included. Salli Midgley advised that reporting had been piloted and the outcomes would be shared with the Clinical Quality and Safety Group in December and to Committee in January 2022, she added that there was a schedule and the focus would start on those areas were visits had been on the areas that had not been less frequent. **Committee received the update and were assured of the progress.**	
QAC21/10/194	**Health and Safety – Q2 Report** Committee received the report for assurance and approval Sam Crosby reported the key highlights. The focus for the quarter had been on the significant areas of concerns, which were at partial compliance and linked to reviewing, monitoring and embedding in services.	

	A total of 40% of audits had been completed. Further work had been undertaken to identify the gaps on Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and an action plan had been developed. The maintenance backlog had also been reviewed, one area to note related to fire doors which had been included on the risk register. To noted this had now been resolved with an external company. There had been progress in relation to reporting and a number of reports were now generated from Ulysses, this would be supported by a dashboard. The next steps into Quarter 3 include reviewing the areas of concern, including RIDDOR and updating the trajectories for resolution. There would also be a new focus on two areas; development of an action plan to meet the standards of the Violence Reduction Framework and development of Key Performance Indicators (KPIs) for Heath and Safety. **Committee received the report and were assured by the progress.**	
QAC21/10/195	**Mortality Review Q1-2 Report** Committee received the report for assurance. Vin Lewin reported the key highlights. The system was working well and all deaths had been reviewed during the quarters and random sample checks confirmed this. The mortality reviews feed into the Better Tomorrows project and there will be further work to develop those reports from an assurance perspective. The Chair noted that Committee used to receive information on the structured judgement reviews and outcomes, she asked if they were still taking place. Vin Lewin advised that they were, and being developed with Better Tomorrows project to ensure more staff received the training. Dr Mike Hunter was mindful of the development and asked when Committee and Board would receive reports that included the learning. Vin Lewin reported that further work was required on the triangulation and sharing the learning, and he would expect to have a revised report from Quarter 1. Dr Mike Hunter noted that the structured judgment reviews had continuing and asked how Committee and Board would be assured during the transitional period. Vin Lewin reported that the learning would be included in the Quarter 3 using the new process and advised there were ten to report on. He added the focus had also been on building a bigger multi disciplinary team. Dr Mike Hunter asked if an additional section on learning could be appended to the report for Board in November 2021. Sharon Mays asked if Committee received an annual report and whether there had been any analysis of the impact of the pandemic on mortality. Dr Mike Hunter confirmed there was a register that had tracked both in-patient and community services and when benchmarked against there had been an increase in the number of deaths and this had been reported to Board through the Management of Covid-19 reporting. **Committee received the report and noted the development in reporting and were partially assured.**	
QAC21/10/196	**Learning Lessons Q2 Report** Committee received the report for assurance.	

	Vin Lewin reported the key highlights. The report covered a number of areas where lessons had been shared and included incident de-briefs. There had been improvements and an increase in incident reporting. The Chair asked if future reporting could include the top three highlights/risks. Beverley Murphy referenced a table on Pg11 detailing the impact of reported incidents and noted this indicated a good safety culture and asked if this could be tracked and included in future reporting. She had reviewed the data for exploitation and abuse and noted that whilst there had been an increase in safeguarding reporting, the services had worked very differently during the pandemic and that there was a need to watch this indicator. Salli Midgley noted there was a lot of good learning and asked when it would be shared with staff. Vin Lewin advised this was in development and options being explored regarding the format. He added that this would be presented in the first instance to the Clinical Quality and Safety Group. He agreed there was a lot of positive information to share and would append a summary to future reporting to Committee. Beverley Murphy referenced a table on pg24 and noted that Committee could take further assurance that the Trust benchmarked favourably in relation to the timescales for reporting and investigating incidents. She also noted that there were a number indicators linked to quality of care at Birch Avenue that she was concerned about and required investigation though the quality performance reviews. **Committee received the report and noted the development in reporting and were partially assured.**	
QAC21/10/197	**Safeguarding Adults and Children – Q2 Report** Committee received the report for assurance and approval Hester Litten reported the key highlights. The focus had been delivery of the rapid development plan and specifically Level 3 Safeguarding (inc domestic abuse) training, which was being delivered by an external consultancy and would continue into 2022. In addition “bite size” training sessions had been scheduled through 2022. Four policies had also been through policy governance and approved by Committee. The key risks to activity included the non compliance for the delivery of Prevent Level 3 training, the level of external notifications from Local Authority which had increased significantly and further work in transferring documentation from Insight to Ulysses. All risks had been included on the risk register. The next steps included the Safeguarding Conference, promoting safeguarding as everybody’s business, continued focus on training to meet compliance targets and the transition to Ulysses. Heather Smith asked if the training categorisation had been completed. Hester Litten reported that it had, and the report reflected the different levels. She also asked if the team had capacity with the increased workload. Hester Litten advised that additional resource was being explored to support the delegated functions. Salli Midgley added that capacity was a risk and had been flagged. She noted that the review of the contract for the delegated duties was overdue and a request had been made to Local Authority. In relation to supporting continuity of the	

	service, additional bank staff were being assigned. The last quarter has identified an increase in workload and this will be fed back to the Safeguarding Assurance Committee and the Multi Agency Safeguarding Hub (MASH). Dr Mike Hunter was mindful that increased reporting needed to be triangulated against harm, as it could be interpreted as a cultural shift or deterioration in safeguarding. He asked how this would triangulated with other measures. Salli Midgley reported that the daily incident huddles are reporting all incidents at the same time as safeguarding concerns and there was a robust process, she added that there were no concerns from an internal perspective. **Committee received the report and noted the development against the improvement plan**	
QAC21/10/198	**Integrated Performance and Quality Report (IPQR) and Projects** The Chair reported that the IPQR would be discussed after the three highlight reports, she noted that Committee had, had a detailed discussion on the IPQR at its meeting in October 2021. a) <u>Deep Dive - Older Adults G1 (Q2 Progress Update)</u> Committee received the report for information and assurance. Emma Highfield, Dr Claire Pocklington and Kirsty Dallison-Perry attended Committee to update on the progress of the Deep Dive for G1. Emma Highfield presented the report and noted that progress had been made in a number of areas including the reduction in restricted practice and reduction in the number of incidents and assaults on staff. The Chair thanked the team for the report and was pleased to see the improvements. Beverley Murphy advised that the report would be shared with the Commissioners, NHS Sheffield Clinical Commissioning Group (NHSSCCG) and the focus of the discussion would be the purpose of the unit. Beverley Murphy also noted that there had been a significant decrease in the episodes of seclusion as a result restricted practice interventions. She advised that a number of actions were taken during the pandemic which had included restrictions on visiting to maintain a safe environment. She had subsequently had a conversation with a carer who had shared their views and the impact that had, had on them not being able to visit. A review of visiting on G1 was subject for discussion. The Chair asked for clarity on the guidance and if G1 remained closed to visitors. Beverley Murphy advised that the NHS guidance is more lenient than for residential nursing homes and that the priority had been to maintain a safe environment. She believed there was further work required to ensure a least restrictive and family friendly environment. Emma Highfield acknowledged there was further work in this area and it linked to a specific workstream focused on working with and understanding family needs. Dr Claire Pocklington advised that G1 were experiencing their fifth outbreak and therefore the unit was closed to visitors, the source may have	

been staff or a relative, she added that relatives did not always adhere to guidelines of PPE or social distancing. Dr Claire Pocklington advised that the ward does not have a visiting room and visits take place off the unit, meaning staff have to go off the unit to supervise. She added that this had been picked up in the Worcester University environmental assessment.
She advised that virtual visits had also been initiated during the pandemic but this had been difficult due to the patient group.

Heather Smith noted the number of actions and asked how they would be prioritised and whether the team were involved in the decision making. Emma Highfield reported that the project group had multi disciplinary representation and included the new Ward Manager who is focused on reducing restricted practice. The group are also engaging with families.

Kristy Dallison-Perry reported that she was leading the meetings and reviewing and monitoring the workstreams and noted the current priorities are focused on restricted practice, reducing falls and physical health.

The Chair referenced the assessment report and asked if the review of the recommendations could be prioritised.

Neil Robertson wished to thank the team for their work and noted there had been some significant outputs.

Dr Mike Hunter wished to acknowledge the pressures and challenges the team had faced from the early stages of the pandemic, managing patients pre vaccination. In relation to the improvements he noted that the starting point appeared to have be out of process control and the improvements had now aligned to being in control, he asked if there were plans to engage with the Quality Improvement Team. Emma Highfield advised that there was representation from the QI team on the project group and the group seemed more hopeful that progress had been made and for the momentum to continue. Salli Midgley added that she had also spent time with the team and focused on empowered leadership.

Committee received the report and were assured of progress.

b) Task and Finish Group – Nursing Medication Administration Improvement Work
Committee received the report for assurance.

Salli Midgley reported that the framework had been agreed and was being piloted. She added that the actions had been updated, noting that one was regulatory and tracked to Back to Good and the remainder were improvement actions.

Committee received the report and were assured of progress.

c) **Community Mental Health Services Transformation (Q2 Report)**
Committee received the report for assurance

Neil Robertson updated on the progress of the work for Community Mental Health Services. He reported that Committee had received a report in February 2021 and had not been assured by the direction of travel. He had

	subsequently reviewed and consolidated an action plan for the redesign and reported that this was now moving at pace, and added that co-produced was at the centre. He advised that there would also be strong alignment with Primary Care Mental Health. He noted that the Trust would buddy with Humber as they had recently transformed their services. Prof Brendan Stone referenced the risks and noted that one was linked to staff engagement, he asked how Committee could be assured of this. Neil Robertson advised that Greg Hackney, General Manager and himself had leaned in and met with stakeholders from the Recovery Teams to discuss t next steps. The feedback resulted in a session on outcomes and process. He also noted that there had been a number of positive elements in the past which would be reviewed and reconsidered. He was also mindful that this reconfiguration had started 2016/17 and had caused some unrest amongst staff, and the need to hear the their experiences and be compassionate. Prof Brenda Stone noted the references to co-production, and believed that service users felt that they had not been heard or considered at the time of the 2016/17 reconfiguration. Committee needed assurance this was now real and authentic. Neil Robertstown advised that co-production would be embedded and part of the continuous improvement journey and that the Lived Experience Group had, had input into discussions. Heather Smith noted the reference to the strategic aims and was mindful that a number were linked to decision making of external partners and that, that could delay the process. She also noted the challenges of keeping people motivated over the period of change. Sharon Mays reported that she had only recently joined the Trust and that the reconfiguration had been raised a number of occasions and high on their agenda, including Governors. The need for co-production would be key and she would like to work with Neil Robertson and Beverley Murphy on the engagement with the Governors. Dr Mike Hunter asked if evidence was being used to inform development of the model, which would align with the Clinical and Social Care Strategy. and link with the Research and Innovation Strategy. He asked if there was a connection with clinical effectiveness. Neil Robertson advised the session on care process would be opportunity to reflect and ask the question of "What are we doing, and what does the outcome look like" and using evidence and experience to triangulate. Neil Robertson advised that Prof Scott Weich (Governor) had been engaged in the process. The Chair referenced the co-dependencies and links, but noted the lack of reference to Local Authority and Social Care, she was mindful that they are health and social care delivery services and the connectivity to the Care Act and delegated responsibilities on behalf of LA, she also noted there was no reference to LA leadership and its Mental Health statutory responsibilities. Neil Robertson advised that there was connectivity with the Lead Social Worker and a benchmarking exercise against the Care Act Standards was scheduled. He added that the Care Quality Commission will be focused on Local Authorities from 2022. **Committee received the report and were assured of the development and progress although concerns were raised about timescales for delviery.**	

	Integrated Performance and Quality Report (IPQR) Committee received the report for assurance. Beverley Murphy reported that there had been no signification changes or new risks to note in the IPQR. Dates had been added to the risks to track the timeline and progress. She noted that the Out of Area position remained static and that through the reports presented to Committee today, there was evidence of improvements in restricted practice in some teams, she was however mindful that the position remained static and attributed this to an increase in some areas. She would work with Deb Cundey to extract some of the data and look at compliance with Health and Social Care Standards to assure Committee. **Committee received the report and were assured** **Further work on Restricted Practice**	
QAC21/10/199	**Research, Innovation, Effectiveness and Improvement Group (RIEIG) Q2 Report** Committee received the report for assurance. Nick Bell reported on the key highlights. The research performance was on track to meet its recruitment targets. He noted that whilst the objectives set by the Clinical Research Network (CRN) had been suspended during the pandemic, the Trust would meet them all. The clinical audit programme and the quality improvement projects were on a trajectory to be delivered to plan. The next steps are to review and strengthen quality improvement and clinical effectiveness and NHS England/Improvement are supporting this programme. Beverley Murphy noted that she was keen to see how the stocktake of standards would align with the Integrated Performance and Quality Report (IPQR), Key Performance Indicators (KPIs) and outcomes for service users. The Chair asked there this aligned with the fundamental standards visits. Dr Mike Hunter noted the evidence based quality standard will be captured in the IPQR whilst using them as the tool to in the visits and ensuring they are at the centre of RIEIG. Salli Midgley added that this evidence is also used in serious incidents, and the need include the standards in the terms of reference. She asked where the oversight of the audits, effectiveness and quality improvement would sit and suggested a synopsis is included in future reporting. She also suggested it would be beneficial for a member of the Serious Incident Team join the group. **Committee received the report and noted the areas of improvement and were assured.**	
QAC21/10/200	**Policy Governance Group** Committee received the report for assurance and approval. Amber Wild reported that the following policies had been through governance process and Committee were asked to support the recommendations to	

	approve them. • Antibiotic Policy MD 014 • Medicines Optimisation Policy MD 013 – Nursing Associates Addendum Interim Review • Quality and Equality Impact Assessment Policy NP 034 • Safeguarding Supervision Policy – New Policy • Safeguarding Adults Policy – New Policy • PREVENT Policy – New Policy • Learning from Deaths Policy MD 002 – Extension to Review Date • Aggression and Violence NP 030 – Extension to Review Date The Chair referenced the policy spreadsheet and asked if Committee could receive an update on the development of the protocol for the Transition of Young People from CAMHS to Adult Mental Health Services (RED Rating 31/10/21) **Committee received the report and approved the recommendations.**	
QAC21/10/201	**Emerging Quality risks** Beverley Murphy reported that she would follow up on Birch Avenue as noted under Minute Ref: QAC21/10/196 – Learning Lessons. Beverley Murphy advised Committee that the senior leadership team had raised concerns with the increased level of incident reporting on Dovedale 2 Ward (decant ward – estates project). Committee would receive an update in December 2021.	BM
QAC21/10/202	a) <u>Annual Work Plan</u> Committee received the work programme for information. b) <u>Significant issues to report to the Board of Directors (Alert/Assure/Advise)</u> <u>Alert</u> • Quality Objectives – moderate assurance • Mortality Review – further work on learning lessons • Emerging Quality Risks – Dovedale 2 <u>Assure</u> • Back to Good Implementation Plan - process, work on impact/outcomes • Health and Safety Quarterly Report • Learning Lessons – continued work on understanding trends • Safeguarding Quarterly Report – number of concerns being addressed • Deep Dive G1 • Medications • Community Teams Transformation – assurance but noted a number of risks identified to work on. • Research, Innovation, Effectiveness and Improvement Group Quarterly Report - progressing and engaging with effectiveness and improvement. <u>Advise</u> • Fundamental Standards – assurance of process • Policy Governance Group – approved policy recommendations	

	c) Changes in level of assurance (Board Assurance Framework) No changes in the level of assurance. d) Meeting Effectiveness Mean Score 7.5/10 Further improvement in relation to quality of reporting and contributions from Committee.	
QAC21/10/203	**Any of Other Business** No other business was discussed.	

Date and time of the next meeting: Wednesday 8 December 2021, 10am to 12:30pm
Format: MS Teams

Apologies to Sharon Sims, PA to The Chair and Director of Corporate Governance
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