# Board of Directors (Open)

| SUMMARY REPORT | Meeting Date: | 23 March 2022 |
|---|---|---|
| | Agenda Item: | 18 |

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| **Report Title:** | **Committee Activity** | |
| **Author(s):** | Amber Wild, Corporate Assurance Officer | |
| **Accountable Director:** | Susan Rudd, Director of Corporate Governance<br><br>Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director, Chair of Mental Health Legislation Committee<br><br>Heather Smith, Non-Executive Director, Chair of People Committee, and Interim Chair Quality Assurance Committee<br><br>Richard Mills, Non-Executive Director, Chair of Finance and Performance Committee<br><br>Anne Dray, Non-Executive Director, Chair of Audit and Risk Committee | |
| **Other Meetings presented to or previously agreed at:** | **Committee/Group:** | Quality Assurance Committee<br>Finance and Performance Committee<br>People Committee<br>Mental Health Legislation Committee<br>Audit and Risk Committee |
| | **Date:** | As detailed below. |
| **Key Points:** | This report highlights key matters, issues, and risks discussed at committees since the last report in January 2022 to advise, assure and alert the Board.<br><br>Minutes approved by each 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 in their Alert, advice, Assure (AAA) Reports:

**Alert** – areas which the committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on;

**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 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.

Quality and Assurance Committee reports include the AAA reports from 9 February and 9 March 2022 meetings, and the minutes from 12 January and 9 February 2022 meetings. These are attached as an appendix to this summary report.

Finance and Performance Committee reports include the AAA reports from February and March 2022 meetings. These are attached as an appendix to this summary report.

People Committee reports include the AAA Report from 8 March 2022 meeting, and minutes from the 11 January 2022 meeting.

Audit and Risk committee reports include the AAA report from 18 January 2022 – a verbal report was given to Board in January 2022 and the written report is attached in the appendix of this report. Minutes of the 18 January meeting will be submitted to Board following approval at committee in April 2022.

Mental Health Legislation Committee is providing a verbal AAA report following their meeting on 15 March 2022 and the written report will be presented to the Board in May 2022. Approved minutes from 15 December 2021 are attached in the appendix of this report.

**Recommendation for the Board/Committee to consider:**

| **Consider for Action** | **X** | **Approval** | | **Assurance** | **X** | **Information** | **X** |
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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:**

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| 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 |
|---|---|---|---|---|---|
| Service User and Carer 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:** **Quality Assurance Committee** **Date:** **9 February 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 |
|---|---|---|---|---|
| Back to Good Reporting - Supervision and mandatory training on Acute Wards compromised | The impact of Omicron has caused staffing gaps. Mitigations are in place, and it has been challenging. | Limited assurance relating to training and supervision. More work required to stabilise issue post-Omicron and provide high quality supervision. Recovery Plan for all areas under 80% target. | Linda Wilkinson leading on supervision and training. QAC to receive Improvement Plan through the governance of Back to Good in April 2022. | April 2022 |
| IPQR: SPA, EWS, SAANs, and GDC waiting times | Waiting lists, demand, and caseloads remain a concern. | Recovery plans are in place and have been regularly received, there is limited assurance of impact. | Committee moved risks for Gender Dysphoria and SAANs to CRR and will continue to work with Commissioners.<br><br>Recovery plans to be reviewed by Clinical Directors and presented at QAC April 22. | April 22 |
| IPQR: Length of stay and flow issue | Issues remain, particularly in Acute Wards and Endcliffe PICU. | Recovery Plans in place, limited assurance of impact. | Review of Memory Service model agreed.<br><br>Acute leadership team will review the approach to ensuring bed capacity to provide the right care. | April 22 |
| IPQR: CPA Annual Review | Completion of review needs to be addressed, especially in the South Recovery Team. | Limited assurance received. Recovery plan in place. | Focus on supporting South Recovery Team and ensuring completion of annual CPA reviews until alternative systems are in place. For review in QAC. | April 22 |

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| Physical Health Strategy | Progress is not where the Committee want it to be. Impact of risks on patient safety needs to be understood. | Report and strategy received. Committee noted limited assurance. | Measurement Plan to be reported to QAC in March 2022 to clarify what will be measured and to assure the Committee that action is being taken. | 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** |
| Quality Improvement at Birch Avenue | Plan in place for Quality Improvement at Birch Avenue. Plan in place for Restrictive Practice Strategy at Birch Avenue, utilising G1 models. | Report and improvement plan received. Committee were reassured that the ongoing issues of visiting restrictions are being addressed. Assurance from improvement plan and transference of good practice from G1. | Ongoing priorities: easing of visiting restrictions, revise Care Home Visiting Policy in line with national guidance, and risk assessments to be on a case-by-case basis.<br>Progress report to QAC in April 2022. Potential further progress report to QAC in July 2022 dependant on outcome. | April 2022 |
| IPQR | IPQR indicates areas of good performance, for example inpatient length of stay for older adults and Forest Close, START Assessment waiting times, and reduced restrictive practice. | Good assurance received: G1 reduced length of stay, START – significant improvements seen in December 2021, engagement with the Least Restrictive Practice Strategy commended. | Continue monitoring and reporting through IPQR. | Monthly reporting |
| Quality Objectives | Objectives have been fully articulated and are progressing. | Good assurance: Data gathered, and detailed analysis will inform work going forward. IAPT supported to set ambitious but achievable goals. CoG to agree direction of travel. | Report to CoG meeting 15/02/2022.<br><br>Commence work to action the data collected. | Complete<br><br>Annual framework for QA reporting is set. |
| Nursing Medication Administration improvement work | Significant advancements made. | Implementation Plan in place to mitigate against risk involved in embedding the work. Tier 2 Groups to identify early warning triggers and will escalate to QAC. | Medicines Safety Group will report on uptake to QAC within the quarterly update. | Quarterly progress reports. |
| Clinical Service Reviews | Outcome received, and cross cutting themes noted. | Key themes link clearly to current activity within the Trust. Good progress made and nothing was unknown. Good level of | Feedback has been provided to individual services. | N/A |

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| | | oversight noted. | | |
| Service User Engagement and Experience Strategy | Committee received and endorsed first draft of strategy. | Positive feedback received from Committee. High level of co-production and engagement noted. Actions and KPIs will be co-produced. | Section on Green Plan to be included. Measurable and achievable targets with timescales required. Strategy will go to Board for feedback, developed further, then return to Board for approval and Implementation Plan established. | BoD meeting 23/02/2022<br>QAC on 09/03/2022<br>BoD meeting 23/03/2022 |
| Quality Strategy | Committee received and endorsed first draft of strategy. | Agreement and support received from Committee regarding work undertaken and general direction. | Concern that strategy has lost its balance will be addressed before Board. Section to be included emphasising strategic focus on quality of care received. Measurable and achievable targets with timescales required. Strategy will go to Board for feedback, developed further, then return to Board for approval and Implementation Plan established. | BoD meeting 23/02/2022<br>QAC on 09/03/2022<br>BoD meeting 23/03/2022 |
| **ASSURE** (Detail here any areas of assurance that the Committee has received) | | | | |
| **Issue** | **Committee Update** | **Assurance Received** | **Action** | **Timescale** |
| G1 | Quality of care at G1 has improved. | Good assurance that leadership, clinical and environmental issues are being improved. | Progress report to QAC in April 2022. Potential further progress report to QAC in July 2022 dependant on outcome. | April 2022 |
| IPQR: Serious Incident processes | Processes have significantly improved. | Good Assurance that rapid development plan has delivered improvements which triangulates with the 360Assurance – Significant Assurance received. | Three Actions remain but associated work is either complete or underway. Any issues that arise will be escalated to the IPQR. | N/A |
| Research performance | Progress with objectives, and links with strategies and clinical effectiveness aspirations noted. | Committee received good assurance around: research performance and progress with objectives that link to the strategy, and aspirations relating to clinical effectiveness. | Understanding what the benchmarks and best practice are will be discussed in RIEIG. Work to obtain investment for the strategy continues. Next report to QAC in May 2022 | May 2022 |
| Health and Safety Report | Committee received the report | High level of assurance received. | Quarterly updates to QAC to | May 2022 |

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| | which indicated strong leadership and a good grasp of issues. | Progress made and risks clearly identified. Committee has confidence that the team are focussed on key issues and commended them for their work. | continue. Next update May 2022. | |
| Community Service Transformation | Continues to progress with strong links to strategic priorities. | Assurance received - anticipated level of progress is being made. Recognition that some challenges remain. | Ensure Service User and carer voice is reflected. Focus on metric outcomes and structures for model delivery. Move to individualised care planning – governance currently being set up.<br><br>Changes with Local Authority present risks to progress that are not yet fully understood. | QAC meeting May 2022 |

# COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

**Committee:** **Quality Assurance Committee** **Date:** **9 March 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 |
|---|---|---|---|---|
| IPQR: Achieving flow across Acute Adult Inpatient System | This is becoming a high risk and has implications for out of area placements, about which further detail was requested. Completion of CPA reviews, waiting times, increased demand at the Memory Clinic, and allocations of permanent Care Co-ordinators all remain an issue. | Report received. Recruitment into Recovery Teams successful. Areas of good performance noted, e.g., restrictive practice in Burbage Ward. | Recovery Plans to be reported on at April 2022 QAC | QAC meeting 13/04/2022 |
| Patient and Carer Experience Quarterly Report | Managing Complaints remains a significant challenge. Volunteer process, and recruitment of Lived-Experience roles and feedback the Trust gathers also noted as a risk. | Progress report received. Complaints can be made to the Trust, CQC, and the CCG. Complaints to the Trust are investigated thoroughly and a response issued to the Service User and the CQC. However, response times and overall grip not yet achieved. | Continue work to improve scope and quality of Lived-Experience feedback and embedding Lived-Experience roles within the Trust, and the process and response times of complaints. | Quarterly progress reports |

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

| Issue | Committee Update | Assurance Received | Action | Timescale |
|---|---|---|---|---|
| Board Visits | Themes and outcomes of visits were detailed for the Committee. | On track for all services visited within one year going forward. | All services will have been visited by the end of May 2022. | May 2022 |

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| | | | 48 visits booked from January to December 2022. | Quarterly progress reports |
| Annual Quality Account | Report no longer required to be published on NHS website. | Timeline provided to Committee for information. | Draft to go to May 2022 QAC. Final draft to go to June 2022 BoD. Publish on Trust website 30/06/2022. | QAC meeting 11/05/2022 BoD meeting 22/06/2022 Publish 30/06/2022 |
| Clinical and Social Care Strategy | Committee were updated on the progress of implementation, which had experienced some setbacks due to staffing issues. Consideration being made as to how information is presented to staff teams and Service Users. | Programme Manager now recruited and starts in April 2022. Lead Co-Production Consultant role filled. Committee were assured by the report and noted the scale of change and challenges this brings. | Measurement Strategy outlining what is being measured needs to be included in next report to provide further assurance to QAC. | TBC |
| Physical Health Care Strategy | Number of actions due for completion by end of March 2022. Two completed ahead of schedule. | Measurement Plan received and high assurance noted regarding actions and thoroughness of process. | Complete remaining actions and report to QAC via next progress report. | Quarterly progress reports |
| Out of area placements | During Physical Health Care item, out of area placements was discussed and highlighted as an area of concern because of the impact on Service Users. | Identification of gaps and risks relating to out of area framework gave assurance that these are being newly reviewed. QAC to further discuss Quality element. | Deep Dive of Therapeutic Environments at May 2022 BoD. | BoD meeting 25/05/2022 |
| Service User Engagement and Experience Strategy | Committee received and endorsed final draft of strategy. | QAC agreed that previous feedback had been included in this draft. | Small adjustments noted and will be made before submission to Board. Send to Board for ratification. | BoD meeting 23/03/2022 |
| Quality Strategy | Committee received and endorsed final draft of strategy. | QAC agreed that previous feedback had been included in this draft. | Send to Board for ratification. | BoD meeting 23/03/2022 |
| **ASSURE** (Detail here any areas of assurance that the Committee has received) | | | | |
| **Issue** | **Committee Update** | **Assurance Received** | **Action** | **Timescale** |
| Learning Disability and Autism Transformation progress | Programme on track. Inpatient Pathway Group progressing well. Re-design of Community offering being implemented to prevent admission to bed-based/inpatient services. | Verbal update on service model progress and consultation plans received and noted. Recruitment of multiple posts successful. No inpatient admissions offer but robust Admission Protocol in place. Project Manager in post for six months – will support and | Full report to be presented to April 2022 QAC. | QAC meeting 13/04/2022 |

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| | | improve engagement with Sheffield Voice. | | |
| Back to Good Programme | Committee updated of risks and actions. Supervision particularly difficult issue to address on the Acute pathway. | Assurance and oversight received of the plans to mitigate the key risks. Acute and PICU requirements lifted. | Improving Supervision report to April 2022 QAC.<br><br>Committee endorsed Improvement Plan. Send final plan to CQC. | QAC meeting 13/04/2022<br><br>Due to CQC 13/03/2022<br><br>Monthly reporting |
| Medicines Safety | Increasingly well monitored but more progress is required.<br><br>Dovedale 2 – level of unaccountable controlled drugs remains high and Ward Manager not at work. | Many issues identified in Q2 report have been resolved and assurance received that these are under control. | Continue to mitigate and monitor improvements put in place.<br><br>Dovedale 2: action noted that Operational solution needed. | Quarterly progress reports<br><br>April 2022 |
| Incident Management | Internal Audit Report gave three medium risks and one low risk – actions agreed on all. | Report received at Tier 2 Group. Internal Audit Report gave Significant Assurance rating on Incident Management processes. | Continue to implement and complete actions required by report. | 2 x actions 31/03/2022<br>1 x action 31/07/2022<br>1 x action 30/11/2022 |
| Learning Lessons | Committee received detail of the progress made regarding processes, increase in staff and patient de-briefs, the range of learning, culture and language shift, and incident hub and huddles. Low threshold for incident reporting highlighted. | Quantitative and qualitative data noted and provided assurance of progress. | Use of bed stock, staffing and staffing numbers are an emerging theme and will be presented within the next quarterly report. | Quarterly progress reports |
| IPC | Good assurance received from report regarding processes in place and their impact. Dana Wood, interim Lead Nurse for IPC, was introduced. | Risks identified to Committee. Dana Wood to pick these up, and additional support for the team also secured. | For all report writers: Closed risks to be noted within the summary on the front sheet to give a clear and accessible audit trail. | Quarterly progress reports |
| Safeguarding | Committee noted increasingly high number of referrals from the Local Authority as a risk. Training is on track. Risk level downgraded to moderate. Progress in reporting culture. | Report provided assurance that systems and processes are working. Safeguarding and Mental Health Practitioner post filled and two staff taken on via expressions of interest to ease | Beverley Murphy has been suggesting to the Local Authority that within upcoming changes early modifications to Safeguarding are prioritised so there is clarity of where the | Quarterly progress reports |

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| | | workload. | responsibilities lie. | |

# COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

**Committee:** **Finance and Performance Committee** **Date:** **10 February 2022** **Chair:** **Richard Mills**

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## 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 |
|---|---|---|---|---|
| Capital Programme 2021/22 | Year to date expenditure marginally ahead of plan. Significant capital expenditure planed in Q4 (c£3.5m) with c£400K potential underspend | Where underspends have been forecast a number of new schemes have been instigated | To alert Board of concerns. | March 22 |
| 5 Year Capital plan development | Capital situation is volatile due to the impending sale of Fulwood House and it's potential impact on capital budget in future years. | Noted first Draft capital plan, including areas where external funding will be required. long term thereuputic environments requirements (i.e. new inpatient facilities)<br>Further prioritising is required | To alert Board plan is in development and challenges re future capital needs vs allocated system budget. | March 22 |
| Annual Operational Plan | Work needed to align strategic priorities<br>Risks created by uncertainty in predicted timing of finances for 22/23 created by the sale of HQ | Update to be given to March FPC meeting | Updated plan to go to Board in March 22 | March 22 |

**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 |
|---|---|---|---|---|
| Draft Financial Strategy | Delayed due to the lack of financial guidance for 2022/23. | Draft strategy to March 22 FPC meeting | PE, PK and MW working together to complete the draft. | March 22 |

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

| Issue | Committee Update | Assurance Received | Action | Timescale |
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| 360 Assurance Internal Audit Report – Transformation &Project Management | Received outcome of 360 assurance report | Represents significant improvement around the Trust and is linked to CQC recommendations | To notify Board of assurance given. | March 22 |

2021/22 RM/EA

# COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

**Committee:** **Finance and Performance Committee** **Date:** **10 March 2022** **Chair:** **Richard Mills**

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## 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 |
|---|---|---|---|---|
| Relocation of Trust HQ | Received the Transformation Portfolio Report. | Noted short notice 1 month delay to the move due to landlord capital works and utility provider work delays.<br>Received assurance of no detrimental impact on overall timescales of the planned HQ move. | Landlord works to be completed within planned contingency. Alternative utility providers being considered. | April 2022 |
| Relocation of Trust HQ | The relocation of Assertive Outreach and Community Forensic services | Noted Assertive Outreach and Community Forensic services teams currently based in Fulwood house temporarily have not yet been accommodated within the plan for the Trust's new office location. | The Community facilities program will address this issue. | April 2022 |
| Health roster | Issues with resourcing and underestimating the scope of the project, which has delayed full roll out by approximately 6months. | Received assurance did not affect staff pay. The Trust is not yet seeing the full benefit of implementing the system. The replanning incorporates work required to aligh ESR and finance structures. (extending the original scope) | Work is ongoing in this area.<br><br>Invest is being sort to extend project by 6 months | April 2022 |
| 2022/23 Financial Plan | Update on progress | There is a variation in the plan of between +£2.5m and -£10m dependant on the future recruitment levels | The Committee will continue to monitor the situation. | April 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) | | | | |
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| **Issue** | **Committee Update** | **Assurance Received** | **Action** | **Timescale** |
| Finance Strategy | The Committee received a first draft of the strategy for comment. | Committee feedback will be incorporated within the next iteration of the draft strategy. | The revised draft of the strategy will to go Board of Directors forconsideration and input. | March / April 2022 |
| Procurement Strategy | The Committee received a first draft of the strategy for comment. | Committee feedback will be incorporated within the final draft. | The final draft of the strategy will be presented to FPC in two months time. | May 2022 |
| BAF / CRR | BAF and CRR to be reviewed to reflect risks identified in meeting | Noted no significant change | None | April 2022 |

| **ASSURE** (Detail here any areas of assurance that the Committee has received) | | | | |
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| **Issue** | **Committee Update** | **Assurance Received** | **Action** | **Timescale** |
| Finance Report for the Period ending February 2022 | Received routine report of monthly Finance position | Routine reporting of financial performance. | Receive monthly report | April 2022 |

2021/22 RM/EA

# COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

**Committee:** **People Committee** **Date:** **08 March 2022** **Chair:** **Heather Smith**

| KEY ITEMS DISCUSSED AT THE MEETING | | | | |
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| **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 and Retention data | Sickness levels continue to rise as does the turnover rate which is creating a significant risk to the trust and its ability to deliver effective care. | Lack of assurance in terms of sickness and turnover. The Committee asked for more information on sickness absence support measures in order to gain full assurance of measures being taken. | Colleagues are monitoring this data on a monthly basis. | |
| People Pulse results | The results are indicative of burnout in a number of staff. | The situation is being monitored. Health and wellbeing provision in place including wellbeing conversations and position monitored in regular returns. | Results will be considered with outcomes from the Staff Survey and shared with teams. | April 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** |
| People Strategy Delivery Plan | The People Strategy Delivery Plan has been updated for 2022/23. | The plan includes new KPIs which will be used to monitor work. | KPIs, RAG rating and performance dashboard to be refined and finalised. | May 2022 |
| Vaccination campaign | The withdrawal of the government mandate was noted, | 90% of staff have received their Covid vaccination | The committee expressed thanks for the work done in this area. | Complete. |

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| | and staff who were moved in the first phase are returning to roles as appropriate. | 74% of staff had received their Flu vaccination | | |
| Key OD objectives | Charlotte Turnbull, the new Head of Leadership and Organisational Development, is now in post and attended the meeting. | Charlotte Turnbull updated the Committee on leadership and OD objectives for the year and the progress to date. | To continue to keep the Committee updated on progress in order to provide an assurance report. | Ongoing. |
| Freedom to Speak Up Report | The Committee received and noted the actions and learning within the Report. | An interim Freedom to Speak Up Report was provided to the Committee | The Committee asked to link FTSU work being done with the staff survey. | Next meeting of Committee in May 2022 will receive the FTSU Annual Report. |
| Gender Pay Gap Report | The Committee received the formal report. | It was noted that the Trust remains 'Green', but that there are a high proportion of males in higher pay bands.<br>Flexible working offers and career pathways need to be increased. | Paper to go to March 2022 Board Meeting. | March 2022. |

| **ASSURE** (Detail here any areas of assurance that the Committee has received) | | | | |
|---|---|---|---|---|
| **Issue** | **Committee Update** | **Assurance Received** | **Action** | **Timescale** |
| Health and wellbeing | The Committee received a report from the Staff Health and Wellbeing Group | The Health and Wellbeing system is aligned with national regional priorities and initiatives. | | |
| Staff Health & Wellbeing Audit | The Committee received the Staff Health & Wellbeing Audit Report. | Significant Assurance rating given to the measures in place. | | |
| Workforce Return / Annual Operational Plan | Annual Operational Plan received. | Annual Operational Plan aligned with key concerns linked to the People Strategy Delivery Plan. | | |
| International recruitment of nurses | The Committee received an International Recruitment Plan and progress. | Progressing in an informed and robust way with support from NHSEI. | | |

# COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

**Committee:** **Audit and Risk Committee** **Date:** **18 January 2022** **Chair:** **Anne Dray**

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## 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 |
|---|---|---|---|---|
| None to report | | | | |

**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 |
|---|---|---|---|---|
| 360 Assurance Progress report and Stage 2 head of Internal Audit Opinion Report | Not on track for achieving the follow up rate for actions that had been agreed and the dates agreed to do them by.<br><br>Initial HoIA Opinion Statement stands at Limited Assurance | Three significant assurance reports received: Transformation & Project Management, Health & Wellbeing, and Strategic Governance. Receipt of report and improvements noted. | Head of Internal Audit Opinion Stage 2 Report to be signed off by the Trust and then circulated | February 2022 |
| 360 Assurance Internal Audit (IA) | 1st draft presented, prioritisation work commencing with Executive to reduce from 400 days of work to 200 days and ensure a balance of risk areas and ensuring appropriate use of Clinical Audit and IA programmes | Audit Plan 2022/23 | Topics for potential inclusion. Final draft plan for 2022/2023 available for consideration and approval in April. | April 2022 |
| KPMG External Audit Draft 2021/22 Audit Plan | Two new risk areas:<br>IFRS16 has been added on in terms of leases<br>Disposal of Fulwood House | Report received. Early and open conversations between audit and Trust officers to continue | Recommended: Adopt IFRS16 from 1st April.<br>Both risks to be reviewed during Year End processes. | April 2022 |
| Board Assurance Framework and | Coherence and completion of all BAF and significant risks | Risk Oversight Group to provide moderation and review of risks | Establish Risk Oversight Group – February 2022. | February 2022/April 2022 |

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| Corporate Risk Register | | before they come to committees and Board | Refreshed Risk Management Strategy to be considered – April 2022. | |
| Digital Information Governance Group – Escalation & Update Report – DSPT Standards | Not likely to meet the requirements as arrangements have changed. This is usual, and an improvement plan will be in place. | Escalation report received. No further action requested by ICO. | Continue to monitor incidents, watching brief maintained by DIGG. | April 2022 |
| **ASSURE** (Detail here any areas of assurance that the Committee has received) | | | | |
| **Issue** | **Committee Update** | **Assurance Received** | **Action** | **Timescale** |
| Impact of Introduction of IFRS16 | Moving to accounting for capital assets in a different way around leases. | Small revenue impact | Follow up on the potential for external funding of that revenue | April 2022 |
| Going Concern | Agreed accounts should be prepared on going concern basis, final version would be received at the next meeting prior to approval at the Board of Directors. | Reviewed draft report for consideration by members | Final report to next meeting | April 2022 |

# Quality Assurance Committee

CONFIRMED Minutes of the Quality Assurance Committee held on Wednesday 12 January 2022 at 10am. Members accessed via Microsoft Teams Meeting.

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

**In Attendance:**
Tania Baxter, Head of Clinical Governance
Susan Barnitt, Head of Care Standards
Susan Rudd, Director of Corporate Governance
Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services
Amanda Jones, Director of Allied Health Professions (AHP)
Deborah Cundey, Interim Head of Performance
Christopher Wood, Manager Clinical Support
Dr Michelle Horspool, Deputy Director of Research
Dr Jonathan Mitchell, Clinical Director
Dr Robert Verity, Clinical Director for Acute and Community Services
Emma Highfield, Head of Nursing, Acute Inpatient and Older Adult Services
Maggie Sherlock, NHS Sheffield Clinical Commissioning Group (NHSSCCG)
Dani Hydes, NHSCCG
Amber Wild, Corporate Assurance Manager
Toni Wilkinson, IAPT Head of Service
Kirsty Dallison-Perry, Deputy Head of Nursing
Francesca O'Brine, Corporate Assurance Officer, (Minutes)

**Apologies:**
Abiola Allinson, Chief Pharmacist and Controlled Drugs Accountable Officer
Chris Digman, Governor
Linda Wilkinson, Director, Psychological Services & Consultant Clinical Psychologist

| Minute Ref | Item | Action |
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| QAC22/01/224 | **Welcome & Apologies**<br>The Chair welcomed everyone to the meeting and noted the apologies. | |
| QAC22/01/225 | **Declarations of Interest**<br>Professor Brendan Stone noted his Board membership of Sheffield Flourish. | |
| QAC22/01/226 | **Minutes of the meeting held on 08 December 2021**<br>The Chair noted that in minute QAC21/12/204, incorrectly stated that it was her first QAC meeting. With this correction made, the minutes of the meeting held on 08 December 2021 were agreed as an accurate record. | |
| QAC22/01/227 | **Matters Arising**<br>No matters arising to note. | |
| QAC22/01/228 | **Action Log** | |

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| | Committee received the action log for information and noted the updates to the February 2022 actions. | |
| QAC22/01/229 | **Board Assurance Framework (BAF)**<br>Committee received the report for assurance.<br><br>Susan Rudd reported that the Quality and Assurance Committee has oversight of three BAF Risks. BAF0024 has been reduced from 15 to 12.<br><br>The Chair questioned what had changed and who had made the recommendation. Susan Rudd explained that effort was being made with risk owners to assess and add on to the cover sheet the occurrence of changes, for example, adding text in italics for clarity. It is unclear who updated the risk. Risks are updated and the audit trail must be scrutinised to identify who made the entry.<br><br>Beverley Murphy noted that it was a historic update. Clinical leaders are asked to express confidence levels that essential improvements had been delivered and if this was a reliable judgement.<br><br>Dr Mike Hunter agreed that it would be helpful to hear from colleagues. However, the Committee is not able to deal with the item and be assured based on the reasons that Susan Rudd has given.<br><br>The Chair requested that an action is taken to identify the rationale behind the change. This will return to the Committee in February 2022 as an exception. The Chair agreed with Richard Mills that the BAF and Corporate Risk Register (CRR) should be at the end of the agenda.<br><br>Olayinka Monisola Fadahunsi-Oluwole agreed that the addition of italics would be helpful.<br><br>**Corporate Risk Register (CRR)**<br>Committee received the report for assurance.<br><br>Susan Rudd reported to the Committee that there are three new risks recommended to be added to the CRR, relating to GDPR requirements, the Omicron variant of Covid19, and the delivery of the delegated function for Safeguarding Adults.<br><br>Beverley Murphy told the Committee that the new entry, Risk 4805, is about the Trust's ability to deliver the delegated function. However, there is a discrepancy around the delegation. Beverley Murphy will review the wording of the risk.<br><br>Dr Mike Hunter noted that the agenda item, Back to Good, will discuss the risk in delivering Back to Good posed by the wave of the Omicron Covid19 variant.<br><br>The Chair reiterated that the CRR will be at the end of agenda from the February 2022 meeting onwards. From reading the report it is difficult to receive assurance that the risks are in hand. Key actions should be included under each new risk to address them.<br><br>Richard Mills noted Risk 4615, RIDDOR. This was discussed at People Committee January 2022, under the Health and Safety Q2 reports. Issues were highlighted and it is worth focussing on this risk to ensure that the actions taken do reduce it.<br><br>**Committee received the reports. An action was taken for BAF0024, and it will** | ACTION SR<br><br>ACTION BM<br><br>ACTION SR |

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| | **be discussed again at the February 2022 QAC meeting.** | |
| QAC22/01/230 | **Complaints – Rapid Development Plan**<br>Committee received the report for assurance.<br><br>Tania Baxter reported to the Committee. The Complaints Improvement Plan was implemented to develop and enhance the process. Learning from complaints is the next part of the process and is not discussed within the report. It will form part of the quarterly Patient Experience Report and minimal changes are anticipated. A new Complaints Manager has recently started in post.<br><br>Richard Mills welcomed the progress made. Complaints has been an issue for the Trust for many years. Richard Mills asked for a report that clearly showed processes are embedded and consistent, and targets are being met.<br><br>Tania Baxter agreed and reiterated the need to push forward with progress. Lack of stable staffing has been an issue and the department have a backlog. Changes made so far have been received positively by operational colleagues. Monitoring was tightened and performance regularly reported on through the Clinical Quality and Safety Group. There may be isolated incidences to be escalated to the Quality Committee, but the expectation is that the department will maintain its position and progress.<br><br>Salli Midgley added that there was a considerable backlog, but consistent and enhanced monitoring was built in. Weekly Complaints Trackers are submitted to the Serious Incident Panel for investigation. It is vital that people's concerns are addressed. It is hoped that these measures will prevent the need to bring this back as an issue to QAC. The aim is for it to align with improvements to Serious Incidents and that the team can report quarterly through the Patient Experience Report to bring out themes and respond in a timely way.<br><br>Richard Mills noted that it would have been helpful if that content was included within the report.<br><br>Beverly Murphy told the Committee that in November 2021 the Complaints function was moved out of Corporate Governance and into the Quality Team for a pilot period. This gave the Trust the opportunity to triangulate learning across incidents and issues of all kinds. The location of the Complaints function is under review but the processes being implemented are adding value which will be demonstrated over future months through the Learning Lessons Reports.<br><br>Dr Mike Hunter noted that it was good to see the actions within the plan were mostly complete or on track. There are areas relating to policy development and training subject to minor slippage during December and February. Dr Mike Hunter questioned if the Trust carried any risk regarding these.<br><br>Tania Baxter added that changes to processes have been made but policies are behind on this. It is on the team's radar, but no risks have been identified. The aim is to allow the new starter some influence around a review of the robustness of policy and process. Training will be delivered by the end of March 2022 and will enhance the Trust's position.<br><br>Salli Midgley told the Committee that the approach to training was to use an array of sources. Lived Experience informs the purpose of responding to complaints. The Chief Executive, Jan Ditheridge, who signs off the complaints is participating in the training. It was important to make the process changes first so responses to | |

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| | people are appropriate. There has been a slight delay, but it was necessary to run through the changes to ensure the training matches the process. Staff skills are being fine-tuned and the complainant's experience is a strong focus.<br><br>Olayinka Monisola Fadahunsi-Oluwole highlighted that complaints are very emotive. Regarding the backlog, often an informal approach of speaking to people on the telephone and keeping the complainant updated is helpful.<br><br>The Committee heard from the Chair that Complaints is on agenda because it has been a recurring and longstanding issue. The Committee can take assurance that this has now been addressed and the focus is on the learning. The report included a good description of actions taken to improve process. An indication of what systems are in place to ensure process is followed was missing. Detail regarding monitoring should have been included. The Committee can take reassurance that a more robust process is there and only partial assurance that this is currently working as this data was not presented.<br><br>Salli Midgley recommended that it returned to the QAC agenda within the Learning Report. The figures will be seen in the Patient Experience Report. Monitoring evidence will be given in the first instance to offer the Committee assurance that the process is running smoothly.<br><br>**Committee received the report. The Committee can take reassurance that a more robust process is in place and only partial assurance that this is currently working as this data was not presented. This will return to QAC via the Learning Report.** | |
| QAC22/01/231 | **Back to Good – Progress and Risks**<br>Committee received the report for assurance.<br><br>Salli Midgley reported to the Committee. The report provides an overview of all the actions. It presents plans around how assurance will be demonstrated in relation to the completion of actions. Going forward, these will be embedded in terms of where the Committee expect to see them reported through to.<br><br>Key points:<br>• Three actions remain in exception<br>• Five requirements received approved extensions<br>• Acute and PICU Section 29a closure<br>• Firshill Rise update<br><br>Emma Highfield highlighted the enormous pressure on staffing caused by the Omicron Covid19 variant, and the need to prioritise Service User care and the delivery of services. Mandatory training is very important, but it is expected that the uptake of training will reduce. There is assurance that the Trust is responding positively with the development of bitesize training on Jarvis to increase accessibility. It cannot be compared to mandatory training but does encourage the continuation of learning, development, and reflection.<br><br>Dr Mike Hunter noted that the Establishment Review of staffing and rolling out eRostering provides the Trust with information that can used as the basis to plan. What is does not solve is the immediate problem of high levels of vacancies and the day to day clinical and operational challenges in filling those. | |

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| | When this paper was submitted potential risks of the Omicron variant wave were defined. Within one week it has emerged that some building work may slip from February to March because of the impact of Omicron on contractors. This is a fast-moving situation. There has been some evidence in the numbers that the Omicron wave has peaked or is peaking.<br><br>The Chair expressed how helpful this analysis was and recognised how much pressure staff are working under.<br><br>Olayinka Monisola Fadahunsi-Oluwole requested clarification on the progress of the 55 CQC requirements.<br><br>Salli Midgley told the Committee that the Trust are on track, excluding the five items in exception. There will be a change in reporting. Back to Good Programme reports were previously delivered within the month but this caused complications. Reports will now be delivered a month afterwards, driven by the change in the Back to Good Board. Completed actions will be demonstrated for the end of the month and will have received sign off, aiding a more robust process. Salli Midgley will produce a summary of some of the 55 CQC requirements to present a broader picture to the Committee.<br><br>Mike Hunter added that regarding reporting, what was seen at the Board of Directors (BoD) meeting after QAC would be updated on a whole new month's reporting cycle. This arose from an eagerness to get things through to Board as quickly as possible. This does not allow for a period of analysis and judgement and efficient governance. At January 2022 BoD, Board members should expect to see a paper that does not look materially different to what QAC are receiving today. From February 2022 this will in sync.<br><br>The Committee is asked to agree the recommendation that the new risk to the delivery of the Back to Good Programme posed by the wave of the Omicron Covid19 variant is adopted onto the CRR and escalated in this way.<br><br>The Chair confirmed agreement with the Committee.<br><br>**Committee received the report and were assured by the escalation of the risk to the CRR. Committee to receive a judgement report on the CQC requirements at the next meeting.** | ACTION SM |
| QAC22/01/232 | **Fundamental Standards of Care (FSC) Visits**<br>Committee received the report for assurance.<br><br>Sue Barnitt reported to the Committee. The summary report gives an overview of the process. It highlights the transition of the Fundamental Standards of Care into the Culture and Quality visits that are in place now and the roll out of Tendable (the new term for Perfect Ward). The appendix details some of the key actions and the main source of ongoing monitoring in terms of the FSC.<br><br>Areas highlighted from visits included:<br>• Inconsistency in understanding of the presence of Ligature Anchor Point (LAP) assessments onsite. Recommendation is made to make this more visible to clinical teams<br>• Culture and Quality Visits – due to the capacity and thoroughness of the visits the ability to undertake one a month is challenging. Recommendation is made to return in March 2022 with some prioritisation indicators to assist in targeting resources to ensure risk-based assurance | |

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| | Two risks were highlighted within the report. As Tendable is the new ongoing monitoring process, there is a risk with the increased impact on capacity and staffing for the potential of slippage.<br><br>Richard Mills expressed gratitude for the efforts that staff are making to keep services going over the last few weeks. Monitoring these visits is an important process. The way the report is constructed requires improvement going forward to support this. It is better that this is conducted well and therefore prioritisation of areas that are most at risk is supported. There are certain issues across the Trust that continually reoccur, such as the lack of understanding of the onsite LAP assessments.<br><br>Sue Barnitt added that the new Culture and Quality Visits should allow the Trust to understand why these issues occur. A key methodology used is structured conversations with staff and to encourage an understanding of the background to *why* something is done or not done.<br><br>Richard Mills temporarily deputised for the Chair while connectivity was reinstated.<br><br>Rather than visiting less often the Trust must take a risk-based approach. Beverley Murphy will take an action to work with the Senior Management Team and Deborah Cundey to set out ten indicators that would trigger a full Culture and Quality Visit to a team. Others may be looked at differently.<br><br>Olayinka Monisola Fadahunsi-Oluwole added that it was important to relay the positive feedback from Service Users to staff.<br><br>Salli Midgley told the Committee that in developing the Culture and Quality Framework, those triggers are there but are not necessarily what is expected. From a culture perspective and from what the CQC's work relays, it is often where services are less busy and therefore less feedback is received. The purpose of the Culture and Quality Framework is to have a two-tier system. The first tier is to extract data around the culture indicators. With Trust-wide support one service or team should be visited per month as a minimum, otherwise it will take too long. Prioritisation is important to consider based on culture, not just the current IPQR indicators. This is not just about the Quality Team doing Culture and Quality Visits, there is a need to ask a range of sources for support.<br><br>Brendan Stone reflected on the Culture and Quality feedback received from Wainwright Crescent. It is difficult to take assurance from the way that Service User feedback was reported and the context around how it was obtained. All the feedback was overwhelmingly positive. The one suggestion that a Service User made relating to the Sensory Room is not reflected in the summary of recommendations at the end of the report.<br><br>Salli Midgley explained that teams were asked to spend a minimal amount of time writing reports and that a short summary of the visit is produced. More of the comprehensive feedback goes to the staff. Comments were collated from Service Users who chose to speak to Lived-Experience experts on the day.<br><br>Brendan Stone noted the information about process was helpful and it would be interesting to read this for assurance.<br><br>Richard Mills added that it would be helpful if report writers considered context as | ACTION BM |

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| | this would aid NED's understanding, especially for new issues.<br><br>Dr Mike Hunter noted that here has been slippage with Tendable and this is understandable given the circumstances. This is not a criticism. The Trust had anticipated that this would be the major audit tool that would provide key information around gap areas, for example, Physical Health Monitoring, and Seclusion. Given this slippage, how is the Trust minimising those risks that relate to consistency?<br><br>Susan Barnitt told the Committee that there are background actions that can be taken. Tendable have launched a data element to the platform. Weekly Utilisation Reports were requested. They can be shared with each service so that uptake, audits completed, and shortfalls are identified, and additional support can be put in place. Troubleshooting meetings are also being held.<br><br>Beverley Murphy told the Committee that once services start to use Tendable they will see the benefits. The process must be in place to start with. A Utilisation Report will go into the Quality and Performance Reviews monthly with each of the separate triumvirate leadership teams. This will be included from February so accurate reporting will be possible in future months. It will also inform how SHSC is meeting its Quality Standards.<br><br>Chair, Heather Smith, re-joined the meeting.<br><br>Richard Mills suggested that the progress report is returned to the Committee in March. Consideration is needed around what monitoring this Committee requires and how it takes forward the outcomes. It needs to be manageable for the Committee and those who are reporting.<br><br>The Chair confirmed that the progress report on prioritisation is to be presented at the next meeting. There also needs to be a proposal of how the monitoring will be done in the future so this can be easily viewed. The impact needs to be understood, ensuring more robust assurance processes.<br><br>**Committee received the report and were assured by the progress that has been made regarding Culture and Quality Visits and Tendable. The governance part of the process is in development.** | |
| QAC22/01/233 | **Integrated Performance and Quality Report (IPQR)**<br>Committee received the report for assurance.<br><br>The Chair congratulated colleagues on the improvements made, particularly given the pandemic context within which this work is being carried out.<br><br>Deborah Cundey noted items that are to be escalated to Board should be indicated within the summary paper.<br><br>Dr Mike Hunter questioned the rendering of information and pointed towards page 19 where medication incidents show as decreasing over six consecutive blue dots. These would usually lead to a recalibration of control limits. The recalibration of control limits is never seen within reporting. It has an affect on interpretation of the data.<br><br>Deborah Cundey highlighted the principles being followed regarding the use of SPC Charts. If a change can be identified as a result of intentional actions, then this can be annotated, and the limits recalculated. | |

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| | Heather Smith noted that a written comment is needed when recalibration has been implemented.<br><br>Dr Mike Hunter requested a discussion regarding SPC Charts outside of QAC.<br><br>**Committee received the report, noted the improvements made and areas where further improvement in performance is needed.** | ACTION MH/DC |

a) <u>Reducing Waiting Times</u>
Committee received the report for assurance.

Beverley Murphy suggested:

1. Specialist Psychotherapy Services (SPS) for Mood and Anxiety and Post Traumatic Stress Disorder (PTSD), and SPS for Personality Disorder and Complex Trauma have made changes to the way that they work and significantly reduced waiting times. The reports propose the closure of these Recovery Plans for these two teams and to move the monitoring into the IPQR.

2. Demand for the Gender Dysphoria Clinic (GDC) and Sheffield Adult Autism and Neurodevelopmental Service (SAANs) has outstripped the commissioned resource for a significant amount of time. The impact on Service Users remains but the proposal is to treat it as a commissioning issue and report through the IPQR as there is a limited scope of interventions the Trust can take. The Trust's commissioners recognise the issue.

3. The Committee should focus on the waiting list for the Adult Recovery Service and the unacceptable waiting times to access the Single Point of Access and Emotional Wellbeing Service.

Brendan Stone noted that the reports provide a sense of the effort and labour that has been undertaken. This is appreciated. There is no assurance within the reports regarding how Services Users feel about the implementation of recovery. The recommendation emerges from triangulating against national targets. The concern with moving issues to the IPQR is that it is easier for them to drop off the Trust's line of sight. SAANs waiting times is a commissioning issue but this is immaterial to the people waiting to use the Trust's services.

Richard Mills added that the Trust should be concerned about all the items but needs to prioritise. It is right to concentrate on the areas where the most progress can be made. These are dependent on service re-design. In other areas, adequate levels of service have not been commissioned. It needs to be resolved but a monthly report to QAC is not the best way forward.

Beverley Murphy agreed that comments around Service User experience are absolutely accepted however, within the SPS Recovery Plans, the Trust has improved performance beyond the target. The Organisation focus efforts. The Trust should never accept that the performance against nationally and regionally commissioned, highly specialist services are acceptable as they are. Robust conversations with commissioners must continue regarding actions that can be taken to make improvements.

Dani Hydes (CCG) added that, in terms of SAANs, the CCG have had discussions with the Trust regarding the redesign of a model which has caused delays. Investment has been put into the service. Agreement on a model is imminent and investment to increase staffing will follow. Consultation

has been sought through university practices to reduce referrals to the Trust.

Jonathan Mitchell noted that there must be an understanding of people's needs who are referred into SAANs. Once this information has been compiled it will likely need to be brought back to QAC.

Brendan Stone agreed that Beverley Murphy's approach is pragmatic and is understood.

Salli Midgley noted that there are plans for a Service User Reference Group regarding the transformation and could include how Service Users feel care is now in terms of safety and access to services.

The Chair made a proposal that the Committee seek to close the loop on the SPS by having a report on Service User input on those changes, ensuring full assurance. Salli Midgley to pick this up and bring back to QAC. Focus on the SPA Recovery Service should continue. A short statement on GDC and SAANs should be brought to QAC each month stating position and comments on any progress or internal or external changes.

**Committee received the report and agreed the recommendation for the reporting of Recovery Plans and waiting times going forward.**

ACTION SM

b) <u>Birch Avenue (Quality Risks Update)</u>
Committee received the report for assurance.

Kirsty Dallison-Perry reported to the Committee. Over the last week a new risk emerged relating to family and carer's involvement and due to Covid19 outbreaks at Woodland View and Birch Avenue. There has been a blanket approach to Essential Care Giver's Status. No families or carers have been given this status. The status allows relatives to visit during a Covid19 outbreak.

The model for G1 development work will be followed. Kirsty Dallison-Perry will conduct a meeting with the General Manager for Older Adults, Service Manager, and the leadership team for Birch Avenue to identify a lead for each risk area. A Workstream will be implemented, and monthly updates provided. Outcome measures and timescales for each Workstream must be decided.

Dani Hydes clarified that the beds are wholly CCG commissioned. The beds are not to be used as step up/step down. As part of the review the beds should be made more formal as they are not formally commissioned. Any developments related to changes in the model or building will need to be undertaken with the CCG.

Richard Mills reflected that it has been a devastating two years for nursing homes generally. In terms of assurance, there are elements of concern for quality of care. Input from families is an early warning sign and it is not there. The Committee need to see an action plan. There are real concerns, and it is good they were highlighted. South Yorkshire Housing Association (SYH) have an excellent reputation and the Trust have a good working relationship with them. SYH are not sighted on these issues and concerns. The complexity of the corporate relationships could mean it is more difficult to get work done.

Dani Hydes noted that it would be beneficial if CCQ and SYH conduct a joint visit with SHSC to Birch Avenue. Discussions and concerns can then be triangulated.

Dr Mike Hunter told the Committee that, in terms of the Care Giver's Status, the default position for visits should be reversed. It covers emotional

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| | wellbeing, so the question should be – why would this person not be given this status?<br><br>Jonathan Mitchell told the Committee that the latest version of the National Visitor Guidance states that every care home resident should have access to an essential care giver.<br><br>The Chair agreed the requirement for urgent action with regards to care giver status and requested that this is addressed quickly. In terms of quality of care, this is an Alert for the Board but there is reassurance that the Trust is taking rapid action. A Recovery Plan and impact measures will be brought to the February 2022 QAC meeting.<br><br>**Committee received the report, noted the new risk, and requested a Recovery Plan and impact measures at the next QAC.** | ACTION KDP/DH |
| QAC22/01/234 | **Equality and Inclusion in IAPT**<br>Committee received the report for information.<br><br>Toni Wilkinson told the Committee the report was to highlight the work being done around equalities within IAPT and welcomed questions. There are national priorities regarding improving access for people from Black, Asian, and Minority Ethnic (BAME) communities and older adults. The Trust has established a new Equality and Outreach Team which will broaden the equality agenda to focus on key populations. This is an Advise paper.<br><br>Brendan Stone asked how the training provider, Bespoke Mental Health, was chosen and questioned if we could be assured that the different profiles of groups of people who may be placed under the term BAME could be disaggregated. Also, a query in terms of the training and support for staff in place for them to be able to be culturally sensitive.<br><br>Toni Wilkinson noted the difficulty in obtaining high quality Cultural Sensitivity Training. SHSC IAPT has implemented its own Equality Master Classes, drawing on good practice and interpreters.<br>Multiple training providers were consulted with, but many could not accommodate IAPT's c200 staff members. Bespoke Mental Health are tied in with IAPT expertise and offer specific Cultural Sensitivity Training for psychological Wellbeing Practitioners, Cognitive Behavioural Therapists, and Counsellors.<br><br>The team has worked to support the agenda, collaborating with Service Users from different BAME backgrounds. Information is delivered in various languages by bi-lingual staff. There is a Patient Experience and Engagement Group within IAPT. There is difference within every population and the role is to be able to reach the person in front of us.<br><br>Beverley Murphy added that the report had come to the Committee to advise of work going forward in advance of a full report on the implementation of the Patient and Carers Race Equality Framework (PCREF) within SHSC. Beverley Murphy to work with Salli Midgley to establish a timeframe for this assurance report. The aim of the PCREF is to provide a framework to ensure the Trust meets its regulatory duties in terms of equality and inclusion, ensure co-production, and that the Trust understands and is publicly reporting against and improving the racialised experience of Service Users.<br><br>**Committee received the report and noted the assurance report to be brought** | ACTION BM/SM |

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| | **to QAC in the future - date to be confirmed.** | |
| QAC22/01/235 | **Lived Experience Strategy**<br>Committee received the report for assurance.<br><br>Susan Barnitt welcomed questions on the report and added that the Trust will be offering Zoom consultation events to Service Users and carers. The report updates on the progress of the strategy.<br><br>Richard Mills noted how interesting the details of the workshop were. It resonated with cultural issues within the Trust. It is powerful and encouraging that Service Users are highlighting the same issues as the Board. It emphasised the value of this work and quality of the feedback.<br><br>The final strategy is due for sign off at the February 2022 Board. The strategy will go out for consultation in the next two weeks. It will go through Service User experience and engagement processes via the Service User Engagement Group (SUSEG) and the Lived-Experience and Co-Production Assurance Group (LECAG). Wider clinical services will support to identify people who may wish to contribute.<br><br>**Committee received the report and were assured by the insight and progress.** | |
| QAC22/01/236 | **Research and Innovation Strategy**<br>Committee received the report for assurance.<br><br>Dr Michelle Horspool presented the full outline of the strategy to the Committee which incorporated feedback received. The Committee were asked for final comments and to recommend it is taken to Board on 26th January 2022.<br><br>Dr Mike Hunter clarified that the strategy would go to Board as a draft so that the full Board can contribute.<br><br>The Chair noted the assurance taken from the process of wider consultation. It will feed into what the Trust requires strategically from the Board moving forward.<br><br>Richard Mills noted that the lack of comments was a clear sign of the excellent work that has been done.<br><br>**Committee received the report and recommended that it go to January 2022 Board for comment.** | |
| QAC22/01/237 | **Policy Governance – Ratification of Decisions by PGG**<br>Committee received the report for assurance.<br><br>Amber Wild reported that the following items had been through the governance process and the Committee were asked to ratify the recommendations:<br>• Clinical Risk Assessment and Management of Harm Policy NP 035 – Extension to Review Date<br>• Use of Seclusion and Segregation Policy NPCS 009 – Extension to Review Date<br>• Nursing Home Falls Policy MD 007 – formerly Falls (Residential Areas Only) Policy<br>• Associate MHA Managers Policy NPCS 012 – Extension to Review Date<br>• Complex Case Management Policy NP 042 – New policy<br>• Incident Management Policy MD 023 – Interim Review<br>• Duty of Candour and Being Open Policy MD 010 – Interim Review | |

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| | • Ligature Anchor Point and Blind Spot Risk Assessment Policy NP 043 (replaces Ligature and Blind Spot Risk Reduction Policy MD 003) – New policy<br><br>The Chair requested that the phrasing of Test 5 *That staff wellbeing has not been negatively impacted*, was expanded to include whether a policy update has enhanced staff wellbeing in any way. It would be a useful tool to review the impact of changes on staff and would link into the Trust's health and wellbeing aspirations.<br><br>**Committee received the report and approved the recommendations.** | ACTION SR |
| QAC22/01/238 | **Emerging Quality Risks**<br>Committee received the verbal report from Beverley Murphy for assurance.<br><br>The impact of Omicron affecting levels of staffing should be noted. There is assurance that there are plans in place and everything that can possible be done is being carried out, however it is difficult.<br><br>The Chair expressed thanks and respect for all the work being done to keep people well under the tremendously challenging circumstances.<br><br>**Committee received the report.** | |
| QAC22/01/239 | **Any Other Business**<br>Beverley Murphy noted that the Medicines Task and Finish Group Report was completed on time and should have been included on the agenda. It will be on the February 2022 agenda. | |
| QAC22/01/240 | a) <u>Annual Work Plan</u><br>Committee received the workplan for information. A review of the Work Plan is being conducted. Some papers have a five-day turnaround from quarter end to expected submission date. This is not possible.<br><br>b) <u>Significant issues to report to the Board of Directors (Alert, Assure & Advise)</u><br><u>Alert</u><br>• Impact of Covid19 and the Omicron variant, and the reflection of this on the Corporate Risk Register<br>• Waiting Times in SPA recovery service – Committee will continue to focus on those and the emergence of the Recovery Strategy<br>• Report on Birch Avenue received – Recovery Plan and Impact Measures requested for February QAC meeting. CCG involvement necessary for clarity<br><u>Assure</u><br>• IPQR – progress being made on key issues identified within IPQR and numerous services, e.g., Restrictive Practice, Inpatient Length of Stay, Management of Incident Reviews<br><u>Advise</u><br>• Back to Good Programme continues to be tracked and subject to scrutiny<br>• Complaints process – considerable progress in terms of process development allowing focus of meetings to move to learning from complaints<br>• Progress report on Culture and Quality pilots received – progress noted, more detail has been requested on monitoring and communication to | |

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| | Committee<br>• GDC and SAANs waiting lists – continues to be monitored but Committee recognises issues with the contractual and commissioning route that needs to be pursued<br>• SPS waiting lists – recovery plan received, and Committee recognises progress on waiting times. Further assurance necessary regarding Service User input<br>• Work is underway around Equality and Inclusion - Committee received a report from IAPT and noted that this work is linked to National development and will form part of the Trust's response to the overall Improvement Framework, Patient and Carer Race Equality Framework (PCREF)<br><br>c) <u>Changes in level of assurance (Board Assurance Framework)</u><br>Committee agreed there had been no changes in level of assurance but that the BAF report would return to QAC in February 2022 for assurance relating to BAF0024.<br><br>d) <u>Meeting Effectiveness</u><br>Comments are invited in the Chat Box.<br><br>The Chair noted that the Least Restrictive Practice paper that went to the Mental Health Legislation Committee is available for information. The excellent work on this should be acknowledged. | |

**Date and time of the next meeting: Wednesday 09 February 2022, 10am to 12:30pm**
**Format: MS Teams**
*Apologies to Francesca O'Brine, Corporate Assurance Officer*
*<u>Francesca.O'Brine@shsc.nhs.uk</u>*

# Quality Assurance Committee

CONFIRMED Minutes of the Quality Assurance Committee held on Wednesday 9 February 2022 at 10am. Members accessed via Microsoft Teams Meeting.

**Present:** (Members)
Heather Smith, Non-Executive Director (Chair)
Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director
Dr Mike Hunter, Executive Medical Director
Beverley Murphy, Executive Director of Nursing, Professions and Operations
Richard Mills, Non-Executive Director
Professor Brendan Stone, Associate Non-Executive Director

**In Attendance:**
Jan Ditheridge, Chief Executive
Tania Baxter, Head of Clinical Governance
Susan Barnitt, Head of Clinical Quality Standards
Susan Rudd, Director of Corporate Governance
Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services
Samantha Crosby, Health and Safety Manager
Vin Lewin, Patient Safety Specialist
Deborah Cundey, Interim Head of Performance
Kirsty Dallison-Perry, Deputy Head of Nursing, Acute Inpatient and Older Adult Services
Dr Jonathan Mitchell, Clinical Director
Nicholas Bell, Director of Research Development
Zoe Sibeko, Head of Project Management Office
Jo James, Deputy Director, Intensive Support, NHSE&I
Teresa Clayton, Head of Experience
Emma Highfield, Head of Nursing, Acute Inpatient and Older Adult Services
Maggie Sherlock, NHS Sheffield Clinical Commissioning Group
Dani Hydes, NHS Clinical Commissioning Group
Neil Robertson, Director of Operations and Transformation
Abiola Allinson, Chief Pharmacist and Controlled Drugs Accountable Officer
Linda Wilkinson, Director of Psychological Services & Consultant Clinical Psychologist
Amber Wild, Corporate Assurance Manager
Francesca O'Brine, Corporate Assurance Officer, (Minutes)

**Apologies:**
Alun Windle, NHS Sheffield Clinical Commissioning Group
Salli Midgley, Director of Quality
Chris Digman, Governor

| Minute Ref | Item | Action |
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| QAC22/02/246 | **Welcome & Apologies**<br>The Chair welcomed everyone to the meeting and noted the apologies. Governor, Chris Digman, views the recording of the meeting and reflects back to the Chair. | |

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| QAC22/02/247 | **Declarations of Interest**<br>Professor Brendan Stone noted his Board membership of Sheffield Flourish. | |
| QAC22/02/248 | **Minutes of the meeting held on 12 January 2022**<br>The minutes of the meeting held on 12 January 2022 were agreed as an accurate record, with the correction of *head* to *heard* on page 4 made. | |
| QAC22/02/249 | **Matters Arising**<br>These items are for clarification. A full report was not required.<br><br>**a) Birch Avenue – Assurance of implementation of improvement actions**<br>Committee received the report from Kirsty Dallison-Perry for assurance.<br><br>The Chair told the Committee that clarification and an action plan were required around the quality of care issues identified and visiting accessibility for families.<br><br>Ongoing priorities:<br>• Focus on the easing of visiting restrictions<br>• Revise Care Home Visiting Policy in line with national guidance. Meeting with Birch Avenue and Woodland View arranged<br>• Risk assessments to be on a case-by-case basis<br><br>A plan is in place with Restrictive Practice Lead, Lorena Cain, for a Restrictive Practice Strategy at Birch Avenue. G1 models will be utilised.<br><br>Olayinka Monisola Fadahunsi-Oluwole highlighted that when recruiting from abroad it is important to understand the support needed for staff and their families. Beverley Murphy noted that the Trust has a programme of work set up and are learning from other Organisations. A further conversation is welcomed beyond this meeting. The Chair added that this is reviewed at People Committee and these comments will be included.<br><br>**The Committee were reassured that the ongoing issues of visiting restrictions are being addressed and were assured by the action plan and transference of best practice from G1. Kirsty Dallison-Perry and Beverley Murphy to agree timeframe for future report.**<br><br>**b) Deep Dive G1 Quarterly Update – Assurance of progress with improvement actions**<br>Committee received the report from Emma Highfield for assurance.<br><br>Key risks and priorities:<br>• Timing of repurpose of seclusion space compromised by delay to flooring to 1st April 2022. Delay escalated<br>• De-escalation spaces must be available in line with this work<br>• Learning from Acute Wards to be utilised<br>• Vast improvements on G1. Risk of being falsely assured in the future and need to mitigate for this with pre-emptive indicators. Important to move forward mindfully with sustainable practice.<br><br>A G1 Ward Manager is now in post, giving assurance of leadership going forwards. In June 2022, the aim is to move Stanage onto Burbage, which does not have a seclusion room, which has been agreed by staff. | ACTION<br>BM/KDP |

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| | Beverley Murphy noted the work that went into removing the two seclusion rooms. The impact on Service Users cared for in a more holistic and compassionate way should not be underestimated.<br><br>Beverley Murphy confirmed for Dani Hydes that delayed discharges are shared with the local authority and the CCG every week, including G1. It is important to note this regarding G1 because the social care element is not integrated.<br><br>The Chair thanked and congratulated the team on their work. In 3.2, the list of critical metrices could be used in a future report to identify their place in the IPQR.<br><br>**Committee received the report for assurance and will be updated in the next quarterly report.** | |
| QAC22/02/250 | **Action Log**<br>Committee received the action log for information.<br><br>Beverley Murphy updated the Committee:<br>• Action 22/01/234 - the Patient and Carers Race Equality Framework (PCREF) programme will be brought to the March 2022 QAC | |
| QAC22/02/251 | **Back to Good Reporting**<br>Committee received the report for assurance.<br><br>Sue Barnitt presented the report to the Committee on behalf of Salli Midgley. The report includes work completed up until the end of December 2021.<br><br>Key risks and priorities:<br>• Impact of Omicron –on staffing, training, supervision, and environmental changes<br>• Work is underway to request updated trajectories<br>• Six requirements reported to the Programme Board - exception requests approved<br><br>Key achievements:<br>• Section 29a Warning Notice requirements completed<br>• Some actions completed earlier than requested<br><br>Beverley Murphy reported that the CQC Inspection Report was sent back for factual accuracy on 8th February 2022. Challenges raised were minimal and publication is expected within the next one to three weeks.<br><br>Dr Mike Hunter asked triumvirate leaders what was being done to build resilience in supervision and training during the transition from the pandemic to endemic phase of Covid19. In response, Emma Highfield noted:<br>• Supervision and training do not need to be lengthy to be valuable<br>• Accessible, bitesize training can be effective and impactful<br>• Group supervision settings in acute services could be implemented<br><br>Simon Barnitt emphasised the importance of purposefully making space for supervision and of recognising and recording all forms of supervision.<br><br>Dr Jonathan Mitchell added that as the quality of supervision improves the rate of participation will improve, and staff will find more value in it. | |

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| | Beverley Murphy confirmed that Director of Psychological Services and Consultant Clinical Psychologist, Linda Wilkinson is leading on this work.<br><br>**Committee received the report, were assured by progress but noted that some issues needed to stabilise post-Omicron.** | |
| QAC22/02/252 | **Integrated Performance and Quality Report (IPQR)**<br>Committee received the report from Beverley Murphy for assurance.<br><br>Key risks:<br>• Waiting times for routine assessment in the Emotional Wellbeing Service (EWS) and the allocation to a permanent care coordinator – recovery plans are in place, and material change is dependent on transformation. Work with staff-side, Primary Mental Health Care, and the local authority will impact this<br>• Care Programme Approach (CPA) annual review completion – one recovery team have struggled to demonstrate compliance<br>• Achieving flow in Acute Adult Inpatient units and Psychiatric Intensive Care Units (PICU) – we currently have 40% rate of delayed care<br><br>Brendan Stone questioned the language of the cover report. Waiting times are more than a concern, they are a serious concern (including SAANs and the Gender Identity clinic).<br><br>Richard Mills noted:<br>• The Memory Clinic – Pat Keeling and Richard Mills to visit next week and will discuss issues<br>• IAPT and Secondary Care Services: Forecast Demand page 36 – does the Trust have forecast demand for community services? Actual demand is significantly below predicted. Could this be a sign of supressed demand?<br>• NHS funding to address wait times - Mental health waits are overlooked<br><br>Beverley Murphy noted:<br>• The Trust have received regular recovery plans for all community services, including the Gender Identity (GI) and the Sheffield Adult Autism and Neurodevelopmental Service (SAANs)<br>• The Committee moved these risks to the Corporate Risk Register (CRR) and will work with Commissioners on that<br>• Executives attend a range of meetings at the Integrated Care System (ICS), considering the specific mental health priorities for the year ahead and the availability of funding for this<br><br>Dani Hydes confirmed for Chief Executive, Jan Ditheridge, that next year's investment priorities had been discussed with Contract Management, but the CCG's funding cannot currently be commented on. Mental Health is at the forefront of the agenda.<br><br>Olayinka Monisola Fadahunsi-Oluwole added that the Committee should be encouraged by the work of the Crisis Solution Home Team. Beverley Murphy to confirm who gave compliments in terms of diversity.<br><br>**a) Serious Incident Rapid Development Plan – the risks to delivery and assurance of progress with the improvement actions**<br>Committee received the report from Tania Baxter for assurance. | |

- Three actions remain but work is either complete or underway. No risks identified in relation to achieving goals
- The Plan has been validated by a 360Assurance document and significant assurance was received
- Key Performance Indicators (KPIs) will be reported through the Clinical Quality and Safety Group
- Issues to be escalated to the IPQR

Beverley Murphy added that in the CQC Inspection Report of Acute and PICU, the opportunity and demonstration that Service Users and families could be involved in the reviewing of incidents was noted.

**b) Community Service Development Update – Assurance of progress**
Committee received the report from Neil Robertson for assurance.

There is a high-level model of evidence-based interventions to be provided across Single Point of Access (SPA), EWS, and Recovery Teams.

Next steps:
- Ensure Service User and carer voice is reflected
- Focus on metric outcomes and structures for model delivery. Dependencies that will influence the structure are being worked on. Updates to follow in the next two weeks
- Abolition of CPA – moving to individualised care planning which will reflect five principles. Governance currently being set up. Paper to be presented to QAC in the future

The Trust is moving forward in relation to the community service re-design and having a clear approach.

Risks:
- Timings – need to offer clarity around delivery

Brendan Stone asked what the plans are to ensure engagement of a diverse range of people who use services. How will the Organisation ensure that co-production is in depth? It is encouraging to see the recognition that good co-production cannot be rushed.

Neil Robertson noted that it is important to reflect diverse voice and engagement. The Trust are looking to partners to assist with platforms. Transformation is key. Leadership is being strengthened, and support of the North Recovery Team is a focus. The Finance and Performance Committee (FPC) and QAC are sighted on recovery work relating to waiting lists.

Jan Ditheridge noted:
- The Trust is choosing to pursue the Clinical Effectiveness route and the person-centred co-produced pathway. These have been commented on and requested by many Services Users locally and nationally
- It is vital to ensure this is evidence-based. Clinical effectiveness and guidance will be included
- This is building on work undertaken over the last couple of years,

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| | learning from change, and adding in new evidence bases<br>• It is explicit within the report how this directly links to the Trust's Clinical and Social Care Strategy principles<br><br>Dr Mike Hunter noted:<br>• The Clinical Effectiveness part is clearly linked to the evidence-led cornerstone of the Clinical and Social Care Strategy<br>• The evidence comes from the study of populations and average effects. The skill is making this come alive in an individual's life by reference to their story and aspirations, therefore making it meaningful. The strategy deliberately sets out the tension between the two<br><br>The Chair highlighted the key risks:<br>• Achieving the right model<br>• The cultural aspect - staff not getting on board<br><br>Beverley Murphy added that there was an Extraordinary Joint Consultative Forum (JCF) meeting held on 17th December 2021 to discuss what success would look like. An agreeable position on this was reached. Sue Highton used the Community Programme Board to test a wider audience with several measures. The aim is to get to a position of recognition that there is agreement more than dispute.<br><br>Jan Ditheridge noted that the next leadership team meeting will discuss key risks in those services: risks of recruitment, waiting time in terms of caseloads, and vacancies. One meeting component will address how staff are led, managed, and supported, particularly those who are burdened by what happened in 2017.<br><br>**Committee received the report. The Chair confirmed with Neil Robertson that the Board can be assured that the anticipated level of progress is being made, but there are potential risks going forwards.** | |
| QAC22/02/253 | **Quality Objectives Q3 – progress report on delivery of priorities**<br>Committee received the report from Tania Baxter for assurance.<br><br>Activity:<br>• Data gathering relating to ethnicity of referrals to review equity across services, and identify gaps in referrals<br>• Detailed analysis of data will inform work going forwards<br>• Discussions with IAPT supporting their understanding of equality work and setting ambitious but achievable targets<br>• Presentation to the Council of Governors on 15th February 2022 - feedback and agreement on direction of travel<br><br>Brendan Stone noted:<br>• This data and work are very welcome. The paper outlines an intelligent and focussed method. The co-production approach is encouraging<br>• It is easy to misinterpret data.The triangulation process of data supplemented by co-production is critical. Stories are key to understanding data<br>• It is important for organisations to focus on what data is needed to ensure an appropriate amount is generated<br><br>Beverley Murphy added that it will be important to work with the Performance | |

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| | Team to ensure that data is given as a proportion of the overall community.<br><br>Olayinka Monisola Fadahunsi-Oluwole asked how the Committee can be assured of the level of opportunity to engage with diverse groups before their acceptance into services. Beverley Murphy responded that data shows an overrepresentation of Black, Asian, and Minority Ethnic (BAME) Communities in inpatient services which is consistent with the picture nationally. It is on the agenda and is one of the Committee's focussed priorities because it is possible that people from these communities are not being reached soon enough.<br><br>Jonathan Mitchell noted that the Trust must address what it can do about difference and how can it work with external partners to do the same.<br><br>**Committee received the report. The Chair noted the important next step of actioning the data. The work so far is encouraging.** | |
| QAC22/02/254 | **Health and Safety Quarterly Report**<br>Committee received the report from Samantha Crosby for assurance.<br><br>Key concerns:<br>• Lack of embedding and monitoring<br>• No process relating to Reporting Injuries, Diseases, and Dangerous Occurrences (RIDDOR) in Health and Social Care reporting – actions noted to carry forward<br>• Lack of progress of identification and maintenance of fire doors on premises – this is on the Corporate Risk Register (CRR)<br><br>Richard Mills noted:<br>• The team has shown thoroughness and professionalism<br>• External visits to services and being a visible presence makes an impact<br>• The progress is encouraging and there is confidence that the changes are reducing the risks<br>• Comments around altering cultures are vital and speak to the wider cultural work within the Trust<br><br>**Committee received the report, and the Chair noted a high level of assurance received. There is confidence that the team are focussed on the most important issues.** | |
| QAC22/02/255 | **Mortality and Learning from Deaths Quarterly Report**<br>Committee received the report from Vin Lewin for assurance.<br><br>Key risks, actions, and findings:<br>• Every Service User death was reported<br>• Occurrences of deaths within six months of having contact with Trust services were reviewed<br>• Deaths of Service Users with a Learning Disability were reported through the Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) process<br>• Mortality Team reviewed data and report an increase in deaths of Service Users with substance misuse, particularly in the Opiate Services, in 2020, and a reduction in 2021. Further work required to extract learning<br>• Learning taken from Structured Judgement Reviews (SJRs) and linked with Better Tomorrow project. Lower-level risks involved with this work<br>• Aim for Q4 - develop a Dashboard which automatically extracts learning from SJRs. Risk associated with ensuring this is in place on Ulysses and there are enough staff able to conduct SJRs | |

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| | Dr Mike Hunter noted that in Q1 of 2020 the Trust experienced excess deaths of c40% because of the first wave of Covid19. Within this there appears to be a specific vulnerability of people with substance misuse issues relating to opiates. It is clearly linked with Covid19, but the direct and indirect effects are not yet fully understood. A workshop has been arranged with the team to understand the detail of this vulnerability so these Service Users can be protected in the future.<br><br>Richard Mills requested that the Committee and Board consider re-focusing on the substance misuse service at a future meeting as addictions and environments are constantly evolving.<br><br>Vin Lewin noted that there is currently an imbalance of being process-heavy and learning-light. The emphasis of the Better Tomorrow programme is to redress this.<br><br>**Committee received the report and were assured by the progress. Process versus a focus on impact is an ongoing piece of work.** | |
| QAC22/02/256 | **a) Physical Health Update and Assurance Report**<br>Committee received the report from Sue Barnitt for assurance.<br><br>Key risks:<br>• Delays in relation to completion of the Training Needs Analysis for Physical Health Skills for staff<br>• Procurement of training for essential skills<br>• Completion of audits on Tendable to provide assurance – issues around capacity within Clinical teams to undertake audits<br>• Compliance with essential Standards. Spot audits: Clozapine, Red Bag Checks, and glucose calibration<br><br>Key achievements:<br>• Draft End of Life Policy in place<br>• Robust piece of work completed around equipment tagging<br><br>Beverley Murphy highlighted that the Trust has a new mechanism to provide assurance. It is an accessible system to identify which teams are doing well and can be learned from, but it is not being utilised by leaders.<br><br>Richard Mills added that Physical Health Checks are a challenge but are vital. Are there other cultural issues that mean this is repeatedly not getting done?<br><br>Sue Barnitt noted:<br>• The Trust is starting to see change and is embedding an understanding that mental and physical health go hand in hand<br>• Bitesize training is being utilised<br>• Emphasis on responding to the needs of the individual<br>• Lead Nurse interviews commence tomorrow<br><br>Emma Highfield noted progress:<br>• New roles and key leaders are focussing on the Physical Health agenda: training/qualified Nurse Associates and Advanced Clinical Practitioners<br>• Learning from the Safeguarding practices<br>• Taking time to reflect is key and Physical Health needs to be at the forefront of this<br><br>Dr Mike Hunter met with the Sheffield Teaching Hospital's Medical Director. An agreement was met to explore reciprocal training and development arrangements | |

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| | allowing each organisation to improve its capability in respect of Mental and Physical Health.<br><br>Simon Barnitt and Jonathan Mitchell highlighted how the new Electronic Patient Record (EPR) system will improve processes relating to Physical Health in the long-term.<br><br>**Committee received the report. The Chair noted that this is a risk to the Trust. Progress is slow. Sue Barnitt to discuss with Beverley Murphy what measures are being used to track progress. Alert to Board.**<br><br>**b) Physical Health Strategy – Final Draft**<br>Committee received the report from Sue Barnitt. The report and strategy required the Committee's approval.<br><br>The report outlines the priorities within the Physical Health Strategy. There is a need to clarify what the actions and objectives relate to. The recommendation is that further work is continued to establish this.<br><br>**Committee received the report and supported the actions.** | ACTION BM/SB |
| QAC22/02/257 | **Task and Finish Group: Nursing Medication Administration Improvement Work – Assurance of progress made**<br>Committee received the report from Abiola Allinson for assurance.<br><br>Key risks and actions:<br>• Risk involved in embedding the work. Implementation is in place<br>• Medicines Safety Group will report on uptake to QAC within the quarterly update<br>• High quality multi-disciplinary work was undertaken to deliver this<br><br>The Chair advised that, going forward, positive, or negative updates should be highlighted clearly within the quarterly report. The Committee should be focused on early warning triggers. Tier 2 groups should be identifying triggers and escalating them to QAC.<br><br>**Committee received the report and were assured by the progress.** | |
| QAC22/02/258 | **Research, Innovation, Effectiveness, and Improvement Group (RIEIG)**<br>Committee received the report from Nicholas Bell for information.<br><br>Assurance:<br>• Research, clinical audit, and quality improvement<br>• Research, Innovation and Effectiveness Strategy – ambitious piece of work and sets the standard<br><br>Risks:<br>• Investment required to achieve objectives. Business case submitted for research investment, and mandate for clinical effectiveness investment<br>• Board requested development of quality improvement at scale and pace – investment required to deliver. Mandate submitted<br><br>Beverley Murphy highlighted the report was missing reference to commitment to each service and understanding what the benchmarks and best practice are. Nicholas Bell told the Committee that this was being worked on and is discussed in RIEIG. | |

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| | Dr Mike Hunter added that it is not just a story about resources but how to work together and get the best from teams.<br><br>Jan Ditheridge noted that it was not a Board decision to bring Quality Improvement and Clinical Effectiveness together. It was the idea of the Research department and was then welcomed and backed by Board. Board wants to see effectiveness, innovation, and research as well as assurance on Quality Improvement.<br><br>**Committee received the report. The Chair confirmed good assurance regarding:**<br>• **The research performance and progress with the objectives that link to the Research Strategy**<br>• **Aspirations around clinical effectiveness** | |
| QAC22/02/259 | **Quality and Equality Impact Assessments (QEIA) Q3 Report**<br>Committee received the report from Zoe Sibeko for information.<br><br>Risks against Quality:<br>• Five QEIAs. All have been approved<br>• The panel have reviewed mitigating actions and risk scores against key criteria. All scored low or very low, except for two relating to financing and one relating to the Therapeutic Environments Programme and completion of Ligature Anchor Point work. Mitigation is in place for these<br><br>Equalities:<br>• No risks to any Protected Characteristic groups<br>• The new EPR system is compliant with the Accessible Information Standard<br>• Benefits identified for Service Users with autism relating to the move from Wainwright Crescent<br>• Specific prayer room at new location, not previously available at Wainwright Crescent<br><br>**Committee received the report. The Chair noted how impact was becoming more visible. The actions required are clear.** | |
| QAC22/02/260 | **Clinical Service Reviews – Methodology and Summary of Cross Cutting Themes**<br>Committee received the report from Jo James for information.<br><br>Highlights:<br>• Key themes link clearly to current activity and work programmes within the Trust<br>• Key risk – ensure these proceed at pace and scale and that everyone is included within the work<br>• Good progress being made. Nothing was unknown to the Trust<br>• Feedback has been provided to individual services<br>• In the future, NHSE&I's focus will be on compliance documents and notes<br>• Important to celebrate successes and reflect on the positive<br><br>Jan Ditheridge confirmed for Olayinka Monisola Fadahunsi-Oluwole that agency and bank staff are incredibly valuable to the Trust. It is ensured that induction is provided and that these staff have the appropriate training and skills. The Committee and Board must have oversight of the balance of temporary and substantive staff through Safer Staffing as this is an area of risk. | |

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| | **Committee received the report. The Chair noted that it was important to receive the triangulation and that the Trust had a good level of oversight.** | |
| QAC22/02/261 | **Service User Engagement and Experience Strategy – Draft**<br>Committee received the report from Teresa Clayton for information. The draft strategy required the Committee's endorsement.<br><br>Richard Mills highlighted that a section on the Green Plan should be included within all strategies. There is also a need to present measurable and achievable targets with timescales against both strategies.<br><br>Brendan Stone noted:<br>• Good to see goals of embedding the voices of people with lived experience, and aspirations to diversify the number of experts-by-experience that the Trust collaborate with<br>• Important to take an intelligent and nuanced approach when considering what diversity is. This should not be tokenistic<br>• In this Trust, diversity would also include the range of diagnoses and experiences<br>• Reflecting deeply on why diversity matters is critical<br><br>Beverley Murphy noted:<br>• This strategy has been accomplished through a great deal of engagement and co-production<br>• It was important for the Trust to recognise that engaging in a way that makes a difference in communities has not been within its core skillset in the development of strategies such as this one, and therefore the Trust utilised the skills of Flourish<br>• The Trust should continue to work with the Third Sector<br><br>Teresa Clayton confirmed:<br>• The strategy will go to Confidential Board, feedback will be incorporated, and further development actioned. It will then return to Board for approval and an implementation plan established<br>• Actions and KPIs will be co-produced. The aim is to learn from the previous strategy in terms of setting out achievable actions<br><br>Maggie Sherlock questioned whether the patient safety element could be included in both strategies to ensure patient engagement with incident reviews.<br><br>Beverley Murphy noted the triangulation with the CQC. The CQC are now seeing Service User and Carer involvement in reviews of incidents.<br><br>**Committee received the report and endorsed the strategy. The Chair noted positive feedback from the Committee, including links to the strategic direction and co-production to date. The table of intended benefits are input related. If this was reversed to output related, then impact measures would be clear.** | |
| QAC22/02/262 | **Quality Strategy – Draft**<br>Committee received the report from Sue Barnitt for information. The report and strategy required the Committee's endorsement.<br><br>Highlights:<br>• This is a draft strategy for comment from the Committee<br>• There will be an implementation plan supporting the strategy. Approval is | |

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| | required regarding the high-level goals<br>• The strategy was co-produced with Service Users through the Service Users Engagement Group (SUSEG) and staff through various engagement events<br>• Staff were asked what quality looks like and what support is needed to help them to deliver good quality care<br><br>Brendan Stone told the Committee that Priority 1 relating to continuous improvement was key. It should also be articulated that co-production and people with lived experience are assets for continuous improvement.<br><br>Particularly regarding the previous item, the Service User Experience and Engagement Strategy, it would be useful to publish an Easy Read version of the strategy. Accessibility should be acknowledged.<br><br>Beverley Murphy added that this strategy has been worked on for many months. There is a concern that the strategy has lost its balance. It is about continuous improvement and quality management. The Quality Team and Quality Improvement have worked well together and with NHSE&I, utilising resources to move forward. However, the document does not emphasise enough that the key is around the quality of care that people receive.<br><br>**Committee received the report and endorsed the strategy. The Chair noted that there should be a front section detailing the overview of all activity, to emphasise the strategic focus on quality of care received. There is agreement and support from the Committee regarding the work being undertaken and of the general direction. There will be a slightly revised version to come, based on Beverley Murphy and Brendan Stone's comments. There is now good continuity of themes across strategies.** | |
| QAC22/02/263 | **Quality Related Policies**<br>**Policy Governance – Ratification of Decisions by PGG**<br>Committee received the report from Susan Rudd.<br><br>Susan Rudd reported that the following items had been through the governance process and the Committee were asked to ratify the recommendations:<br>• Seclusion and Segregation Policy NPCS 009<br>• Resuscitation Policy NPCS 007<br>• Clinical Risk Assessment and Management of Harm Policy NP 035 – Extension to Review Date<br>• Sexual Safety Policy CG 008 – Extension to Review Date<br><br>**Committee received the report and approved the recommendations.** | |
| QAC22/02/264 | **Board Assurance Framework – BAF 0024 Update**<br>Committee received the report from Susan Rudd for assurance.<br><br>It was requested at the January 2022 QAC meeting that this item be brought back to the Committee. Clarification was required as to why the risk rating had been reduced from 15 to 12.<br><br>Susan Rudd was satisfied that an extensive review had been carried out on BAF 0024.<br>• Controls have been added alongside internal and external assurances, and actions<br>• More work is needed to note progress against actions<br><br>The Chair noted that changes still need to be presented more clearly but that the | |

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| | progress to improve reporting was encouraging.<br><br>**Committee received the report and approved the recommendation. The Chair confirmed that the Committee were confident that this could now be reported to Board.** | |
| QAC22/02/265 | **Emerging Quality Risks**<br>Committee received the verbal report from Beverley Murphy for assurance.<br><br>• At the end of January 2022, a wheelchair was used to move a Service User from one environment to another. This is defined as a mechanical restraint under the Code of Practice. A Significant Event Audit (SEA) is underway to understand this. Standard Trust incident reporting processes will be applied. The CQC have been notified.<br><br>• The Trust moved a Service User on PICU, out of prolonged seclusion and into long-term segregation. This has provided the individual with a bedroom, bathroom, access to fresh air, and is reviewed under a different structure. There is a governance process in place. This will be reported in detail to the Mental Health Legislation Committee (MHLC).<br><br>**Committee received the report and confirmed assurance.** | |
| QAC22/02/266 | **Any Other Business**<br>None. | |
| QAC22/02/267 | **a) Annual Work Plan**<br>Committee received the Work Plan for information. Beverley Murphy will be collaborating with colleagues over the next couple of months regarding the rationalisation of the timing of reports and the delegation to Tier 2 Committees.<br><br>Jan Ditheridge told QAC that this approach should be carried across all Committees.<br><br>**b) Alert, Assure & Advise: Significant issues to report to the Board of Directors**<br>Alert:<br>• Supervision and mandatory training on the Acute Wards have been compromised by staffing gaps caused by Omicron. Mitigations are in place, but changes are necessary<br>• Concerns remain around waiting lists, demand, and caseloads in some areas, for example SPA, EWS, SAANs, and GDC<br>• Length of stay and flow issues remain, particularly at Endcliffe Ward<br>• CPA Annual Review completion needs addressing, especially in the South Recovery Team<br>• Physical Health strategy progress is not where we want it to be<br><br>Assure:<br>• G1 – quality of care has improved, and many actions are in place<br>• Serious Incident processes have significantly improved, and this has been externally validated (audit report)<br>• Research performance - good assurance received. Progress with objectives, and links with strategies and clinical effectiveness aspirations noted<br>• Health and Safety Report indicates strong leadership, a good grasp of issues, progress made, and risks are clearly identified | |

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| | • Community Service Transformation – assurance was received. This continues to progress with strong links to strategic priorities. There is a recognition that some challenges remain<br><br>Advise:<br><br>• Plan in place for Quality Improvement at Birch Avenue<br>• IPQR indicates areas of good performance, for example, inpatient length of stay for older adults and Forest Close, START Assessment waiting times, and reduced restrictive practice<br>• Quality Objectives have been fully articulated and are progressing<br>• Nursing Medication Administration improvement work - significant advancements made<br>• Clinical Service Reviews – outcome received, and cross cutting themes noted<br>• First draft of Service User Engagement and Experience Strategy received<br>• First draft of Quality Strategy received<br><br>**c) Changes in level of assurance - Board Assurance Framework**<br>BAF 0024 was discussed and agreed by the Committee.<br><br>**d) Meeting Effectiveness**<br>Comments were invited in the Chat Box. The Committee were asked to consider how the Trust's Values are modelled within the meeting conduct. | |

**Date and time of the next meeting: Wednesday 9 March 2022, 10am to 12:30pm**
**Format: MS Teams**
Apologies to Francesca O'Brine, Corporate Assurance Officer
Francesca.O'Brine@shsc.nhs.uk

ITEM 3a, 11-01-21
CONFIRMED

Sheffield Health and Social Care NHS Foundation Trust

# People Committee

**Minutes of the People Committee meeting held on Tuesday 11th January 2022, via teleconference**

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| **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:** | |
| 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:** | |
| Simon Barnitt | Head of Nursing for Rehab and Specialist Services (SBar) |
| Sarah Bawden | Deputy Director of People (SBaw) |
| Fleur Blakeman | NHSEI Intensive Support Director (FB) |
| Deborah Cundey | Interim Head of Performance (DC) (for item 5) (part) |
| Samantha Crosby | Health and Safety Manager (SC) (for item 4) |
| Karen Dickinson | Head of Workforce Development and Training (KD) |
| Liz Friend | Trust Governor (LF) observing the meeting |
| Sally Hockey | HR Business Partner (SHo) (for item 3bii) |
| Maria Jessop | HR Business Partner (MJ) (for item 7) |
| Liz Johnson | Head of Equality and Inclusion (LJ) |
| Philip Jonas | EDI Engagement Lead for Workforce Race Equality Standard (PJ) (observing and for item 1) |
| Pat Keeling | Director of Special Projects / Strategy (PK) |
| Victoria Racher | Workforce Systems Manager (VR) (for item 5) |
| Neil Robertson | Director of Clinical Operations and Transformation (NR) (part) |
| Charlotte Turnbull | Head of Leadership and OD (CT) observing the meeting |
| Amber Wild | Corporate Governance Manager (AW) supporting Susan Rudd |
| Helen Walsh | PA to Executive Director of People (HW) (minutes) |

## Welcome and Apologies

The Chair, Ms Heather Smith welcomed members to the meeting and introductions were provided for those observing the meeting – Liz Friend, Staff Governor, Charlotte Turnbull, Head of Leadership and OD and Philip Jonas, EDI Engagement Lead for Workforce Race and Equality Standard

Apologies were received from:
Beverley Murphy, Executive Director of Nursing, Professions & Operations (Neil Robertson attends Committee).
Emma Highfield, Head of Nursing for Older Adults and Acute Inpatient Services (attends Committee on rotation with Simon Barnitt).

The Chair invited colleagues on the call to take part in open discussion for each of the items presented, and contribute as freely as they wish to.

| Min Ref | Item | Action |
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| **1/01/22** | **Staff Voice**<br><br>The Chair welcomed Mr Philip Jonas, EDI Engagement Lead for Workforce Race and Equality Standard (WRES), to the meeting.<br><br>• Mr Jonas shared a staff story concerning experience of microaggressions that occurred in 2021 with the aim of promoting learning from the events that occurred but also to share good practice relating to the positive outcomes identified. The events happened to a senior clinician in our Trust who was happy for Mr Jonas to share her | |

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| | story anonymously.<br>• The Chair and Ms Parry thanked Mr Jonas for a powerful presentation that demonstrated how micro-aggressions can impact on someone's life. Mrs Dray observed that our newly approved Grievance Policy describes mediation as a positive option rather than escalating to a formal process and suggested that cases of this nature can actually influence our policies, whilst maintaining anonymity.<br>• Mr Mills observed that it would be an advantage if we could develop a culture where it was ok for staff to escalate their concerns direct to senior management. Mr Jonas agreed that staff should feel supported and have the confidence to do that.<br>• Ms Parry added that the People Directorate have and are able to produce data and share learning about informal cases and on a formal level there are a number of different routes where staff can report their concerns. All of our People Directorate policies are underpinned by a Just and Learning culture which encourages staff to speak up before it gets to a formal stage which can take a while to resolved and is often stressful for all parties. This is an approach that we continue to work on.<br>• Ms Johnson thanked Mr Jonas for presenting the item and added that one of the aims of Mr Jonas' role as EDI Engagement Lead for WRES is to understand how we can engage better – good progress is being made, linking in with HR Business Partners and Advisers. Ms Johnson added that the Chairs of the Staff Network Group have received training from the Freedom to Speak Up Guardian which will be beneficial for them to be able to signpost staff to the most appropriate support available.<br>• The Chair summarised that there are a number of ongoing pieces of work, including leadership training, that fall under the 'allyship workstream' which is being developed, but it is clear that there is more work to do. | |
| **2/01/22** | **Declaration of interests**<br><br>No declarations of interest were made. | |
| **3a/01/22** | **Minutes of the meeting held on 9th November 2021**<br><br>The minutes of the meeting held on 9th November 2021 were agreed as an accurate record, subject to a typo on page 7.<br><br>POST MEETING NOTE: typo now corrected. | |
| **3b/01/22** | **Matters arising / Action Log**<br><br>The Chair confirmed that all actions contained in the minutes are recorded in the Action Log. The three actions below were brought forward -<br><br>**i. Assurances re external contracts**<br><br>It was agreed that the following be transferred to the Audit Committee, as the most appropriate forum to action the query –<br><br>**ACTION BFWD FOR AUDIT COMMITTEE – To determine what would be the most appropriate forum to receive assurances on Trust-wide external contracts such as maintenance contracts, Occupational Health and Payroll.** | AD |
| | **ii. BAF RISK – OD, Leadership and Talent**<br><br>At the meeting in November, SBaw confirmed that the risk rating for OD, Leadership and Talent 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.<br><br>**ACTION Bfwd – SBaw to provide an update for the action log.** | SBaw |

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| | **iii. Independent Inquiry affecting healthcare settings**<br><br>**ACTION Bfwd – SBaw to contact Susan Rudd, Interim Director of Corporate Governance to check which of our Trust policies will need reviewing / amending to add / reinforce wording relating to third parties who work on Trust premises.** | SBaw<br>SR |
| | **iv. Annual Equality and Human Rights Report**<br><br>**ACTION Bfwd – Mr Robertson and Ms Johnson to contact Salli Midgley to add the Annual Equality and Human Rights Report to the Quality Committee agenda.** | NR<br>LJ |
| | A briefing paper on each of the following matters arising, relating to audit reports, were received by Committee. | |
| | **v. Audit – Quality of Personal Development Reviews update**<br><br>Ms Dickinson provided a briefing report and the following was noted.<br><br>An action plan is being developed to respond to all nine actions identified in the PDR Audit Report. This will include reviewing the PDR form and policy wording; reporting and compliance processes; improving quality of PDRs; and mandatory training for all PDR reviewers. | |
| | **vi. Audit – Staff Engagement update**<br><br>Mrs Hockey provided a briefing report update and the following was noted.<br><br>The Staff Engagement Audit from April 2021 along with Staff Survey key themes and trends has been used to consider our position. The Audit opinion outcome – "Limited assurance" was noted.<br><br>Next steps –<br>• Assess the impact and value of the staff engagement and experience framework implemented early into 2021.<br>• Review of how feedback from staff has been coordinated; the value and impact of this and a future proposal to be agreed for 2022 calendar year where change identified.<br>• Assess mechanisms for staff engagement in 2022, using the feedback from the last audit in this evaluation to ensure effective central oversight and appraisal. | |
| | **vii. Staff Survey 2021 briefing**<br><br>Mrs Hockey provided a briefing report and the following was noted.<br>• 1290 responses from 2488 staff.<br>• 52% participation rate increase of 11% from 2020 survey – team effort to engage people, strong participation from corporate teams, more work and consideration to be centred on acute wards and community teams in readiness for 2022 Survey.<br>• In comparison to other MH Trusts overall response rates sits 5 points above the average (52% v 47%).<br>• High level results received 10th December 2021.<br>• Report currently embargoed will go to Board January 2022.<br><br><u>Feedback from leavers questionnaires</u><br><br>Mr Mills requested analysis of the rich feedback from leavers described in the briefing report. SBaw responded that, since the launch of the new process and leavers questionnaire, we | |

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| | have received 66 completed questionnaires which is a vast improvement to what we had before. By May 2020 we should have a good body of data to enable analysis as part of a report on retention (also requested by Committee).<br><br>**ACTION – Mrs Bawden and Mrs Hockey to provide feedback and analysis from leavers questionnaires for the <u>May meeting</u> as part of the timetabled report to Committee from the Recruitment and Retention Group.** | SBaw<br>SH |
| | **Involvement of Committees in monitoring Audit Reports**<br><br>Following a query from the Chair, Mrs Dray confirmed that Internal Audit (360 Assurance) work closely with the Responsible Officers for each Audit Report to update the actions relating to the Auditors recommendations; and a quarterly report is provided to Audit Committee on all Trust Audits.<br><br>**ACTION – The Chair and Mrs Dray to discuss how People Committee and other Committees can assist in the monitoring of Audit Reports to ensure that recommendations are actioned and followed up within the timescales outlined.** | HS<br>AD |
| **Health and Safety** | | |
| **4/01/22** | Ms Crosby, Health and Safety Manager presented this item and the following was noted.<br><br>Committee acknowledged receipt of the Health and Safety Report Quarter 2 which seeks to demonstrates the current position of health and safety compliance within our Trust, including a clear action plan to support progression of health and safety (including fire) management arrangements, activities, and performance for the period 1st July 2021 to 30th September 2021, within premises owned by our Trust.<br><br>Committee noted the following significant areas of concern:<br>• Lack of embedded monitoring and review systems within the health and safety team<br>• Lack of clear process in relation to RIDDOR reporting<br>• Lack of clarity and process regarding the identification and maintenance of identified fire doors within SHSC premises<br>• Lack of provision of statistical data from Ulysses.<br><br>Committee were assured that actions have been completed and 4 new actions identified:<br>• Final statement of intent to be presented to the Quality Assurance Committee and then implemented<br>• Health and safety manager to lead a task and finish group in relation to standardising mattress and evacuation aids (including personal including personal emergency evacuation plans) provision within SHSC services<br>• A report to be submitted to the Health and Safety Committee relating to identifying the gaps within the current RIDDOR process and actions to address them<br>• Request to be made to receive a monthly report regarding open risks, on the risk register, related to health and safety topics, that can then be provided to the Health and Safety Committee.<br><br>Committee were made aware of the following work to be undertaken in Q3:<br>• Violence prevention and reduction standard framework action plan to be devised and presented to Health and Safety Committee | |

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| | • RIDDOR process action plan to be devised and presented to Health and Safety Committee<br><br>• Development of health and safety KPI's<br><br>Mr Mills queried the BAF risk 4615 relating to the RIDDOR process and procedures – high risk 16. It was noted that this appears on the Quality Committee Risk Register but not the People Committee Risk Register. It was suggested that some of the issues are cultural with regards to health and safety and therefore should be on the PC RR as well.<br>Ms Crosby explained that since the report was written significant work has taken place which will be reported to Quality Committee by the end of Quarter 3. In the meantime Ms Crosby and Mrs Bawden are working together on this issue.<br>Ms Crosby explained that the new action plan would be presented to People Committee in due course. Likely July 2022 – Quarter 4.<br><br>Mrs Dray reported that she feels much more assured where the issues and concerns are with health and safety and how they are being addressed, which is an improvement on previous reports but raised a general point about future reports highlighting which element is being monitored by which Committee.<br><br>Ms Parry thanked Ms Crosby for the report which helpfully triangulates Trust-wide projects. A lot of progress has been made but it is clear that there is more to do.<br>Ms Parry added that she is aware that Ms Crosby is linked in with the work of the Staff Health and Wellbeing Group particularly around 'violence and aggression towards staff' and highlighted that work is continuing in relation to achieving consistent support for staff.<br>Ms Parry continued adding that the 'statement of intent' is really important and is a reminder to our leaders of their responsibilities in health and safety and creating a safe culture. Ms Parry suggested that there may be an opportunity at one of the Leaders Calls to present an interactive session to remind our leaders about their responsibilities for health and safety.<br><br>The Chair thanked Ms Crosby for doing an excellent job in improving the quality of health and safety reports which enables our Trust-wide Committees to enact assurance on what the issues are and the progress being made. | |
| **Performance Monitoring** | | |
| **5/01/22** | Ms Racher and Mrs Cundey attended the meeting for these items and the following was noted.<br><br>**a. Integrated Performance and Quality Report**<br><br>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.<br><br>The Chair highlighted that there are some positive improvements to report with regards to some waiting times, some inpatient length of stay, management of incident reviews and decreasing use of restrictive practice in a number of areas. However, there are some KPIs that are indicating slow improvement such as our Supervision stats.<br><br>Following discussion it was agreed that Ms Cundey escalate to Board, via the IPQR, the following data subjects – turnover, retention, sickness. Committee would also like to see FTE/Vacancies vs Bank/Agency (safer staffing), Covid absences in a future iteration of the report. Ms Parry added that she has also requested that Ms Cundey and Ms Racher reconcile the IPQR and Dashboard to avoid duplication and to include, in a future report, data on OD and culture and our Staff Survey results.<br><br>**ACTION – Ms Cundey to escalate to Board, via the IPQR, the following data subjects – turnover, retention, sickness.**<br><br>**ACTION – Ms Cundey and Ms Racher to reconcile the IPQR and Dashboard to avoid duplication, and to note for inclusion in a future report – data on OD and culture and data on our Staff Survey results, FTE/Vacancies vs Bank/Agency (safer staffing) and Covid absences.** | DC<br><br>DC, VR |

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| | **b. Performance KPIs**<br><br>Committee acknowledged receipt of the report.<br>Ms Racher presented this item and the following was noted.<br><br>• The turnover rate remains high but is benchmarking well against peer Trusts.<br>• The vacancy rate has increased since November, however, from April 2021 there have been more new starters than leavers.<br>• The sickness absence rate has increased since November and continues to climb. The HR Team are provided with relevant data to enable appropriate conversations with managers and provide as much support as possible.<br>• Mr Robertson added that he is pleased with the increase of registered Nurse inpatient staffing compared to the position approximately 4 months ago. However, there are a number of vacancies for Support Workers that remain unfilled which can be attributed to movements from Community Teams but does not present safe staffing concerns. Mr Robertson said he was surprised to note the rate of sickness in November adding that staffing levels were more affected in December, predominantly due to Covid. The Chair was pleased to note that Nurse staffing numbers are improving and said she would report this back to Board.<br>• Mr Mills requested that Covid absence figures are shown separately to other absence figures, and to also include diverse groups. Ms Cundey and Ms Racher agreed to include this in the next report.<br><br>**ACTION – Ms Cundey and Ms Racher to separate out the Covid absence figures from other absence and to also include data for diverse groups.**<br><br>**c. Staff vaccinations**<br><br>Committee acknowledge receipt of the report which seeks to provide a progress in delivering on the Flu and Covid-19 booster vaccination campaigns. The paper also seeks to provide data on those vaccinated benchmarked against last year's performance, current regional benchmarking, a breakdown of data in relation to service uptake, and flu data relating to diverse groups and age. Mr Robertson presented this item and the following was noted.<br><br>New Government legislation – Vaccination as a Condition of Deployment (VCOD) states that, by 3rd February 2022 all NHS staff who are in scope (i.e. they work in a patient-facing role or in an area where they may come into contact with patients) must have received at least one Covid vaccination, and in order to remain employed by the NHS must have received two doses of the Vaccination by 1st April 2022. The same legislation applies to other healthcare settings.<br><br>Mr Robertson reported that the data for our Trust indicates just under 80% of staff have received their Covid booster vaccination and just over 73% have received their flu vaccination. Following a query from Ms Johnson, Mr Robertson responded that the figures include Bank staff as well as substantive staff. Mr Robertson said he would provide an update on vaccinations for substantive staff, Bank staff and diverse groups at the next meeting in March as well as a further update on our VCOD data. Ms Johnson reported that she would share the national Equality Impact Assessment document that describes which protected groups are affected by the latest legislation regarding COVID vaccinations.<br><br>Mr Robertson added that we now have flexible approaches to how the vaccines are delivered in order to increase take-up. The rate of take-up from diverse groups remains a concern. Work continues to address vaccine hesitancy particularly in diverse groups. Extensive ways of engaging with staff to allay vaccine hesitancy are being put into place – such as workshops led by our Chief Pharmacist. Covid vaccinations (1st, 2nd and booster) for staff will continue to be delivered by our Trust until 31st March 2022 to enable our Trust to respond and administer boosters and Covid vaccinations to any member of staff who hasn't yet received two doses as the deadline approaches.<br>Following a query from Mr Mills, Mr Robertson responded that he will include data | DC, VR |

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| | relating to Covid vaccination uptake for frontline diverse groups for the next report in March. Ms Parry added that guidance on Covid vaccination legislation is expected to be received 14th January 2022. We will remain consistent with other Trusts as outlined by the ICS. FB added that our Board need to be aware of the implications for our unvaccinated patient-facing staff and that affected staff won't receive entitlement to redundancy payments.<br><br>Following a query from the Chair, Mr Robertson confirmed that work has been done to establish which of our staff are in scope / in patient-facing roles/areas. There are 42 staff who are in scope and have confirmed they are refusing vaccinations. There are 50 staff who are in scope who have yet to declare their vaccination status and we are working hard to address this.<br><br>The Chair thanked Mr Robertson and colleagues for a comprehensive report, and robust plan, on such a challenging and sensitive subject.<br><br>**ACTION – Mr Robertson to provide an update on vaccinations for substantive staff, Bank staff and diverse groups at the next meeting in March, as well as a further update on our VCOD position.**<br>[post-meeting note: verbal update sufficient, due to change in government advice]<br><br>**ACTION – Ms Johnson to share the national Equality Impact Assessment document that describes which protected groups are affected by the latest legislation regarding COVID vaccinations (VCOD).** [post-meeting note: no longer relevant due to change in government advice] | NR<br><br>LJ |
| **People Strategy theme: Health and Wellbeing** | | |
| | **Report from the Staff Health and Wellbeing Group**<br><br>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 May, Sept and January if agreed with the Chair. | |
| **People Strategy theme: Recruitment and Retention** | | |
| **6/01/22** | **Report from the Recruitment and Retention Group**<br><br>Mrs Bawden presented this item and the following was noted.<br><br>Committee acknowledged receipt of the report which seeks to provide assurance on the work being undertaken to address the recruitment and retention challenge across all staff groups. Recruitment and retention actions are in review including strategic intentions for recruitment supported by ICS retention activity. International recruitment is agreed and in progress.<br><br>The report that was provided to Committee in November 2021 outlined the known impact of actions already taken and progress made against the deliverables and areas of focus, challenges, and achievements to support the Trust with our recruitment and retention activity. This latest report summarises progress and actions specifically focussed on improving our ability to attract and retain high quality staff in all our professions, but in particular Nursing and Health Care support. At this time recruitment activity is buoyant (over 350 Active recruitments in progress). The report builds on the planned actions from the Nursing recruitment and workforce development plans submitted in September 2021.<br><br>Moving forward we intend to report on Attraction and Retention activity applicable to all professions and identify milestones and actions by our professions under the headings: *Medical, Nursing HCSW (Additional Clinical) Psychology and AHP Corporate (including IT, Finance, People, Communications, Estates and Facilities, Quality, Corporate Governance, R&D).* This should allow greater line of sight on the specific actions and challenges for each grouping of staff. | |

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| | Mr Mills requested a focus on retention to be included in the next report in May, and in terms of international recruitment asked where we are recruiting from and what support will be offered to internationally recruited staff? Mrs Bawden agreed to respond to the latter point via a Matters Arising briefing for the March meeting.<br><br>Mrs Dray asked about the zero percentage target. Mrs Bawden explained that a realistic target needs to be set (based on Model Hospital benchmarking) and that the zero percentage, which has been set nationally only relates to healthcare support workers.<br><br>Ms Parry reported that she is pleased to see that our efforts are achieving positive results and added that there is cross-over between this work and that of the Inclusion and Equality Group particularly in terms of targets that will support the Workforce Race Equality Standard objectives and actions. Ms Parry suggested that this is outlined in the May report.<br><br>The Chair was pleased to note that our interventions appear to be making an impact and requested more detail on impact measures in the next report in May. The Chair was also pleased to see an example of the engagement groups feeding into the assurance groups in order to influence the strategic direction. This is particularly evident with regards to current issues with Medics feeling overwhelmed with workload, which the Chair asked for an update on next time.<br><br>**ACTION – for a Matters Arising briefing in March – Mrs Bawden to outline our international recruitment plan (where recruiting from and what support will be offered).**<br><br>**ACTION – for the next R&R Group report in May – Mrs Bawden to: describe the impact measures, set a target for recruitment numbers, focus on retention (including Medics) as well as international recruitment and to also describe how our work on recruitment links in with the targets, objectives and actions set by the Workforce Race Equality Standard.**<br><br><u>Additional hours to cover nurse vacancies</u><br><br>Following a query raised by Mrs Dray at a previous meeting relating to safer staffing and ensuring that our Trust aren't outliers in terms of the number of shifts not covered by substantive staff, Committee acknowledged receipt of the report that describes our temporary staffing utilisation. Mr Robertson thanked the Workforce Information Team for providing the data.<br><br>The reported provided a number of charts to demonstrate the following –<br><br>- the number of Registered Nurse shifts that have been fulfilled by our substantive staff and the temporary staffing utilised on a monthly basis.<br><br>- the WTE of the Registered Nurse staff utilisation per month.<br><br>- the number of Healthcare Assistant shifts that have been fulfilled by our substantive staff and the temporary staffing utilised on a monthly basis.<br><br>- the whole time equivalent of the Healthcare Assistant staff utilisation per month.<br><br>Mrs Bawden stated that she would like a future iteration of the report to include the data alongside vacancies. Mr Robertson also explained that he would like to provide next time, the overtime component of the data in order to provide a complete picture of where additional hours are needed to cover nurse vacancies.<br><br>**ACTION – Mr Robertson and Workforce Information Team to provide the following as part of the Recruitment and Retention report <u>in May</u>: shifts covered by Bank/Agency, shifts covered by overtime, percentage of shifts for qualified and non-qualified – alongside vacancies.** | SBaw<br><br>SBaw<br><br>NR<br>VR |

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| | ***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.***<br>Mrs Bawden stated that our residual risk is currently at 16 and added that we are less likely (rather than likely) to be unable to recruit to our vacancies given the initiatives we have and are putting in place, so this would place the rating at 12. Our target rating is 6. Initiatives we have put in place since September 2021 are having a positive impact. The Chair agreed to formalise any change to the BAF Risk later in the agenda – item 12. | |
| **People Strategy theme: OD, Leadership and Talent** | | |
| | Following reorganisation of the Organisational Development Team, and appointment of Charlotte Turnbull, Head of Leadership and OD, 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 May, September, January 2023 if agreed with the Chair. | |
| **7/01/22** | **Just and Learning Culture Report**<br>Committee acknowledged receipt of the report, produced by Maria Jessop, HR Business Partner, working closely with the EDI Team looking at data relating to ethnically diverse staff.<br>Following a query from Mrs Dray about how we are measuring progress Mrs Bawden agreed to quantify how the new process has improved things and present to Committee in July 2022 as part of the report from the OD Group. The Chair requested that this includes any barriers / risks preventing cases from progressing.<br>Following a query from Mr Mills, Ms Parry confirmed that Staff Side colleagues receive an update on casework at our Joint Consultative Forum meetings and Staff Side work with People Directorate colleagues to establish and work through with managers any blockers that may be preventing cases from completing. The Executive Team are also sighted on our casework tracker. Ms Parry added that any points of significance from JCF meetings are verbally provided at each meeting of People Committee. Staff Side are also closely involved in policy development.<br>Mrs Bawden highlighted that the addendum provided to Committee (produced by Phil Jonas) describes that the number of new cases impacting on ethnically diverse staff has started to decrease. We would assume from this that the check-point process that was introduced is having an impact but would like to monitor this over a longer period of time and report back to Committee as suggested. Likely July.<br>The Chair summarised that she is pleased to note that the average case length is reducing and thanked colleagues for their hard work in achieving this.<br>**ACTION – As part of the July report from the OD Group, Mrs Bawden agreed to quantify how the new casework tracker process is having an impact and include any barriers / risks that may be preventing cases from progressing.** | SBaw |
| | It was noted that the item 'Pulse Survey – analysis and comparators with the Staff Survey results' has been deferred to the March 2022 agenda along with a full Staff Survey update. | |
| **Break** | | |
| | Committee members observed a 10 minute break. | |
| **People Strategy theme: Inclusion and Equality** | | |
| **8/01/22** | **Report from the Inclusion and Equality**<br>Ms Johnson presented this item. 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 that Committee are assured of progress against our Equality Objectives and Priorities. Key priorities (aligned with the terms of reference) are: | |

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| | • Ensure a strategic approach to Equality, Diversity and Inclusion and ensure that action plans are developed, implemented, reviewed, and revised.<br>• Receive updates and briefings on new and emerging policy and legislation in order to inform an early and strategic response.<br>• Oversee responses to relevant requirements set out in the NHS Standard Contract and oversee provision of reports and information for the use of other groups and committees.<br>• Ensure that equality, diversity, and inclusion is an integral part of the Trust's agenda and is actively promoted and communicated both for the workforce and to promote equality and inclusion for people who use our services.<br>• Support action planning, partnership working and engagement in working to reduce health inequalities for groups protected by equalities legislation.<br>• Ensure the effective performance management of the Equalities and Inclusion agenda through overseeing monitoring of progress against agreed targets and actions.<br>• Ensure that active management of progress is undertaken (using a wide range of indicators) and benchmarking against past and current position and against performance of similar organisations.<br>• Promote our values and intentions around inclusion and equality and ensure that achievements are communicated to all stakeholders internally and externally.<br>• Establish and receive progress reports from task and finish groups established by the Group.<br><br>Following a query from Mrs Dray, Ms Johnson responded that she intends to produce a Gannt Chart excel workbook, as part of the next update in May, that will seek to triangulate our EDI projects with all of our Assurance Groups and outline progress / impact. For example there is a Recruitment and Retention Action Plan and a Disparity Ratio Action Plan which are both reporting through the Recruitment and Retention Group rather than the Inclusion and Equality Group.<br><br>Following a further query from Mrs Dray, Ms Johnson confirmed that the recruitment of overseas nurses is also being reported via the Recruitment and Retention Group. Ms Johnson and Phil Jonas, EDI Engagement Lead for Workforce Race and Equality Standard (WRES) are both members of the R&R Group.<br><br>Ms Parry thanked Ms Johnson for the enormous amount of work put into the report and for progressing the Inclusion and Equality Group in such a short space of time and for ensuring that EDI is on the agenda at meetings Trust-wide. It is clear that staff are more engaged with EDI topics and feel more empowered to discuss in teams and help us reach our targets. Ms Parry also reported that an action from the Workforce Planning and Transformation Group this morning is for Andy Algar to present the learning from the positive experiences of our international students to the Recruitment and Retention Group.<br><br>The Chair was pleased to note that the EDI Team has developed and colleagues are taking forward a number of important initiatives and asked for identification of key impact measures in order to assure Committee that our interventions are working. Ms Johnson agreed with this approach and added that she intends to provide some benchmarking data using the Model Hospital and other Trusts as comparators.<br><br>**ACTION – As part of the May report from the Inclusion and Equality Group, Ms Johnson agreed to produce a Gannt Chart to triangulate all areas of EDI, identify key impact measures and provide benchmarking data using the Model Hospital and other Trusts as comparators.** | LJ |

***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.***

The Chair agreed to note any changes to our associated risks in this area, later on in the agenda.

**People Strategy theme: Workforce Transformation**

**09/01/22** **Report from the Workforce Planning and Transformation Group**

Ms Dickinson presented this item. Committee acknowledged receipt of the report which seeks to highlight key topics identified at the Workforce Planning and Transformation Group (Apprenticeships and Nursing placement capacity) and also provides updates on previous actions: new role evaluation, centralised training budget and workforce planning.
It was also important to note the links with other projects and Assurance Groups such as the Recruitment and Retention Group.

We have 79 current staff on apprenticeship pathways from level 2 to level 7 and across a range of clinical and non-clinical roles. The use of apprenticeships continues to expand and supports our recruitment and retention objectives.

We benchmark favourably with other Trusts across SYB ICS @ 2.03% for the national apprenticeship public sector target of 2.3%. We are on an upwards trajectory for apprenticeship levy spend and year on year are using more of the accumulated levy.
There are some current issues regarding the capacity of the procurement team to support contractual requirements for apprenticeships. There is an ongoing risk (4748) that accumulated levy will be lost unless numbers of apprenticeships are further expanded.
The Head of Procurement is taking action to secure additional resources. Following a query from Mrs Dray, Ms Dickinson confirmed that unfortunately we are not able to utilise any of the levy for infrastructure to support our apprentices.

Development of further apprenticeship opportunities is aligned to our service and workforce plans for example: the recent expansion into OT degree apprenticeship route; agreement of the support worker career progression pathway; and links with the DWP Restart programme for entry level roles.

There are ongoing challenges in placement capacity across the healthcare system and our main training provider Sheffield Hallam University will shortly be providing further detail of what placements they need from us to ensure students can qualify in September 2022. We have been able to meet all placement requests for the 1st and 2nd years starting in January and February 2022. Pressure on learning environments is high with competing demands from multiple learners (students, new roles and apprenticeships) combined with staff turnover, Covid pressures, and CQC improvement work.

At the time of writing the report have been unable to increase capacity over the last 3 months and receive frequent requests from clinical teams to reduce the number of students (risk 4409). However, two of our inpatient areas are now in a position to begin rebuilding their capacity to pre-Covid levels. Since writing the report there is an improvement in the deficit. We plan to offer final placements in teams where students have secured employment. This will be popular, and many teams will take these students above their normal numbers. We now have access to Practice Supervisor training through ESR, this has significantly increased the number of supervisors available to our students. Thirty staff will also have completed the STH Practice Assessor course by the end of the financial year.

In collaboration with SWYFT and SHU we have been successful in securing funding of £100k for the Clinical Placements Expansion Programme (CPEP) to develop multi-professional technology enhanced placements in community teams.

Following a query from Ms Blakeman about support our younger population into the wider workforce, Ms Dickinson confirmed that we have OT apprenticeships and our support worker apprenticeships are very much a pipeline into other clinical roles not just nursing.

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| | Ms Johnson added that we have a Work Experience (Widening Participation) Policy that Covers many aspects of deploying a younger workforce.<br><br>The Chair was pleased to note the improved position with apprenticeships and nursing placement capacity. The Chair requested that the next report shows EDI data and how all of the initiatives fit into an overall plan for workforce transformation with actions, timescales and progress in order for Committee to enact assurance.<br><br>**ACTION – As part of the May report from the Workforce Planning and Transformation Group, Ms Dickinson agreed to provide EDI data relating to apprenticeships, support workers / new roles and also how all of the initiatives fit into an overall plan for workforce transformation - with actions, timescales and progress.** | KD |

***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).***

The Chair agreed to note any changes to our associated risks in this area, later on in the agenda.

| **Governance** | | |
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| **10/01/22** | **Joint Consultative Forum verbal briefing**<br><br>Ms Parry provided the following highlights from the last meeting of JCF that took place on 15th December 2021 –<br>• The main topic for the 15th December meeting was a focussed session about the Community Mental Health Teams Transformation Programme (this work has been ongoing since the reconfiguration of CMHT services in 2017).<br>• Since 2017 significant concerns have been raised by staff and Staff Side about the process and Unions invoked a collective dispute procedure. ACAS were then engaged to work through the issues with both parties which avoided a ballot for strike action. A programme of work was put in place alongside a Memorandum of Understanding and a Programme Board was set up. Since then a number of issues have surfaced which needed to be addressed as quickly as possible.<br>• Staff Side and Management Side provided separate presentations followed by a one hour discussion. Staff Side stewards and service managers attended the meeting.<br>• Following discussion, it was agreed to provide a summary and next steps to the CMHT Programme Board meeting the following day, chaired by Beverley Murphy and Susan Highton.<br>• We have a shared commitment to address the issues raised and take forward the recommendations.<br><br>Following a query from Mr Mills about learning from the process, Ms Parry responded that part of the work that has taken place since 2017 is a refresh of our Organisational Change Policy in partnership with Staff Side and JCF also now receive notification of any change processes at an early stage, for verbal 'sign-off' from Staff Side that they can progress to the next stage. Ms Parry agreed that a summary of the learning points would be beneficial to share with Committee at a later date via the OD Group Report.<br><br>**ACTION – To note for a future agenda, as part of the OD Group Report – a summary of the learning points from the Community Mental Health Teams Transformation Programme 2017 to date. Likely July.** | CP, CT |
| **11/01/22** | **People Directorate Policies**<br><br>Susan Rudd, Interim Director of Corporate Governance and Ms Wild, Corporate Governance Manager presented this item and the following was noted.<br><br>**Assurance document from Policy Governance Group**<br><br>The Policy Governance Group met on 29th November 2021 and 20th December 2021, and the following recommendations were made to Committee - | |

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| | **a. People Directorate Policies for ratification**<br>Committee members ratified the following policies, as approved by the Policy Governance Group –<br>Employment and Deployment for Short-term Cover Policy<br>Retirement Policy<br>Stress Management Policy<br>Grievance Policy – interim review | |
| | **b. People Directorate Policies – extension requests for ratification**<br>Committee members ratified the following extension request as approved by the Policy Governance Group –<br>Work Experience (Widening Participation) Policy – Extension | |
| | **c. People Directorate Policies status**<br>Committee members were asked to note, for information, the People Directorate policies due to expire **in quarter 4**, as identified in the Master Policies Register.<br><br>Mrs Dray asked what the process is for staff who are already part of a grievance process when a new version of the policy is issued. Ms Parry and Mrs Bawden responded that the People Directorate Advisory Team would always encourage and support dialogue with individuals concerned in order to take the best course of action. However, it was noted that changes to the Grievance Policy, in particular, concentrate on seeking a resolution before cases reach formal process stage.<br><br>Following an observation from the Chair, it was noted that test 5, rather than focussing on whether or not each policy has a negative impact on health and wellbeing, should also establish if there is a positive impact on health and wellbeing. Mrs Rudd agreed to take this suggestion back to the Policy Governance Group.<br><br>**ACTION – Ms Rudd to suggest to Policy Governance Group that test 5 also focusses on whether or not each policy provides a positive impact on health and wellbeing.** | SR |
| **12/01/22** | **Board Assurance Framework and Corporate Risk Register**<br><u>Board Assurance Framework</u><br><br>Ms Rudd reported that there are four Board Assurance Framework Risks assigned to People Committee. It was confirmed that at the time of writing the report there were no recommendations to amend the risk ratings of the four entries. However, during the course of this meeting the following recommendations were made –<br>• 0014 Retention of staff – currently scored at 16 – recommended to reduce to 12. Ms Parry recognised the significant amount of work ongoing in this area but was keen for the rating to remain at 16 for now until we can be more certain of the impact our initiatives are having on retention. Mr Mills agreed with this approach and added that he would like to see evidence of a sustainable positive impact before reducing the risk rating. To revisit in May 2022.<br>• 0013 Health and Wellbeing Audit – Ms Rudd stated that she is aware of work ongoing with Internal Audit with regards to health and wellbeing for shift workers but she isn't certain if this is linked to the Health and Wellbeing Audit. This is an example of where we need to improve our assurances. Ms Blakeman concurred adding that she would like to more dynamic narrative in the BAF. Ms Wild confirmed that Risk Management Training is planned for the People Directorate Senior Management Team which will focus on controls in order to enact assurance from Committee. | |

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| | • Mrs Dray asked a general question about how the risk ratings are graded and suggested that it is made clear what type of actions would need to be put in place to shift a rating from a 16 to an 8 for example. Mrs Dray also asked that any amendments to the Board Assurance Framework are highlighted in red typeface to make it clear what has changed since the last report. Ms Rudd agreed that she would explore if Ulysses will allow the typeface to be coded but, if not, suggested instead that the cover sheet clearly outline what the changes are.<br><br><u>Corporate Risk Register</u><br><br>Ms Rudd confirmed that the Risks have been updated by Risk Owners but there are no recommendations to change any of the risk scores.<br><br>**ACTION – Ms Rudd to explore if Ulysses will allow the typeface to be coded on both the BAF and CRR and, if not, ensure that the cover sheets clearly outline what the changes are.**<br><br>**ACTION – Ms Rudd to also confirm what type of actions would need to be put in place to shift a rating from a 16 to an 8 for example.** | SR<br><br>SR |
| **13/01/22** | **Confirmation of Significant Issues to report to our Board of Directors**<br><br>Committee members noted the following significant issues to report to Board.<br><br>**TO ALERT** (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)<br><br>• 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. Committee requested sickness data to be presented as COVID and non-COVID.<br>• Covid vaccinations – There remains a number of patient-facing staff who have declined the Covid vaccination (42) and a number of patient-facing staff who haven't yet declared their Covid vaccination status (50). Some services are particularly at risk e.g. Maple Ward. Committee is assured that colleagues are working to improve the position. Colleagues are working with staff and line managers in a number of ways to encourage patient-facing staff to take-up the Covid vaccination.<br>An update is to be provided at the March meeting.<br><br>**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)<br><br>• Data quality has improved which is encouraging. Supervision data is now more accurate and continues to improve. Monitored monthly via the IPQR Data received at Committee each meeting (bi-monthly). Vacancy rate data is now more accurate.<br>• Nursing vacancy position improving. The number of nurses is increasing steadily. The Recruitment Report describes a positive position for our nursing figures. Committee will continue to receive an up-to-date position regarding our nurses.<br>• There is a plan in place for work on violence and aggression against staff. The Health and Safety manager is taking the lead on this matter. Fuller assurance to be received in terms of data when the next H&S report is received at July Committee.<br>• 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. Next full report due to Committee in May, to include Gannt Chart and impact measures.<br>• The Workforce Planning Transformation Group Report advised and Committee were assured that a forward plan / trajectories for workforce planning is being developed. Next report to Committee in May. Positive news re apprenticeships and fulfilling our nursing placement capacity.<br>• BAF and CRR. 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 may review this rating again at the March meeting, although the next R&R Group report isn't expected until May. | |

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| | • 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.<br><br>**ASSURE** (areas of assurance that Committee has received)<br><br>• 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 May.<br>• Average casework length is decreasing and the number of ethnically diverse staff involved in formal cases is decreasing. Assured via the casework data received as part of the Just and Learning Report.<br>• 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. | |
| **14/01/22** | **For information**<br><br>a. Agenda items for 8th March 2022<br><br>**Key agenda items for the March 2022 meeting of Committee**<br><br>Committee received the Work Programme / Annual Planner for information.<br><br>Anyone who is unable to meet the deadline for papers should let the Chair know in advance.<br><br>b. Review of the Terms of reference<br><br>The Chair indicated that she would follow this up outside of the meeting with Ms Wild, particularly in respect of a change to Committee membership.<br><br>**ACTION – The Chair to liaise with Ms Wild regarding amendment of the membership of People Committee in the terms of reference.** | HS, AW |
| **Any other Business** | | |
| **15/01/22** | **To note any other business within the scope of the Committee's Terms of Reference** | |
| | Mrs Dray observed that some of the summary reports that are submitted to Committees don't contain an actual summary of the key points. The Chair and Mr Mills concurred with this stating that although the quality of report writing had improved hugely there was a need to fine tune the summary reports. Streamlining the key points will help Non-Executive Directors, and other colleagues, to review each paper, especially given that a number of Committees take place in the same week or same two weeks each month.<br><br>No further business was noted. | |
| **16/01/22** | **Evaluation** | |
| | **Determine meeting effectiveness**<br><br>Committee members reflected positively on the meeting by indicating a score out of 10 in the MS Teams Chat. | |

HS CHECKED 01-03-22

CONFIRMED xx-xx-22

**Date and time of next meeting:**

**Tuesday 8th March 2022, 2:00pm – 4:30pm, via teleconference**

*Apologies to: Helen Walsh, EA to Executive Director of People*

Helen.Walsh@shsc.nhs.uk

Sheffield Health and Social Care NHS Foundation Trust

# Mental Health Legislation Committee (MHLC)

**CONFIRMED** Minutes of the Mental Health Legislation Committee held on 15 December 2021 at 11:30am. Members accessed via Microsoft Teams Meeting.

**Present:** (Members)
Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director
Dr Mike Hunter, Executive Medical Director
Sandie Keene, Non-Executive Director
Heather Smith, Non-Executive Director
Salli Midgley, Director of Quality
Susan Rudd, Director of Corporate Governance

**In Attendance:**
Lorena Cain, Nurse Consultant for Restrictive Practice
Dr Robert Verity, Clinical Director for Acute and Community Services
Jamie Middleton, Head of Mental Health Legislation
Dr Jonathan Mitchell, Clinical Director for Rehabilitation and Specialist Services
Julie Houlder, Consultant - Charis Consultants Ltd
Tallyn Gray, Human Rights Officer
Sharon Mays, Trust Chair - Observer
Adam Butcher, Service User Governor – Observer
Amber Wild, Corporate Assurance Manager
Sharon Sims, PA to Chair and Director of Corporate Governance
Francesca O'Brine, Corporate Governance Administrator (Minutes)

**Apologies:**
Hester Litten, Head of Safeguarding
Neil Robertson, Director of Operations and Transformation

| *Min Ref* | Item | Action |
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| *MHLC21/12/036* | **Introduction and Welcome**<br>The Chair welcomed everyone to the meeting and thanked them for their support.<br><br>The Chair noted it was Sandie Keene's final Mental Health Legislation Committee meeting and expressed gratitude towards her example of good leadership, professionalism, and compassion, and wished her well on behalf of the Committee. | |
| *MHLC21/12/037* | **Apologies and confirmation of quoracy**<br>Apologies were received and the meeting was quorate. | |
| *MHLC21/12/38* | **Declarations of interest**<br>There were no declarations of interest. | |
| *MHLC21/12/39* | **Minutes of the meeting held on 7 September 2021**<br>The minutes of the meeting held on 7 September 2021 were agreed as an accurate record. | |
| *MHLC21/12/40* | **Matters Arising and Action Log:**<br><br><u>Care Quality Commission (CQC) Matters</u><br>The Committee heard from Dr Mike Hunter that since the circulation of this | |

agenda, the Trust has received a CQC inspection in relation to the Section 29a Warning Notice; the Acute and PICU Wards.

From a governance point of view, there are no current actions for the MHLC to take. The inspection is currently at an operational level.

High level verbal feedback to managers included:

- CQC saw good progress in relation to the reduction of risks in the built-in environments and clinical practice within them
- Evidence of quality improvement work specifically in relation to sexual safety
- Good progress was noted in the reduction of restrictive interventions
- CQC were impressed by the contribution of psychologists and other professionals to multi-disciplinary care planning
- Gaps were identified regarding missed physical health checks, practice relating to Section 17 Leave of Absence under the Mental Health Act, and Mental Capacity Act Best Interests recording, as well as a concern about admitting patients to the Place of Safety as a hospital bed

It is important to note that within the Section 29a Warning Notice headline comments were around risk, particularly environmental risk, and its mitigation, and safeguarding. Positive CQC feedback received maps directly to those areas.

MHLC21/09/029 (i) Mental Health Legislation Operational Group – Terms of Reference

Dr Mike Hunter explained that the Committee has clarified the standard governance process is not for Board Sub-Committees to receive full notes from the second order groups but to instead receive reports.

MHLC21/09/029 Mental Health Legislation Operational Group – Q1 Report

Dr Mike Hunter noted that this action related to the expansion of KPIs in Q2 reporting, and the incorporation of those medical staffing KPIs into a further expanded set by Year End.

Jamie Middleton addressed the Committee. The process raised questions relating to whether the current KPIs are useful. It highlighted issues around clarity on meaning and interpretation. Gaps have been identified including the lack of governance oversight over the work around the Mental Capacity Act and the Court of Protection. The Trust has obligations relating to restricted patients. Restricted patients often have a criminal history and are on legal orders. There are no KPIs to monitor how the Trust ensures these individuals are being supervised.

Jamie Middleton advised the Committee work has begun to identify gaps using data indicators. Once complete this will be brought to the Mental Health Legislation Operational Group (MHLOG) and Clinical Services with the aim of reducing this to core KPIs. Information must be purposeful and meaningful. A more comprehensive report will be presented to the Committee in March 2022.

Sandie Keene suggested it could be useful to review the types of data that other Trust's collect. Jamie Middleton noted that the Trust has delegated arrangements from the local authority. There are additional responsibilities that other Trusts may not have, such as Court of Protection issues.

Dr Mike Hunter concluded that the original action was complete. The

significant piece of work and subsequent consultation that has been identified by Jamie Middleton will require a new action to be opened. A paper will be presented at the next Committee meeting in March 2022 which outlines the approach to long listing and short listing KPIs, the consultation, and recommendation.

ACTION JM

MHLC21/09/033 Corporate Risk Register
Dr Mike Hunter noted that this action was associated with Wi-Fi stability at Mental Health Review Tribunals, and its escalation to the Corporate Risk Register. This has been actioned. At the next meeting the Committee will be presented with evidence of de-escalation. It will remain on the Corporate Risk Register for a short period.

**Care Quality Commission (CQC) Matters, and Action Log were approved.**

**Action - Paper outlining work on KPIs to be presented to Committee in March 2022**

*MHLC21/12/41* **Mental Health Legislation Operational Group**

**a MHL Q2 Report**

Committee received the report for assurance and information.

Jamie Middleton presented this report. Information contained within the report incorporates clinical service feedback, for example the CQC Plan relating to information from mental capacity assessments from clinical directors.

There has been a CQC Mental Health Act monitoring visit. These visits are specifically to check compliance with Mental Health Legislation. Since the last meeting there was one visit to Grenoside Grange. Issues noted were regarding visiting, staffing, and use of agency staff. In accordance with requirements the Trust has produced an action plan to address this. Actions include increased the number of visiting slots, ensuring more individualised risk assessments and care plans, and improved processes regarding Section 62 Urgent Treatment.

The Trust must ensure that individuals have mental capacity to consent to the admissions and care arrangements on a ward. This is captured in the completion of an assessment form.

Overall, the Trust have seen an improvement in the number of these assessments taking place prior to admission. This is a positive trajectory. The overall number of assessments has gone down. Previously, the Trust might do these assessments post-admission thus increasing the total overall.

Data is showing that many patients have not received a Mental Health Capacity Assessment when transitioning from detention to being an informal patient. However, it may be capturing patients who are being discharged that same day. Work is underway to improve the accuracy and clarity of this data.

Consent to treatment or detention under the Mental Health Act is subject to different safeguards for varying purposes. It is regularly audited. Compliance of 98% was achieved in Quarter 2. 100% should be achieved but this is representative of a snapshot in time.

At Endcliffe Ward Psychiatric Intensive Care Unit, figures indicating a

decrease in compliance were concerning. Since this report, individual cases have been investigated. All legal safeguarding systems were in place, but forms from ward audits had been completed incorrectly. The ward has worked on this, and the figures have significantly improved.

When a patient is detained, there is a legal obligation to read them their rights under Section 132. Endcliffe Ward has not been achieving as well as other areas. This was escalated to ward managers and the head of service. Section 132 is now covered as part of routine shift handovers and the staff board for requirements is more strategically placed on the ward.

Section 17 Leave of Absence KPI is a vast area and therefore open to interpretation. The Trust needs to monitor the frequency by which Section 17 Leave of Absence does not take place because of staffing difficulties. Data is being captured but there is not assurance that it is as accurate and comprehensive as necessary. A consistent approach to the definition is required.

Dr Mike Hunter noted that regarding Section 136 Place of Safety, there is a standard to see individuals within four hours. It is important for the Committee to understand how an experience at SHSC compares to one at a Trust with shorter waiting times. There are experiences to account for as well as risks that the Trust carries.

Dr Jonathan Mitchell added that the issue with documentation remains. In practice, an assessment is started but is not recorded until later. It is not always appropriate to record immediately but patients should be assessed as early as possible. Causes for delays need to be understood.

Sandie Keene requested more information regarding the issue of health-based place of safety beds, Section 136, and Section 12 doctors. There are implications that there are not enough Section 12 doctors. What risks is the Trust carrying and what is being done?

Robert Verity addressed the Committee. Sheffield's population is c560,000 people and there are two health-based places of safety within the Trust at Maple Ward. If these are occupied, then other areas of South Yorkshire are utilised, and vice versa. Some local Trusts with smaller population sizes have the same provision as SHSC. The allocation of doctors throughout South Yorkshire is consistent with this.

An assessment requires two doctors. There is a rota and system for internal doctors that is effective. 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. Internal staffing has improved. 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.

Heather Smith noted that a 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.

Robert Verity answered that assurance could 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. 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. The relative provision of beds in the different services cannot be answered by SHSC alone.

Lorena Cain addressed the Committee to provide further assurance. Some events that unfold in the health-based place of safety, such as delays, create more restrictions and can lead to restrictive practice. 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.

Jamie Middleton expressed concern that there has already been a CQC action regarding the breaching of timescales and yet the most prevalent incidents reported are the Breach of Seclusion Reviews.

Dr Mike Hunter addressed the issue of delays in the place of safety. The discussion has provided reassurance but is minimal regarding assurance overall. This needs to be mapped directly onto the work around more robust KPIs and the data quality behind the KPIs.

The responsibility to find Section 12 doctors other than within the Trust lies with the local authority. There is an engagement piece required between SHSC and the local authority that the Board should be alerted to.

Robert Verity noted that there were CQC actions relating to seclusion reviews. A piece of work was undertaken to assess junior doctor's medical reviews at Endcliffe Ward and Grenoside Grange not being completed to time. 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.

Independent reviews must be conducted by a senior doctor that has not looked after the patient. These reviews occur once patients have been held in seclusion for eight hours continuously, or for twelve hours within a 48-hour period. 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.

Sandie Keene highlighted that if the level of concern is high then a trajectory is required for oversight. It also needs to be included in the Back to Good Programme. There has been an issue raised around the attendance and commitment to these meetings. Can we be assured that everybody is working as a team to ensure these mental health legislation matters are addressed?

Salli Midgley confirmed for Sandie Keene that the development of the Committee and the MHLOG is now robust which is reflected in attendance and contributions to discussions. There has also been collaboration with Performance regarding data. Wards are reporting data more effectively and this continues to be monitored. The team are sighted on the issues raised. This is only verbal assurance and next quarter these reports will be more aligned in the way that they are presented.

Dr Mike Hunter requested that key areas of concern relating to mental health legislation are captured within the monthly Integrated Performance and Quality Report (IPQR). This goes via the Quality and Assurance Committee to Board every month so that Board can do the read across.

ACTION JM

The Chair noted that this was a productive discussion but there was not full assurance. Board must be alerted to certain areas.

**Committee received the MHL Q2 Report. There was some assurance, but other areas are being worked on.**

**The discussion provided reassurance but is minimal regarding assurance overall. This needs to be mapped directly onto the work around more robust KPIs and the data quality behind the KPIs.**

**Action to capture key MHL concerns in monthly IPQR**

**a (i) Risk Register**

Committee received the report for assurance and information.

Jamie Middleton presented this report. This presentation is to request agreement for the escalation of two issues onto the Corporate Risk Register.

There is still no Code of Practice for Liberty Protection Safeguards, and there are no regulations and operational national guidance. It must be assumed that the start date is 1st April 2022. This is very concerning. It has been escalated to directorate level but also attracts a Corporate Risk level.

Seclusion review breaches continue. Processes have been put in place to address this but there is already a CQC Action. As this is a regulatory response the Trust should be sighted at a Corporate Risk level. The Committee agreed.

Sharon Mays, Trust Chair, noted that the risk could be referred into the risk management process to be reviewed as to whether it is a separate risk or already covered within an existing one. The fact that this is not covered under the Back to Good Programme should be discussed between Sandie Keene and Jamie Middleton to ensure read across between committees.

**Committee received the Risk Register Report.**

ACTION JM/SK

**Action - Discussion regarding inclusion in Back to Good Programme needed**

**Action - Corporate Risk Register items to be discussed with Corporate Governance**

**b Horizon Scanning Report**

Committee received the report for assurance and information.

ACTION JM/AW

Jamie Middleton presented the report and confirmed for Sandie Keene that items listed are on a radar and some do not ever materialise. Items are escalated further when necessary.

Dr Mike Hunter noted that the items within the Horizon Report and the Liberty Protection Safeguard require escalation to the Corporate Risk Register.

**Committee received the Horizon Scanning Report.**

**c Liberty Protection Safeguards**

Committee received the report for assurance and information.

Jamie Middleton updated the Committee in respect of this report. This is a significant organisational risk. All organisations are in the same position as SHSC. There will be an extraordinary MHLOG meeting in January 2022 to specifically address Liberty Protection Safeguards. A worst-case scenario contingency plan will be put forward for feedback. This can be brought back to MHLC if necessary. There seems to be minimal progress, but assurance can be had that there is full oversight of issues.

**Committee received the Liberty Protection Safeguards report.**

*MHLC21/12/42*

**Least Restrictive Practice Oversight Group (LRPOG)**

**a Q2 Report**

Committee received the report for assurance and information.

Salli Midgley spoke to the Committee on behalf of Lorena Cain.

This is a developing report and data is improving. Next quarter will focus on work relating to protected characteristics. The report includes implementation of the strategy and there is a wide range of actions. There is a risk regarding the use of secure transport. The Trust stopped using a particular provider because of the use of mechanical restraint. There are providers in place, but a more substantive contract is being sought. There are no risks with the interim providers.

Sandie Keene noted that it was positive that things are beginning to go in the right direction. Information regarding the transport provider was reassuring but assurance that this will not reoccur is required. The Trust is behind on targets for the RESPECT Training. What is the timescale for this?

Salli Midgley confirmed that the transport provider being used does not use mechanical restraint. This is within the contract and meets the Restraint Reduction Standards. Regarding the RESPECT Training implementation, issues have primarily been caused by Covid19 and the need to reduce staff numbers being trained at one time. There is a business case in development because, aligned with the Use of Force Act, there will be a need to increase the number of trainers. The training requirements are being realigned and the programme will be simplified. The target is summer 2022. The highest priority is for Level 3 to be completed by all relevant staff. Salli Midgley confirmed for Sharon Mays that the Statistical Process Chart is based on Trust Data. As this develops, NHS benchmarking will be used and included in the next quarter.

Dr Mike Hunter added that the Trust benchmark is in the middle ground for restraint, a high user of seclusion, and a low user of rapid tranquillisation. Ideally, they will all reduce. There was an indication that the underuse of rapid tranquillisation was a sign of an overuse of seclusion. They are all linked.

Salli Midgley confirmed for Dr Mike Hunter that, regarding the transport provider, the groundwork is complete but there is not a contract with one individual provider. A pre-approved range of providers that meet the Restraint Reduction Network Standards are being utilised. The aim

is to finalise a contract that would be regularly reviewed. Dr Mike Hunter emphasised the importance of the Trust having its own check and balance as it cannot rely on the existing procurement framework. The Trust should request a start and end date.

Salli Midgley will discuss this with Director of Operations and Transformation, Neil Robertson, and will report back to the Committee with a date. ACTION SM

Salli Midgley confirmed for the Chair that in the next quarter there will be further detail around protected characteristics. The Sheffield African Caribbean Mental Health Association (SACHMA) have recruited into the role of Race Equity. The postholder starts in January 2022 and will inform the Trust's work around the use of restrictive practice on people from Black and Minority Ethnic backgrounds (BAME). The next report will reflect on this.

**Committee received the Q2 Report.**

**Action – Confirm with Neil Robertson start and end date of transport contract**

**b Use of Force Implementation Plan**

Committee received the report for assurance and information.

Salli Midgley presented this report. New guidance on the Use of Force Act 2018 has been released. Implementation timescales have not been given. Updates to the policy will be completed in December 2021, ensuring compliance as soon as possible.

Focus needs to be on the information that is outward facing to Service Users. This risk is aligned to the publication of the guidance. There is a lot of work in progress, soon to be a completed action to be submitted to CQC for scrutiny.

Heather Smith queried if there was anything at risk of not being completed and how much assurance can be taken when the action plan is completed.

Salli Midgley confirmed her role as the Responsible Person which is a serious responsibility on behalf of the Trust Board. At the next Committee meeting, an assurance report will be provided outlining evidence such as policy and the RESPECT Training. The risk highlighted relates to the timely completion of work with Service Users and families.

Salli Midgley answered Sandie Keene regarding anticipation of any new KPIs. Dataset Version 5 is already within the Use of Force Act 2018 and the Trust is compliant.

**Committee received the Use of Force Implementation Plan.**

**c Human Rights Workplan**

Committee received the report for assurance and information.

The Chair welcomed Tallyn Gray to the meeting who presented this report to the Committee. 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. The plan incorporates the voices and participation of individuals with lived experience and is a

central dynamic to its development and delivery. Challenges were encountered regarding levels of involvement in the co-production process which has caused delays in obtaining the information required.

Work beyond this includes collaboration with the Least Restrictive Practice Oversight Group (LRPG) and the progress and realisation of reducing restrictive practices throughout the Trust. This includes 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.

Tallyn Gray confirmed for Salli Midgley that as the programme grows more staff will undertake the training, particularly as it is incorporated into the Electronic Staff Record (ESR) training. Teams that are more likely to use restrictive practice have been prioritised. Specialist training will be implemented in 2022 to target individual wards, for example as requested at Firshill Rise, to meet the specific needs of teams and wards. Once there is a network of staff trained this will embed human rights practice across the Trust.

Heather Smith noted that the main measurement was number of staff being trained but there is also a wider vision for the Trust. It would be useful to consider in terms of impact, what it would look like to have human rights high on the agenda and what the progress indicators would be.

Dr Mike Hunter echoed this thought and suggested consideration of what a human rights base for learning disability and autism services would look like and how the Trust could measure this. In future reports and implementation plans it would be helpful to have a clear measurement of confidence for each action's progress.

Sharon Mays noted that the Board, Board development and leadership were specifically mentioned as well as monitoring, evaluation and learning lessons in the process. Sharon Mays requested that Tallyn Gray get in contact to discuss Board development in terms of human rights at SHSC.

The Chair added that the Trust should have a statement on its position on human rights.

**Committee received the Human Rights Workplan report.**

*MHLC21/12/43* **Meeting Evaluation**

Annual Work Plan

Committee received the workplan for information.

Dr Mike Hunter noted that the Committee required clarity on where the Associate Mental Health Act Managers (AMHAMs) was within the workplan, as discussed in the previous report.

Significant Issues to report to Board.

**Alert**

- Section 136 delays and a related point regarding the availability of Section 12 doctors and engagement across partners including the CCG
- Missed seclusion reviews
- Resolution of a procurement arrangement with a provider that does not use mechanical restraint
- Liberty protection safeguard issue and that it has been changed on the Corporate Risk Register
- Corporate Risk Register – how missed seclusion reviews are captured on the register and the review through the risk management process

**Advise**

- Least Restrictive Practice Conference received positive feedback
- MHLC has received the Human Rights Workplan and that is positive compared with other Mental Health provider organisations

**Assurance**

The Committee were assured on the remaining reports with the exception of items added to the Action Log.

Changes in level of assurance (BAF)

Committee agreed there was no change in level of assurance.

*MHLC21/12/44* **Any Other Business**

Evaluation from the Least Restrictive Practice conference

Salli Midgley noted that the Least Restrictive Practice Conference was a great success, and the recording will shortly be available to view on Jarvis. A highlight was the Lived Experience of the Carer session, and the feedback from this will be taken forward.

Jamie Middleton and Amber Wild highlighted that the updated Deprivation of Liberty Safeguards Policy was not on the agenda. It had received approval from the Policy Governance Group (PGG) and requires ratification from the MHLC. Susan Rudd confirmed that all tests were satisfied at the PGG meeting. Dr Mike Hunter added that there should be a standing item on the agenda for ratification of policies. Heather Smith suggested that the report is circulated to Committee members and comments are requested. If there are no dissentions after two days, then the policy is ratified. The Committee agreed. ACTION SR/FO

Dr Mike Hunter confirmed for Sharon Mays that reporting from associate hospital managers is received by the MHLOG and then MHLC. Jamie Middleton advised that there are gaps, and this is a KPI that requires attention. Dr Mike Hunter requested to know where AMHAMs reporting into the Committee was within the workplan. Jamie Middleton to confirm this at the next Committee meeting. ACTION JM

The Chair thanked the Committee and closed the meeting.

**Date and Time of Next Meeting:** Wednesday 16 March 2022 from 11:30am to 1:30pm
**Meeting Format:** MS Teams
**Apologies to:** Francesca O'Brine, Corporate Assurance Officer Francesca.O'Brine@shsc.nhs.uk