Board of Directors (Public)

SUMMARY REPORT	**Meeting Date:**	28 September 2022
	Agenda Item:	28

Report Title:	**Corporate Governance Report**	
Author(s):	Deborah Lawrenson, Director of Corporate Governance	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Board sub committees Terms of reference were considered at the Board committees which took place in August and September
	Date:	• People Committee – 13 September 2022 • Quality Assurance Committee – 14 September 2022 • Finance and Performance Committee – 15 September 2022 • Mental Health Legislation Committee – 21 September 2022 • Audit and Risk Committee – 26 July 2022 (TORs were discussed and were subsequently updated for consistency with the other Board TORs)
Key Points recommendations to or previously agreed at:	• The Annual Reports from the committees are presented with the cover sheets to the receiving committees • Appended to these are o Latest workplans o Latest Terms of Reference post updating for consistency purposes and received and agreed at committees in September are presented **for approval**. Audit and Risk Committee were received via email. Track changes have been accepted. Any additional changes proposed by the Director of Corporate Governance post receipt at the September meetings are highlighted. There are some formatting issues on the TORs still to resolve before publishing and roles will be included on all organograms rather than current post holder names for	

	further consistency. • The TORs for the Remuneration Committee and an Annual Report from the committee to Board will be received in October for receipt at the November Board.

Summary of key points in report

This report provides:

The Annual Reports from the Board sub committees to the Board:

Appendix 1

- Audit and Risk Committee Annual Report
    - 1.1 forward plan
    - 1.2 terms of reference for final approval
    - 1.3 review of effectiveness

Appendix 2

- Quality Assurance Committee Annual Report
    - 1.1 forward plan
    - 1.2 terms of reference for final approval
    - 1.3 review of effectiveness

Appendix 3

- Finance and Performance Committee Annual Report
    - 1.1 forward plan
    - 1.2 terms of reference for final approval
    - 1.3 review of effectiveness

Appendix 4

- Mental Health Legislation Committee Annual Report
    - 1.1 forward plan
    - 1.2 terms of reference for final approval
    - 1.3 review of effectiveness

The report from the Remuneration Committee will be received at the November Board meeting.

In completing the reports consideration has been given to:

- Frequency of meetings, membership and attendance
- Self assessments
- Key activity areas

As a reminder NHSE have identified roles which are recommended to be held by Non-Executive directors and roles which can now be covered by committees or other Executive individuals. These are reflected as appropriate in the Terms of Reference.

Roles to be held by Board sub committees or other named roles

Issue	Person	Committee
Hip fracture, falls and dementia	Can be an Executive	**Quality and safety**
Learning from deaths	Quality committee to champion	**Quality and safety**
Safety and risk	Can be a committee role	**Quality and safety Audit and Risk**
Palliative and end of life care	Can be a committee role	**Quality and safety**
Health and safety	Can be a committee role	**Cuts across Quality - People - Finance**
Children and Young People	Can be the Chair of Quality or a committee role	**Quality and Safety**

Resuscitation	Can be a committee role	**Quality and safety**
Cybersecurity	**SIRO – Held by Executive Director of Finance**	Finance and Performance Audit and Risk
Emergency preparedness	**Needs to be Board level – held by Executive Director of Nursing, Professions and Operations**	Audit and Risk
Safeguarding	Can be a committee role	**Quality and safety**
Counter Fraud	**Held by Executive Director of Finance**	Audit and Risk
Procurement	**Held by Executive Director of Finance**	Finance and Performance
Security management, violence and aggression	Committee role	**QAC – covered in H & S and at People in workforce support reporting**

Roles which are recommended to be held by non-executive director champions

Role:	**Held by:**
Maternity safety champion – recommended for Trusts providing maternity services.	NA
Wellbeing guardian – recommended	**Heather Smith**
Freedom to Speak up – recommended	**Richard Mills**

Review of Effectiveness

The Board review of effectiveness will be provided as a late appendix

Board is recommended to:

1) **Receive for assurance** the Annual Reports from the sub committees to the Board including the reviews of effectiveness and latest forward plans (these will be further updated, as required to ensure flow with the updated Board forward plans agreed at Board where these are not already reflected)
2) **Receive for approval final** updated Terms of Reference for the Board sub committees
3) **Note** the report, review of effectiveness and updated TORs for the Remuneration committee will be received in November
4) **Note** the revised date for the Annual Members meeting of 20 October 2022 which will be held in person.
5) **Note** the review of standing orders will be received at Board in November following discussion at the October Audit and Risk Committee
6) **Receive and discuss** the Board review of effectiveness

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Getting through safely	*Yes*	***X***	*No*	
CQC Getting Back to Good	*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	*Yes*	***X***	*No*		***"Good Governance*** *- The provider of your care must have plans that ensure they can meet these standards.* *"They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to your health, safety and welfare."*
IG Governance Toolkit	*Yes*		*No*	***X***	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*	***X***	*No*		In relation to the ToRs for the Quality Assurance Committee
Financial (revenue &capital)	*Yes*	***X***	*No*		In relation to the ToRs for the Finance and Performance Committee
OD/Workforce	*Yes*	***X***	*No*		In relation to the ToRs for the People Committee
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		Covered as appropriate in reports
Legal	*Yes*	***X***	*No*		In relation to the ToRs for the Audit and Risk Committee; and in relation to the necessity to meet statutory obligations around the Annual Members' Meeting
Sustainability	*Yes*	***X***	*No*		Covered as appropriate in reports

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APPENDIX 1

AUDIT AND RISK COMMITTEE

AUDIT AND RISK COMMITTEE DRAFT ANNUAL REPORT	**Meeting Date:**	26 July 2022
	Agenda Item:	14

Report Title:	**Draft Audit and Risk Committee Annual Report to the Board**	
Author(s):	Phillip Easthope, Director of Finance and Deborah Lawrenson, Director of Corporate Governance	
Accountable Director:	Anne Dray Non-Executive Director and Chair of the committee	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	NA
	Date:	NA
Key points/ recommendations from those meetings	NA	

Summary of key points in report

The Audit and Risk Committee Annual Report is attached for assurance and approval. It provides an update on the membership and attendance at meetings; meeting frequency during the year and planned for the year ahead; work of the committee over the last year; key matters escalated to the Board; delivery against its objectives; outcome of the review of effectiveness and any proposed changes to the Terms of Reference.

Key NED lead Roles affecting the remit of the Committee and key roles assigned to the Committee

- Freedom to Speak up, (NED lead - Richard Mills) – recommended
- Safety and Risk, committee role - jointly with Quality and Safety Committee – required
- Cyber Security –committee role - (SIRO Lead - Executive Director of Finance)
- Emergency Preparedness, assigned committee role (Board accountable role – Chief Executive)
- Counter Fraud, assigned committee role (Executive lead role Executive Director of Finance)
- Clarification being sought around requirements around roles for doctors disciplinary and security management

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**	**x**	**Assurance**	**x**	**Information**	

The committee is asked to receive and approve for assurance and onward reporting to the Board, the annual report on how the Audit and Risk committee has met its obligation as a sub committee of the Board.

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

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*		*No*		*(pls see writers crib sheet)*
Data Security and Protection Toolkit	*Yes*		*No*		*(pls see writers crib sheet)*
Any other specific standard?					*(pls specify)*

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*		
Financial (revenue &capital)	*Yes*		*No*		
Organisational Development /Workforce	*Yes*		*No*		
Equality, Diversity & Inclusion	*Yes*		*No*		*Please complete section 4.3 in the content of your report*
Legal	*Yes*		*No*		
Sustainability	*Yes*		*No*		

DRAFT Annual Report from the Audit and Risk Committee to the Board

1. Introduction and background

1.1 The purpose of this report is to:

Provide assurance to the Board that the Audit and Risk Committee has carried out its obligations with its Terms of Reference (ToR). A copy of the ToR is provided at **Appendix A**. There are two amendments proposed to the Terms of Reference:

- Additional line in *Quorum* – "Deputies may attend, with the agreement of the Chair. This will be by exception; theymust be fully briefed and if formally deputising will count towards the quorum."
- Inclusion of the ARC governance structure

1.2 Provide an update to the Board on the work of the Audit and Risk Committee during 2021/22, a reminder of matters escalated to the Board or referred to other Board sub committees, and detail on the work plan and objectives for the financial year 2022/23.

2. Membership and meetings

Membership

2.1 The ToR's require three non-executive directors to be members of the committee. The meeting is quorate if two members are present. The ToRs identify Directors or senior leaders who are required to participate as regular attendees. Other Executive Directors have also been requested to attend the Committee throughout the year to discuss specific items.

Meetings and frequency

2.2 In the period April 2021 – March 2022 the Committee met 6 times on the following dates:

- 20th April 2021
- 18th May 2021
- 9th June 2021
- 21st July 2021
- 19th October 2021
- 19th January 2022

The committee has remained quorate throughout the year

It is recommended the meeting frequency for 2022/23 be retained as c6 meetings a year.

Attendance at meetings

2.3 All meetings were quorate in 2021/22 and up to the point of submission of this report to Audit and Risk Committee in July 2022.

2.4 The Audit and Risk Committee Terms of reference require membership of the following roles.

Attendance of individual members for the meeting held during the financial year were as follows:

Member name and role	**Attendance record**
Anne Dray, Chair of the Committee	6/6
Sandie Keene, Non-Executive Director *	5/5
Richard Mills, Non-Executive Director	6/6

*Sandie Keene left the Trust 31.12.21

The following individuals also routinely attended meetings:

Name and role
Phillip, Easthope, Executive Director of Finance 6/6
James Sabin Deputy Director of Finance to October 2021 3/4
Matt White, Deputy Director of Finance from October 2021 2/2
David Walsh, Director of Corporate Governance until October 2021 5/5
Susan Rudd, Interim Director of Corporate Governance from November 2021 – April 2022 1/1 Deborah Lawrenson, Director of Corporate Governance from April 2022 onwards (new financial year)
Amber Wild, Corporate Assurance Manager and/or Corporate Assurance Officer providing meeting support

<u>Internal Audit</u> Lianne Richards, Client Manager, Internal Audit 360Assurance 6/6 Leanne Hawkes, Director, Internal Audit 360Assurance 5/6
<u>Counter Fraud</u> Chris Taylor, Anti-Crime Specialist, 360Assurance, 2/6 Amanda Smith, Anti-Crime Specialist, 360Assurance, 2/6 Matthew Curtis, Anti-Crime Team Manager, 360Assurance, 1/6
<u>External Audit</u> Rashpal Khangura, Director, External Audit, KPMG 6/6 Matthew Moore, Audit Manager, KPMG 2/6

3. Work plans and activity during the year

Work plan for 2021/22

3.1 The Audit and Risk Committee has a well-established 'forward work plan' which sets out the annual cycle of work and reporting. This is received at each meeting and updated as required.

3.2 The committee works with other Board Committees and will receive matters for its consideration and refer matters to the other Committees as required for assurance purposes.

3.3 Prior to the meeting the Chair of the committee reviews the planned agendas with the Executive Leads, the Executive Director of Finance and the Director of Corporate Governance (Trust Secretary).

Committee activity in 2021/22

3.4 Key activity during the financial year included the following:

External Audit

- KPMG External Audit Interim Report (April)
- KPMG External Audit VFM Audit Plan (May)
- External Audit ISA260 Report (June, January)
- Draft Management Letter of Representation (June)
- External Auditors Annual Report (June)
- KPMG External Audit Progress Report (July, October, January)
- External Audit Draft Plan (January)

Internal Audit

- Internal Audit Service Progress Report (April, May, July, October, January)
- Counter Fraud, Bribery and Corruption Progress Report (April, October, January)
- Internal Audit Plan (April, July)
- Counter Fraud Plan (April, January)
- Charter (April)
- Head of Internal Audit Opinion Statement (Interim April, Final May, Annual Report June, Stage 2 Report January)
- Counter Fraud, Bribery and Corruption Draft Government Counter Fraud Functional Standard Return (May, Annual Report June)
- Internal Audit Report – Data Security and Protection Toolkit (July)

Governance, financial and other matters

- Draft Annual Governance Statement (April, May, June, January)
- Draft Annual Report (April, May, June)
- Losses and Special Payments Full Year Report (April)
- Going Concern Report (full April, draft January)
- Material Estimates Report (April)
- Accounting Policies and Financial Reporting Manual Review (April, January)
- Compliance against Provider Licence Conditions (April)
- Single Tender Waivers (April, June, July, October, January)
- Single Tender Waivers Process Assurance Report (October)

- Annual Accounts and Remuneration Report (Draft May, Final Audited June)
- Analytical Review (May)
- Impact of Introduction of IFRS 16 (January)
- Register of Interests, Hospitality, Sponsorship and Gifts (May)
- Standing Orders, Standing Financial Instructions, Standards of Business Conduct – Breaches Report (January)
- Risk Management Strategy (April)
- DIGG Report (April, July, October, January)
- BAF (April, May, July, October, January)
- CRR (April, July, October, January)
- EPRR (April, July, October, January)
- ARC Annual Review of Committee Effectiveness (April, and objectives October)
- Committee Governance Review – TORs (July)
- ARC Self-Assessment Questionnaire (January)
- Well-Led – CG Structure Review (April)
- Policies for Ratification (May, July, October, January)
- Annual Report on Policy Governance (May)
- Freedom to Speak Up Annual Self-Assessment (May, Annual Report July)
- Data Loss – Information Commissioner's Office Investigation (July)
- Mid-year Review against Committee Objectives (October)
- Line of Sight on Action Plans – Audit and Risk Committee (October)
- 2022 Schedule of Meeting Dates (October)

3.5 Updates on key areas in more detail are provided below:

Annual Report and Accounts

Development and delivery of the Annual Report and Accounts.

The submission of the Annual Report and Accounts for 2021/22 was delayed due to continuing work by external audit on the closure of the accounts - an additional extraordinary Board meeting was put in place in late June to accept final documents. A review is taking place from the perspective of both the Trust and the auditors on the process to ensure lessons are learned for the 2022/23 process.

External Audit

External Audit support is provided by KPMG. The effectiveness of the external audit function is assessed annually by the members of the Audit and Risk Committee utilising the methodology provided for such an evaluation by the Audit Committee Institute. For 2021/22 this was carried out as part of a self-assessment questionnaire of members.

KPMG carried out no other services for the Trust during the financial year 2021/22.

The Audit and Risk Committee did not review the performance and value for money of the audit function during 2021/22. This will be taken forward in 2022/23 for all audit functions.

Internal Audit and Counter Fraud

The Trust's internal audit function is carried out by 360 Assurance. The annual audit plan is derived following an overarching risk assessment and is translated into the annual internal audit operational plan and three-year strategic plan.

The internal audit plan was developed through discussion with members of the Audit and Risk Committee, the executive team and other directors and a review of the Board Assurance Framework to identify a range of key risks, including those affecting the health sector generally. Reviews were identified across a range of areas including financial management, information management and technology, performance, clinical quality, people management and governance and risk.

A report is taken to every Audit and Risk Committee meeting detailing progress against the plan and drawing attention to any concerns.

The internal audit programme overseen at the Audit and Risk Committee provides a further mechanism for supporting overseeing governance arrangements. The internal auditors identify high, medium and low priority recommendations within their audit reports, which are monitored in an internal audit recommendations tracker and reviewed frequently both internally by the Executive Team and with our auditors. In 2021/22 performance in our in-year audits improved with the in-year position moving from limited to significant assurance. The Board Assurance Framework and Corporate Risk audit remained 'moderate' although it was recognised work to continue to embed these had been made.

The following reports were received with Limited Assurance:

- Procurement
- Waiting List Data Quality and Management with one high risk finding identified
- Quality of Performance Development Reviews (PDRs) with one high risk finding identified – note this report is from the 2020/21 audit programme.

The following reports were received with Significant Assurance

- Incident Management
- General Ledger and Financial Reporting Arrangements
- Strategic Governance
- Policy Management
- Transformation and Project Management
- Health and Wellbeing
- Payroll

At the time of writing testing was in progress for the 2021/22 reports for Safeguarding Adults and Children, and Recruitment Reviews. The Health and Safety audit was also ongoing with the final draft awaiting sign off. There have been some delays with implementing some of the internal audit recommendations during the financial year (predominantly low or medium risk actions), and as a result of this the overall Head of Internal Audit Opinion remained 'moderate'. The Committee recognises this is an area which requires improvement and is assured systems to address and improve upon this are being put in place to support improving the end of year position in 2022/23.

Counter Fraud

3.5 The Trust takes the prevention and detection of fraud very seriously and has appointed Counter Fraud Specialists through 360 Assurance to continue to work to raise the profile, explore potential and investigate cases of fraud. Each year, the Audit Committee receives and considers the annual Counter Fraud plan, regular

progress reports and updates and the annual Counter Fraud report. The Trust's Deputy Director of Finance is a Fraud Champion.

Data Security and Data Protection

3.6 Following our 2020/21 Data Security and Protection Toolkit (DPST) submission, a plan was agreed with NHS Digital to address those areas identified as requiring improvement but the requirement to submit the outcome was subsequently dropped so our attainment level is recorded as 'Approaching Standards'.

The Trust continues to work to implement further improvements to enhance our performance against DPST requirements. An Information Security Group meets monthly and is focussed on the requirements of the toolkit to support the organisation to be 'audit ready' in all areas. A phishing exercise was undertaken by internal audit which identified fragilities in the organisation's IT security and as a result changes were made to strengthen our arrangements. This continues to be an area of focus.

Information governance training is included as part of the core training for new starters and all staff are required to undertake annual information governance training. Other specific training sessions have been provided to staff.

Information governance and data security incidents and risks are recorded and reported through the Trust's risk management processes.

During 2021/22 four incidents were reported to the ICO. One related to a service writing to a service user at the wrong address; one related to an allegation by a service user that an external interpreter had shared their information inappropriately (although this was not verified); one occurred when a temporary member of staff shared information about a service user who was known to them; and one related to out of date details being used resulting in a former carer of a service user being contacted. In each of these cases processes were reviewed and updated where appropriate and the ICO has taken no further action. These are reflected on the risk register and the Electronic Patient Record project will be a significant contributor to mitigating the risks with other safeguards also in place.

Governance, Risk and Assurance

3.7 Key areas of development/achievement in year

- Robust Board development plan alongside executive development, non-executive development, governor development and staff leadership programmes
- Embedding of the revised governance structure that was introduced in 2020/21 with assurance reporting to the Board of Directors via a new Alert, Assure Advise (AAA) report from Committee Chairs to Board replacing the previous significant assurance reports
- Increased reporting and scrutiny of the BAF with challenge at committee level
- Embedding of the Performance Framework and the performance management reviews
- The work of the Back to Good Board ensuring that improvement actions are completed in time and escalating if appropriate
- We have retained external support in our development work throughout the year which will continue into 2022/23 and has been of significant benefit

- Support has continued to be provided to report authors to improve the quality of reports received at Committees and Board with further work planned in the coming year
- Triangulation of data and performance information with Board and Executive visits and through cross reporting from the Board Committees has improved across the board
- Work has been identified to support our continuing programme of improvement
- Movement of our overall CQC rating from Inadequate to Requires Improvement and movement in the following services/areas from inadequate to requires improvement
    - Mental health wards for older people
    - Crisis and health-based places of safety
    - Acute wards for adults of working age and psychiatric intensive care unit
    - Well Led
- Previous Section 29A enforcement notice close
- Movement of the organisation from SOF segment rating 4 to SOF rating 3 with recovery support no longer required
- We have had a number of significant assurance internal audit reports in the year which provides assurance around our improving systems and controls; and whilst we had a small number of reports with limited assurance only two contained high risk recommendations.

Corporate Risks

3.8 As at 31 March 2022, there were 21 risks on the Corporate Risk Register and the top 6 risks scoring 15 or above were as follows

Risk that patients with a Learning Disability/and or with Autism will be admitted onto an acute mental health ward due to the current closure of ATS at the Trust (Risk score16)	Mitigations: • The Community Intensive Support team and Community Learning Disability team are working closing with services users and providers to support into the community and to support admissions avoidance. • Learning Disability Multi-Disciplinary Team will in-reach into the wards to provide specialist support and training to mental health staff. • Standard Operating Procedure for emergency admission avoidance/admissions has been developed. • List of CQC rated Good ATS inpatient settings across the country was to be used if admission cannot be avoided (if available) • Risk action plans include ongoing work with the Learning Disability Programme Board and the development of a new community enhanced model for Sheffield; and discussion with regional Commissioners about future planning for Learning Disability beds at and Integrated Care system and regional level.
Risk to patient safety arising from the quality and safety of the ward environments across Trust hospital sites, including access to ligature anchor points	Mitigations: • Policies and Standard Operating procedures are embedded, including ligature risk reduction, observation and risk management. • Inpatient environments have weekly health and safety checks. • The ward works on all adult acute wards is continuing

(Risk score 15).	in line with the programme. • 14 commissioned beds are in place to mitigate the reduced bed base whilst refurbishment work to remove Ligature anchor points is progressed.
Risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity (Risk score 15).	Mitigations: • All referrals are triaged within a 24hr period to determine need and urgency. • Customer Service Improvement Programme Manager in post to improve response time and caller experience. • Written information and advice on accessing help in a crisis given to services users waiting assessment. • Waiting time trajectory is reported to Quality Assurance Committee. Voluntary, Community and Social Enterprise (VCSE) offer went live in February 2022 and will be evaluated in April 2022.
Risk that there are insufficient beds to meet service demand; caused by bed closures linked to the eradication of dormitories and ward refurbishment; resulting in a need to place service users out of city (Risk score 15).	Mitigations: • Clinical Director and Executive Director (out of hours) approval for out of area authorisation. • Crisis Resolution and Home Treatment team support for ward discharges and gatekeeping of admissions. • Additional 12 acute beds and additional 6 Psychiatric intensive Care beds (PICU) beds procured.
Risk to patient safety, caused by key clinical documents being deleted resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g., missed appointments (Risk score 15).	Mitigations: • New Electronic Patient Record (EPR) programme which will deliver a new EPR allowing Insight to be fully replaced is the full mitigation for this risk. • Improved backup infrastructure is in place to provide faster recovery of deleted documents. • Hourly snapshots of data in place to reduce volume of data that could be lost in an incident. • Standard Operating Procedure in place to handle document deletion incidents with oversight from Digital Information Governance Group (DIGG). • Quarterly planning overseen by IMST Senior Management Team (SMT). • Information Security Group within IMST for planning of security and governance actions.
Risk that complaints will not be responded to in a timely manner which will give rise to breaches of contractual standards and dissatisfaction from service users, carers and families	Mitigations: • Complaints Manager and Complaints officer employed to support the administration and processing of complaints. • Quality Directorate provides oversight. • Rapid improvement plan developed and monitored through Quality Assurance Committee.

(Risk score 15).	

Board Assurance Framework – strategic risks

3.9 At the start of 2021/22 financial year, the Trust had nine BAF risks to the delivery of the strategic objectives. A further risk was added during the year 'risk that engagement with systems partners is ineffective or lacking; caused by weaknesses in partnership relationships or supporting governance arrangements; resulting in a poorer quality of services, missed opportunities and potential costs' and is monitored by the Board. The Audit and Risk Committee and the Board received the final version of the 2021/22 BAF at their meetings in May and June 2022 after which arrangements were put in place to review the revised BAF for 2022/23 which at the time of writing was due for receipt through Audit and Risk Committee and Board in July 2022.

A separate COVID-19 risk register was maintained with reporting through the Command structure and the Quality Assurance Committee and to Board.

In March 2021 the Trust commissioned a review of its systems processes, capacity and capability around risk to support ongoing improvement and the outcome of this review was received through the Audit and Risk Committee and Board in June 2022 and actions agreed to take forward due to be reported to the Audit and Risk Committee in July 2022.

Reports from sub committees/groups

3.10 The committee received reports from its sub committees:

- Data Information Governance Group (DIGG)

The Risk Oversight Group will be established in 2022/23 and will report into the Committee.

Other matters

Private meetings with auditors

3.11 There was one private meeting held with auditors in 2021/22 in January 2022. Private meetings have been scheduled into the forward plan for 2022/23 in July and January and will also be held as required.

4. Matters escalated to the Board or referred to other Board sub committees

4.1 After each meeting the Audit and Risk Committee has provided an Alert, Advise and Assure (AAA) report to the Board.

4.2 Key matters escalated to the Board in the financial year included the following:

- Value for money audit – risks
- The committee asked that the process through which Internal Audit reports receive full committee oversight be explored with a view to improving processes around this

- Annual Governance Statement (AGS) and the Compliance Statement – which declared significant control gaps in 2020/21, whilst there were control issues at the start of the financial year in relation to Firs Hill overall there was and an improved position in 2021/22 with the move from SOF 4 to SOF 3 at the end of the financial year and the move from CQC 'inadequate' to 'requires improvement' overall.

- 360 Assurance progress report - Concerns raised over progress with follow up actions, impact of non-delivery of Committee objective and impact on Head of Internal Audit Opinion. Executive review of all aged actions and new process established for committee oversight was outlined as required. This was put in place in liaison with Internal Audit in 2022/23 although progress was made it was insufficient to improve the HOIA for 2021/22 from 'moderate assurance'.

4.3 Examples of matters referred to other Board Committees included the following:

- Internal Audit Progress reports – Physical Health Report (limited assurance) referred to Quality and Safety Committee. PDR (limited assurance) referred to People Committee.

5. Committee effectiveness

Process for review of committee effectiveness

5.1 A self-assessment review was last undertaken by the Committee and received at the committee in June 2022. This involved circulation of a questionnaire with statements for members to confirm their level of agreement the committee fulfilled the stated requirement. This form will be reviewed in 2022/23 to ensure it meets current needs, it will include opportunity for comments, and it will made available in electronic form for ease of completion and to support data extraction for onward reporting. The self-assessment process looking back at 2022/23 will take place in readiness for reporting to committees in January/February 2023 and to Audit and Risk Committee in April followed by an amalgamated report on annual reports from all Committees to the Board in May 2023.

5.2 There is a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting

Assessment against objectives agreed for 2021/22

5.3 The following objectives were agreed by the committee for 2021/22, with progress outlined.

Committee objectives	Progress update
Clinical Audit Plan	Clarity that oversight of Clinical Audit Plan is with Quality Committee
Improve upon Moderate HOIAO	Compared to 2020/21 additional oversight of agreed action plans by Executive Team and Board Committees put in place during

	2021/22. Sufficient improvement to move opinion from 'moderate' not achieved.
Oversight of organisational action plans	Work commenced on this in 2021/22 and will be embedded during 2022/23

6. Committee objectives for 2022/23

6.1 In reviewing the effectiveness of the Audit and Risk committee in 2021/22 the committee it is proposed the following objectives be agreed for 2022/2023 as follows:

Committee objectives
Work closely with External Audit to ensure strengthened oversight processes resulting in demonstrable improvement in the Annual Report and Accounts processes for the 2022/23 submission
Put in place and embed a Board 'line of sight' tool for providing clarity on the monitoring arrangements for all major action plans
Achieve significant assurance in the Head of Internal Audit Opinion
Consider improvements around governance arrangements including undertaking a review against the revised Code of Governance and associated actions required

6.2 Progress against the objectives will be reviewed at either six monthly or quarterly intervals depending on the frequency of the committee meetings.

7. Work plan 2022/23

7.1 The Committee's workplan for 2022/23 is detailed in **Appendix A** and is presented for approval and agreement to share with the Board for endorsement.

8. Review of Terms of Reference

8.1 The Terms of Reference have been reviewed and are attached at **Appendix B** and are presented for approval and agreement to share with the Board for endorsement. No changes are proposed other than the sentence regarding deputising under *Quorum* and including an organogram of committees reporting into it.

9. Conclusion

9.1 The Committee assures the Board it continues to function appropriately as a standing committee of the Trust's Board of Directors, effectively overseeing the duties as set out in the agreed Terms of Reference.

Supporting information

Appendix A – Audit and Risk Committee workplan 2022/23 updated as at Sept 2022

Appendix B – Audit and Risk Committee terms of reference (July 2022 for re-approval) updated as at Sep 2022

AUDIT & RISK COMMITTEE - WORK PROGRAMME

		2022				2023
Item	**Lead**	**April**	**June**	**July**	**Oct**	**Jan**
Date for Submission of Papers		12	14	12	11	10
Meeting Dates 2022/23		19	7	19	18	17
Standing Items						
Apologies	Chair AD	X	X	X	X	X
Declaration of any conflict of interest	Chair AD	X	X	X	X	X
Minutes/notes of last meeting	Chair AD	X	X	X	X	X
Action log	Chair AD	X	X	X	X	X
Meeting work programme	Chair AD	X	X	X	X	X
Review of meeting effectiveness (verbal)	Chair AD	X	X	X	X	X
Workplan Programme						
Financial Statements & Annual Report						
Annual Report & Accounts Production Timetable	Dir CG					X
FT Annual Reporting Manual Changes						X
Accounting Policies Review	MW	X				X
Draft Annual Governance Statement	Dir CG	X	X			X
Draft Going Concern Report – Preparation of Accounts	MW	X				X
Draft Accounts & Related Issues	MW	X	X			
Draft Annual Report & Related Issues	Dir CG	X	X			
Annual Report and Accounts Development Plan *(and progress report at every meeting)*	Dir CG/PE				X	Progress report
Losses & Special Payments Full Year Report	MW	X				
Material Estimates Paper (PPE)	MW	X				
ISA 260 Annual Report - Progress Against Actions	Dir CG					X
Analytical Review			X			
~~Internal planning approach for the Annual Report and Accounts preparation 2022/23 and progress updates to be received at subsequent meetings~~	*Removed as item duplicated above*					
Internal Control & Risk Management						
Board Assurance Framework	Dir CG	X	X	X	X	X
Corporate Risk Register	Dir CG	X	X	X	X	X
Risk Management Strategy	Dir CG			X (D) Refresh Deferred from Apr22. Needs to reflect Risk Management Review - Report	X	

				agreed to be received in Oct		
Monitoring of Risk Review Action Plan	Dir CG				X (ARC July requested further update and confirmation of next steps at Oct ARC)	X For 2023 only DL 17/06/2022
Whistleblowing						
FTSU / Whistleblowing Bi-Annual / Annual Report				Annual	X (DL added in 19/07/2022)	Bi-Annual

Item	Lead	2022 April Q1	June Q1	July Q2	October Q3	2023 January Q4
Date for Submission of Papers		12	14	12	11	10
Meeting Dates 2021/22-2022/23		19	7	19	18	17
Corporate Governance						
Emergency Preparedness Resilience & Response Assurance Framework Report	BM	X	X		X	X
Declaration of Interests Exercise & To receive the Register of Interests & Hospitality, Sponsorship & Gifts 2022, and process for calling in updated declarations for 2022/23	Dir CG		Update		X (AW to produce)	
Third Party Assurances	Dir CG			X (D) Report not ready. Deferred from April 2022. Next Work Plan back to April and October		X (D) Report not ready. Deferred from Oct 2022. Next Work Plan back to April and October
Mid-Year Review against Self-Assessment Actions	Dir CG				X	
Self-Assessment Questionnaire	Dir CG					X
Self-Assessment Outcome	Dir CG	X				
TORs for all Committees for approval	Dir CG			X Via e-Governance Aug/Sept for 22		
Tier 2 Committee/Group Annual Review of Effectiveness Reports with TORs	DIGG ROG PGG			X(D) DL added new item to agenda then deferred to Oct	X	
Internal Audit						
Progress Report		X	X	X	X	X
Plan Update				X		
Counter Fraud, Bribery & Corruption Report					X	X
Draft Plan		X				X
Final Plan		X				
IA Charter		X				
Head of IA Opinion Statement		X Interim	X Final			
Internal Audit Annual Report			X(D) Previously scheduled for May22 meeting,			

			which was cancelled, so moved to Jun22			
Counter Fraud Annual Report			X(D) Previously scheduled for May22 meeting, which was cancelled, so moved to Jun22			
External Audit						
Progress Report		X	X	X	X	X
Plan						X
ISA 260 Report			X			
Draft Management Letter of Representation			X			
VFM Request (DL added to agenda 17/06/2022)					X	

		2022				2023
Item	**Lead**	**April**	**June**	**July**	**October**	**January**
Date for Submission of Papers		12	14	12	11	10
Meeting Dates 2021/22-2022/23		19	7	19	18	17
Standing Orders; SFIs; Standards of Business Conduct						
Revised SFIs, Standing Orders, Scheme of Delegation *(If reviewed)*	PE				X Added to Oct post-Aug PGG meeting confirmation from Carl T and DL – they are being updated. Oct to ARC, Nov to Board	X (normally January but TBC post-Oct ARC)
Breaches Report	PE					X
ARC Sub-Committee Reports						
Digital Information Governance Group Annual Assurance & Escalation Report (Including Annual SIRO Report - July)	PE	X	X	X Including Annual SIRO & Caldicott Report	X	X
Policy Governance Update	Dir CG	X	X	X	X	X
Annual Report on Policy Management	Dir CG	X				
Risk Oversight Group Report					X	X
Risk Oversight Group Review of TORs					X	
Other						
Informal Private Discussion with Audit Representatives & NED Members *(one hour before ARC meeting, not an agenda item)*			Non-agenda item			Non-agenda item
Claims and Litigation Annual Report Moved from QAC work plan – REPORTING DATE TBC *QAC September 2022: Committee agreed this is not a quality report and should be moved to the ARC Work Plan. Learning Lessons will be included in reporting to QAC.*						X - TBC
Governance						
Compliance Against the new NHS Code of Governance			X			X(D) (DL moved from Oct 5/9/22 – likely new doc will not be out in time for internal work)
Governance Processes around Action Plans (ARC priorities 2021/22)			X	X	X (DL added to workplan 19/07/2022)	
Annual Report and Accounts – discussion about learning on th process for the 2021/22 process and submissio			X (Verbal added by DL)	X (Formal report confirmed for Oct		

				ARC at July ARC)		
Terms of reference review (annual)	Dir CG	X				
Annual review of meeting effectiveness	Dir CG	X				X (DL added to workplan 19/07/2022)
Audit Committee Annual Report *(Share draft Q4/end Jan/early Feb 2023)*				X		Draft Feb (DL added in Feb 19/07/2022)
Annual Reports from Other Board Committees (to be received via e-governance in Aug/Sept drafted by Exec leads, signed off by Chairs, Oct 2022 formal receipt at ARC, April 2023 going forward)				X(D) Deferred to October for 2022, then April 2023 on next Work Plan	X	

Internal Audit Plan 2022/23 – Assurance Reports			
Governance and Risk Management	**Executive**	**BAF Reference**	**Phasing Quarter**
1. Head of Internal Audit Opinion	Director of Corporate Governance	All	Q1-4
2. Risk Management	Director of Corporate Governance	All	Q3/4
Financial Management	**Executive**	**BAF Reference**	**Phasing Quarter**
3. General Ledger and Financial Reporting Arrangements	Executive Director of Finance	BAF.0022	Q3/4
4. *Ledger Replacement - Advisory*			
5. Cost Improvement Programme	Executive Director of Finance	BAF.0022	Q2
6. Income Reconciliation	Executive Director of Finance	BAF.0022	Q2
7. Estates	Director of Strategy	BAF.0025	Q1
Information Management and Technology	**Executive**	**BAF Reference**	**Phasing Quarter**
8. Data Security Standards	Executive Director of Finance	BAF.0021	Q1
Quality	**Executive**	**BAF Reference**	**Phasing Quarter**
9. Infection, Prevention and Control	Director of Quality and Executive Director of Nursing, Professions and Operations	BAF.0023	Q1/2
10. Complaints	Director of Quality and Executive Director of Nursing, Professions and Operations	BAF.0024	Q3/4
11. *Client-Wide Project – Liberty*			

Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019 - Advisory			
People Management	**Executive**	**BAF Reference**	**Phasing Quarter**
12. Grievances and Disciplinaries	Director of People	BAF.0020	Q2
13. Recruitment	Director of People	BAF.0014	Q4

Terms of Reference

Document History:	
Version Number:	**3**
Approved by:	**Trust Board (pending – approval September 2022)**
Date approved:	**TBC for circulation to Audit and Risk Committee members via email – September 2022**

Name of Committee	**Audit and Risk Committee**
Type of Committee	Board Assurance Committee reporting to Board of Directors (the "Board")

1.	**Purpose of Committee**
	The Audit & Risk Committee ("the Committee") has been established to provide assurance to the Board of Directors in consultation with the other Board Committees that adequate and appropriate governance structures, processes and controls are in place throughout the Trust. In carrying out this function, the Committee will primarily use the work of internal audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from directors and managers as appropriate. The Committee may request and review reports and assurances (positive or negative) from directors and managers on the overall arrangements for governance and risk management. The Committee shall provide assurance to the Board on the probity of theTrust and support the other Board Committees in the achievement of clinical effectiveness and safe outcome for service users, maintaining positive service users and carer experience and equality and inclusion.
2.	**Scope**

The scope of the committee is Trust wide.

The Committee will:

- monitor~~ing~~ the integrity of the financial statements, assisting the Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions (this will include overseeing and monitoring arrangements for Data Governance and Cyber Security Management, Policy Governance and Risk Oversight which are supported by groups reporting into the Committee.
- provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities (clinical and non-clinical) both generally and in support of the annual governance statement.

The Board is responsible for ensuring effective financial decision-making, management and internal control including:

- management of the Foundation Trust's activities in accordance with statute and regulations;
- the establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

3. Authority/Accountability

The Committee is constituted as an assurancecommittee of the Board of.

The Committee is authorised by the Board to establish and delegate powers to sub-committee(s)and work groups. The Committee will oversee the work of those sub-committee(s) and work groups.

The Committee is authorised by the Board to investigate any activity withinits terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or independent professional advice or expertise as required to support it in discharging its duties. The budget for such advice must be within agreed financial constraints.

The Committee will advise the Board of Directors of any investigation being undertaken that instructs professional advisors and update the Board on progress.

The Committee will advise the Board of Directors of any investigation being undertaken that instructs professional advisors and update the Board on progress.

The Committee is authorised to make decisions that are not reserved to the Trust Board. Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions of the Trust.

The following matters that must be referred to the Board:

- Where there is significant revenue, capital or cash implications as determined by the Trust's Standing Financial Instructions
- Conflict with statutory obligations, or have significant governance implications
- Likely to arouse significant public or media interest.

4. Objectives of Committee

Financial statements and the annual report

(i) The Committee will: monitor the integrity of the financial statements of the Foundation Trust, any other normal announcements relating to the Trust's financial performance, reviewing the significant financial reporting judgements contained in them

(ii) review the Annual Statutory Accounts, before they are presented to the Board for approval, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- the meaning and significance of the figures, notes and significant changes;
- areas where judgement has been exercised;
- adherence to accounting policies and practices;
- explanation of estimates or provisions having material effect;
- the schedule of losses and special payments;
- any unadjusted statements; and
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

(iii) recommend to the Board that the Annual Statutory Accounts areapproved

(iv) review the Annual Report and Annual Governance Statement and recommend to the Board of Directors that the documents are approved

(v) review each year the accounting policies of the Trust and make appropriate recommendations to the Board

(vi) Review all accounting and reporting systems for reporting to the Board, including in respect of budgetary control

(vii) the Committee will be notified of and scrutinise losses, write-offs and compensation including special payments, ex-gratia payments and extra statutory or extra regulatory payments.

Internal Control and Risk Management

The Committee will:

(i) review the Foundation Trust's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance

(ii) review and maintain an oversight of the Foundation Trust's general internal controls and risk management systems

(iii) review processes to ensure appropriate information flows to the Committee from executive management and other Board committees in relation to the Trust's overall internal control and risk management position

(iv) review the adequacy of the policies and procedures in respect of all counter-fraud work. Receive the annual report from counter fraud

(v) review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks, including the Board Assurance Framework (BAF).

(vi) utilise and review the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors, managers, committee's and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

(vii) review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

Freedom to Speak Up: Raising Concerns (Whistleblowing)

The Committee will:

(i) review arrangements that allow staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters

(ii) Ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action, and ensure safeguards are in place for those who raise concerns.

Emergency Planning Resilience and Response (EPRR)

The Committee will:

(i) review and monitor compliance with the NHS England EPRR core standards, Civil Contingencies Act 2004 and provide positive assurance to the Board of compliance.

Corporate Governance

The Committee will:

(i) monitor and provide assurance to the Board on corporategovernance compliance (e.g. compliance with terms of the Licence, Constitution, Codes of Conduct, Standing Orders, Standing FinancialInstructions, maintenance of Registers of Interests).

consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

Internal Audit

The Committee will:

(i) at least annually, monitor and review the effectiveness of the Foundation Trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements

(ii) review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation. This includes ensuring the programme covers the breadth of the internal control environment ensuring relevant coverage of Clinical Quality, Governance, Risk Management and Legislation, performance and Data Quality, Workforce and Finance

(iii) oversee on an ongoing basis the effective operation of internal audit in respect of:

- adequate resourcing;
- its co-ordination with external audit;
- meeting relevant internal audit standards;
- providing adequate independence assurances;

(iv) it having appropriate standing within the Foundation Trust; consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations

(v) consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal of internal audit staff

(vi) where an audit report relates to a follow-up audit and high risk recommendations are still outstanding, the Executive Director shall attend the Committee meeting to provide an update on actions taken to address these recommendations

(vii) an audit recommendation self-assessment report, which includes a log of audit reports submitted to the Committee and any outstanding actions, shall be submitted to each meeting of the Committee for review

(viii) directors are responsible for providing an update at the Committee meetings on any outstanding actions that fall within their remit

(ix) assuring itself that the management of the Trust has implemented the agreed recommendations of internal audit reports in a timely and effective way.

External Audit

(i) The Committee will: review and monitor the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements.

(ii) assess the external auditor's work and fees each year. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards

(iii) oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, support the the Council of Governors in the appointment of the external auditors

(iv) the Council of Governors will take the lead in agreeing with the Committee the criteria for appointing, re-appointing and removing external auditors. To support them in this task, the Audit & Risk Committee should:

- provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees.
- Advise the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that advice is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons for non-adoption.

(v) discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other external auditors in the local health economy.

(vi) review external audit reports, including the Annual Audit Letter, together with the management response, and to monitor progress on the implementation of recommendations.

(vii) to develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance.

Standing Orders, Standing Financial Instructions and Standards Of Business

The Committee will:

(i) review Standing Orders, Standing Financial Instructions and any waiver or suspension on the documents

(ii) review the reasons for such waivers or suspensions must be reported by the Lead Executive to the Board of Directors and reports shall be received by the Committee.

(iii) review the Scheme of Delegation.

Other

The Committee will:

(i) review performance indicators relevant to the remit of the Committee

(ii) examine any other matter referred to the Committee by the Board and initiate investigation as determined by the Committee. Report back to theBoard on any finding following an investigation

(iii) the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector. Reports shall be received by the Committee.

(iv) oversee the work of, and receive assurance from the Data Information Governance Group (including data standards and data security arrangements)

(v) oversee the work of, and receive assurance from, the Policy Governance Group

(vi) oversee the work of, and receive assurance from, the Risk Oversight Group

5.	**Membership**

	The membership of the Committee will be: • Three Non-Executive Directors, one of which, with recent and relevant financial experience, will be appointed by the Board to chair the meetings • The Trust Chair should not be a member of the Committee, • The Committee shall have sufficient skills amongst its members to be able to discharge its responsibilities Executive Directors should not be appointed to the Committee. The role of the Executive is to attend, to provide information, and to participate in discussions, either for the whole duration of a meeting or for particular items.
6.	**Attendees**

Meetings of the Committee will normally be attended by:

- Executive Director of Finance
- Director of Corporate Governance (Board Secretary)
- Deputy Director of Finance
- A representative of the external auditors and a representative of the internal auditors
- A representative of the local counter fraud service may be invited to attend meetings of the Audit & Risk Committee.
- Governor observer

Other Non-executive Directors can attend as desired. Executive Directors will be invited to attend the Committee dependent on the business being discussed by the Committee.

7. Chair, Quorum, Attendance and Meetings

Chair
The NED Chair will preside at all meetings. In extraordinary circumstances where the Chair cannot attend, one of the Non-Executive Director members will chair the meeting.

Quorum
The Committee is quorate when at least two members are present.

Deputies may attend, with the agreement of the Chair. This will be by exception; they must be fully briefed and if formally deputising will count towards the quorum.

On the occasions when the Committee has arranged to meet and the Committee is not quorate, business can be discussed and provisional decisions can be made, but those decisions must be taken back to the next meeting of the Committee for ratification.

Attendance
Members are expected to attend all meetings. Apologies must be received by the Administrator in advance of the meetings. All members will be required to attend **a minimum** of two thirds of all meetings held annually. Members should not be absent for more than two consecutive meetings without the agreement of the Chair.

Any Committee member may participate in a meeting by way of telephone, computer or any other electronic means of communication provided that each person is able to hear and speak. A person participating in this way is deemed to be present in person although their actual location shall be noted in the minutes and is counted in a quorum and entitled to vote.

The meeting is deemed to take place where the largest group of those participating is

assembled, or if there is no such group, where the Chair of the meeting is located.

Meetings

Where a specific matter is deemed to be of a confidential or commercially sensitive nature the Chair has the authority to restrict attendance at the meeting to members only and to ask all invitees to leave the meeting.

If any member or invitee has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member or invitee to withdraw until its consideration has been completed.

8. Frequency and Notice of Meetings

Frequency

The Committee will normally meet five times per year. Additional meetings can be arranged for specific purposes as necessary, with agreement by the Chair.

If a matter of urgent business arises and an extraordinary meeting is required, this may be convened by the Chair, subject to the agreement of a quorum number of members. Decisions will be subject to achieving quorum attendance.

Where a decision needs to be taken outside the normal cycle of meetings, and where the matter is not deemed by the Chair to require an additional meeting to be called, the decision may be made via e-mail. The preference is for decisions to be taken at meetings. The decisions via e-mail process will be used on an exceptions basis. The process for decision via e-mail will be as follows:

a) An e-mail setting out the matter for decision will be sent to all members on the same working day. This shall include a statement setting out how the members should signify what their view on the matter is and the deadline for doing so.

b) Members will generally be given no less than five working days in which to respond.

c) For a decision to be passed, all of the members must express the same view on the matter.

d) Where members have comments on the proposed decision or recommendation/s these will be circulated to other Committee members by the Administrator within one working day of receipt.

e) If any individual member wishes to debate an item proposed for decision via e-mail at a meeting instead they may ask the Chair to arrange an additional meeting or defer the item for decision until the next meeting (such agreement by the Chair not to be unreasonably withheld).

f) Decisions via e-mail will be reported to the next meeting and the wording of the decision minuted. Any decision made in this manner will be effective from the date of agreement of all of the members and confirmed by email by the Administrator.

Notice of meetings

Meetings shall be called by the Administrator at the request of the Chair or any of its members.

Unless otherwise agreed, notice of each meeting and agenda of items to be discussed, shall be forwarded to each member, any other person required to attend no later than five full working days before the date of the meeting. Supporting papers shall be sent to

members and to other attendees as appropriate, at the same time.

Notices, agendas and supporting papers can be sent in electronic form where the recipient has agreed to receive documents in such a way.

A meeting workplan will be agreed on an annual basis, setting out the main work items to be carried out at each meeting to ensure that adequate time is given to the main objectives of the Committee.

9. Minutes and Reporting Arrangements

Tier II groups will report to the Committee as agreed within the governance structure.

The Committee will report to the Board on how it discharges its responsibilities. The Board will report back if it has any concerns about its adherence to the Terms of Reference.

The minutes of Committee meetings will be formally recorded and submitted to the Board. The Chair of the Committee will draw to the attention of the Board anyissues or decisions for disclosure or require executive action.

The Board will receive standing reports following each meeting and additional reports as part of the scheduled programme of annual reports.

In addition, the Committee will receive thematic 'deep dive' reports or reviews as required to enable greater discussion about specific issues and to facilitate in depth discussions between the members and those staff providing services.

The Board has ultimate responsibility for the effectiveness of its governance below Board. The Board will rely on the work of its Committees to provide assurance on the effectiveness of the governance structure.

10. Administrative arrangements

The Committee will be supported by a nominated Administrator who will:

- produce a schedule of meetings and maintain the annual work plan for the Committee
- prepare the agenda and papers with the Chair and circulate five working days prior to the meeting;
- maintain accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting;
- draft minutes, recording where the Committee has delivered its purpose through relevant reports and subsequent discussion, debate and challenge, and where further information is required, for circulation to the meeting Chair within five full working days of the meeting;
- organise future meetings; and
- file and maintain records of the work of the Committee in the required corporate records folder.

11. Meeting effectiveness review

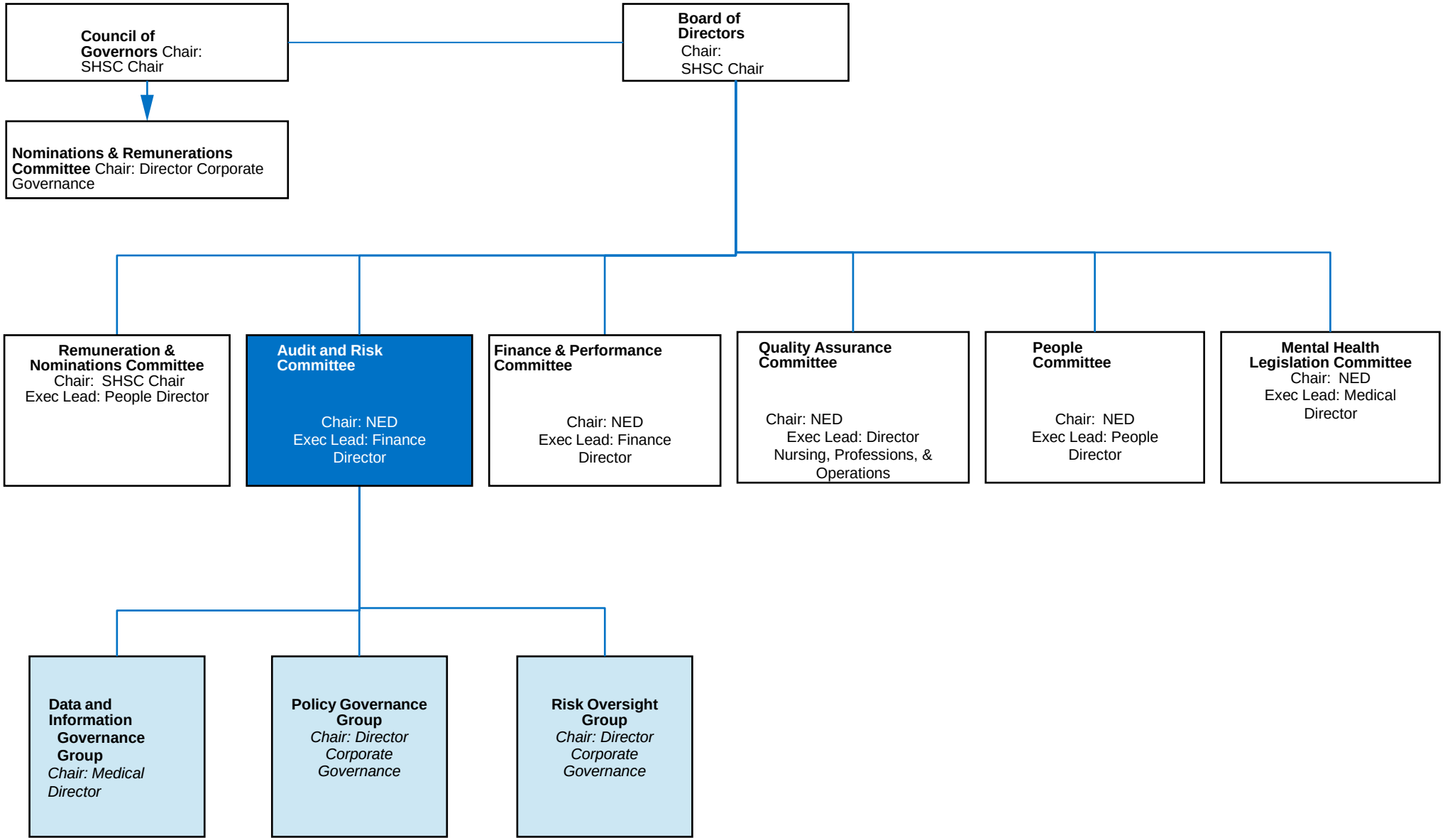
The Committee shall at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

	The Committee shall undertake appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members. A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair of the Committee.	
12.	**Review to be conducted by Committee Chair**	
	Date Committee established	1 July 2008
	Terms of Reference to be reviewed	Annually
	Date of last review	September 2022 amendments post last receipt at ARC were circulated for agreement via email prior to receipt at September Board.
	Date of next review	September 2023

The governance table will be updated to include roles.

Sheffield Health and Social Care NHS FT Governance Structure

Board & Committee Governance Structure – Audit & Risk Committee



ARC - SHSC Audit and Risk Committee – Self-Assessment 2022

Theme 1 – Committee focus

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
1a	The committee has set itself a series of objectives it wants to achieve this year	**3**				
1b	The committee has made a conscious decision about the information it would like to receive	**2**	**1**			
1c	Committee members contribute regularly across the range of issues discussed	**3**				
1d	The committee is aware of the key sources of assurance and who provides them.	**1**	**2**			
1e	Where appropriate, the committee receives assurances from third parties who deliver key functions to the organisation – for example NHS Shared Business Services (Payroll; Occupational Health) or private contractors	**1**	**1**	**1**		Delayed paper this year / still embedding Received some assurance from third parties across org re governance
1f	Equal prominence is given to both quality and financial assurance	**2**	**1**			

Theme 2 - Committee Team Working

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
2a	The committee has the right balance of experience, knowledge and skills to fulfil its role		**3**			Challengin g year with staff changes
2b	The committee has structured its agenda to cover quality, data quality, performance targets and financial control	**1**	**2**			
2c	The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives		**3**			
2d	Management fully briefs the committee on key risks and any gaps in controls	**1**	**2**			BAF dev and follow up weaknesse s

2e	Other committees provide timely and clear information in support of the Audit Committee	1	**1**	**1**		
2f	The committee environment enables people to express their views, doubts and opinions	**3**				
2g	Committee members understand the messages being given by external audit, internal audit and counter fraud specialist	**2**	**1**			
2h	Internal audit contributes to the debate across the range of the agenda		**2**			**1**
2i	Members hold their assurance providers to account for late or missing assurances		**3**			
2j	Decisions and actions are implemented in line with the timescale set down		**2**	**1**		Follow up concern again

Theme 3 – Committee Effectiveness

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
3a	The quality of committee papers received allows committee members to perform their roles effectively	**1**	**2**			
3b	Members provide real and genuine challenge – they do not just see clarification and/or reassurance	**3**				
3c	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints, etc.	**3**				
3d	Each agenda item is “closed off” appropriately so that I am clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.	**2**	**1**			
3e	At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc.	**3**				
3f	The committee provides a written summary report of its meetings to the governing body	**1**	**1**			**1**
3g	The governing body challenges and understands the reporting from this committee		**1**	**1**		**1**

3h	There is a formal appraisal of the committee's effectiveness each year	**1**	**2**			Behind schedule this year

Theme 4 – Committee Engagement

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
4a	The committee actively challenges management and other assurance providers during the year to gain a clear understanding of the findings	**1**	**2**			
4b	The committee is clear about its role in relationship to other committees	**2**	**1**			
4c	The committee receives clear and timely reports from reporting groups	**2**	**1**			
4d	We can provide two examples of where we as a committee have focused on improvements to the system of internal control as a result of assurance gaps identified	**1**	**2**			AAA dev / embedding Com gov, BAF

Committee Leadership (not to be completed by Chair)

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
5a	The committee Chair has a positive impact on the performance of the committee	**2**	**1**			
5b	Committee meetings are chaired effectively	**3**				
5c	The committee Chair is appropriately visible within the organisation and is considered approachable	**1**	**1**			**1**
5d	The committee Chair allows debate to flow freely and does not assert his/her own views too strongly	**3**				
5e	The committee Chair provides clear and concise information to the governing body on committee activities and gaps in control	**1**	**1**			**1**

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Board of Directors – Open

APPENDIX 2

SUMMARY REPORT	**Meeting Date:**	28th September 2022
	Agenda Item:	7

Report Title:	**Quality Assurance Committee Meeting Effectiveness Annual Report**
Author(s):	Beverley Murphy, Director of Nursing, Professions and Operations & Deputy CEO
Accountable Director:	Beverley Murphy, Director of Nursing, Professions and Operations & Deputy CEO and Heather Smith, Non-Executive Director and QAC Chair
Other meetings this paper has been presented to or previously agreed at:	Quality Assurance Committee, 10/08/2022
Key points/ recommendations from those meetings	None

Summary of key points in report

The Quality Assurance Committee Annual Report is attached for assurance and approval. It provides an update on the membership and attendance at meetings; meeting frequency during the year and planned for the year ahead; work of the committee over the last year; key matters escalated to the Board; delivery against its objectives; outcome of the review of effectiveness and any proposed changes to the Terms of Reference. The objectives for the following year are also included.

Recommendation for the Board/Committee to consider:

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

The committee is asked to receive and approve for assurance and onward reporting to the Board, the annual report on how the Quality Assurance committee has met its obligation as a sub committee of the Board.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good – Continuing to improve	*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*		*Quality and safety standards which we are regulated by the CQC to meet as set out in the Health and Social Care Act.*
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?		***X***			*Across the year a range of subject matter experts present for which their area standards to meet, for*

					example health and safety. Our Obligations to deliver care consistent with the requirements of the Health and Social Care Act and the NHS Constitution provide a good overarching set of standards for this overarching report.

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*	***X***	*No*		*This is an annual report on the committee effectiveness and looks at a full range of reports across a 12-month cycle. Each of the individual papers as presented has set out considerations against these themes.*
Financial (revenue &capital)	*Yes*	***X***	*No*		
Organisational Development /Workforce	*Yes*	***X***	*No*		
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		
Legal	*Yes*	***X***	*No*		

Annual Report from the Quality Assurance Committee to the Board received at committee in September 2022

1. Introduction and background

The purpose of this report is to:

- Provide assurance to the Board that the Quality Assurance Committee has carried out its obligations with its Terms of Reference (ToR). A copy of the ToR is provided at **Appendix B**, the ToR was reviewed in July 2022 and updated.

- Provide an update to the Board on the work of the Quality Assurance Committee during 2021/22, a reminder of matters escalated to the Board or referred to other Board sub committees, and detail on the work plan and objectives for the financial year 2022/23.

2. Membership and meetings

Membership

2.1 The ToR's require three non-executive directors to be members of the committee. The meeting is quorate if two members are present. The ToR's identify Directors or senior leaders who are required to participate as regular attendees. Other Executive Directors or managers including the Director of Strategy have also been requested to attend the Committee throughout the year to discuss specific items including.

At the review of the ToR in 2022 it was agreed that the Committee can move to having a representative of the Clinical Leadership Team for each of the Clinical Directorates and not needing both the Head of Nursing and Clinical Director at each meeting.

The 2022 review of the ToR also resulted in a change in attendance by the SY ICS Sheffield, formerly the CCG. In recognition of the changing CQC rating regarding the quality of care, the removal of SHSC from needing enhanced support from NHSE (Special Measures) and the improvement in the segmentation within the oversight framework from 4 to 3 the SY ICS Sheffield are no longer members or attendees at the Quality Assurance Committee, a set of papers are made available to SY ICS Sheffield for information.

Meetings and frequency

2.2 In the period April 2021 – March 2022 the Committee met 12 times on the following dates:

- Wednesday 14 April 2021
- Wednesday 12 May 2021
- Wednesday 9 June 2021
- Wednesday 14 July 2021

- Wednesday 11 August 2021
- Wednesday 8 September 2021
- Wednesday 13 October 2021
- Wednesday 10 November 2021
- Wednesday 8 December 2021
- Wednesday 12 January 2022
- Wednesday 09 February 2022
- Wednesday 9 March 2022

The committee has remained quorate throughout the year

It is recommended the meeting frequency for 2022/23 be reduced by one meeting removing the December meeting and consideration was given about removing the August meeting, going forward, with the opportunity to stand up a short meeting for matters pertaining to risks as required. A decision was taken at the August 22QAC to keep the meeting date in the diary and only to use the August meeting for issues of risk or concern that could not wait until a future meeting.

Attendance at meetings

2.3 All 12 meetings were quorate in 2021/22.

2.4 The Quality Assurance Committee Terms of reference require membership of three Non-Executive Directors, two Executive Directors – Nursing and Medicine and the Director of Quality.

Attendance of individual members for the meeting held during the financial year were as follows:

Member name and role	**Attendance record**
Sandie Keene, Committee Chair and Non-Executive Director Left January 2022	8/9
Richard Mills, Non-Executive Director	7/12
Heather Smith, Non-Executive Director Committee Chair from January 2022	12/12
Professor Brendan Stone, Associate Non-Executive Director	6/6
Beverley Murphy, Director of Nursing, Professions and Operations & Executive Director	10/12*
Dr Mike Hunter, Executive Medical Director	11/12*
Dr Olayinka Fadahunsi, Non-Executive Director	8/10
*Absence was planned with appropriate deputy attendance	

The following individuals also routinely attended meetings:

Name and role
Susan Barnitt, Head of Clinical Quality Standards
Alun Windle (or deputy), Chief Nurse Sheffield CCG
Tania Baxter, Head of Clinical Governance
Neil Robertson, Director of Operations and Transformation
Susan Rudd, Director of Corporate Affairs (now Deborah Lawrenson)
Christopher Wood, Head of Nursing
Simon Barnitt, Head of Nursing
Emma Highfield, Head of Nursing (now Kirsty Dallison – Perry)
Vin Lewin, Patient Safety Specialist
Deborah Cundey, Interim Head of Performance
Teresa Clayton, Head of Experience
Dr Robert Verity, Clinical Director
Dr Jonathan Mitchell, Clinical Director
Dr Helen Crimlisk, Deputy Medical Director
Samantha Crosby, Health & Safety Manager

3. Work plans and activity during the year

Work plan for 2021/22

3.1 The Quality Assurance Committee has a well-established 'forward work plan' which sets out the annual cycle of work and reporting. This is received at each meeting and updated as required.

3.2 The committee works with other Board sub committees and will receive mattes for its consideration and refer matters to the other sub committees as required for assurance purposes.

3.3 Prior to the meeting the Chair of the committee Heather Smith reviews the planned agendas with the Executive Lead Beverley Murphy and the committee secretariat Francesca O 'Brine.

Committee activity in 2021/22

3.4 Key activity during the financial year included the following:

- Monthly consideration of the Integrated Quality and Performance report and using the data and the discussion to understand the risks to quality and the areas of improvement.

- The Committee has focussed on key risks including the unacceptable waits for some community services, the delay in a bed being available at the point of need and the challenge with consistently achieving an acceptable standard of Care Programme Approach reviews. The committee has also followed up reports where the risk to quality had been identified including care at Woodland View, G1 ward and Birch Avenue.

- In 2021 the committee gave energy to understanding the identified quality of care issues at Firshill Rise Assessment and Treatment Unit and has followed closely the development of a proposed new model of care for the citizens of Sheffield.

- Consideration of the selection of Quality Priorities and ensuring oversight of the progress across the year.

- The Committee has received a quarterly report on patient experience and has been focussed across a range of reports on how we achieve involvement and co-production across all our services and more generally as part of our Team SHSC culture. Closely linked to this has been the receipt of the Carers and Young Carers Strategic reports helping us to keep alive the importance of Carers in all that we do. The Lived Experience Strategy was received and approved as well as the co-production standards as well as the Service User Engagement and Experience strategy.

- Considering a range of reports pertaining to incidents of harm to patients and exploring the learning and changes in practice that have taken place. This includes medicines safety reports, the committee has supported the need to improve prescribing and administration competence to reduce potential harm to patients.

- The Committee is the reporting route for the Mortality Reporting process and has been keen to understand how we get the best learning to promote change out of the death of a service user.

- Consideration of how we are meeting our commitment to improve quality and get back to Good. Reports detail how we are meeting our regulatory requirements to improve and improve beyond the actions we must and should meet. A key focus in this work has been how we achieve a consistent and good standard to physical health care across our services, the Committee received and approved the Physical Health Care strategy which included a progress report on End-of-Life Care. Related to this the Committee has been keen to understand the new approach to Culture and Quality visits as a mechanism for assessing how services are doing and being curious about the potential of a closed culture and the impact on care.

- Seeking assurance on the progress with development of fit for purpose Community Service models has been a regular feature in the committee. The Committee sought to understand the immediate risks to quality as well as the need to transform and meet the commitment of the Long-Term Plan.

- As a part of the SHSC commitment to drawing in learning from outside the Committee received and considered a set of recommendations from the Ockenden report. Committee members had reflected on the applicability of the learning, and we could further improve our commitment to consistently high-quality care where any risk to quality and safety is understood and acted upon to improve care.

- The Committee has received detailed reports in how we are meeting our responsibilities to protect people from harm. This information is from regular presentations of our Safeguarding reports, subject matter experts present to the committee and elucidate our responsibilities.

- The outcomes from Board visits have been presented to be used to triangulate with the data and narrative about our services and for the Committee to seek assurance that actions are being taken forward.
- The Committee has sought assurance that we have a robust QEIA process in place and that we understand the potential impact of our transformation and change activity.
- The Committee has demonstrated a keen focus on understanding the need to reduce restrictive practice and has monitored this closely including receiving the Reducing Restrictive Practice Strategy and strategy implementation progress reports.
- The Committee has been interested to understand the nature of complaints, the timeliness of responses to service users and the learning that is taking place.
- Our compliance with Infection Prevention and Control standards has been reported into the Committee for oversight and assurance. All reports have been supported by a subject matter expert.
- The Committee has received and considered the outcomes of CQC inspections and the improvement actions that have followed. The focus on this is name as Back to Good which is a routine area of focus at each Committee.
- The Adult Secure Provider Collaborative was discussed to support decision making about the leadership of this programme in the year ahead.
- The Committee has extended the focus on effectiveness beyond research and has been seeking information about innovation, effectiveness and improvement. The Research and Innovation strategy was received and approved. This is an area for development and in the year ahead the Committee is very keen to receive the outcomes of clinical audit and Quality Improvement.
- The Committee has also considered reports on Nutrition and Hydration, Health and Safety, Sexual Safety, Eliminating Mixed Sex Accommodation, Litigation and Claims and the Care Act. Reports on Supervision have been considered and it is recognised this is a focussed area for the People Committee.

The committee activity is consistent with the areas of focus required to achieve assurance and the proximity of risks in line with the BAF risks held by the committee 2021 - 22:

Current Risk Score			Target Risk Score		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
BAF 0025: There is a risk that patients could come to harm in our inpatient wards and that inpatient and community environments do not support therapeutic care; **caused by** environments that are not fit for purpose and present unacceptable risks to patient safety; **resulting in** an over reliance on enhanced observations, a restrictive approach to manage safety issues thereby deskilling staff, staff time dedicated to managing environments rather than delivering patient care and giving a very poor patient experience.					
4	5	20	3	3	6
BAF 0023: There is a risk that we fail to protect service users and staff from the spread of Covid19 infection; **caused by** operational systems and processes staff and patients not adhering to the relevant IPC guidance consistently; **resulting in** preventable spread of infection and risks to health and safety of our staff and the people in our care.					
3	5	15	1	4	4
BAF 0024: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care; **caused by** leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic; **resulting in** risk of harm to people in our care and a breach in the Health and Social Care Act					
3	4	12	2	3	6

The BAF has been amended in year in accordance with the assurances received in year. It is recognised that in the year ahead the BAF should be utilised in a more dynamic way to set the agenda for the Committee and to seek assurances that close gaps in assurance and enable us to have a good understanding of the risks to quality and the mitigations that are required to reduce the likelihood of risks materialising.

4. Matters escalated to the Board or referred to other Board sub committees

4.1 As of July 2021 following each meeting the Quality Assurance Committee has provided an Alert, Advise and Assure (AAA).

4.2 Key matters escalated to the Board in the financial year included the following:

- The volume of Safeguarding Referrals that SHSC are managing within the delegated duties from the Local Authority.
- The need to learn and improve on our medicines management.
- Risks to the quality of care on G1 Ward and Birch Avenue.
- The need to accelerate the replacement of fire doors in some areas.
- The capacity to assure ourselves that all providers in the secure collaborative are delivering high quality care.
- The risk that the increasingly outdated utility of Insight has in clinical care.
- Inconsistent delivery of Physical Health Care.
- Non delivery of internal audit actions.

- The need for the Board Assurance framework and Corporate Risk Register to be used in a dynamic way as live documents.
- Challenges with achieving flow across the acute care pathway, the length of stay in some areas and the use of out of area placements.
- Gaps in the CIP planning process leading to risks to delivery.
- Waiting times in some community services and a lack of traction with recovery.
- The impact of Covid outbreaks on internal capacity to deliver improvements.
- The lack of improvement in Care Programme Approach targets in the community recovery teams and early intervention.
- Poor supervision rates in some teams.
- The need to improve our grasp of complaints in order that people in our care have a quality response, we have confidence we are meeting our duty of candour and we are clear about what we have learned.

4.3 An example of a matters referred to other Board sub committees included the following:

- There has been a cross cutting conversation between the Quality Assurance Committee and the People committee about the compliance with the Supervision standard and the quality of the supervision.

5. Committee effectiveness

Process for review of committee effectiveness

5.1 A self-assessment review was undertaken by the Committee and received at the committee in July 2022. This involved circulation of a questionnaire with statements for members to confirm their level of agreement the committee fulfilled the stated requirement; the outcome of the questionnaire was received in the July 2022 Committee. This form will be reviewed in 2022/23 to ensure it meets current needs, it will include opportunity for comments, and it will made available in electronic form for ease of completion and to support data extraction for onward reporting. The self-assessment process looking back at 2022/23 will take place in readiness for reporting to committee in January/February 2023 and to Audit and Risk Committee in April followed by an amalgamated report on annual reports from all sub committees to the Board in May 2023.

The committee focus was generally thought to be positive with indication that more could be done to ensure all members contribute and that we are clear about our objectives. The responses were mostly positive about the team working in the committee. The committee was rated as effective with a comment being made about agendas that are full and one response indicating the need for increased challenge. The leadership of the committee was unanimously rated as effective.

5.2 There is a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting. There is recognition that the time to complete this activity has been limited.

5.3 The outcome of the annual review report was received at the committee held on 10th August 2022.

Assessment against objectives agreed for 2021/22

5.4 The following objectives were listed with the ToR the committee for 2021/22:

The Committee will:

- Ensure Trust-wide clinical governance, clinical risk management arrangements and quality improvement and assurance strategies are in place and fit for purpose.
- Ensure clinical governance and clinical risk management systems and processes are continually developed and monitored to deliver high quality clinical care to the highest standards and minimise risk to service users.
- Ensure that negotiations with commissioners and stakeholders are based on maintaining high quality standards.
- Oversee the key performance indicators capable of demonstrating improvements in safety, effectiveness and service user experience and/or early warning of risk at all levels of the organisation.
- Oversee development and review of the Annual Quality Report and recommend approval to the Board of Directors.
- Seek assurance that service users and carers are engaged in the business of the organisation and have a voice in service provision, organisational change and service improvements.
- Seek assurance that risk management processes are underpinned by a culture of openness and transparency.
- Ensure robust mechanisms are in place to maintain its registration with any required regulatory bodies; oversee all risks delegated to the Committee via the
- Corporate Risk Register (CRR) and Board Assurance Framework (BAF).
- Monitor improvement following visits by the Care Quality Commission, including evidence of practice being embedded where necessary.
- Monitor the timely review of policies in relation to its area of responsibility following approval by the Policy Governance Group.
- Review the outcome of audits relating to its area of responsibility and contribute views to the Audit and Risk Committee as required.
- Uphold the values of the organisation in the work it does. In particular it will look for assurances that these values are being delivered as part of its overall governance role on behalf of the Board.

6. Committee objectives for 2022/23

6.1 The committee objectives were discussed at the August 2022 Quality Assurance Committee; in the year ahead the committee will focus on:

- Recovering performance in the use of inappropriate Out of Area bed use, completed CPA reviews and delays in people accessing care
- Inclusion, equality, and diversity across the range of issues considered
- Supporting the development of the tier two committees that report into QAC to strengthen our learning and assurance.

6.2 Progress against the objectives once agreed and approved by the Board will be reviewed at either six monthly or quarterly intervals depending on the frequency of the committee meetings.

7. Work plan 2022/23

7.1 The Committee's workplan for 2022/23 is detailed in **Appendix A** and is presented for approval and agreement to share with the Board for endorsement.

8. Review of Terms of Reference

8.1 The Terms of Reference have been reviewed and are attached at **Appendix B** and are presented for approval and agreement to share with the Board for endorsement.

9. Conclusion

9.1 The Committee assures the Board it continues to function appropriately as a standing committee of Trust's Board of Directors, effectively overseeing the duties as set out in the agreed Terms of Reference.

Supporting information

Appendix A – Committee workplan 2022/23 updated as at Sept 2022

Appendix B – Terms of Reference updated as at Sep 2022

Annual Planner for Quality Assurance Committee July 2022 - June 2023

Standing items	**Frequency**	**Exec Lead**	**Author**	**13/7/22 Q1**	**10/8/22 Q1**	**14/9/22 Q1**	**12/10/22 Q2**	**9/11/22 Q2**	**14/12/22 No meeting**	**11/1/23 Q3**	**8/2/23 Q3**	**8/3/23 Q3**	**12/04/23 Q4**	**10/5/23 Q4**	**7/6/23 Q4**
Apologies	Monthly	Chair	N/A	X	X	X	X	X		X	X	X	X	X	X
Declaration of Interests	Monthly	Chair	N/A	X	X	X	X	X		X	X	X	X	X	X
Minutes of previous meeting	Monthly	Chair/EDoNPO	N/A	X	X	X	X	X		X	X	X	X	X	X
Matters Arising	Monthly	Chair	N/A	X	X	X	X	X		X	X	X	X	X	X
Action log	Monthly	Chair/EDoNPO	N/A	X	X	X	X	X		X	X	X	X	X	X
Emerging Quality Risks	Monthly	EDoNPO	N/A	X	X	X	X	X		X	X	X	X	X	X
Any Other Business	Monthly	Chair	N/A	X	X	X	X	X		X	X	X	X	X	X
Governance	**Frequency**	**Exec Lead**	**Author**	**13/7/22 Q1**	**10/8/22 Q1**	**14/9/22 Q1**	**12/10/22 Q2**	**9/11/22 Q2**	**14/12/22 No meeting**	**11/1/23 Q3**	**8/2/23 Q3**	**8/3/23 Q3**	**12/04/23 Q4**	**10/5/23 Q4**	**7/6/23 Q4**
Quality Related Policies	Monthly	Dir Corp Gov	D.Lawrenson	X	X	X	X	X		X	X	X	X	X	X
Board Assurance Framework	Quarterly	Dir Corp Gov	D.Lawrenson	X		X		X		X		X		X	
Corporate Risk Register	Quarterly	Dir Corp Gov	D.Lawrenson	X		X		X		X		X		X	
Internal Audits – Action Tracking Report *(new standing item for each sub-committee as agreed by ARC)*	Monthly	Dir Corp Gov	D.Lawrenson	X	X	X	X	X		X	X	X	X	X	X
Safer Staffing Mid-Year Review	Two per year	EDoNPO	B.Murphy		X	X (verbal report only at Aug, so full at Sept)					X				
Self-Assessment Questionnaire to be distributed to and completed by Committee in December 2022	Annual - December														
Committee Effectiveness Questionnaire Review	Annual	Dir Corp Gov	D.Lawrenson							X					
Terms of Reference Review	Annual	Dir Corp Gov	D.Lawrenson							X					
Annual Report of Meeting Effectiveness To Include: Collaboratives Alliancing	Annual	EDoNPO	B.Murphy	X(D)	X (Behind on all comm effectiveness reports so deferred to Aug)						X				
Review of Effectiveness of Tier 2 Groups that report into QAC (Back to Good action)	Annual	EDoNPO	B.Murphy			X						X (late in 2022)			
Eliminating Mixed-Sex Accommodation (EMSA) Declaration of Compliance	Annual	EDoNPO	V.Lewin											X	
Complaints Annual Report	Annual	EDoNPO	T Baxter												X (Workplan development – BM moved to June for 2023 (July in 2022))
~~**Claims and Litigation Annual Report**~~ *QAC September 2022: Committee agreed this is not a quality report and should be moved to the ARC Work Plan. Learning Lessons will be included in reporting to QAC.*	~~Annual~~	~~Dir Corp Gov~~	~~D.Lawrenson~~	~~X (D)~~	~~X (D) (DL instructed move to Aug (14/06/22) no info received from Capsticks)~~	~~X (deferred from Aug as no data available)~~									
CQC Statement of Purpose Annual Review	Annual	S.Barnitt	B.Murphy			X									
Annual Quality Account	Annual +6-monthly Progress Report	EDoNPO	T.Baxter											Draft Version	Final Version
Quality Objectives	Quarterly	EDoNPO	T.Baxter		X (D)	X (deferred from Aug as report not available)		X (To include progress report on annual report)			X			Q4 included in draft & final Qual Acc	Q4 included in draft & final Qual Acc
Strategies	**Frequency**	**Exec Lead**	**Author**	**13/7/22 Q1**	**10/8/22 Q1**	**14/9/22 Q1**	**12/10/22 Q2**	**9/11/22 Q2**	**14/12/22 No meeting**	**11/1/23 Q3**	**8/2/23 Q3**	**8/3/23 Q3**	**12/04/23 Q4**	**10/5/23 Q4**	**7/6/23 Q4**

Quality Strategy (Patient Safety Strategy is embedded within this) Progress with implementation of work plan	6-monthly Progress Report	EDoNPO/EMD	S.Barnitt				Progress Report (SM requested Oct progress report 15/09/22)	X(D) Deferred from Oct as quality event postponed						Progress Report	
Clinical and Social Care Strategy **Progress Report with the implementation of work plan** To include slide set reporting on: Progress of key performance areas - on or off trajectory New risks Progress with implementation of work plan	Annual +6-monthly Progress Report	EMD	L.Wilkinson				Progress Report (moved from Sept – workplan development – different months to Qual Strat, report in separate quarter)						Annual (moved from March – workplan development – different months to Qual Strat, report in separate quarter)		
Research Strategy **Progress report – progress with implementation of work plan**	Annual +6-monthly Progress Report	EMD	M.Horspool							Annual					Progress Report
Lived Experience Strategies (including Carer's Strategy)	Annual +6-monthly Progress Report							Progress Report						Progress Report	
Safety and Excellence in Patient Care	**Frequency**	**Exec Lead**	**Author**	**13/7/22 Q1**	**10/8/22 Q1**	**14/9/22 Q1**	**12/10/22 Q2**	**9/11/22 Q2**	**14/12/22 Q2**	**11/1/23 Q3**	**8/2/23 Q3**	**8/3/23 Q3**	**12/04/23 Q4**	**10/5/23 Q4**	**7/6/23 Q4**
Back to Good Reporting - full report Full report for information and assurance, risks for escalation up front	Quarterly	EMD	S.Barnitt		x		x				x			x	
Back to Good Reporting - risk report To include slide set reporting on: Progress of key performance areas - on or off trajectory New risks	Quarterly	EMD	S.Barnitt			X (5 mins)		X (5 mins)				X (5 mins)			X (5 mins)
CQC - inspection reports/notices/improvement plans	Agenda placeholder	EMD													
IPQR To Include: Risks Improvement plans	Monthly	EDoNPO	HoN/CD	X	X	X	X	X		X	X	X	X	X	X
Improvement Plans: 1. **CPA Compliance (how we look at compliance going forward)** 2. **OOA Use** 3. **Waiting Times** **Allocation of Key Workers**	Aligned to FPC	EDoNPO	HoN/CD		X Waits V Length of Stay	X				X		X			X
Infection, Prevention, and Control Report **Progress Report to include:** PLACE IPC Group 3A Report Implementation of work plan	6-monthly progress report + Annual	EDoNPO	A.Hendzell		Annual						Progress Report				
Learning Disability Transformation: Clinical Model Progress Report	Quarterly	EMD	H.Mahmood	X			X			X			X		
Health and Safety Report Annual report & quarterly progress report with implementation of workplan and any key risks highlighted To include slide set reporting on: Progress of key performance areas - on or off trajectory New risks	Annual + quarterly progress report	Dir Strategy	S.Crosby			X	Annual				X				X
Physical Health Progress Report To Include: PH Group 3A Report **Physical Health Annual Report** To Include: Progress with strategy, progress on Nutrition and Hydration	3 times per year – remains a risk	EDoNPO	PH Lead Nurse		X						X				Annual

Safeguarding Report **Progress Report with implementation of workplan, key activity, and key risks** To Include: Safeguarding Assurance Committee 3A Report	6-monthly + Annual	EDoNPO	H.Litten	Annual (D)	Annual (D) - (Salli M confirmed deferral to Aug as prioritising SG training (15/06/22))	Annual (deferred from Aug to ensure Safeguarding Assurance Committee received first)				Progress Report - (work plan development – moved along one month to align with 6-monthly)					
Clinical Quality and Safety Tier 2 Report To Include: **04/09/2022: Serious Incidents information (aligned to Ockenden) key learning from incidents, complaints, and Sis (previously known as learning lessons)** 3A Report Tendable, Culture and Quality, Incident and Complaint KPIs, PSIRF Ligature Anchor Points. Staff learning bulletins Quarterly: Slide set reporting on progress of key performance areas - on or off trajectory, and new risks	Every other quarter Quarterly slides	EDoNPO	S.Midgley/ V.Lewin/G.Kinsey-Oxspring / A.Eckhardt			X				Quarterly slides		X			Quarterly slides
Medicines Safety Report **6-monthly progress report with implementation of work plan** To Include: MOC 3A Report **Annual Report** To Include: Work plan	Annual	EMD	A.Allinson			Progress Report							Annual		
Mortality Report To Include: What we can learn and change	Quarterly	EDoNPO	V.Lewin		X			X			X		Annual	X	
Lived Experience and Co-Production Assurance Group Report To Include: 6-monthly slide set reporting on progress of key performance areas - on or off trajectory, and new risks Progress report to include implementation of work plan and key risks	Annual +6-monthly Progress Report	EDoNPO	S.Midgley/T.Clayton				Progress Report						Annual		
Restrictive Practice Report (for information)	Annual + 6-monthly report	EDoNPO	S.Midgley/L.Cain		X (Aug – in 2022 only, 6-months after annual)		Annual after Sept MHLC						X		
Community Mental Health Services Progress Report	3 per year	EDoNPO	N.Robertson/G. Hackney	X				X				X			
National Documents	Agenda placeholder														
Efficient and Effective Use of Resources through Evidence-Based Clinical Practice	**Frequency**	**Exec Lead**	**Author**	**13/7/22 Q1**	**10/8/22 Q1**	**14/9/22 Q1**	**12/10/22 Q2**	**9/11/22 Q2**	**14/12/22 No meeting**	**11/1/23 Q3**	**8/2/23 Q3**	**8/3/23 Q3**	**12/04/23 Q4**	**10/5/23 Q4**	**7/6/23 Q4**
Community Mental Health Survey	Annual	EDoNPO	N.Robertson							X					
Infection, Prevention, and Control Internal Audit Report	As per Internal Audit Plan. Before Oct ARC	EDoNPO	360Assurance				~~X~~			X (D) Deferred from Oct – delayed to Q3/4 – BM & 360Assurance clinical specialist agreed to deferral (Angela Hendzell 21/09/22)					
Receipt of SHSC Clinical Audit Outcomes *placeholder line*	**TBC – CHECKING WITH MIKE**														
Complaints Internal Audit Report	As per Internal Audit Plan. Before Jan or Apr ARC	EDoNPO	360Assurance							X					
Board Visits	6-monthly	EDoNPO	A.Eckhardt				X								X
Quality and Equality Impact Assessments	Quarterly	EDoNPO	Z.Sibeko		X (verbal report to QAC – none to report. Defer to next report to QAC)			X			X			X	
Research, Innovation, Effectiveness, and Improvement Group (RIEIG) Quarterly Report To include slide set reporting on: Progress of key performance areas - on or off trajectory New risks **RIEIG Annual Report** To Include: All clinical audits - POMH-UK Audit, NCAP All published NICE guidance including technology assessment National best practice National learning CQUINs Horizon scanning	Quarterly + Annual	EMD	N.Bell		X		Annual			X					X

To Note for future Agendas	Frequency	Exec Lead	Author	13/7/22 Q1	10/8/22 Q1	14/9/22 Q1	12/10/22 Q2	9/11/22 Q2	14/12/22 No meeting	11/1/23 Q3	8/2/23 Q3	8/3/23 Q3	12/04/23 Q4	10/5/23 Q4	7/6/23 Q4
SHSC Response to Sheffield Adult Crisis Pathway Review *Requested at May 2022 QAC: bring back to Committee to close the loop on actions and feedback on progress*	One-off request	EDoNPO	C.Wood							X					
Substance Misuse Contract Expansion (*Neil to confirm when paper will come back to QAC*)	One-off	EDoNPO	N.Robertson		X (FPC report received – report to come to QAC once flow of money is understood)										
Infection, Prevention, and Control Committee: options to meet FFP3 compliance *(under review – BM to discuss when back off leave whether to take in October)*	One-off – **under Any Other Business**						X (TBC)								
Implementation Plan for Ockenden		EDoNPO	S.Midgley				X								
Annual Equality and Human Rights Report *(Will be presented to PC Nov 2022 and progress report to Nov 2022 Board. Liz Johnson is speaking to Heather about this.)*	Annual		L.Johnson					X							
Crisis Service Information and Telephone Helpline/Sheffield Crisis Service Review *(Kirsty Micklethwaite emailed to ask if this was on the Oct QAC agenda and that Chris Wood is leading on this item.)*			C.Wood				X								

KEY
6-monthly reporting

Terms of Reference

Document History:	
Version Number:	**12**
Approved by:	**Trust Board (pending – September 2022)**
Date approved:	**For receipt at QAC September 2022**

Name of Committee	**Quality Assurance Committee**
Type of Committee	Board Assurance Committee reporting to Board of Directors (the "Board")

1. Purpose of Committee

The Quality Assurance Committee (the "Committee") has been established to oversee and ensure the effective delivery of:

- safe care at all times;
- timely access to effective care;
- positive experience and outcomes for service users and carers;
- effective quality assurance and improvement underpins all we do.

The Committee shall provide assurance to the Board on the probity of theTrust and support the other Board Committees in the achievement of clinical effectiveness and safe outcomes for service users, maintaining positive service userand carer experience and equality and inclusion.

Some specific areas identified by NHSE/I are requiring oversight at committee level or by named individuals and which would be covered by this committee as part of regular reporting includes where relevant: *Hip fracture, falls and dementia; learning from deaths; safety and risk; palliative and end of life care; health and safety; children and young people; resuscitation policy and safeguarding.*

2. Scope

The scope of the Committee is Trust-wide. It will review and monitor arrangements around quality and safety of care, experience and outcomes following an annual programme of work.

Authority/Accountability

3.	The Committee is an assurance Committee of the Board of Directors for matters relating to quality assurance as stated in the purpose. The Committee reports to the Board and sits within the portfolio of the Executive Director of Nursing, Professions and Operations. The Committee is authorised by the Board to establish and delegate powers to sub-committee(s)and work groups. The Committee will oversee the work of those sub-committee(s) and work groups. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and expertise as required to support it in discharging its duties. The budget for such

advice must be within agreed financial constraints.

The Committee is authorised to make decisions that are not reserved to the Trust Board. Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions of the Trust.

The following matters that must be referred to the Trust Board:

- Where there is significant revenue, capital or cash implications as determined by the Trust's Standing Financial Instructions
- Conflict with statutory obligations, or have significant governance implications
- Likely to arouse significant public or media interest.

4. Objectives of Committee

The Committee will:

(i) ensure Trust-wide clinical governance, clinical risk management arrangements and quality improvement and assurance strategies are in place and fit for purpose;
(ii) ensure clinical governance and clinical risk management systems and processes are continually developed and monitored to deliver high quality clinical care to the highest standards and minimise risk to service users;
(iii) ensure that negotiations with commissioners and stakeholders are based on maintaining high quality standards;
(iv) oversee the key performance indicators capable of demonstrating improvements in safety, effectiveness and service user experience and/or early warning of risk at all levels of the organisation;
(v) oversee development and review of the Annual Quality Report and recommend approval to the Board of Directors;
(vi) seek assurance that service users and carers are engaged in the business of the organisation and have a voice in service provision, organisational change and service improvements;
(vii) seek assurance that risk management processes are underpinned by a culture ofopenness and transparency;
(viii) ensure robust mechanisms are in place to maintain its registration with any required regulatory bodies; oversee all risks delegated to the Committee via theCorporate Risk Register (CRR) and Board Assurance Framework (BAF); the Committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps. The Committeeshould provide assurance to the Board on the risks delegated to the Committee and highlight any key areas of concern identified by the Committee.
(ix) monitor improvement following visits by the Care Quality Commission, including evidence of practice being embedded where necessary;
(x) monitor the timely review of policies in relation to its area of responsibility following approval by the Policy Governance Group;
(xi) review the outcome of audits relating to its area of responsibility and contribute views to the Audit and Risk Committee as required;
(xii) uphold the values of the organisation in the work it does. In particular it will lookfor assurances that these values are being delivered as part of its overall governance role on behalf of the Board.

5. Membership

	Three Non-Executive Directors – one of which will be appointed chair. Executive Director of Nursing, Professions and Operations (Executive Lead) Executive Medical Director

	Director of Quality Membership will be reviewed annually.
6.	**Attendees**
	Meetings will normally be attended by: • Director of Operations and Transformation • One representative from each Clinical Directorate clinical leadership team • Director of Quality • Service User Representative • Committee Administrator • Governor Observer Other directors or their deputies may be asked to attend meetings or part meetings for discussions on matters relating to their portfolio, if required. The provisions of the Trust's Standing Orders relating to acting up arrangements and joint members will apply to this Committee with respect to decision making authority. The Director of Corporate Governance (Board Secretary) will attend as required and provide advice to the Chair and members to ensure that the Committee has the appropriate administrative and secretarial support (an Administrator). A minute taker will also attend all Committeemeetings and be stated as in attendance.
7.	**Chair, Quorum, Attendance and Meetings**

Chair
The NED Chair will preside at all meetings. In extraordinary circumstances where the Chair cannot attend, one of the Non-Executive Director members will chair the meeting.

Quorum
A quorum will be 3 members and must include 2 Non-Executive Directors and 1 Executive Director.

Deputies may attend, with the agreement of the Chair. This will be by exception; they must be fully briefed and if formally deputising will count towards the quorum.

If the Committee is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate no decisions shall be made at that meeting and such matters must be deferred until the next quorate meeting.

Attendance
Members are expected to attend all meetings. Apologies must be received by the Administrator in advance of the meetings. All members will be required to attend **a minimum** of two thirds of all meetings held annually. Members should not be absent for more than two consecutive meetings without the agreement of the Chair.

Any Committee member may participate in a meeting by way of telephone, computer or any other electronic means of communication provided that each person is able to hear and speak. A person participating in this way is deemed to be present in person although their actual location shall be noted in the minutes and is counted in a quorum and entitled to vote.

The meeting is deemed to take place where the largest group of those participating is assembled, or if there is no such group, where the Chair of the meeting is located.

Meetings
Where a specific matter is deemed to be of a confidential or commercially sensitive nature the Chair has the authority to restrict attendance at the meeting to members only and to ask all invitees to leave the meeting.

If any member or invitee has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member or invitee to withdraw until its consideration has been completed.

8. Frequency and Notice of Meetings

Frequency

The Committee will normally meet monthly. Additional meetings can be arranged for specific purposes as necessary, with agreement by the Chair.

If a matter of urgent business arises and an extraordinary meeting is required, this may be convened by the Chair, subject to the agreement of a quorum number of members. Decisions will be subject to achieving quorum attendance.

Where a decision needs to be taken outside the normal cycle of meetings, and where the matter is not deemed by the Chair to require an additional meeting to be called, the decision may be made via e-mail. The preference is for decisions to be taken at meetings. The decisions via e-mail process will be used on an exceptions basis. The process for decision via e-mail will be as follows:

a) An e-mail setting out the matter for decision will be sent to all members on the same working day. This shall include a statement setting out how the members should signify what their view on the matter is and the deadline for doing so.

b) Members will generally be given no less than five working days in which to respond.

c) For a decision to be passed, all of the members must express the same view on the matter.

d) Where members have comments on the proposed decision or recommendation/s these will be circulated to other Committee members by the Administrator within one working day of receipt.

e) If any individual member wishes to debate an item proposed for decision via e-mail at a meeting instead they may ask the Chair to arrange an additional meeting or defer the item for decision until the next meeting (such agreement by the Chair not to be unreasonably withheld).

f) Decisions via e-mail will be reported to the next meeting and the wording of the decision minuted. Any decision made in this manner will be effective from the date of agreement of all of the members and confirmed by email by the Administrator.

Notice of meetings

Meetings shall be called by the Administrator at the request of the Chair or any of its members.

Unless otherwise agreed, notice of each meeting and agenda of items to be discussed, shall be forwarded to each member, any other person required to attend no later than five full working days before the date of the meeting. Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

	Notices, agendas and supporting papers can be sent in electronic form where the recipient has agreed to receive documents in such a way. A meeting workplan will be agreed on an annual basis, setting out the main work items to be carried out at each meeting to ensure that adequate time is given to the main objectives of the Committee.
9.	**Minutes and Reporting Arrangements**
	Tier II groups will report to the Committee as agreed within the governance structure. The Committee will report to the Board on how it discharges its responsibilities. The Board will report back if it has any concerns about its adherence to the Terms of Reference. The minutes of Committee meetings will be formally recorded and submitted to the Board. The Chair of the Committee will draw to the attention of the Trust Board any issues or decisions for disclosure or require executive action. The Board will receive standing reports following each meeting and additional reports as part of the scheduled programme of annual reports. In addition, the Committee will receive thematic 'deep dive' reports or reviews as required to enable greater discussion about specific issues and to facilitate in depth discussions between the members and those staff providing services. The Board has ultimate responsibility for the effectiveness of its governance below Board. The Board will rely on the work of its Committees to provide assurance on the effectiveness of the governance structure.
10.	**Administrative arrangements**
	The Committee will be supported by a nominated Administrator who will: • produce a schedule of meetings and maintain the annual work plan for the Committee • prepare the agenda and papers with the Chair and circulate five working days prior to the meeting; • maintain accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting; • draft minutes, recording where the Committee has delivered its purpose through relevant reports and subsequent discussion, debate and challenge, and where further information is required, for circulation to the meeting Chair within five full working days of the meeting; • organise future meetings; and • file and maintain records of the work of the Committee in the required corporate records folder.
11.	**Meeting effectiveness review**

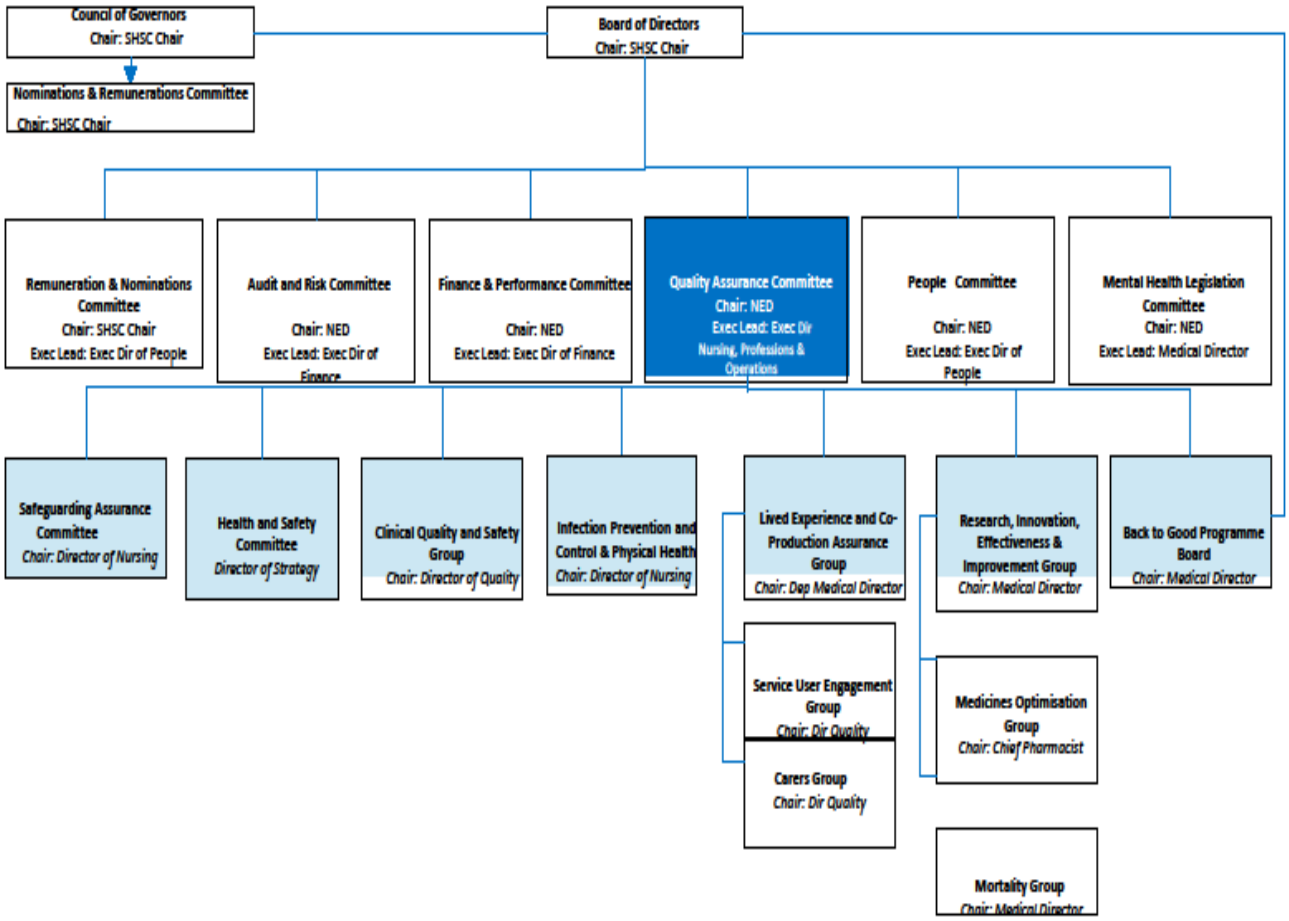
The Committee shall at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Committee shall undertake appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

	A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair of the Committee.	
12.	**Review to be conducted by Committee Chair**	
	Date Committee established	1 April 2011
	Terms of Reference to be reviewed	Annually
	Date of last review	September 2022 pending
	Date of next review	July 2023

Sheffield Health and Social Care NHS FT Governance Structure

Board & Committee Governance Structure – Quality Assurance Committee



QAC - SHSC Assurance Committees – Self-Assessment 2022

Theme 1 – Committee focus

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
1a	The committee has set itself a series of objectives it wants to achieve this year	1	2	2	1	1
1b	The committee has made a conscious decision about the information it would like to receive	5	1			sometimes
1c	Committee members contribute regularly across the range of issues discussed	1	5		1	
1d	The committee is aware of the key sources of assurance and who provides them.	2	3			1 sometimes
1e	Where appropriate, the committee receives assurances from third parties who deliver key functions to the organisation – for example NHS Shared Business Services (Payroll; Occupational Health) or private contractors		1	1		5

Theme 2 - Committee Team Working

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
2a	The committee has the right balance of experience, knowledge and skills to fulfil its role	3	2	1		1
2b	The committee has structured its agenda to cover quality, data quality, performance targets and financial control	4	1	1		1
2c	The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives	4	3			
2d	Management fully briefs the committee on key risks and any gaps in controls	2	3			2
2f	The committee environment enables people to express their views, doubts and opinions	4	3			

2i	Members hold their assurance providers to account for late or missing assurances	2	4	1		
2j	Decisions and actions are implemented in line with the timescale set down	2	3			1 sometimes

Theme 3 – Committee Effectiveness

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
3a	The quality of committee papers received allows committee members to perform their roles effectively	1	5			sometimes
3b	Members provide real and genuine challenge – they do not just see clarification and/or reassurance	3	3	1		
3c	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints, etc.	2	3 Yes, but agenda is often quite full	1		
3d	Each agenda item is "closed off" appropriately so that I am clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.	3	4			
3e	At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc.	3	3			1
3f	The committee provides a written summary report of its meetings to the governing body	2	3			2
3g	The governing body challenges and understands the reporting from this committee		3	1		3
3h	There is a formal appraisal of the committee's effectiveness each year	3	4			

Theme 4 – Committee Engagement

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
4a	The committee actively challenges management and other assurance providers during the year to gain a clear understanding of the findings	3	2 sometimes	1		
4b	The committee is clear about its role in relationship to other committees	2	4			1
4c	The committee receives clear and timely reports from reporting groups	2	4			1

Committee Leadership (not to be completed by Chair)

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
5a	The committee Chair has a positive impact on the performance of the committee	4	2			
5b	Committee meetings are chaired effectively	5	1			
5c	The committee Chair is appropriately visible within the organisation and is considered approachable	3	2			1
5d	The committee Chair allows debate to flow freely and does not assert his/her own views too strongly	4	2			
5e	The committee Chair provides clear and concise information to the governing body on committee activities and gaps in control	2	3			1

Finance & Performance Committee (FPC)

APPENDIX 3

SUMMARY REPORT	**Meeting Date:**	11 August 2022
	Agenda Item:	19

Report Title:	**Annual Report of the Finance & Performance Committee**	
Author(s):	Phillip Easthope, Executive Director of Finance Richard Mills, Chair – Finance & Performance Committee	
Accountable Director:	Phillip Easthope, Executive Director of Finance Richard Mills, Chair – Finance & Performance Committee	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	NA
	Date:	NA
Key points/ recommendations from those meetings	NA	

Summary of key points in report

The Finance & Performance Committee Annual Report is attached for assurance and approval. It provides an update on the membership and attendance at meetings; meeting frequency during the year and planned for the year ahead; work of the committee over the last year; key matters escalated to the Board; delivery against its objectives; outcome of the review of effectiveness and any proposed changes to the Terms of Reference.

Recommendation for the Board/Committee to consider:

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

The committee is asked to receive and approve for assurance and onward reporting to the Board, the annual report on how the Finance & Performance Committee has met its obligation as a sub-committee of the Board.

Please identify which strategic priorities will be impacted by this report:

Covid-19 Recovering effectively	*Yes*		*No*	***X***
CQC Getting Back to Good – Continuing to improve	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*		*No*	***X***
Partnerships – working together to make a bigger impact	*Yes*		*No*	***X***

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

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***	
Financial (revenue &capital)	***Yes***	***X***	***No***		*See updates provided on key items received during the financial year 2021-22*
Organisational Development /Workforce	***Yes***		***No***	***X***	
Equality, Diversity & Inclusion	***Yes***		***No***	***X***	
Legal	***Yes***		***No***	***X***	
Sustainability	***Yes***	***X***	***No***		*See updates provided on key items received during the financial year 2021-22*

Draft Annual Report of the Finance & Performance Committee

1. Introduction and background

The purpose of this report is to:

- Provide assurance to the Board that the Finance & Performance Committee has carried out its obligations with its Terms of Reference (ToR). A copy of the ToR reviewed at the July meeting is provided at **Appendix A.** These TORS and are subject to further review and refinement by the Director of Corporate Governance prior to receipt at the Board in September, alongside all Board Sub-Committee TORs to ensure consistency in language and to explicitly reflect any specific roles assigned to committees by NHSEI.

- Provide an update to the Board on the work of the Finance & Performance Committee during 2021/22, a reminder of matters escalated to the Board or referred to other Board sub committees, and detail on the work plan and objectives for the financial year 2022/23.

2. Membership and meetings

Membership

2.1 The ToR's require three non-executive directors to be members of the committee. The meeting is quorate if two members are present. The ToRs identify Directors or senior leaders who are required to participate as regular attendees. Other Executive Directors or managers including the Director of Operations & Transformation have also been requested to attend the Committee throughout the year to discuss specific items including financial recovery plans, estate plans, Integrated Performance and Quality Report (IPQR), strategy and the new Electronic patient record

Meetings and frequency

2.2 In the period April 2021 – March 2022 the Committee met 12 times on the following dates:

- 15 April 2021
- 13 May 2021
- 10 June 2021
- 15 July 2021
- 12 August 2021
- 9 September 2021
- 14 October 2021
- 11 November 2021

- 9 December 2021
- 13 January 2022
- 10 February 2022
- 10 March 2022

It is recommended the monthly meeting frequency for 2022/23 be retained.

Attendance at meetings

2.3 All 12 meetings were quorate in 2021/22.

2.4 The Finance & Performance Committee terms of reference require membership of three Non-Executive Directors, the Executive Director of Finance, IMST & Performance and the Executive Director of Nursing, Professions & Operations.

With effect from January 2022, it was agreed that the Executive Director of Nursing, Professions & Operations would step back from attending all meetings and that the Director of Operations & Transformation would regularly attend meetings in her place.

Attendance of individual members for the meeting held during the financial year were as follows:

Member name and role	**Attendance record**
Richard Mills, Committee Chair & Non-Executive Director	11/12
Anne Dray, Non-Executive Director	11/12
Olayinka Monisola Fadahunsi-Oluwole (w.e.f. October 2021)	6/6
Phillip Easthope, Executive Director of Finance	12/12
Beverley Murphy, Executive Director of Nursing, Professions & Operations Note: BM stepped away from the committee in December 2021	5/9
Neil Robertson, Director of Operations & Transformation (took over routinely deputising for Beverley Murphy from December 2021)	5/5

The following individuals also routinely attended meetings:

Name and role
Pat Keeling, Director of Strategy & Special Projects (NB: Approved as member in 22/23)
David Walsh, Director of Corporate Governance/Board Secretary
Susan Rudd, Director of Corporate Governance/Board Secretary (Interim)
Matt White, Deputy Director of Finance (Interim)
James Sabin, Deputy Director of Finance (April – July 2021)
Deborah Cundey, Head of Performance
Ben Duke, Deputy Lead Governor – as observer

3. Work plans and activity during the year

Work plan for 2021/22

3.1 The Finance & Performance Committee has a well-established 'forward work plan' which sets out the annual cycle of work and reporting. This is received at each meeting and updated as required.

3.2 The committee works with other Board sub committees and will receive mattes for its consideration and refer matters to the other sub committees as required for assurance purposes.

3.3 Prior to the meeting the Chair of the committee reviews the planned agendas with the Executive Lead (Phillip Easthope) and the Director of Corporate Governance/Board Secretary.

3.4 NHSE/I have identified roles they recommend are held by Non-Executive Directors and roles which will now be covered by Board Sub Committees or other, Executive individuals. Detail is provided below for those elements which sit within the remit of the Finance and Investment Committee, these will be made explicit in the TORs where appropriate:

Issue	Person	Committee(s)
Health and safety	Can be a committee role	Cuts across Quality - People - Finance (elements related to be determined e.g. in respect of the FPC – estates related H & S issues)
Cybersecurity	SIRO – Held by Director of Finance	Finance and Performance Audit and Risk
Procurement	Held by Director of Finance	Finance and Performance

Committee activity in 2021/22

3.4 Key activity during the financial year included the following:

Financial Management and Performance

- Finance Report (Monthly)
- CIP programme (May, Aug, Oct, Jan)
- Integrated Performance and Quality Report (IPQR) (Monthly)
- IPQR KPI development timeline (Dec)
- Recovery Plans (May, Aug, Nov)
- Performance Framework – refresh of KPIs (April, May)
- Performance Reviews (May, Aug, Dec)
- Estates KPIs and dashboard (Sep, Jan)

- Financial Planning (April, May, Nov, March)
- Financial planning principles (Nov)
- Financial planning and reporting governance arrangements (Nov)
- Finance Strategy (Feb, March)
- Operational Planning Update (April, July, Oct, Jan)
- Annual Operation plan (April, June, Feb)
- Contracting quarterly update (May, July, Oct, Jan)
- Contract management Group and Board reporting (Oct
- Patient level Information & Costing System (PLICS) (Jul, Jan)

Capital Management

- Electronic Patient Record (May, OBC in July, Sep, Nov, Dec (FBC), Jan,)
- Estate Strategy (June, July)
- Disposal of Fulwood (June, Sep)
- Relocation of Trust HQ BC (May, June, Sep, Oct, Jan (FBC))
- Capital quarterly update (Aug, Nov)
- Capital 5 year plan refresh (Aug, Dec, Feb)
- Digital Strategy Refresh (Sep, Nov)
- Review of Working capital facility (Oct)
- Ligature Anchor Point (LAP) BC phases 1& 2 (Nov)
- Ligature Anchor Point (LAP) BC phases 3 (Jan)

Governance

- Adult Secure Provider Collaborative (April, June, July)
- Transformation portfolio report (Monthly)
- Business Planning Update (May, Sep, Dec)
- Information Commissioner's Office Investigation regarding Insight Document loss (April)
- NHS England/Improvement Financial overview (April)
- Board Assurance Framework (Monthly)
- Corporate Risk Register (Monthly)
- Insight Risk – Mitigation of system weakness (May
- Annual Review of Effectiveness (April, May, Jan)

- Policy Governance Summary
    - Non-NHS Income Policy (April)
    - Delegation of Budgetary Authority (May)
    - FPC master register (July, Mar)
    - Procurement policy (Aug)
    - Income collection (Sep)
    - Treasury Management (Oct)
    - Responding to tenders (Oct)
    - Hardship, Salary Advance (Oct, Dec)
    - Security Policy (Nov)
    - Sustainable Procurement Policy (Jan)
- Primary Care & Community Mental Health Care (June, Nov)
- Review of Standing Orders, SFIs and Scheme of Delegation (July
- Sustainability Strategy, Green plan (Sep, Dec, Jan)
- Finance & Performance Committee Annual Report to ARC process (Jan)
- Procurement Strategy Refresh (Feb, March)
- Internal Audit Report – Transformation and project Management (Feb)
- Gift of Time (March)

3.5 Updates on key areas in more detail are provided below:

- The Trust's performance against its annual financial plan and budgets has been kept under review, escalating issues such as CIP performance and significant cost pressures as appropriate. The performance reporting has been developed to include more information on cost pressures as required although further developments in the regard is required.
- Directorate performance has been reviewed as part of the finance report and the Integrated Performance Report (IPQR). The development of the IPQR has progressed well throughout the year and its analytical detail has been key to providing greater oversight not just to this committee, but to other committees and the Board.
- Aligned to this, the committee has approved a Performance Framework, KPIs and received assurance around service performance reviews as the performance framework is embedded across the organisation. This has enabled performance management, scrutiny and triangulation, across the committees and at Board.
- The Committee has received various recovery plans, including the Out of Area recovery plan for assurance
- The Committee received the various draft Sustainability Strategy and Green plan, and agreed an ambitious target for recommendation to the Board
- The Committee has overseen the development of key plans and business cases in relation to key transformation programmes including the Electronic Patient Record and Leaving Fulwood

- The committee receives monthly report from the Transformation Board detailing updates against key milestones, risks and issues; the Transformation Update also reported upwards to Board.
- The committee received numerous updates in regards to the changing financial regime under COVID and had oversight and sign off of the development of financial plans for H1 and H2 and initial financial plan for 2022/23.
- Delivery of the Committee's key responsibilities, and specifically its role in the development of our strategic and financial objectives and on-going scrutiny of the business planning processes.
- The Committee is responsible for the risks delegated to it via the Board Assurance Framework and Corporate Risk Register. These were regularly reviewed and discussed to ensure that identified controls were appropriate to mitigate the risks to a level within the risk appetite. The Committee has provided challenge to ensure the appropriate level of risk has been identified, reviewed the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps.
- Reviewed contracting updates on an exception basis to ensure risks are understood and reflected in financial performance reports.
- The committee has had oversight of capital expenditure and received updates on the Capital Programme throughout the year.
- The committee received and approved revisions to the Digital and Estate strategies before onward receipt and approval at Board and is overseeing the development of the Trust Finance Strategy which will be approved in 2022/23
- The committee retained oversight of policies within its remit, holding Policy Governance Group to account for undertaking appropriate testing of policies prior to their approval and recommendation for ratification.

4. Matters escalated to the Board or referred to other Board sub committees

4.1 After each meeting the Finance & Performance Committee has provided an Alert, Advise and Assure (AAA) to the Board of Directors.

4.2 Key matters escalated to the Board in the financial year included the following:

- Significant risk, concerns over capacity and capability to undertake the lead provider for the South Yorkshire and Bassetlaw (SYB) Adult secure Provider Collaborative
- Consideration of Electronic Patient Record (EPR) outline business case (OBC) and full business case (FBC) for approval
- Cost Improvement Plan (CIP) planning gap, concerns and lack of assurance, further work required re cultural engagement
- Lack of assurance over trajectories for waiting times recovery plan
- Escalation of Transformation portfolio board reporting, risk and issues, including funding of the community forensic teams and proposals to set up new Community Facilities Programme board to improve community estate.
- Updates on Relocation of Trust HQ and progress with ligature anchor point removal
- Progress on Green Plan

4.3 Examples of matters referred to other Board sub committees included the following:

- Oversight of Changes to the Board Assurance Framework (BAF) format and process to Audit and Risk Committee (ARC) as responsible committee

- Ensure reporting and escalation of Data loss and Information Commissioner's Office (ICO) investigation to ARC

5. Committee effectiveness

Process for review of committee effectiveness

5.1 A self-assessment review was undertaken by the Committee and received at the committee in June 2022. This involved circulation of a questionnaire with statements for members to confirm their level of agreement the committee fulfilled the stated requirement. The responses were generally very supportive of the committee in fulfilling its role with key areas for further consideration identified around ensuring effectiveness of reporting from Tier II groups, timely completion of some actions and identifying clear objectives for the committee.

This form will be reviewed in 2022/23 to ensure it meets current needs, it will include opportunity for comments, and it will made available in electronic form for ease of completion and to support data extraction for onward reporting. The self-assessment process looking back at 2022/23 will take place in readiness for reporting to committee in January/February 2023 and to Audit and Risk Committee in April followed by an amalgamated report on annual reports from all sub committees to the Board in May 2023.

5.2 There is a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting.

5.3 The outcome of the review was received at the committee held in July 2022.

Assessment against objectives agreed for 2021/22

5.4 The 2020/21 objectives focused on the on-going development of committee governance with particular improvements required to ensure that papers are more effectively tailored to meet the Committee's needs. Specifically, that any implications are reflected in the Corporate Risk Register and Board Assurance Framework. Ensuring that when consideration or challenge is given at the committee on a relevant paper or discussion item the corporate risk register and Board Assurance Framework are updated accordingly.

For 2021/22 the Committee continued to work on these objectives, with a particular emphasis on taking account of the well led review, and wider changes within the Trust. This included further development of the agenda, and the agenda setting process, and the introduction of the three A's assurance process.

6. Committee objectives for 2022/23

6.1 In reviewing the effectiveness of the Finance and Performance committee in 2021/22 the committee has agreed objectives for 2022/2023 as follows:

Committee objectives
To ensure the Trust meets its key financial duties for the year, specifically achieving its financial control total target for the year, including monitoring achievement of cost improvement processes.
To ensure effective oversight of transformation projects, including capital and investment issues.
To further develop governance processes, including responding to Board and other committees (including Tier II committee reporting and timely completion of actions).

6.2 Progress against the objectives will be reviewed at either six monthly or quarterly intervals depending on the frequency of the committee meetings.

7. Work plan 2022/23

7.1 The Committee's workplan for 2022/23 is detailed in **Appendix A** and is presented for approval and agreement to share with the Board for endorsement.

8. Review of Terms of Reference

8.1 The Terms of Reference were reviewed and approved in July 2022 and are attached at **Appendix B**. Further refinement of these is taking place during August alongside the other TORs to ensure consistency in language and to reflect NHSEI identified roles for committee oversight.

9. Conclusion

9.1 The Committee assures the Board it continues to function appropriately as a standing committee of Trust's Board of Directors, effectively overseeing the duties as set out in the agreed Terms of Reference.

Supporting information

Appendix A – Finance and Performance Committee workplan 2022/23 updated as at Sept 2022

Appendix B – Finance and Performance Committee terms of reference updated as at Sep 2022

SHSC FINANCE & PERFORMANCE COMMITTEE WORK PROGRAMME 22/23

		2022									2023		
Item		**April**	**May***	**Jun**	**July**	**Aug***	**Sept***	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March***
Date for Submission of Papers *Wednesday the week before the meeting*		6	4	1	6	3	7	5	2	8	4	8	8
Meeting Dates 2022/23	**Lead**	**14**	**12**	**9**	**14**	**11**	**15**	**13**	**10**	**16**	**12**	**16**	**16**
Standing Items													
Apologies	RM	X	X	X	X	X	X	X	X	X	X	X	X
Minutes/ notes of last meeting	RM	X	X	X	X	X	X	X	X	X	X	X	X
Action log	RM	X	X	X	X	X	X	X	X	X	X	X	X
Declaration of any conflict of interest	RM	X	X	X	X	X	X	X	X	X	X	X	X
Meeting work programme	RM	X	X	X	X	X	X	X	X	X	X	X	X
Review of meeting effectiveness (verbal)	RM	X	X	X	X	X	X	X	X	X	X	X	X
Financial Management & Performance													
Finance Strategy (Review 6mthly as suggested by Director of Corporate Governance)	PE	X Final(D)			X Final (D)	X Final		X					
Procurement Strategy Refresh (Upon finalisation of Policy refresh & review 6mthly as suggested by Director of Corporate Governance)	PE		X Final (D)	X Final	X Discussio n			X	X				
Financial Planning & Reporting Governance Arrangements	JS		X						X				
Annual Operational Plan - Monitoring Framework	PK			X (D)		X	X			X			X
Operational Plan Quarterly Update Q1 Aug, Q2 Oct, Q3 Feb & Q4 Apr	PK	X			X			X			X	X	
2022-23 Financial Plan (NHS Priorities & Planning Guidance Q3 Q4 Draft Updated Financial Plan)	PE / JS		X						X Q3/Q4 Update				
New Year Financial Plan	PE / JS	X Final							X Principles		X Draft		X Update
Finance Report	PE	X	X	X	X	X	X	X	X	X	X	X	X
Business planning group QTR report (includes contracting & procurement)	PK / JS	X			X			X			X		
Annual report of Business planning group												X	
Service Line Management Update Report (update in Nov, Annual report in May)	JS								X				
National Cost Collection – Process & Systems(to confirm timeline etc)	JS						X						
National Cost Collection Publication Review (depending on publication)	JS										X		
National Cost Collection Return/Sign Off	JS										X		
Annual review of performance framework	PE											X	
Performance Framework schedule and KPIs	PE						X						
Triannual Performance Reviews – Feedback & Summary of Outcome	PE		X			X (D)	X			X			
Integrated Quality & Performance Report	PE	X	X	X	X	X	X	X	X	X	X	X	X
Recovery Plans: OOA; SPA Waiting Times; Recovery Waiting Times (Aligned with QAC)	BM			X (D)	X		X			X			X
Capital Management													
Estates Strategy (Review 6mthly as suggested by Director of Corporate Governance)	PE		X (D)		X		X		X				
Capital Programme Quarterly Update	MW		X			X	X		X			X	
Five Year Capital Plan Refresh	PE	X(D)				X		X				X	

Capital business cases over £2m	PK						X						

		2022									2023		
Item		**April**	**May***	**Jun**	**July**	**Aug***	**Sept***	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March***
Date for Submission of Papers *Wednesday the week before the meeting*		6	4	1	6	3	7	5	2	8	4	8	8
Meeting Dates 2022/23	**Lead**	**14**	**12**	**9**	**14**	**11**	**15**	**13**	**10**	**16**	**12**	**16**	**16**
Treasury Management													
Treasury Management Policy Review (due Sept 2024)	MW							X					
Working Capital Review (Oct 2022)	MW							X					
Investment Appraisal													
CIP update monthly report	PK					X	X	X	X	X	X	X	X
Annual Review of Business Case forBenefits	MW			X (D)				X					
Transformation Portfolio Report	PK	X	X	X	X	X	X	X	X	X	X	X	X
Therapeutic Strategic Outline Case (SOC)	PE / PK		X (D)		X								
Investment Update	MW							X			X (D)		
Governance													
Internal Audit actions update	DL					X	X	X	X	X	X	X	X
Review BAF Financial Risks	DL	X	X	X	X	X	X	X	X	X	X	X	X
Review CRR Financial Risks	DL	X	X	X	X	X	X	X	X	X	X	X	X
Policy Governance Summary	DL	X	X	X	X	X	X	X	X	X	X	X	X
Terms of Reference Review & Adoption	DL	X			X								X (D)
Committee Meeting Schedule for coming year	RM		X					X					
FPC Annual Report	DL	X			X (D)	X					X Verbal	X Final (D)	
Annual review of meeting effectiveness	DL	X Results		X							X Question naires out		X Results
Constitution Changes & Supporting Documents (as necessary)	DL				X (D)								
Review of Compliance with SOs, SFIs & Scheme of Delegation	JS / DL										X		
Review of Standing Orders, SFIs & Scheme of Delegation (as necessary)	DL / JS				X (D)		X						
National IFRS 8 Operating Segment Declaration	JS										X		
Returns made to NHSE/I - assurance of compliance	PE		X										
Other													
Charitable Fund Requests (as received)	PE	X	X	X	X	X	X	X	X	X	X	X	X
Charitable Fund Annual review	PE				X (D)		X						
Sustainability Strategy (Review 6mthly as suggested by Director of Corporate Governance)	PE				X (D)		X				X		
Sustainability Delivery Group Quarterly report		X			X			X			X		
Sustainability Delivery Group Annual report												X	
Digital Transformation Strategy Review (Review 6mthly as suggested by Director of Corporate Governance)	PE					X						X	
Digital Strategy Group (quarterly updates)	PE	X			X			X			X		
Digital Strategy Group Annual Report	PE											X	

Item		2022									2023		
		April	**May***	**Jun**	**July**	**Aug***	**Sept***	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March***
Date for Submission of Papers *Wednesday the week before the meeting*		6	4	1	6	3	7	5	2	8	4	8	8
Meeting Dates 2022/23	**Lead**	**14**	**12**	**9**	**14**	**11**	**15**	**13**	**10**	**16**	**12**	**16**	**16**
Other (Additional Ad Hoc Items Received)													
Well Led Update / Governance Structure Review Update – FPC (Sam Harrison)	DL												
360 Assurance Internal Audit Report(as received)	PE		X										
LAP Business Cases Business case for Section 136 suite	PK				X								
Substance misuse contract expansion	PE /NR				X								
St. Georges relocation - outline business case	JR						X						
Burbage Overspend	Carl Twibey							X					

Terms of Reference

Document History:	
Version Number:	**2**
Approved by: (parent Committee/group)	**Trust Board – pending approval September 2022**
Date approved:	**September 2022 at Finance and Performance Committee**
Name of Committee/Group	**Finance and Performance Committee**
Type of Committee/Group	Board Assurance Committee reporting to Board of Directors (the "Board")

1. Purpose of Committee/Group

The Finance and Performance Committee and ("the Committee") has been established to provide assurance to the Board in consultation with the other BoardCommittees that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Over-arching review of financial risk
- Overview of the Trust's financial processes and monitoring returns to NHS England/Improvement, ensuring finances are managed within the allocated resources to deliver an efficient and effective service.
- Provide assurance to the Board on the financial controls of the Trust.
- Oversee the Trust's accountabilities in regard to data and information, establishing and regularly reviewing policy, procedures, practice and processes are effective, providing assurance to the Board.
- Provide assure of the Trust's compliance with its regulatory and statutory duties pertaining to data and information and the effective governance of data and information within the Trust.
- Provide assurance that the performance framework enables the Trust to proactively manage its Quality, Financial and People performance agenda including oversight through committees.
- Oversee the Estates Strategy

The Committee shall provide assurance to the Board on the probity of the Trust and support the other Board Committees in the achievement of clinical effectiveness and safe outcome for service users, maintaining positive service users and carer experience and equality and inclusion.

2. Scope

The scope of the Committee is Trust wide, it will:

- Review and monitor the systems and processes for the financial activity within theorganisation ensuring that decisions are in line with the Trust's overall strategic direction and its financial frameworks, including the Financial Strategy, Treasury Management Policy, Procurement Strategy and the Estates Strategy.
- Review and monitor the systems and processes of information governance within the organisation ensuring decisions are in line with the Trust's overall strategic direction, regulatory frameworks and legislation, including the Digital Transformation Strategy.
- Establish and maintain a performance framework that enables the Trust to proactively manage its, Quality, Financial and Workforce performance agenda including oversight through committees.

In delivering this purpose the remit will be to formulate an annual programme of work.

3. Authority/Accountability

The Committee is constituted as a standing committee of the Board.

The Committee is authorised to establish and delegate powers to sub-committee(s) and work groups. The Committee will oversee the work of those sub-committee(s) and work groups.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The budget for such advice must be within agreed financial constraints.

The Committee is authorised by the Board to make decisions that are not of a significantmatter to the parent body. Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions of the Trust.

The following matters that must be referred to Board:

- Where there is significant revenue, capital or cash implications as determined by the Trust's Standing Financial Instructions
- Conflict with statutory obligations, or have significant governance implications
- Likely to arouse significant public or media interest.

4.	Objectives of Committee/Group

Financial Management and Performance

The Committee will:

(i) establish and maintain a detailed knowledge of the Trust's overall strategic objectives

(ii) establish and maintain an overview of the Trust's financial risks and ensure the effectiveness and implementation of the controls for financial risks. Provide assurance to the Board that the controls are in place for any financial risks identified

(iii) provide assurance to the Board on the Trust's financial resilience and sustainability through overview of the Trust's annual business priorities and the associated financial plans through the receipt of the Annual Plan,

(iv) supervise the annual budget setting processes and financial information contained in the Annual Plan and provide assurance to the Board on the process

(v) monitor the Trust's activities in relation to the submission of offers for existing/new business opportunities in line with the agreed growth strategy. Provide regular updates to the Board on the business opportunities being presented to the Committee monitor and provide assurance to the Board on the Trust's affordability, profitability and return on investment of its core business and service developments

(vii) review the most recent monthly finance report prepared for the Board to enablean informed and focussed discussion at the Board meeting, making recommendations and priorities for discussion

(viii) review in detail any major performance variation, in order to obtain assurance on behalf of the Board as to the effectiveness of corrective actions and associated governance arrangements.

(ix) oversee the on-going development of the finance report, to seek assurance that the measures incorporated meet the requirements of external stakeholders and provide assurance to the Board that the Trust's Financial Strategy is being delivered

(x) monitor and provide assurance to the Board on the Cost Improvement/CashReleasing Efficiency Savings Programme(s) as well as any agreed Disinvestment Programmes

(xi) review the activity reports in respect of under/over performance against contracted targets. Escalate to the Board any significant variations to contracts.

(xii) review on a regular basis, the Trust's position in respect of contracts and any impact on overall Trust performance and financial stability

(xiii) scrutinise details of movement in aged reports, specifically in relation to Losses category 3c (bad debts and claims abandoned) for assurance re the validity of information contained in financial reports

(xiv) review, monitor and provide assurance to the Board on the returns to NHSEngland/Improvement (as determined by their reporting processes)

(xv) review the Trust Reference Cost submission and provide assurance to the Board that the Committee is satisfied with the Trust's costing processes and systems,and that the Trust will submit its reference cost return in accordance with the guidance

(xvi) review Reference Cost Index (measure of relative efficiency) on publication and provide assurance to the Board on the value for money of services provided

(i) consider the risks delegated to it via the Board Assurance Framework (BAF) and/or Corporate Risk Register (CRR). The Committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps. The Committee should provide assurance to the Board on the risks delegated to the Committee and highlight any key areas of concern identified by the Committee.

(ii) act as the forum for financial risk to be discussed, and ensure that where serious concerns are raised, action is taken, and that action plans are carried through to completion, and the reporting loops closed. In doing so, ensuring that there are robust links across directorates to ensure a culture risk management is present throughout the organisation.

Capital Management

The Committee will:

(iii) review on behalf of the Board the strategic five year capital programme and the annual capital budgets and recommend to the Board approval of the documentsas appropriate.

(iv) review capital business cases identified within the annual capital budget to ensure that each business case is within the resources approved by the Board and that the business cases comply with the business case standards set by the Trust and outside regulators

(v) approve capital business cases in accordance with the Trust's Detailed Scheme of Delegation (DSoD)

(vi) provide assurance to the Board on the functioning of the capital programme andassociated business cases.

Treasury Management

The Committee will:

a. manage and review investment decisions in accordance with the Trust's Treasury Management Policy and Trust Objectives, and ensure safe harbouring of "cash", following the agreed controls and ensuring all investment is risk averse
b. review the Trust's Treasury Management Policy and make recommendations to the Board for approval
c. review Trust finance applications including loan applications
d. provide assurance to the Board on all Treasury Management issues.

Investment Appraisal

The Committee will:

(i) review and approve the Trust Growth Strategy

(ii) review and approve revenue business cases in accordance with limits in the Trust's DSoD and to make recommendations to the Board on those cases outside of its authority

(iii) review the benefits realisation of business cases and post implementation reviews of business cases it approves to ensure that the standard of business case preparation is consistently high

(iv) review and monitor the Trust's Business and Financial Performance by receiving high level monthly reports from the outputs of the Business Planning Group (BPG)
(v) provide assurance to the Board on all investment appraisal activity.

Digital Strategy

The Committee will:
(i) review and approve the Digital Transformation Strategy
(ii) review and provide assurance regarding the implementation of the transformation programmes to deliver the Digital Strategy.

Other

The Committee will:
(i) Review the performance framework that enables the Trust to proactively manage its, Quality, Financial and People performance agenda, increasing triangulation to inform decision making
(ii) review, approve and provide assurance to the Board on the TrustProcurement Strategy
(iii) review, approve and provide assurance to the Board on the Trust Estate Strategymonitor and approve expenditure in respect of the Trust's Charitable and Endowment funds ensuring appropriate resource allocation
(v) review the Trust's Standing Financial Instructions (SFI) and Standing Orders (SO) and where appropriate make recommendations regarding amendments to the Audit Committee for approval by the Board
(vi) notify the Audit and Risk (ARC) Committee of any statutory reporting concerns or identified system weaknesses
(vii) review any matter referred to the Committee by the Board
(viii) prepare and share with the ARC and the Board an Annual Report that outlines the work undertaken by the Committee during the year.

The Committee will uphold the values of the Trust in the work it does. In particular it will look for assurances that these values are being delivered in the Trust, as part of its overall governance role on behalf of the Board.

5. Membership

The membership of the Committee will be:

- Three Non-Executive Directors (one of which will be appointed to chair the meetings and one of which will have financial experience)
- Executive Director of Finance (Lead Executive and SIRO)
- Executive Director of Nursing, Professions and Operations
- Director of Strategy

Other Non-Executive Directors and Executive Directors can attend as desired but will not form part of the permanent membership of this committee.

Membership will be reviewed annually.

6.	**Attendees**
	Meetings of the Committee shall normally be attended by: • Deputy Director of Finance • Director of Corporate Governance • Committee Administrator • Governor observer Other directors or their deputies may be asked to attend meetings or part meetings for discussions on matters relating to their portfolio, if required. The provisions of the Trust's Standing Orders relating to acting up arrangements and joint members will apply to this Committee with respect to decision making authority. The Director of Governance (Board Secretary) will provide advice to the Chair and members and ensurethat the Committee has the appropriate administrative and secretarial support (an Administrator). A minute taker will also attend all Committee meetings and be stated as in attendance.
7.	**Chair, Quorum, Attendance and Meetings**
	Chair The NED Chair will preside at all meetings having been approved as the Chair by the Board.In extraordinary circumstances where the Chair cannot attend, one of the Non-Executive Director members will chair the meeting. **Quorum** A quorum will be 3 members and must include 2 Non-Executive Director and 1Executive Director. Deputies may attend, with the agreement of the Chair. This will be by exception, they must be fully briefed and if formally deputising will count towards the quorum. If the Committee is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate no decisions shall be made atthat meeting and such matters must be deferred until the next quorate meeting. **Attendance** Members are expected to attend all meetings. Apologies must be received by the Administrator in advance of the meetings. All members will be required to attend **a minimum** of two thirds of all meetings held annually. Members should not be absent for more than two consecutive meetings without the agreement of the Chair.

Any Committee member may participate in a meeting by way of telephone, computer or any other electronic means of communication provided that each person is able to hear and speak. A person participating in this way is deemed to be present in person although their actual location shall be noted in the minutes and is counted in a quorum and entitled to vote. The meeting is deemed to take place where the largest group of those participating is assembled, or if there is no such group, where the Chair of the meeting is located.

Meetings

Where a specific matter is deemed to be of a confidential or commercially sensitive nature the Chair has the authority to restrict attendance at the meeting to members only and to ask all invitees to leave the meeting.

If any member or invitee has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member or invitee to withdraw until its consideration has been completed.

8. Frequency of meetings

Frequency

The Committee will generally meet monthly. Additional meetings can be arranged for specific purposes as necessary, with agreement by the Chair.

If a matter of urgent business arises and an extraordinary meeting is required, this may be convened by the Chair, subject to the agreement of a quorum number of members. Decisions will be subject to achieving quorum attendance.

Where a decision needs to be taken outside the normal cycle of meetings, and where the matter is not deemed by the Chair to require an additional meeting to be called, the decision may be made via e-mail. The preference is for decisions to be taken at meetings. The decisions via e-mail process will be used on an exceptions basis. The process for decision via e-mail will be as follows:

a) An e-mail setting out the matter for decision will be sent to all members on the same working day. This shall include a statement setting out how the members should signify what their view on the matter is and the deadline for doing so.
b) Members will be generally be given no less than five working days in which to respond.
c) For a decision to be passed, all of the members must express the same view on the matter.
d) Where members have comments on the proposed decision or recommendation/s these will be circulated to other Committee/Group members by the Administrator within one working day of receipt.
e) If any individual member wishes to debate an item proposed for decision via e-mail at a meeting instead they may ask the Chair to arrange an additional meeting or defer the item for decision until the next meeting (such agreement by the Chair not to be unreasonably withheld).
f) Decisions via e-mail will be reported to the next meeting and the wording of the decision minuted. Any decision made in this manner will be effective from the date of agreement of all of the members and confirmed by email by the

Administrator**.**

Notice of meetings

Meetings shall be called by the Administrator at the request of the Chair or any of its members.

Unless otherwise agreed, notice of each meeting and agenda of items to be discussed, shall be forwarded to each member, any other person required to attend no later than three full working days before the date of the meeting. Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

Notices, agendas and supporting papers can be sent in electronic form where the recipient has agreed to receive documents in such a way.

A meeting workplan will be agreed on an annual basis, setting out the main work items to be carried out at each meeting to ensure that adequate time is given to the main objectives of the Committee.

9. Minutes and Reporting Arrangements

Tier II groups will report to the committee as agreed within the governance structure.

The Committee will report to the Board on how it discharges its responsibilities.

The Board will report back if it has any concerns about its adherence to the Terms of Reference.

The minutes of Committee meetings will be formally recorded and submitted to the parent body by the Chair of the Committee. The Chair of the Committee will draw to the attention of the Board any issues or decisions that require disclosure to the Trust Board, or require executive action.

This assurance is provided through the provision of minutes and quarterly/bi-annual assurance reports which articulate how their duties and responsibilities have been discharged, highlighting any emerging risks and summarising recommendations and actions taken.

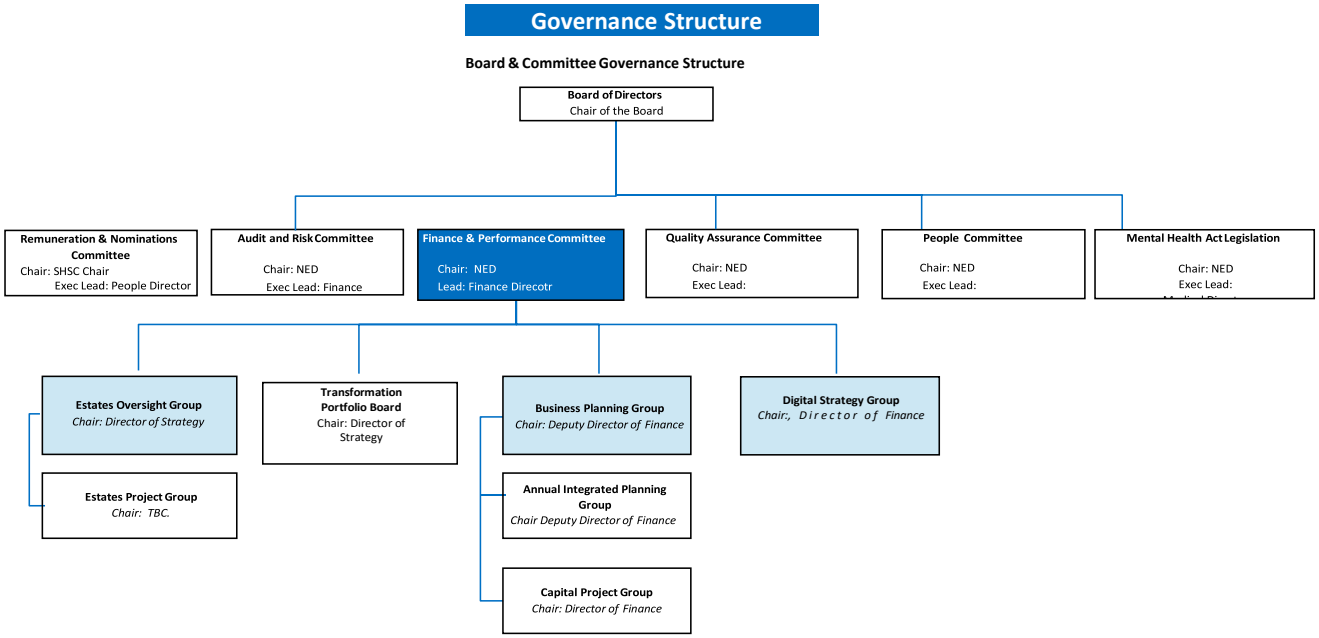
The Committee will receive standing reports following each meeting and additional reports as part of the scheduled programme of annual reports.

In addition, the Committee will receive thematic ‘deep dive’ reports or reviews as required to enable greater discussion about specific issues and to facilitate in depth discussions between the members and those staff providing services.

The Board has ultimate responsibility for the effectiveness of its governance below Board. The Board will rely on the work of its committees to provide assurance on the effectiveness of the governance structure.

10.	**Administrative Arrangements**	
	The Committee will be supported administratively by a nominated Committee Administrator who will: • produce a schedule of meetings and maintain the annual work plan for the Committee • prepare the agenda and papers with the Chair and circulate three working days prior to the meeting; • maintain accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting; • draft minutes, recording where the Committee has delivered its purpose through relevant reports and subsequent discussion, debate and challenge, and where further information is required, for circulation to the meeting Chair within five full working days of the meeting; • organise future meetings; and • file and maintain records of the work of the Committee in the required corporate records folder.	
11.	**Meeting Effectiveness Review**	
	The Committee shall at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval. The Committee shall undertake appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members. A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair of the Committee.	
12.	**Review to be conducted by Committee/Group Chair**	
	Date Committee/Group established	28th July 2008
	Terms of Reference to be reviewed e.g. Annually	The terms of reference of the committee shall be reviewed by the Board when required, but at least annually.
	Date of last review	September 2022
	Date of next review	September 2023

The governance table will be updated to include roles:



SHSC Finance and Performance Committee – Self-Assessment 2022

Theme 1 – Committee focus

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
1a	The committee has set itself a series of objectives it wants to achieve this year		***3***	**1**		
1b	The committee has made a conscious decision about the information it would like to receive	**1**	**3**			
1c	Committee members contribute regularly across the range of issues discussed	***1***	**3**			
1d	The committee is aware of the key sources of assurance and who provides them.	**1**	***3***			
1e	Where appropriate, the committee receives assurances from third parties who deliver key functions to the organisation – for example NHS Shared Business Services (Payroll; Occupational Health) or private contractors		**4**			

Theme 2 - Committee Team Working

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
2a	The committee has the right balance of experience, knowledge and skills to fulfil its role		**4**			
2b	The committee has structured its agenda to cover quality, data quality, performance targets and financial control	**1**	**2**			**1**
2c	The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives	**1**	**3**			
2d	Management fully briefs the committee on key risks and any gaps in controls	**2**	**2**			
2f	The committee environment enables people to express their views, doubts and opinions	**2**	**2**			
2i	Members hold their assurance providers to account for late or missing assurances	**1**	***3***			
2j	Decisions and actions are implemented in line with the timescale set down		***3***	***1***		

Theme 3 – Committee Effectiveness

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
3a	The quality of committee papers received allows committee members to perform their roles effectively	**1**	**2**			**1**
3b	Members provide real and genuine challenge – they do not just see clarification and/or reassurance	**1**	**3**			
3c	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints, etc.	**2**	**2**			
3d	Each agenda item is "closed off" appropriately so that I am clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.	**2**	**2**			
3e	At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc.	**1**	**3**			
3f	The committee provides a written summary report of its meetings to the governing body	**1**	**2**			**1**
3g	The governing body challenges and understands the reporting from this committee		**2**			**2**
3h	There is a formal appraisal of the committee's effectiveness each year	**1**	**3**			

Theme 4 – Committee Engagement

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
4a	The committee actively challenges management and other assurance providers during the year to gain a clear understanding of the findings	**2**	**2**			
4b	The committee is clear about its role in relationship to other committees	**2**	**2**			
4c	The committee receives clear and timely reports from reporting groups		**3**	**1**		

Committee Leadership (not to be completed by Chair)

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
5a	The committee Chair has a positive impact on the performance of the committee	**1**	**2**			
5b	Committee meetings are chaired effectively		**3**			
5c	The committee Chair is appropriately visible within the organisation and is considered approachable	**1**	**2**			
5d	The committee Chair allows debate to flow freely and does not assert his/her own views too strongly	**2**	**1**			
5e	The committee Chair provides clear and concise information to the governing body on committee activities and gaps in control		**3**			

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APPENDIX 4

PEOPLE COMMITTEE

DRAFT PEOPLE COMMITTEE ANNUAL REPORT	**Meeting Date:**	7th July 2022
	Agenda Item:	16

Report Title:	**Draft People Committee Annual Report**	
Author(s):	Caroline Parry, Executive Director of People	
Accountable Director:	Caroline Parry, Executive Director of People Deborah Lawrenson, Director of Corporate Governance	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	N/A
	Date:	N/A
Key points/ recommendations from those meetings	N/A	

Summary of key points in report
The People Committee Annual Report is attached for assurance and approval. It provides an update on the membership and attendance at meetings; meeting frequency during the year and planned for the year ahead; work of the Committee over the last year; key matters escalated to the Board; delivery against its objectives; outcome of the review of effectiveness and any proposed changes to the Terms of Reference.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**	**x**	**Assurance**	**x**	**Information**	

The Committee is asked to receive and approve for assurance and onward reporting to the Board, the annual report on how the People Committee has met its obligation as a sub committee of the Board.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	*Yes*	✓	*No*	
CQC Getting Back to Good	*Yes*	✓	*No*	
Transformation – Changing things that will make a difference	*Yes*	✓	*No*	

Partnerships – working together to have a bigger impact	*Yes*	✓	*No*		

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

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***		Impact of staff experience, capability, and engagement on the quality of service user care
Financial (revenue &capital)	***Yes***		***No***	✓	
Organisational Development /Workforce	***Yes***	✓	***No***		Develop compassionate and inclusive leadership at Team SHSC which enables a just and learning culture
Equality, Diversity & Inclusion	***Yes***	✓	***No***		Promoting and ensuring equality, diversity, and inclusion in all that we do within a diverse organisation
Legal	***Yes***		***No***	✓	
Sustainability	***Yes***	✓	***No***		NA

DRAFT Annual Report from the People Committee to the Board

1. Introduction and background

The purpose of this report is to:

Provide assurance to the Board that the People Committee has carried out its obligations with its Terms of Reference (ToR). A copy of the ToR is provided at **Appendix A**.

Provide an update to the Board on the work of the People Committee during 2021/22, a reminder of matters escalated to the Board or referred to other Board sub committees, and detail on the work plan and objectives for the financial year 2022/23.

2. Membership and meetings

Membership

2.1 The Terms of Reference require three non-executive directors to be members of the committee. The meeting is quorate if two members are present. The Terms of Reference identify Directors or senior leaders who are required to participate as regular attendees. Other Executive Directors or heads of service ~~managers~~ including – Deputy Director of People, Head of Leadership and OD, Head of Equality and Inclusion and Head of Workforce Development and Training have also been requested to attend the Committee throughout the year to discuss/present reports from the Assurance Groups and any exception reports / matters arising briefings related to the Assurance Groups. The five Assurance Groups that report into People Committee are - Workforce Planning and Transformation Group; Staff Health and Wellbeing Group; Organisational Development Group; Equality and Inclusion Group; Recruitment and Retention Group.
Other heads of service / managers who have contributed to the Committee and presented items include – Director of Strategy (formerly the Director of Special Projects Strategy and Estates), Director of Psychology, Executive Director of Nursing, Professions and Operations, Director of Clinical Operations and Transformation, Director of Corporate Governance and Corporate Governance Manager, Freedom to Speak Up Guardian, Staff Side Chair, Health and Safety Manager, People Systems Leads (information and resourcing), EDI Engagement Lead for the Workforce Race Equality Standard, Director of Strategy and Planning, former Head of OD, HR Business Partner, Trainee Digital Business Analyst.

Meetings and frequency

2.2 In the period April 2021 – March 2022 the Committee met six times on the following dates:

- 11th May 2021
- 13th July 2021
- 7th September 2021
- 9th November 2021

- 11th January 2022
- 8th March 2022

The committee has remained quorate throughout the year.

It is recommended the meeting frequency for 2022/23 be retained as bi-monthly, meeting in May, July, September, November, January, and March.
The meeting on 10th May 2022 has taken place and the next meeting will take place on 12th July 2022.
The remaining dates for the financial year 2022/23 are proposed as –
13th September 2022, 8th November 2022, 10th January 2023, and 14th March 2023.

Dates for the financial year 2023/24 are proposed as
9th May 2023
11th July 2023
12th September 2023
14th November 2023
9th January 2024
12th March 2024

Attendance at meetings

2.3 All six meetings were quorate in 2021/22.

2.4 The People Committee Terms of reference require membership of - three Non-Executive Directors (one of which will chair the meeting), the Executive Director of People and the Executive Director of Nursing, Professions and Operations.

Attendance of individual members for the meeting held during the financial year were as follows:

Member name and role	**Attendance record**
Heather Smith, Non-Executive Director, and Chair of Committee	6/6
Caroline Parry, Executive Director of People	6/6
Anne Dray, Non-Executive Director	6/6
Richard Mills, Non-Executive Director n.b. Richard Mills commenced attendance at People Committee from Nov 2021	3/3
Beverley Murphy, Executive Director of Nursing, Professions and Operations n.b. Neil Robertson attended People Committee from Nov 2021 onwards instead of Beverley Murphy	2/6

The following individuals also routinely attended meetings:

Name and role
David Walsh, Director of Corporate Governance up to the Sept 2021 meeting Susan Rudd, Director of Corporate Governance from the Nov 2021 meeting.
Sarah Bawden, Deputy Director of People
Karen Dickinson, Head of Workforce Development and Training

Liz Johnson, Head of Equality, and Inclusion
Charlotte Turnbull, Head of Leadership and OD
Victoria Racher, People Systems Lead

3. Work plans and activity during the year

Work plan for 2021/22

3.1 The People Committee has a well-established 'forward work plan' which sets out the annual cycle of work and reporting. This is received at each meeting and updated as required.

3.2 The committee works with other Board sub committees and will receive matters for its consideration and refer matters to the other sub committees as required for assurance purposes.

3.3 Prior to the meeting the Chair of the committee reviews the planned agendas with the Executive Director of People and the committee support.

Committee activity in 2021/22

3.4 Key activity during the financial year included the following:

- People Strategy bi-annual review and refreshed delivery plan and KPIs
- Staff Voice
- Integrated Performance and Quality Report
- HR Performance Dashboard and exception reports on Staff vaccinations and Casework progress
- Timetabled reports from the five Assurance Groups –
  - Workforce Planning and Transformation Group plus exception reports on implementation and development of new roles, training needs outside of mandatory training, NHS priorities and workforce planning / return.
  - Staff Health and Wellbeing Group plus exception reports on: Health and Wellbeing Hub, rest spaces, Staff Health, and Wellbeing Audit Report.
  - Organisational Development Group plus exception reports on: Staff Surveys – 2020 and 2021, Pulse Survey, Just and Learning Culture, PDR Audit Report, Staff Engagement Audit Report.
  - Equality and Inclusion Group plus exception reports on: BAME project updates – Big Conversation, Workforce Race Equality Standard, Workforce Disability Standard, Anti-Racist Statement, Apprentice Staff Network Group, Gender Pay Gap, Annual Equality and Human Rights Report.
  - Recruitment and Retention Group plus exceptions reports on our Registered Nurse position, Clinical Establishment Review, Nurse Recruitment and Workforce Planning, additional hours being worked to cover nurse vacancies.

- Board Assurance Framework and Corporate Risk Register
- Ratification of HR/People Policies
- Annual Operational Plan and Workforce Plan
- Highlights from the Joint Consultative Forum
- Freedom to Speak Up
- Workplace Wellbeing Annual Report
- Health and Safety Report
- New Headquarters and Leaving Fulwood Plan
- Gift of Time
- Committee Terms of Reference, self-assessment, and Annual Review

4. Matters escalated to the Board or referred to other Board sub committees

4.1 After each meeting the People Committee has provided an Alert, Advise and Assure (AAA).

4.2 Key matters escalated to the Board in the financial year included the following:
n.b. These concerns were escalated at points during 2021/22 and have/are being monitored and sufficient updates received to enable Committee assurance.

Alert:

- Recruitment and retention of registered nurses – Committee requested and received a further report with a focus on retention.
- Data relating to long term sickness, vacancies and significant concern relating to turnover. Committee requested updates indicating initiatives to improve the position.

Advise:

- Capability and Disciplinary Casework – committee received positive reports on our handling of casework
- Equality and inclusion – positive increase in the work related to equality and inclusion

Assure:

- Health and wellbeing – aligned with national and regional priorities and initiatives, and significant assurance rating for the health and wellbeing audit.
- Recruitment and retention – cross-SHSC effort to develop a coherent plan having impact, and international recruitment plan in place.

4.3 Examples of matters referred to other Board sub committees included the following:

- The Health and Safety Report was received by People Committee until July 2021. The report was then presented to Quality Committee instead and timetabled to be provided to People Committee each January and July.

5. Committee effectiveness

Process for review of committee effectiveness

5.1 A self-assessment review was undertaken by the committee via email. This involved circulation of a questionnaire with statements for members to confirm their level of agreement the committee fulfilled the stated requirement. This form will be reviewed in 2022/23 to ensure it meets current needs, it will include opportunity for comments, and it will made available in electronic form for ease of completion and to support data extraction for onward reporting. The self-assessment process looking back at 2022/23 will take place in readiness for reporting to committee in January/February 2023 and to Audit and Risk Committee in April followed by an amalgamated report on annual reports from all sub committees to the Board in May 2023.

5.2 There is a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting.

5.3 The outcome of the review will be received at the committee held on 12th July 2022.

Assessment against objectives agreed for 2021/22

5.4 The following objectives were agreed by the committee for 2021/22, with progress outlined.

Committee objectives	Progress update
Provide assurance to the Board of Directors that Committee members are assured that there is a positive working environment for staff that promotes psychological safety, a supportive, open culture that helps staff do their job to the best of their ability.	Freedom to Speak Up Reports Reports from the Organisational Development Assurance Group Progress updates on the embedding of a Just and Learning culture Refresh of SHSC values Staff Network groups embedded
Provide assurance to the Board of Directors that Committee Members are assured that there is support and opportunities for staff to maintain their health, wellbeing, and safety	Engagement in positive health and wellbeing activity at ICS and national level. Reporting from the Health and Wellbeing assurance group on progress against the People plan. Effective staff counselling and consultation service through workplace wellbeing identifying key issues informing our work
Be assured that staff engagement strategies are in place prior to consultation exercises with staff to enable staff to be fully engaged in the decision-making processes that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements.	All organisational change activity presented to the Joint Consultation Forum and updates fed into the People Committee Consultation process in place to engage staff in the development of organisational strategies. Organisational Change policy
Be assured that appropriate policies to raise	All people related policy

issues, grievances and concerns are in place, are fit for purpose and allow fair and consistent treatment of staff.	development reported into the People Committee, following engagement with stakeholders regarding any proposed changes to policy including Freedom to Speak up, Grievance, Unacceptable Behaviours policies.
Review achievement against the following strategic areas – workforce, equality and diversity, recruitment and retention, staff health, safety and wellbeing, organisation development, and achievement of goals set out in the People Strategy Delivery plan and Organisational Development plan.	Bi-annual review presented to the Committee in October 2021, tracking progress against the strategic priorities within the People strategy including Health and Wellbeing, Recruitment and retention, Workforce Transformation and Leadership and Culture.
Be assured that there is an appropriate range and scope of training for all members of staff.	OD plan in place to support leadership development, access to a range of internal and external provision and mandatory training programme available to staff. Personal development plans discussed as part of the Performance Development Reviews.

6. Committee objectives for 2022/23

6.1 It is proposed that the objectives for 2021/2022 listed in 5.4 will carry forward, and the following, subject to discussion of the review of the effectiveness of the People Committee on 12/07/2022:

Committee objectives
Continue to receive timetabled reports from the Assurance Groups – Workforce Planning and Transformation Group; Staff Health and Wellbeing Group; Organisational Development Group; Equality and Inclusion Group.
Continue to uphold the values of SHSC in the work it does. In particular it will look for assurances that these values are being delivered in SHSC, as part of its overall governance role on behalf of the Board.

6.2 Progress against the objectives will be reviewed at either six monthly or quarterly intervals depending on the frequency of the committee meetings.

7. Work plan 2022/23

7.1 The committee's workplan for 2022/23 is detailed in **Appendix A** and is presented for approval and agreement to share with the Board for endorsement.

8. Review of Terms of Reference

8.1 The Terms of Reference have been reviewed and are attached at **Appendix B** and are presented for approval and agreement to share with the Board for endorsement.

The only changes currently proposed to the People Committee Terms of Reference are those contained in the membership section. These changes are highlighted in the attached (Appendix B). The outcomes of the review of the Annual Committee Effectiveness Self-Assessment report, will also inform any further changes pending discussion at the People Committee.

9. Conclusion

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9.1 The committee assures the Board it continues to function appropriately as a standing committee of Trust's Board of Directors, effectively overseeing the duties as set out in the agreed Terms of Reference.

Supporting information

Appendix A – People Committee workplan 2022/23

updated as at Sept 2022

Appendix B – People Committee terms of reference

updated as at Sep 2022

People Committee Work Programme 2022/23 as of September 2022

		2022						2023 (dates TBC)		
Item	**Lead**	**11th Jan**	**8th Mar**	**10th May**	**12th Jul**	**13th Sept**	**8th Nov**	**10th Jan**	**14th Mar**	**9th May**
Latest date for submission of papers =		05-01-22	01-03-22	03-05-22	05-07-22	06-09-22	01-11-22	03-01-23	07-03-23	02-05-23
Mandatory Items										
Apologies (and confirmation of quoracy)	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declaration of any conflict of interest	ALL	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action log / Matters Arising Communication / escalation issues	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of last meeting	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Any other Business	ALL	✓	✓	✓	✓	✓	✓	✓	✓	✓
Staff Voice										
Staff voice item	Chair Caroline Parry	x	x	(D)	x	✓	✓	✓	✓	✓
People Strategy										
Refreshed People Strategy Delivery Plan and KPIs	Caroline Parry Sarah Bawden	x	x	x	x	x	x	x	✓	x
Refresh of People Strategy		x	x	x	x	✓	x	x	x	x
Health & Safety (briefing report following Quality Committee)										
Health and Safety Report (Q4 July and Q2 January)	Samantha Crosby	✓	x	x	✓	x	✓	✓	x	x
People Strategy Theme: Health & Wellbeing										
****Report: Staff Health and Wellbeing Group. Each Nov, March, July** see action log for details of specific requested information	CHAIR Sarah Bawden	x	x	✓	✓	x	✓	x	✓	x
Workplace Wellbeing Annual Report **(each July)**	Linda Wilkinson	x	x	x	✓	x	x	x	x	x
People Strategy Theme: Recruitment and Retention										
****Report: Recruitment and Retention Group. Each January, May and Sept** see action log for details of specific requested information	CHAIRS Sarah Bawden Simon Barnitt	✓	x	✓	x	✓	x	✓	x	✓
People Strategy Theme: Workforce Transformation										
****Report: Workforce Planning & Transformation Group. Each January, May and Sept** see action log for details of specific requested information	CHAIRS Caroline Parry Karen Dickinson	✓	x	✓	x	✓	x	✓ (see action log for details)	x	✓
Clinical Establishment Review progress **CHECK WITH NR WHEN NEXT UPDATE IS DUE**	Neil Robertson	x	✓	x	x	✓ MA	x	x	x	

NHS priorities and planning guidance Q3-Q4 – draft updated workforce return **EACH NOV? CHECK WITH JR**	Jason Rowlands	x	x	x	x	x	✓	x	x	x
Draft Annual Operational Plan 2022-23 and Workforce Plan **EACH MARCH? CHECK WITH JR**	Jason Rowlands	x	x	✓	x	x	x	x	✓	x
People Strategy Theme: Equality, Diversity and Inclusion										
****Report: Inclusion and Equality Group Each Sept, Jan and May** see action log for details of specific requested information *Jan meeting to include NHS Equality delivery system report*	CHAIRS Liz Johnson Neil Robertson	x	x	x	x	✓	✓	✓ update (see action log for details)	✓	✓
Gender Pay Gap Report (Legal requirement to submit every March)	Liz Johnson	x	x	x	x	x	✓ interim	x	✓ formal report	x
NHS Equality Delivery System	Liz Johnson	x	x	x	x	x	x	✓	x	x
WRES Annual Report and Action Plan	Liz Johnson	x	x	x	x	✓	x	x	x	
WDES Annual Report and Action Plan	Liz Johnson	x	x	x	x	✓	x	x	x	
Annual Equality and Human Rights Report (for publication & align with November QAC and Board meetings)	Liz Johnson	x	x	x	x	x	✓	x	x	
People Strategy Theme: OD, Leadership and Talent										
****Report: Organisational Development Group. Each March, July and November** see action log for details of specific requested information. Now includes Staff survey update, Staff engagement framework and Just & Learning culture	Charlotte Turnbull	x	✓	x	✓	x	✓	x	✓	x
Supervisions **UPDATE TO PC WILL NOW FOLLOW QAC. NOTED FOR MAY 2022 PC.**	Linda Wilkinson	x	✓	x	x	x	x	x	x	✓
Freedom to Speak Up **NOTE ANNUAL FTSU REPORT IS DUE IN MAY 2022**	Wendy Fowler	x	x	✓ Annual report	x	x	x	✓ Interim report	x	x
Pulse Survey update **NOTE FOR JULY 2022 PART OF OD REPORT**	Charlotte Turnbull	x	x	x	x	x	✓	x	✓	x
Trust Staff Engagement Framework		✓ draft	x	x	*NOW INCLUDED WITHIN ORGANISATION DEVELOPMENT GROUP REPORT*					
Staff Survey update		x	✓	✓	*NOW INCLUDED WITHIN ORGANISATION DEVELOPMENT GROUP REPORT*					
Just & Learning Culture		x	✓	x	*NOW INCLUDED WITHIN ORGANISATION DEVELOPMENT GROUP REPORT*					
Performance Monitoring										
HR Performance Dashboard. (Deep Dives to be included as necessary / requested).	Victoria Racher	✓	✓	✓	✓	✓	✓	✓ KPIs data	✓ Covid absence data	TBC
Integrated Performance & Quality Report – see action log for specific list of additional metrics to be included	BPM Team	x	x	✓	✓	✓	✓	✓	✓	✓
Vaccination briefing incl Bank and BAME Staff + VCOD update	Neil Robertson Debra Butterworth	x	✓	✓		Vaccinations data now part of performance monitoring section each meeting				
Governance										

People Policies	Amber Wild	✓	✓	✓	✓	✓	✓	✓	✓	✓
Board Assurance Framework +Corporate Risk Register (also BAF is added to each section of agendas)	Amber Wild Deborah Lawrenson	✓	✓	✓	✓	✓	✓	✓	✓	✓
Terms of reference review See action log. SR is proposing an overview of all ToRs and memberships for each Committee. **NEED DATES FOR WORK PROGRAMME**		x	x	x	✓	x	x	x	x	x
Annual review of meeting effectiveness. Committee Annual Self-Assessment. **NEED DATES FOR WORK PROGRAMME**		x	x	✓ verbal	✓	x	x	✓	X	x
Committee Annual Plan for Audit Committee **NEED DATES FOR WORK PROGRAMME**		x	x	x	x	x	x	x	x	
Significant issues to inform Trust Board (verbal). Alert, Advise, Assure	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Highlights from the Joint Consultative Forum (verbal)	Caroline Parry	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee Work Programme	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reviews of Assurance Group's Effectiveness Annual – 1 report from each T2 meeting	Chair Deborah Lawrenson	-	-	-	-	-	✓	x	x	x
Internal Audit action tracking PC actions from DL's tracking spreadsheet	Deborah Lawrenson	-	-	-	-	✓	✓	✓	✓	✓
Miscellaneous / for information (to include external partnership reports etc where appropriate)										
New headquarters and Leaving Fulwood Plan **TO NOTE FOR MAY 2022 AGENDA. CHECK WITH PK**	Pat Keeling	x	x	✓	x	x	x	x	x	x
Regional and National Partnerships /updates/news items	Caroline Parry	-	-	-	-	✓	✓	✓	✓	✓

Commented [EA1]: Questionnaires sent out early June and report to July's meeting.

Commented [EA2]: Process to start Jan/Feb time in 2023. Questionnaires to be sent out in Jan/feb, Reports to Q4 meetings.

****Reports from the Assurance Groups - are timetabled as above but this does not preclude urgent items being presented, at other meetings of Committee, as necessary.**
Each Assurance Group Report must include a 'one page' Delivery Plan with a focus on trajectories and milestones/timelines backed up by data to cross reference, and consider BAF risks.
And must also include any items to escalate to People Committee from the Assurance Groups minutes / action logs.

Terms of Reference

Document History:	
Version Number:	**3**
Approved by: **(parent Committee/group)**	**Board of Directors (pending – September 2022)**
Date approved:	**September 2022 at People Committee**
Name of Committee/Group	**People Committee**
Type of Committee/Group	Board Assurance Committee reporting to the Board of Directors ("Board")

1. Purpose of Committee/Group

The People Committee ("the Committee") has been established to provide assuranceto the Board in consultation with the other Board Committees that adequate and appropriate governance structures, processes and controls are in place in respect of the workforce, organisational development and any other matters that shall be determined to fall within its remit.

The Committee has primary responsibility for receiving assurance regarding all aspectsof strategic workforce and organisational development relating to staff in support of getting the best outcomes.

The Committee will provide assurance to the Board regarding the following strategic areas: workforce, equality and diversity, recruitment and retention, staff development, role transformation, staff health, safety and wellbeing, organisation development and design, culture development, staff engagement, leadership development, talent management and succession planning.

2. Scope

The scope of the Committee is Trustwide it will:

- Assure the Board that the Trust is meeting its legal and regulatory and moral duties in relation to its employees.;
- Receive assurance into any area of work within its remit on behalf of the Board.

In fulfilling its obligations, the Committee will be mindful of the need to improve the diversity of the workforce so that it more accurately reflects the populations which the Trust serves.

3. Authority/Accountability

The Committee is constituted as an assurance committee of the Board, for matters related to areas within its purpose.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staffand all members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to establish and delegate powers to sub-committee(s)and work groups. The Committee will oversee the work of those sub-committee(s) and work groups.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and expertise as required to support it in discharging its duties. The budget for such advice must be withinagreed financial constraints.

The Committee is authorised by the Board to make decisions that are not of a significant matter to the Board. Reference should be made, as appropriate to theStanding Orders and Standing Financial Instructions of the Trust.

The following matters must be referred to Board:

- Where there is significant revenue, capital or cash implications as determined bythe Trust's Standing Financial Instructions
- Conflict with statutory obligations, or have significant governance implications
- Likely to arouse significant public or media interest.
-

4. Objectives of Committee/Group

The Committee will:

(i) provide assurance to the Board of Directors that Committee members are assured that there is a positive working environment for staff that promotes psychological safety, a supportive, open culture that helps staff do their job tothe best of their ability;

(ii) provide assurance to the Board of Directors that Committee Members are assuredthat there is support and opportunities for staff to maintain their health, wellbeing and safety;

(iii) be assured that staff engagement strategies are in place prior to consultation exercises with staff to enable staff to be fully engaged in the decision-making processes that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements.

(iv) be assured that appropriate policies to raise issues, grievances and concerns arein place, are fit for purpose and allow fair and consistent treatment of staff.

(v) review achievement against the following strategic areas – workforce, equalityand diversity, recruitment and retention, staff health, safety and wellbeing, organisation development, and achievement of goals set out in the People Strategy Delivery Plan and Organisational Development Plan;

(vi) be assured that there is an appropriate range and scope of training for all members of staff;

(vii) act as the forum for People risks to be discussed, ensuring actions are taken and action plans carried out to completion, and ensuring there are robust links across directorates to ensure a culture of risk management is present throughout the organisation. The committee will ensure robust mechanisms are in place to maintain its registration with any required regulatory bodies; oversee all risks delegated to the

Committee via theCorporate Risk Register (CRR) and Board Assurance Framework (BAF); the Committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps. The Committeeshould provide assurance to the Board on the risks delegated to the Committee and highlight any key areas of concern identified by the Committee.

The Committee will uphold the values of the Trust in the work it does. In particular it will look for assurances that these values are being delivered in the Trust, as part of its overall governance role on behalf of the Board.

5. Membership

The voting membership of the Committee will be:

- Three Non-Executive Directors (one of which will chair the meeting)
- Executive Director of Nursing, Professions and Operations
- Executive Director of People (Executive Lead) Committee lead with ownership of the agenda in support of the Chair)

Other Non-Executive Directors / Associate Non-Executive Directors and Executive Directors can attend as desired but will not form part of the permanent membership ofthe Committee.

Membership will be reviewed annually.

6. Attendees

Meetings of the Committee will normally be attended by:

- Deputy Director of People (Head of People Transformation and Operations)
- Head of Leadership and Organisation Development
- Head of Equality and Inclusion
- Head of Workforce Development and Training
- Director of Clinical Operations and Transformation
- Deputy Medical Director – to be confirmed

Other directors or their deputies may be asked to attend meetings or part meetings for discussions on matters relating to their portfolio, if required. The provisions of the Trust's Standing Orders relating to acting up arrangements and joint members will apply to this Committee with respect to decision making authority

The Committee may invite other persons to attend a meeting so as to assist in deliberations. The Chair shall be notified of this prior to the meeting.

The Director of Governance (Board Secretary) will provide advice to the Chair and members and ensure that the Committee has the appropriate administrative support. A minute taker will alsoattend all Committee/Group meetings and be stated as in attendance.

7. Chair, Quorum, Attendance and Meetings

Chair

The Non-Executive Director Chair will preside at all meetings having been approved as the Chair by the Board or appointed as such by the Trust Board Chair. In extraordinary circumstances where the Chair cannot attend, the Deputy Chair (similarly approved) will chair the meeting. One of the Non- Executive Director members will chair the meeting.

Quorum

A quorum will be 3 members and must include 2 Non-Executive Directors (including the Chair or Vice Chair) and 1 Executive Director.
Deputies may attend, with the agreement of the Chair. This will be by exception, they must be fully briefed and if formally deputising will count towards the quorum.

If the Committee is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate no decisions shall be made at that meeting and such matters must be deferred until the next quorate meeting.

Attendance
Members are expected to attend all meetings. Apologies must be received by the Administrator in advance of the meetings. All members will be required to attend a minimum of two thirds of all meetings held annually. Members should not be absent for more than two consecutive meetings without the agreement of the Chair.

Any Committee member may participate in a meeting by way of telephone, computer or any other electronic means of communication provided that each person is able to hear and speak. A person participating in this way is deemed to be present in person although their actual location shall be noted in the minutes and is counted in a quorum and entitled to vote. The meeting is deemed to take place where the largest group of those participating is assembled, or if there is no such group, where the Chair of the meeting is located.

Meetings
Where a specific matter is deemed to be of a confidential or commercially sensitive nature the Chair has the authority to restrict attendance at the meeting to members only and to ask all invitees to leave the meeting.

If any member or invitee has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member or invitee to withdraw until its consideration has been completed.

8. Frequency and Notice of Meetings

Frequency

The Committee will normally meet bi-monthly. Additional meetings can be arranged for specific purposes as necessary, with agreement by the Chair or Deputy Chair.

If a matter of urgent business arises and an extraordinary meeting is required, this may be convened by the Chair, subject to the agreement of a quorum number of members. Decisions will be subject to achieving quorum attendance.

Where a decision needs to be taken outside the normal cycle of meetings, and where the matter is not deemed by the Chair to require an additional meeting to be called, the decision may be made via e-mail. The preference is for decisions to be taken at meetings. The decisions via e-mail process will be used on an exceptions basis. The process for decision via e-mail will be as follows:

a) An e-mail setting out the matter for decision will be sent to all members on the same working day. This shall include a statement setting out how the members should signify what their view on the matter is and the deadline for doing so.
b) Members will be generally given no less than five working days in which to respond.
c) For a decision to be passed, all of the members must express the same view on the matter.
d) Where members have comments on the proposed decision or recommendation/s these will be circulated to other Committee members by theAdministrator within one working day of receipt.
e) If any individual member wishes to debate an item proposed for decision via e- mail at a meeting instead they may ask the Chair to arrange an additional meeting or defer the item for decision until the next meeting (such agreement bythe Chair not to be unreasonably withheld).
f) Decisions via e-mail will be reported to the next meeting and the wording of the decision minuted. Any decision made in this manner will be effective from the date of agreement of all of the members and confirmed by email by the Administrator.

Notice of meetings

Meetings shall be called by the Administrator at the request of the Chair or any of its members.

Unless otherwise agreed, notice of each meeting and agenda of items to be discussed, shall be forwarded to each member, any other person required to attend no later than three full working days before the date of the meeting. Supporting papers shall be sentto members and to other attendees as appropriate, at the same time.

Notices, agendas and supporting papers will normally be sent in electronic form.
A meeting calendar will be agreed on an annual basis, setting out the main work itemsto be carried out at each meeting to ensure that adequate time is given to the main objectives of the Committee.

9. Minutes and Reporting Arrangements

The Committee will report to Board on how it discharges its responsibilities.

The Board will report back if it has any concerns about its adherence to the Terms of Reference.

The minutes of Committee meetings will be formally recorded and submitted to the parent body by the Chair of the Committee. The Chair of the Committee will draw tothe attention of the parent body any issues or decisions that require disclosure to theTrust Board or require executive action.

Tier II groups will provide assurance to the committee as agreed in the governance structure.

The Committee will receive standing reports following each meeting and additional reports as part of the scheduled programme of annual reports.

In addition, the Committee will receive thematic ‘deep dive’ reports or reviews as required to enable greater discussion about specific issues and to facilitate in depth discussions between the members and those staff providing services.

The Board has ultimate responsibility for the effectiveness of its governance below Board. The Board will rely on the work of its Committees to provide assurance on the

effectiveness of the governance structure.

10. Administrative arrangements

The Committee will be supported by a nominated Administrator who will:

- produce a schedule of meetings and maintain the annual work plan for the Committee
- prepare the agenda and papers with the Chair and circulate three working days prior to the meeting;
- maintain accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting;
- draft minutes, recording where the Committee has delivered its purpose through relevant reports and subsequent discussion, debate and challenge, and where further information is required, for circulation to the meeting Chair within five full working days of the meeting;
- organise future meetings; and file and maintain records in the required corporate records folder.

11. Meeting effectiveness review

The Committee shall at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to its parent body for approval.

The Committee shall undertake appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair ofthe Committee

12. Review to be conducted by Committee/Group/Forum Chair Meeting effectiveness

Date Committee/Group established	19th November 2013
Terms of Reference to be reviewed	Annually
Date of last review	September 2022
Date of next review	September 2023

Aug 2022

TRUST BOARD

People Committee CHAIR Heather Smith

Strategic Priorities

- Prioritise health and well-being to support staff to feel healthy and well at work
- Recruit and retain the right staff with right skills
- Deliver workforce transformation to meet service needs both now and in the future
- Collective, inclusive and compassionate leadership across the whole organisation with equal opportunity for growth and development

Tier 2 Assurance Groups

- Staff Health and Wellbeing Group
  CHAIR Sarah Bawden
- Workforce Planning and Transformation Group
  CHAIRS Caroline Parry and Karen Dickinson
- Recruitment and Retention Group
  CHAIR Sarah Bawden
- Inclusion and Equality Group
  CHAIR Neil Robertson
- Organisational Design and Development Group
  CHAIR Charlotte Turnbull

Tier 3 Engagement Groups

- Medical Workforce Planning Group
  CHAIR Nicholas Bell
- Medical Staff Committee
  CHAIRS Reem Abed and Jenny Jack
- Nursing Council
  CHAIR Beverley Murphy
- Staff Network Chairs Group
  CHAIR Linda Wilkinson
- Joint Local Negotiating Committee
  CHAIRS Mike Hunter and Simon Mullins
- Joint Consultative Forum
  CHAIRS Jan Ditheridge and Susan Highton
- Staff Engagement Steering Group
  CHAIR Sally Hockey
- Plans for further group/s covering
  Allied Health Professions, Social Workers and Corporate Functions

Tier 4 Staff Network Groups

- Ethnically Diverse Staff Network Group
  CHAIR Paulette Cammidge
  VICE CHAIRS Jamilla Flaherty Themba Dlamini
- Disability Staff Network Group
  CHAIR Karyn Whitaker
- Lived Experience Staff Network Group
  CHAIR Helen Goodson. VICE CHAIR Simon Mullins
- Rainbow Staff Network Group
  CO-CHAIRS Justin Gardner, Henry Harrison
- Carers Staff Network Group
  CO-CHAIRS Pete Sandford, Jana Sandford
- Amazing Women Staff Network Group
  CHAIR Holly Cubitt

SHSC People Committee – Self-Assessment 2022

Theme 1 – Committee focus

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
1a	The committee has set itself a series of objectives it wants to achieve this year	**3**				
1b	The committee has made a conscious decision about the information it would like to receive	**2**		**1**		
1c	Committee members contribute regularly across the range of issues discussed	***2***	**1**			
1d	The committee is aware of the key sources of assurance and who provides them.	**2**	***1***			
1e	Where appropriate, the committee receives assurances from third parties who deliver key functions to the organisation – for example NHS Shared Business Services (Payroll; Occupational Health) or private contractors	**1**	**2**			

Theme 2 - Committee Team Working

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
2a	The committee has the right balance of experience, knowledge and skills to fulfil its role	**1**	**2**			
2b	The committee has structured its agenda to cover quality, data quality, performance targets and financial control	**1**	**1**			**1**
2c	The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives	**1**	**2**			
2d	Management fully briefs the committee on key risks and any gaps in controls	**1**	**2**			
2f	The committee environment enables people to express their views, doubts and opinions	**2**			**1**	
2i	Members hold their assurance providers to account for late or missing assurances	**2**	***1***			
2j	Decisions and actions are implemented in line with the timescale set down	***1***	***2***			

Theme 3 – Committee Effectiveness

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
3a	The quality of committee papers received allows committee members to perform their roles effectively		**3**			
3b	Members provide real and genuine challenge – they do not just see clarification and/or reassurance	**2**	**1**			
3c	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints, etc.	**1**	**1**	**1**		
3d	Each agenda item is "closed off" appropriately so that I am clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.	**2**	**1**			
3e	At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc.	**2**	**1**			
3f	The committee provides a written summary report of its meetings to the governing body		**3**			
3g	The governing body challenges and understands the reporting from this committee		**3**			
3h	There is a formal appraisal of the committee's effectiveness each year	**2**	**1**			

Theme 4 – Committee Engagement

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
4a	The committee actively challenges management and other assurance providers during the year to gain a clear understanding of the findings	**2**	**1**			
4b	The committee is clear about its role in relationship to other committees	**1**	**1**		***1***	
4c	The committee receives clear and timely reports from reporting groups	**1**	**2**			

Committee Leadership (not to be completed by Chair)

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
5a	The committee Chair has a positive impact on the performance of the committee	**2**				
5b	Committee meetings are chaired effectively	**2**				
5c	The committee Chair is appropriately visible within the organisation and is considered approachable	**2**				
5d	The committee Chair allows debate to flow freely and does not assert his/her own views too strongly	**2**				
5e	The committee Chair provides clear and concise information to the governing body on committee activities and gaps in control	**1**	**1**			

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APPENDIX 5

MENTAL HEALTH LEGISLATION COMMITTEE

MENTAL HEALTH LEGISLATION COMMITTEE DRAFT ANNUAL REPORT	**Meeting Date:**	21.9.22
	Agenda Item:	11

Report Title:	**MENTAL HEALTH LEGISLATION COMMITTEE DRAFT ANNUAL REPORT**	
Author(s):	Jamie Middleton Head of Mental Health Legislation, Human Rights & Chaplaincy	
Accountable Director:	Dr Mike Hunter, Executive Medical Director	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	
	Date:	
Key points/ recommendations from those meetings		

Summary of key points in report

The Mental Health Legislation Committee Annual Report is attached for assurance and approval. It provides an update on the membership and attendance at meetings; meeting frequency during the year and planned for the year ahead; work of the committee over the last year; key matters escalated to the Board; delivery against its objectives; outcome of the review of effectiveness and any proposed changes to the Terms of Reference.

Of particular achievement:

- All Mental Health Legislation Committee meetings during the reporting period were quorate.
- Committee has received and considered a range of reports related to mental health legislation, human rights, least restrictive practice, and use of force legislation.
- Committee has started to build mental health legislation into the Board Assurance Framework.
- Range of matters have been escalated to the Trust Board via the 'AAA' reporting.

Areas for development:

- The work undertaken by the Associate Mental Health Managers requires increased governance and oversight.
- Individual patient stories could be considered more so that service user voice does not get lost.
- The information which is collated in respect of mental health legislation and protected characteristics should be reviewed with a view to Committee having more explicit information presented.
- There is a risk that any actions which do not form part of the formal action log drift. Committee may wish to require quarterly reports to provide a summary of previous 'mini' actions.
- At the end of Committee meetings and when the meeting effectiveness is reviewed, Committee may wish to ask not only how effective it was, but also whether the meeting took place in a manner which was consistent with Trust values.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**	**x**	**Assurance**	**x**	**Information**	
The committee is asked to receive and approve for assurance and onward reporting to the Board, and how the annual report on how the Mental Health Legislation committee has met its obligation as a sub committee of the Board.							

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

Is this report relevant to compliance with any key standards ?					State specific standard
Care Quality Commission Fundamental Standards	*Yes*	✓	*No*		*Well led; effectiveness*
Data Security and Protection Toolkit	*Yes*		*No*	✓	
Any other specific standard?					

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*		
Financial (revenue &capital)	*Yes*	✓	*No*		
Organisational Development /Workforce	*Yes*	✓	*No*		
Equality, Diversity & Inclusion	*Yes*	✓	*No*		*Please complete section 4.3 in the content of your report*
Legal	*Yes*	✓	*No*		
Sustainability	*Yes*	✓	*No*		

Annual Report from the Mental Health Legislation Committee to the Board

1. Introduction and background

The purpose of this report is to:

- Provide assurance to the Board that the Mental Health Legislation Committee has carried out its obligations with its Terms of Reference (ToR). A copy of the ToR is provided at **Appendix A**. Proposed changes to the ToR have been highlighted as 'tracked changes'.

- Provide an update to the Board on the work of the Mental Health Legislation Committee during 2021/22, a reminder of matters escalated to the Board or referred to other Board sub committees, and detail on the work plan and objectives for the financial year 2022/23.

2. Membership and meetings

Membership

2.1 The ToR's require three non-executive directors to be members of the committee along with the Director of Quality and Director of Corporate Governance. A quorum will be 3 members and must include 2 Non-Executive Directors and 1 Executive Director including the Chair or deputy chair. The ToRs identify post holders who are required to participate as regular attendees. During this reporting period, the Board Chair has attended a meeting to observe. There has been one occasion when an external consultant attended and observed as part of their governance improvement work they were undertaking. A Council Member also attends as an observer.

Meetings and frequency

2.2 In the period April 2021 – March 2022 the Committee met 5 times on the following dates:

- 13.4.21
- 8.6.21
- 7.9.21
- 15.12.21
- 16.3.22

The committee has remained quorate throughout the year

It is recommended the meeting frequency for 2022/23 be retained as quarterly.

Attendance at meetings

2.3 All Mental Health Legislation Committee meetings were quorate in 2021/22.

2.4 The Mental Health Legislation Committee Terms of reference require membership of three Non-Executive Directors, Medical Director, Director of Quality and Director of Corporate Governance.

Attendance of individual members for the meeting held during the financial year were as follows:

Please note that not all members were required to attend every meeting as this is a new Committee and has undergone around the commencement a period of transition. Some member's roles also changed or some left meaning they would not be expected to have full attendance

Member name and role	**Attendance record**
Anne Dray, Non-Executive Director	1
Dr Olayinka Fadahunsi, Non-Executive Director (Chair)	4
Dr Mike Hunter, Executive Medical Director	5
Sandie Keene, Non-Executive Director	4
Salli Midgley, Director of Quality	5
Richard Mills, Non-Executive Director	1
Mike Potts, Trust Chair	3
Susan Rudd, Interim Director of Corporate Governance	2 (interim post holder)
Heather Smith, Non-Executive Director	2
David Walsh, Director of Corporate Governance	2 (left post during reporting period)

The following individuals also routinely attended meetings:

Name and role
Simon Barnitt, Head of Nursing
Adam Butcher, Service User Governor (observer)
Lorena Cain, Nurse Consultant for Restrictive Practice
Dr Helen Crimlisk, Deputy Medical Director
Tallyn Gray, Human Rights Officer
Emma Highfield, Head of Nursing
Hester Litten, Interim Head of Safeguarding
Jamie Middleton, Head of Mental Health Legislation, Human Rights & Chaplaincy
Dr Jonathan Mitchell, Clinical Director, Rehab and Specialist Services
Dr David Newman, Clinical Director, Learning Disability Services
Francesca O'Brine, Corporate Assurance Officer
Julie Sheldon, Head of Nursing

Neil Robertson, Director of Operations and Transformation
Sharon Sims, PA
Dr Rob Verity, Clinical Director, Acute and Community Services
Amber Wild, Corporate Assurance Manager

3. Work plans and activity during the year

Work plan for 2021/22

3.1 The Mental Health Legislation Committee has a well-established 'forward work plan' which sets out the annual cycle of work and reporting. This is received at each meeting and updated as required.

3.2 The committee works with other Board sub committees and will receive matters for its consideration and refer matters to the other sub committees as required for assurance purposes.

3.3 Prior to the meeting the Chair of the committee reviews the planned agendas with the Executive Lead Dr Mike Hunter, and Jamie Middleton, Head of Mental Health Legislation.

Committee activity in 2021/22

3.4 Key activity during the financial year included the following:

- Review of Quarterly Reports from Mental Health Legislation Operational Group
- Review of Quarterly Reports from Least Restrictive Practice Oversight Group
- Review of Human Rights activity and training
- Confirmed existence of the Trust having an Equality and Human Rights policy in place and having read its contents
- Policies related to mental health legislation received and ratified
- Consideration of mental health legislation issues in respect of the Board Assurance Framework
- Received and considered risks for possible escalation and inclusion top corporate risk register
- Considered and agreed annual work plan
- Mental health legislation related key performance indicators reviewed and agreed
- Received information and provided scrutiny in relation to the Trust's responsibilities contained within the Use of Force Act
- Provision of Alert, Assure and Advise reports to Trust Board
- Received presentation in relation to mental health legislation
- Receive reports in relation to the functions carried out by the Trust's Associate Mental Health Act Managers (AMHAMs)
- Terms of Reference for Mental Health Legislation Operational Group reviewed and approved
- Annual work plan formulated

- Terms of Reference for Least Restrictive Practice Group reviewed and approved
- Papers and updates received in relation to the forthcoming Liberty Protection Safeguards (LPS) along with discussion of potential challenges which the Trust will face when it is implemented
- Paper accepted and approved which constituted the Trust's response to the Government's
- Mental Health Act review consultation
- Least Restrictive Practice Strategy considered and received
- Horizon scan reports received and contents discussed
- Received updates in relation to progress the Trust was making in relation to actions identified following on from CQC Mental Health Act Monitoring Visits.
- Formulation and regular review of the Committee's action log.
- Consideration and receival of the Trust's Use of Force Implementation plan
- Consideration and receival of the Trust's Human Rights workplan

4. Matters escalated to the Board or referred to other Board sub committees

4.1 After each meeting the Mental Health Legislation Committee has provided an Alert, Advise and Assure (AAA).

4.2 Key matters escalated to the Board in the financial year included the following:

- Inconsistent processes in relation to the Trust's management of Court of Protection enquiries and orders
- Delays to the works required to the garden on Maple ward
- Process inconsistencies/gaps being more evident on the acute inpatient wards and Endcliffe ward
- Advisory notifications providing information about forthcoming Mental Health Act reform and expected implementation of the Liberty Protection Safeguards (LPS)
- Information regarding the Trust's training and development plan in relation to human rights
- Advice to the Board regarding the need for the Trust's Equality and Human Rights policy to be reviewed at least annually by Board
- Update provided in relation to new, more in-depth key performance indicators being introduced related to mental health legislation
- Notifying Board of progress in relation to the Trust's Least Restrictive Practice strategy
- Update provided to Board regarding the Use of Force Act Implementation Plan
- Board notified of recent patient death which resulted in a Regulation 28 report issued by the Coroner
- Update provided that the role of the Associate Mental Health Act Managers (AMHAMs) continues to remain uncertain when the anticipated Mental Health Act reform takes place

4.3 Examples of matters referred to other Board sub committees included the following:

- Seclusion review breaches linked in with Back To Good programme

- Mental health legislation started to be considered within the context of the Board Assurance Framework.
- Link noted in respect of administration of medication without lawful authority and reporting to Quality Assurance Committee.
- Discussion re. the Trust's role in respect of the Provider Collaborative (Forensic Services) and where oversight of this sat. This led to discussion of the role of the Transformation Board, and Finance and Performance Committee.

5. Committee effectiveness

Process for review of committee effectiveness

5.1 A self-assessment review was undertaken by the Committee and received at the committee in June 2022. This involved circulation of a questionnaire with statements for members to confirm their level of agreement the committee fulfilled the stated requirement. This form will be reviewed in 2022/23 to ensure it meets current needs, it will include opportunity for comments, and it will made available in electronic form for ease of completion and to support data extraction for onward reporting. The self-assessment process looking back at 2022/23 will take place in readiness for reporting to committee in January/February 2023 and to Audit and Risk Committee in April followed by an amalgamated report on annual reports from all sub committees to the Board in May 2023.

5.2 There is a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting.

5.3 The outcome of the review was received at the committee held on 15.6.22

Assessment against objectives agreed for 2021/22

5.4 The following objectives were agreed by the committee for 2021/22, with progress outlined.

Committee objectives	Progress update
To receive assurance of performance across the Trust against Key Performance Indicators which reflect respect for service users' human rights, effective implementation of the statutes and their Codes of Practice, the guiding principles of the MHA & the MCA, and the requirements of the CQC.	Committee receives detailed reports in respect of mental health legislation key performance indicators. Progress has been made with regards to the style of data presentation which has allowed the group the see performance visually, trends over time, and whether variation is/is not within expected limits. Updates are also received to report on progress in relation to CQC Mental Health Act Provider Action Statements.
To oversee completion and embedding of corrective action, escalating any concerns, identifying trends and themes and	Committee has considered corrective actions when needed. For example, in relation to gaps in

overseeing recommendations.	processes related to Court of Protection orders the committee supported establishment of a s49 Oversight Group. Given that reporting periods are undertaken retrospectively, Committee would expect most matters to have been addressed by the time the next meeting arose. However, where issues are ongoing, Committee will consider how it can support operational teams but also alert Board where necessary.
To ensure the development, implementation and timely review of policies in relation to Mental Health and Human Rights Legislation, ensuring there is adequate engagement and involvement. Ratifying these, following approval by the Policy Governance Group.	Governance in respect of mental health legislation related policies is a standing item on the Committee's agenda. A range of policies have been brought to the Committee for consideration and ratification.
To receive assurance from the Reducing Restrictive Practice Group on implementing the Trust's aim of reducing restrictive practice.	Committee receives detailed information and updates on an ongoing basis.
To receive assurance in respect of the performance and functions of the Associate MHA Managers.	At the start of the review period there was a void in relation to information related to the work of the AMHAMs. As the year has progressed, Committee has started to receive more detailed reports and information regarding AMHAM performance. Historically, the Board's Chair would Chair the AMHAM meetings; similarly, according to the Trust policy the Board Chair would have involvement in responding to any AMHAM performance concerns. A decision was taken during this review period that it is not appropriate for the Trust's Chair to be as involved operationally. Policy has been changed to facilitate this. The Trust Chair will however now attend all AMHAM meetings, albeit not for the whole meeting. Going forward, Committee would like to see more oversight and assurance in relation to the performance of AMHAMs.

To ensure that the Trust actively listens to the experiences of the service user, family and carer feedback in the application of MHA/Mental Health and Human Rights legislation to identify good practice and learning.	This is an area where the Committee needs to develop. Whilst some complaints are reported to Committee, these are by exception and tend to be more 'high risk' or potentially 'high profile'.
To seek assurance that inequalities are recognised where they occur in relation to the use of Mental Health Legislation and associated policies and that remedial action and reasonable adjustments are utilised to address them.	The Committee needs to develop in this particular area of governance as at present scrutiny and challenge is limited as information provided thus far is limited in respect of protected characteristics.
To ensure a coordinated organisational response to the introduction of changes to or new law, regulations, guidance etc.	Committee regularly receives updates in respect of legislative changes/proposed changes and will receive information about implementation plans where necessary.
To oversee training in relevant subject areas, ensuring this is effective to ensure staff are fully trained to implement relevant legislation as part of their work.	Compliance with mandatory training is a standing item on the Committee's agenda. Committee is aware that additional training is provided to facilitate best practice and compliance with the law eg. there is to a training programme to go alongside the revised s17 policy, and new training will be developed to support nursing assistants understand the importance of s132 and patient's rights.
To consider issues arising out of the "Delegated Authority" function for Mental Health Working Age Adults (formerly Section 75 partnership).	Delegated functions are not considered specifically as such but statutory functions undertaken by the Local Authority are monitored eg. Mental Health Act assessment times.
To commission reviews and/or audits of standards and practice as required.	No reviews have been specifically commissioned by the Committee during this reporting period.
To seek assurance on effective implementation of action plans developed in response to reviews and audit to improve legislative compliance and good practice in service user experience.	Committee does provide challenge to those attending in relation to what actions are being taken to address any gaps in practice. Whilst Committee will receive updates at subsequent meetings if the issue is ongoing, Committee does not always get updated on any actions from the previous

	meeting unless they were specific actions which were placed onto the action log. Going forward, Committee could be more explicit about what it wants to be added to the formal action log.
The Committee will uphold the values of the Trust in the work it does. In particular it will look for assurances that these values are being delivered in the Trust, as part of its overall governance role on behalf of the Board.	Committee conducts itself in a professional manner and at the end of each meeting there is reflection upon the effectiveness of the meeting. However, there is not explicit mention of the Trust's values. Improvements can be made in this aspect.

6. Committee objectives for 2022/23

6.1 In reviewing the effectiveness of the Mental Health Legislation Committee in 2021/22 the committee has agreed objectives for 2022/2023 as follows:

Committee objectives
To receive assurance of performance across the Trust against Key Performance Indicators which reflect respect for service users' human rights, effective implementation of the statutes and their Codes of Practice, the guiding principles of the MHA & the MCA, and the requirements of the CQC.
To oversee completion and embedding of corrective action, escalating any concerns, identifying trends and themes and overseeing recommendations.
To ensure the development, implementation and timely review of policies in relation to Mental Health and Human Rights Legislation, ensuring there is adequate engagement and involvement. Ratifying these, following approval by the Policy Governance Group.
To receive assurance from the Reducing Restrictive Practice Group on implementing the Trust's aim of reducing restrictive practice.
To receive assurance in respect of the performance and functions of the Associate MHA Managers.
To ensure that the Trust actively listens to the experiences of the service user, family and carer feedback in the application of MHA/Mental Health and Human Rights legislation to identify good practice and learning.
To seek assurance that inequalities are recognised where they occur in relation to the use of Mental Health Legislation and associated policies and that remedial action and reasonable adjustments are utilised to address them.
To ensure a coordinated organisational response to the introduction of changes to or new law, regulations, guidance etc.
To oversee training in relevant subject areas, ensuring this is effective to ensure staff are fully trained to implement relevant legislation as part of their work.
To consider issues arising out of the "Delegated Authority" function for Mental Health Working

Age Adults (formerly Section 75 partnership).
To commission reviews and/or audits of standards and practice as required.
To seek assurance on effective implementation of action plans developed in response to reviews and audit to improve legislative compliance and good practice in service user experience.
The Committee will uphold the values of the Trust in the work it does. In particular it will look for assurances that these values are being delivered in the Trust, as part of its overall governance role on behalf of the Board.
The Committee will oversee all risks delegated to the Committee via the Corporate Risk Register (CRR) and Board Assurance Framework (BAF). The Committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps. The Committee should provide assurance to the Board on the risks delegated to the Committee and highlight any key areas of concern identified by the Committee.

6.2 Progress against the objectives will be reviewed at the six-month interval.

7. Work plan 2022/23

7.1 The Committee's workplan for 2021/23 is detailed in **Appendix A** and is presented for approval and agreement to share with the Board for endorsement.

8. Review of Terms of Reference

8.1 The Terms of Reference have been reviewed and are attached at **Appendix B** and are presented for approval and agreement to share with the Board for endorsement.

9. Conclusion

9.1 The Committee assures the Board it continues to function appropriately as a standing committee of Trust's Board of Directors, effectively overseeing the duties as set out in the agreed Terms of Reference.

Supporting information

Appendix A – Mental Health Legislation Committee work plan 2022/23

Appendix B – Mental Health Legislation Committee terms of reference

Mental Health Legislation Committee 2022-2023

Report Subject Description	Frequency	Exec Lead	Author(s)	2022 Jun	2022 Sep	2022 Dec	2023 March
				Q4	Q1	Q2	Q3
Date of Meeting				15/06/2022	21/09/2022	21/12/2022	15/03/2022
Date for Submission of Papers				08/06/2022	14/09/2022	14/12/2022	08/03/2022
Standing Items							
Apologies (and confirmation of quoracy)				X	X	X	X
Minutes/notes of last meeting				X	X	X	X
Action log				X	X	X	X
Declaration of any conflict of interest				X	X	X	X
Significant Issues Reporting, Alert, Arise, Advise				X	X	X	X
Meeting work programme				X	X	X	X
Review of meeting effectiveness (verbal)				X	X	X	X
Routine Tier 2 Reporting							
Mental Health Legislation Report	Quarterly			X	X	X	X
Least Restrictive Practice Report	Quarterly			X	X	X	X
Human Rights Framework	Quarterly			X	X	X	X
Governance							
Board Assurance Framework /Corporate Risk Register	Quarterly			X	X	X	X
MHLC Related Policies for Ratification	Quarterly			X	X	X	X
Internal Audits – Action Tracking Report – *(D Lawrenson – standing item for all sub-committees as agreed by ARC)*	Quarterly			X	X	X	X
AMHAMs	Quarterly			X	X	X	X
Self-Assessment Questionnaire to be distributed to and completed by Committee in December 2022	Annual - December					Non-agenda item	
Committee Effectiveness Self-Assessment Questionnaire Review	Annual			X Late - should be in January, to go in Jan 2023 on Work Plans (March for MHLC because of meeting timetable)			
MHLC Annual Committee Effectiveness Report (then signed off at ARC)	Annual			X(D)	X Behind on routine of all Committee Effectiveness reporting hence deferral to September		X March is its regular spot. Went late in 2022 (September) hence twice in year. To be signed off at ARC April 2023
Tier 2 Committee/Group Annual Effectiveness Reports with TORs	Annual	SM/JM					X
Mental Health Act Code of Practice Equality and Human Rights Policy NPCS 010 Review	Annual						X
Key Performance Indicators							
AMHPs	Monthly						
Approved Clinicians	6 monthly						

Court of Protection responsibilities (MCA)	Monthly
CTO patients	Quarterly
Errors in statutory paperwork	Quarterly
Exception to certificate requirements	Quarterly
HBPoS use	Monthly
Mental Capacity Act	Quarterly
Mental Health Review Tribunals	Quarterly
Patient demographics	Quarterly
Referrals to IMHA	Monthly
s132 rights	Bi-Monthly
s17 Leave	Monthly
s4 MHA use	Bi-Monthly
s5(2) use	Bi-Monthly
s5(4) use	Bi-Monthly
Training	Monthly
Key Performance Indicators by exception	
Guardianship	Exception
Legal Action	Exception
Long-term segregation	Exception

Visits to patients	Exception
Phase 2 proposed Key Performance Indicators	
Associate Mental Health Act Managers	Quarterly
Complaints	Monthly
Deprivation of Liberty Safeguards	Monthly
Guardianship	Exception
Hospital admissions	Monthly
Legal Action	Exception
Responsible Clinicians	Monthly
Restricted patients	Quarterly
Seclusion - *Salli Midgley and Jamie Middleton agreed (March 2022 MHLC) not to include in first tranche to avoid duplication with Restrictive Practice Group work*	Monthly

BRING FORWARDS

Report Subject Description	**Frequency**	**Exec Lead**	**Author(s)**	2022 **Jun**	2022 **Sep**	2022 **Dec**	2023 **March**
				Q4	Q1	Q2	Q3
Date of Meeting				15/06/2022	21/09/2022	21/12/2022	15/03/2022
Date for Submission of Papers				08/06/2022	14/09/2022	14/12/2022	08/03/2022

Terms of Reference

Document History:	
Version Number:	**3**
Approved by:	**Trust Board – pending approval September 2022**
Date approved:	**For receipt at MHLC September 2022**

Name of Committee	Mental Health Legislation Committee
Type of Committee	Board Assurance Committee reporting to Board of Directors (the "Board")

1.	**Purpose of Committee**
	The Mental Health Legislation Committee (the "Committee") has been established to ensure of effective application and administration of the Mental Health Act (MHA), the Mental Capacity Act (MCA), including its Deprivation of Liberty Safeguards (DoLS) or, when they come into effect, Liberty Protection Safeguards (LPS) and any associated safeguarding matters, Human Rights Legislation and adherence to the associated Codes of Practice. The Committee shall provide assurance to the Board on the probity of the Trust and support the other Board Committees in the achievement of clinical effectiveness and safe outcomes for service users, maintaining positive service user and carer experience and equality and inclusion.
2.	**Scope**
	The scope of the Committee is Trust-wide. It will review and monitor arrangements for systems and process in place to oversee compliance with Mental Health Act Legislation following an annual programme of work.
3.	**Authority/Accountability**
	The Committee is an assurance Committee for matters of statutory and regulatory compliance in respect of Mental Health and Human Rights Legislation. The Committee reports to the Board and sits within the portfolio of the Executive Medical Director. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to establish and delegate powers to sub-committee(s)and work groups. The Committee will oversee the work of those sub-committee(s) and work groups. The Committee is authorised by the Board to obtain outside legal or other independent

professional advice and expertise as required to support it in discharging its duties. The budget for such advice must be within agreed financial constraints.

The Committee will advise the Board of Directors of any investigation being undertaken that instructs professional advisors and update the Board on progress.

The Committee is authorised to make decisions that are not reserved to the Trust Board. Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions of the Trust.

The following matters that must be referred to the Board:

- Where there is significant revenue, capital or cash implications as determined by the Trust's Standing Financial Instructions
- Conflict with statutory obligations, or have significant governance implications
- Likely to arouse significant public or media interest.

4. Objectives of Committee

(i) To receive assurance of performance across the Trust against Key Performance Indicators which reflect respect for service users' human rights, effective implementation of the statutes and their Codes of Practice, the guiding principles of the MHA & the MCA, and the requirements of the CQC. To oversee completion and embedding of corrective action, escalating any concerns, identifying trends and themes and overseeing recommendations. KPIs to include, but not limited to:

- Progress against Provider Action Statements (PAS) following Monitoring Visits by the Care Quality Commission, including evidence of practice being embedded where necessary
- Practice in respect of capacity to consent to informal admission
- Practice in respect of capacity to consent to treatment
- Adherence to Consent to Treatment Requirements under Part IV and Part 4A of the MHA and/or the MCA
- Practice in respect of the explanation of Rights under section 132 MHA
- Practice in respect of Section 17 Leave
- Practice in respect of the use of short-term sections: MHA s4; 5(2); 5(4)
- Practice in respect of detention in the Health Based Place of Safety
- Compliance with mandatory training
- Practice in relation to the MCA Deprivation of Liberty Safeguards (DoLs – to be replaced by Liberty Protection Safeguards (LPS)).
- Timeliness of the production of reports to MHA hearings
- Human Rights Act training (this KPI will be added during 2021/22).

(ii) To ensure the development, implementation and timely review of policies in relation to Mental Health and Human Rights Legislation, ensuring there is adequate engagement and involvement. Ratifying these, following approval by the Policy Governance Group.

(iii) To receive assurance from the Reducing Restrictive Practice Group on implementing the Trust's aim of reducing restrictive practice.

(iv) To receive assurance in respect of the performance and functions of the Associate MHA Managers.

(v) To ensure that the Trust actively listens to the experiences of the service user,

family and carer feedback in the application of MHA/Mental Health and Human Rights legislation to identify good practice and learning.

(vi) To seek assurance that inequalities are recognised where they occur in relation to the use of Mental Health Legislation and associated policies and that remedial action and reasonable adjustments are utilised to address them.

(vii) To ensure a coordinated organisational response to the introduction of changes to or new law, regulations, guidance etc.

(viii) To oversee training in relevant subject areas, ensuring this is effective to ensure staff are fully trained to implement relevant legislation as part of their work.

(ix) To consider issues arising out of the "Delegated Authority" function for Mental Health Working Age Adults (formerly Section 75 partnership).

(x) To commission reviews and/or audits of standards and practice as required.

(xi) To seek assurance on effective implementation of action plans developed in response to reviews and audit to improve legislative compliance and good practice in service user experience.

(xii) The Committee will uphold the values of the Trust in the work it does. In particular it will look for assurances that these values are being delivered in the Trust, as part of its overall governance role on behalf of the Board.

(xiii) The Committee will oversee all risks delegated to the Committee via the Corporate Risk Register (CRR) and Board Assurance Framework (BAF). The Committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps. The Committeeshould provide assurance to the Board on the risks delegated to the Committee and highlight any key areas of concern identified by the Committee.

5. Membership

Three Non-Executive Directors – one of which will be appointed chair.
Medical Director (Executive Lead)
Director of Quality
Director of Corporate Governance

Membership will be reviewed annually.

6. Attendees

Meetings will normally be attended by:

Director of Operations and Transformation
Clinical Director: Rehabilitation and Specialist Services
Clinical Director: Community and Acute Services
Clinical Director: Learning Disability Services
Lead Social Worker
Head of Mental Health Legislation

Head of Nursing
Nurse Consultant for Restrictive Practice
Safeguarding Lead
Service user/Carer representative
Committee Administrator
Governor Observer

Other directors or their deputies may be asked to attend meetings or part meetings for discussions on matters relating to their portfolio, if required. The provisions of the Trust's Standing Orders relating to acting up arrangements and joint members will apply to this Committee with respect to decision making authority.

The Director of Corporate Governance (BoardSecretary) will provide advice to the Chair and members to ensure that the Committee has the appropriate administrative and secretarial support (an Administrator). A minute taker will also attend all Committee meetings and be stated as in attendance.

7. Chair, Quorum, Attendance and Meetings

Chair
The NED Chair will preside at all meetings having been approved as the Chair by the Trust Board. In extraordinary circumstances where the Chair cannot attend, one of the Non-Executive Director members will chair the meeting.

Quorum
A quorum will be 3 members and must include 2 Non-Executive Directors and 1 Executive Director including the Chair or deputy chair.

Deputies may attend, with the agreement of the Chair. This will be by exception; they must be fully briefed and if formally deputising will count towards the quorum.

If the Committee is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate no decisions shall be made at that meeting and such matters must be deferred until the next quorate meeting.

Attendance
Members are expected to attend all meetings. Apologies must be received by the Administrator in advance of the meetings. All members will be required to attend **a minimum** of two thirds of all meetings held annually. Members should not be absent for more than two consecutive meetings without the agreement of the Chair.

Any Committee member may participate in a meeting by way of telephone, computer or any other electronic means of communication provided that each person is able to hear and speak. A person participating in this way is deemed to be present in person although their actual location shall be noted in the minutes and is counted in a quorum and entitled to vote. The meeting is deemed to take place where the largest group of those participating is assembled, or if there is no such group, where the Chair of the meeting is located.

Meetings
Where a specific matter is deemed to be of a confidential or commercially sensitive nature the Chair has the authority to restrict attendance at the meeting to members only and to ask all invitees to leave the meeting.

If any member or invitee has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that

interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member or invitee to withdraw until its consideration has been completed.

8. Frequency and Notice of Meetings

Frequency

The Committee will meet quarterly. Additional meetings can be arranged for specific purposes as necessary, with agreement by the Chair.

If a matter of urgent business arises and an extraordinary meeting is required, this may be convened by the Chair, subject to the agreement of a quorum number of members. Decisions will be subject to achieving quorum attendance.

Where a decision needs to be taken outside the normal cycle of meetings, and where the matter is not deemed by the Chair to require an additional meeting to be called, the decision may be made via e-mail. The preference is for decisions to be taken at meetings. The decisions via e-mail process will be used on an exceptions basis. The process for decision via e-mail will be as follows:

a) An e-mail setting out the matter for decision will be sent to all members on the same working day. This shall include a statement setting out how the members should signify what their view on the matter is and the deadline for doing so.

b) Members will generally be given no less than five working days in which to respond.

c) For a decision to be passed, all of the members must express the same view on the matter.

d) Where members have comments on the proposed decision or recommendation/s these will be circulated to other Committee members by the Administrator within one working day of receipt.

e) If any individual member wishes to debate an item proposed for decision via e-mail at a meeting instead they may ask the Chair to arrange an additional meeting or defer the item for decision until the next meeting (such agreement by the Chair not to be unreasonably withheld).

f) Decisions via e-mail will be reported to the next meeting and the wording of the decision minuted. Any decision made in this manner will be effective from the date of agreement of all of the members and confirmed by email by the Administrator.

Notice of meetings

Meetings shall be called by the Administrator at the request of the Chair or any of its members.

Unless otherwise agreed, notice of each meeting and agenda of items to be discussed, shall be forwarded to each member, any other person required to attend no later than five full working days before the date of the meeting. Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

Notices, agendas and supporting papers can be sent in electronic form where the recipient has agreed to receive documents in such a way.

A meeting workplan will be agreed on an annual basis, setting out the main work items to be carried out at each meeting to ensure that adequate time is given to the main objectives of the Committee.

9. Minutes and Reporting Arrangements

Tier II groups will report to the Committee as agreed within the governance structure.

The Committee will report to the Board on how it discharges its responsibilities. The Board will report back if it has any concerns about its adherence to the Terms of Reference.

The minutes of Committee meetings will be formally recorded and submitted to the Board by the Chair of the Committee. The Chair of the Committee will draw to the attention of the Board any issues or decisions for disclosure or require executive action.

The Trust Board will receive standing reports following each meeting and additional reports as part of the scheduled programme of annual reports.

In addition, the Committee will receive thematic 'deep dive' reports or reviews as required to enable greater discussion about specific issues and to facilitate in depth discussions between the members and those staff providing services.

The Board has ultimate responsibility for the effectiveness of its governance below Board. The Board will rely on the work of its Committees to provide assurance on the effectiveness of the governance structure.

10. Administrative arrangements

The Committee will be supported by a nominated Administrator who will:

- produce a schedule of meetings and maintain the annual work plan for the Committee
- prepare the agenda and papers with the Chair and circulate five working days prior to the meeting;
- maintain accurate records of attendance, key discussion points and decisions taken and issue necessary action logs within five full working days of the meeting;
- draft minutes, recording where the Committee has delivered its purpose through relevant reports and subsequent discussion, debate and challenge, and where further information is required, for circulation to the meeting Chair within five full working days of the meeting;
- organise future meetings; and
- file and maintain records of the work of the Committee in the required corporate records folder.

11. Meeting effectiveness review

The Committee shall at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Committee shall undertake appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

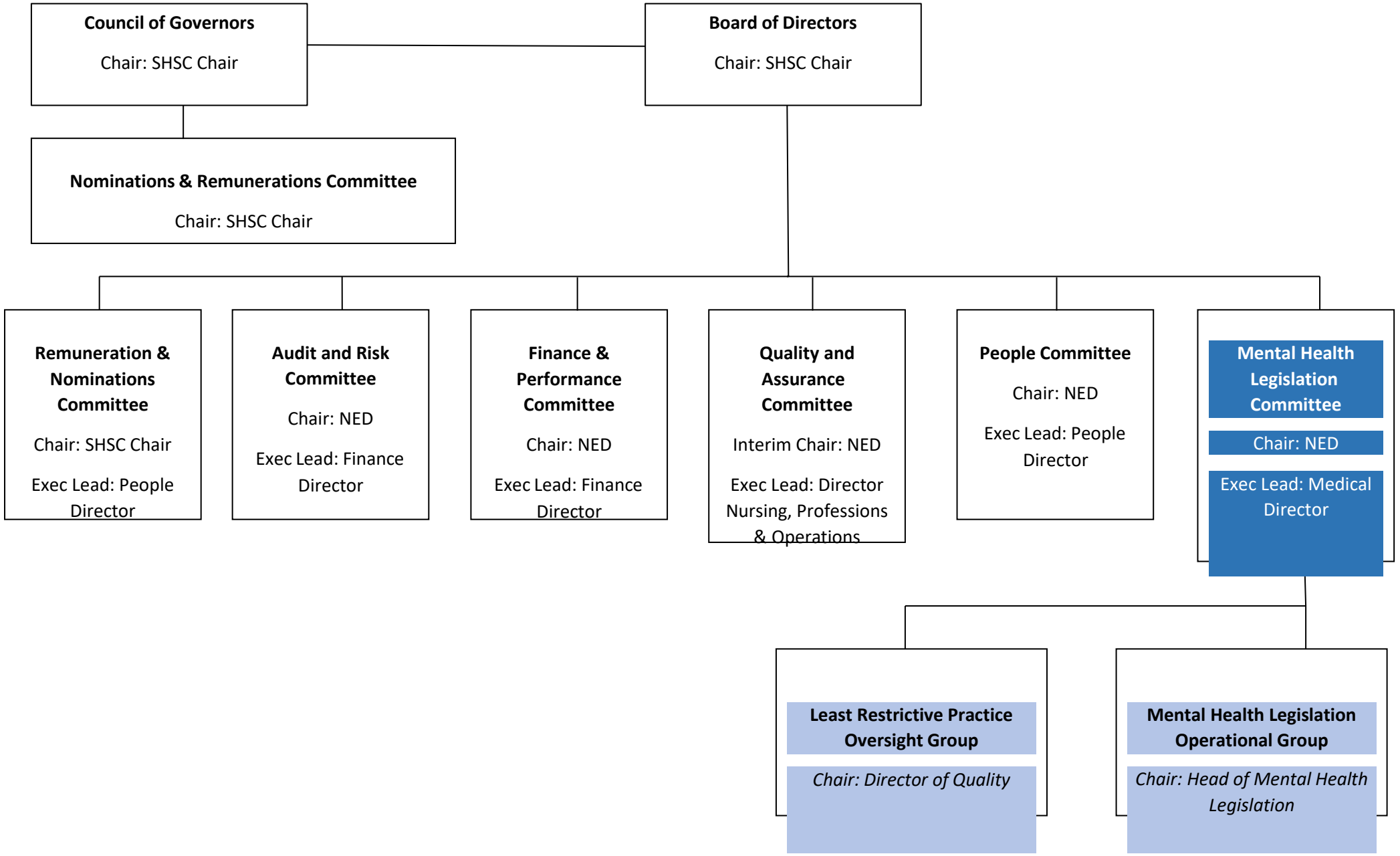
A record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted to the Chair of the Committee.

12. Review to be conducted by Committee Chair

	Date Committee established	1 April 2021
	Terms of Reference to be reviewed	Annually
	Date of last review	September 2022 pending
	Date of next review	September 2023

Sheffield Health and Social Care NHS FT Governance Structure - MHLC

Board & Committee Governance Structure – Quality Assurance Committee



SHSC Mental Health Legislation Committee – Self-Assessment 2022

Theme 1 – Committee focus

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
1a	The committee has set itself a series of objectives it wants to achieve this year		***7***	**1**		
1b	The committee has made a conscious decision about the information it would like to receive	**1**	**7**			
1c	Committee members contribute regularly across the range of issues discussed		**8**			
1d	The committee is aware of the key sources of assurance and who provides them.		***7***	**1**		
1e	Where appropriate, the committee receives assurances from third parties who deliver key functions to the organisation – for example NHS Shared Business Services (Payroll; Occupational Health) or private contractors		**2**	**4**	**1**	**1**

Theme 2 - Committee Team Working

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
2a	The committee has the right balance of experience, knowledge and skills to fulfil its role		**8**			
2b	The committee has structured its agenda to cover quality, data quality, performance targets and financial control		**5**	**3**		
2c	The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives	**3**	**5**			
2d	Management fully briefs the committee on key risks and any gaps in controls		**7**			**1**
2f	The committee environment enables people to express their views, doubts and opinions		7	**1**		
2i	Members hold their assurance providers to account for late or missing assurances		***6***	**1**	1	

2j	Decisions and actions are implemented in line with the timescale set down		***7***		1	

Theme 3 – Committee Effectiveness

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
3a	The quality of committee papers received allows committee members to perform their roles effectively		**7**	**1**		
3b	Members provide real and genuine challenge – they do not just see clarification and/or reassurance		**6**	**2**		
3c	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints, etc.	**1**	**5**	**2**		
3d	Each agenda item is “closed off” appropriately so that I am clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.		**5**	**3**		
3e	At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc.	**1**	**3**	**4**		
3f	The committee provides a written summary report of its meetings to the governing body	1	4	**1**		2
3g	The governing body challenges and understands the reporting from this committee		5			3
3h	There is a formal appraisal of the committee’s effectiveness each year	1	6			1

Theme 4 – Committee Engagement

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
4a	The committee actively challenges management and other assurance providers during the year to gain a clear understanding of the findings		**6**		**1**	**1**
4b	The committee is clear about its role in relationship to other committees		**6**	**2**		
4c	The committee receives clear and timely reports from reporting groups	**1**	**6**			**1**
4d	We can provide two examples of where we as a committee have focused on improvements to the system of internal control as a result of assurance gaps identified		**6**	**2**		

Committee Leadership (not to be completed by Chair)

Ref	*Statement*	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*Unable to Answer*
5a	The committee Chair has a positive impact on the performance of the committee	**1**	**2**	**2**	**1**	**1**
5b	Committee meetings are chaired effectively	**1**	**2**	**2**	**1**	**1**
5c	The committee Chair is appropriately visible within the organisation and is considered approachable	**1**	**3**	**1**	**1**	***1***
5d	The committee Chair allows debate to flow freely and does not assert his/her own views too strongly	**2**	**5**			
5e	The committee Chair provides clear and concise information to the governing body on committee activities and gaps in control	**1**	**2**			***4***