Board of Directors - Public

SUMMARY REPORT	Meeting Date:	23 November 2022
	Agenda Item:	07

Report Title:	**Committee Activity**	
Author(s):	Amber Wild, Corporate Assurance Officer	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director, Chair of Mental Health Legislation Committee Heather Smith, Non-Executive Director, Chair of People Committee, and Interim Chair Quality Assurance Committee Richard Mills, Non-Executive Director, Chair of Finance and Performance Committee Owen McLellan, Non-Executive Director (Chair of Finance and Performance Committee from October 2022) Anne Dray, Non-Executive Director, Chair of Audit and Risk Committee	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Quality Assurance Committee Finance and Performance Committee People Committee Mental Health Legislation Committee Audit and Risk Committee
	Date:	As detailed in the summary section
Key Points:	This report highlights key matters, issues, and risks discussed at committees since the last report in September 2022 to advise, assure and alert the Board. Minutes approved by each committee are presented to Board to provide assurance that the committees have met in accordance with their terms of reference and to advise Board of business transacted at their meeting.	

Summary of key points in report

Each committee has considered 'significant issues' under three key categories in their Alert, advice, Assure (AAA) Reports:

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

Advise – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments.

Assure – specific areas of assurance received warranting mention to Board.

The areas attracting particular focus are those under the 'red' alert headings on each page of the committee reports.

Board sub-committee reports included in this report to Board are as follows:

Appendix 1 - Quality and Assurance Committee:
- AAA reports from October 2022, November 2022
- Minutes from September 2022, October 2022

Appendix 2 - Audit and Risk Committee:
- AAA Report from October 2022
- Minutes from July 2022

Appendix 3 - People Committee:
- AAA Report from November 2022
- Minutes from September 2022

Appendix 4 - Finance and Performance Committee:
- AAA Report from October 2022 and November 2022
- Minutes from September 2022, October 2022 (presented to confidential Board)

Mental Health Legislation Committee:
- None – next meeting December 2022

Recommendation for the Board/Committee to consider:

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

The board is asked
- To formally note the minutes of the committee meetings being present to the Board
- To receive for assurance the attached 'Alert, Assure, Advice' committee activity reports to agree if any further action is required.

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

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

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

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*		*No*	***X***	Not directly in relation to this report – specific detail within the appendices
Financial (revenue &capital)	*Yes*		*No*	***X***	
Organisational	*Yes*		*No*	***X***	

Development/Workforce					
Equality, Diversity & Inclusion	*Yes*		*No*	***X***	
Legal	*Yes*		*No*	***X***	
Sustainability	*Yes*		*No*	***X***	

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Quality Assurance Committee	Date:	12/10/2022	Chair:	Heather Smith

KEY ITEMS DISCUSSED AT THE MEETING					
TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Persistent risks: -Waits -Flow across acute pathway -Care Programme Approach reviews -Supervision rates -Vacancy rates	Committee noted persistent risks and reflected on cumulative risks in terms of service users. Risks were escalated to September 2022 Board. A different way of working is needed	Limited assurance of progress	Report to QAC November 2022 Alert to Board	QAC 9/11/2022 BoD 23/11/2022	24 29
Carer and service user feedback, advocacy, and peer support	Committee noted the need to strengthen carer and service user feedback, advocacy, and peer support. Seeking robust plan for this going forward to help to assure improvements continue on the right track	Limited assurance of carer and service user feedback	Robust plan to assure of improvements continues. Next report to QAC January 2023 Alert to Board	QAC 11/01/2023 BoD 23/11/2022	24 25
Health and Safety Executive (HES): Improvement Notice for Sharps Instruments in Healthcare	HSE improvement notice for sharps and waste management issued to SHSC. Oversight unclear and risks not fully owned	Limited assurance. Director of Quality working closely with Health and Safety Manager and Infection, Prevention, and Control team	Director of Quality has requested assessment to ensure this is not occurring in other areas	November 2022	23
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Back to Good Programme	Improved levels of assurance	Good assurance of progression	Committee requested more	QAC 09/11/2022	24

Board	from Back to Good Programme Board regarding the checking of embedding of actions		information of mitigation relating to training gaps, particularly agency staff		25
Board Visits	Committee acknowledged that the Board visits were progressing well	Good assurance of progression	Review how to improve information received and increase engagement with staff and service users Advise Board 6-monthly report to QAC	BoD 23/11/2022 QAC 07/06/2023	24
Annual Health and Safety report	Committee received draft annual report and gave feedback including improving the tracking of actions	Assurance that report is on track and final copy will go to QAC and Board in November 2022	Feedback to be included. Final report to QAC and Board November 2022	QAC 09/11/2022 BoD 23/11/2022	23
Learning Lessons report	Significant improvement in reporting and inclusion of serious incidents reports in response to Ockenden recommendations	Good assurance of improvements in reporting. For further assurance, future reports must highlight what has changed as a result of learning lessons	Next report to QAC November 2022. Action to include digital incidents relating to patient safety. Board to reflect if any more detail is required	QAC 09/11/2022 BoD 23/11/2022	24 29
Research, Innovation, Effectiveness, and Improvement Group annual report	Committee received a summary of the significant steps taken in developing the strategy and the start of the impact analysis	Good assurance from report of volume of work undertaken over the year	Advise Board Next quarterly report to QAC January 2023. Focus on detailed outcomes and impact, and how to accelerate impact	BoD 23/11/2022 QAC 11/1/2023	24
Internal Audit Action Tracking report	Report received and committee were updated of status of actions	Good assurance that actions are being monitored and are on track. Nothing major identified	Standing item for QAC	QAC 9/11/2022	-
Use of Force annual report	QAC received report for information. Report previously received at September 2022 MHLC	Good assurance	Advise Board of receipt of report	BoD 23/11/2022	-
Learning from Edenfield	Review undertaken with ongoing reflection	Assurance of review and ongoing progress reporting to QAC	Committee requested regular progress reports	QAC 9/11/2022	-

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

Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Lived-Experience and Co-Production implementation plan	Committee acknowledged significant progress being made and positive work underway	Good assurance of progress	Service user feedback to be addressed in next 6-monthly report to QAC. Board alerted to	BoD 23/11/2022 QAC 12/04/2023	24 29

			concerns around service user feedback		
Ockenden report and Paterson review: SHSC implementation plan	Implementation plan in place with coherence across different strategies	Good assurance that a robust implementation plan is in place in response to the report	Exception report to January 2023 QAC	QAC 11/1/2023	24 29

BAF Risk Description

BAF.0023	There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of Service Users and staff which may result in avoidable spread of infectious diseases.
BAF.0024	There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action.
BAF.0025	There is a risk of failure to effectively deliver essential environmental improvements including the reduction in ligature anchor points in, inpatient settings (the therapeutics environment programme) at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skilled staff to deliver works to timeframe required resulting in more restrictive care and a poor staff and service user experience and unacceptable service user safety risks.
BAF.0029	There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users.

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Quality Assurance Committee	Date:	09/11/2022	Chair:	Heather Smith

KEY ITEMS DISCUSSED AT THE MEETING					
TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Persistent risks: • Waits for treatment across community services • Flow across the acute care pathway • Supervision rates not consistently meeting standards • The impact of vacancy rates on the quality of care and staff wellbeing remain a cause for considerable concern, especially on the acute pathways	Committee asked that recovery plans with full detail to be made clearer in the IPQR summary report to provide assurance.	Limited assurance of progress.	To be kept as an alert to Board and future reporting to include the work being completed. Recovery plans for waits next due January 2023, board action 7 is related.	January 2023	BAF 0024
Service user experience • Service user feedback • Person-centred care	Insufficient assurance about service user experience: the committee is not fully cited on the full range of service user feedback mechanisms. Poor collection of personal data across the protected	Limited assurance that various engagement and oversight mechanisms are leading to feedback and learning. Limited assurance	Fundamental standards visit with lived experience/ service user input will be brought forward to December and will be reported to QAC in January 2023. Clinical directorate leaders to	January 23 November 22	BAF 0021

• Access to interpreters.	characteristics and other biographical details will impede ability to provide person centred and culturally sensitive care Access to interpreters is a significant cause for concern. This links to a Back to Good action that is in exception in relation to the provision of accessible information, including information in a range of different languages.	Limited assurance that we are supporting individual communication needs	support improved performance. Proposal that collection of protected characteristic data to be reported in IPQR. Concerns about fulfilment of bookings for some languages including BSL have been raised through our local contract meetings and through the North of England Commercial Procurement Collaborative (NOE CPC) oversight, action has been taken by the provider of the contract this is ongoing action plan. Head of Equality and Inclusion to review with the Director of Quality	TBC TBC	
Positive alert: • CPA compliance is gradually improving • Older adults inpatient service: positive performance in terms of lengths of stay • Waiting time standards were good for the early intervention and IAPT teams • Rehab and Specialist directorate are meeting supervision targets.	There has been an improvement in CPA review compliance, which has been on our high risk list for many months.	Good assurance of continued focus and progress.	N/A	N/A	BAF 0024
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk No
Back to Good Programme Board	There are number of action items awaiting closure	Interim worker has started in post to support capacity issues in the team.	Committee requires assurance on the next report showing the reduction of these items and requested that it is made clear which incomplete actions are high risk, impacting on our aspirations in standards of patient care	January 23	BAF 0024 BAF 0025
Mortality Review	The report is on an upward trajectory of improvement in terms of robustness, more focus is needed to ensure that the learning is articulated in the appropriate report and cross referenced in this report.	Improvements needed were clearly articulated in the report e.g. more learning to be extracted from SJRs and where this learning is reported.	Further improvement work on learning into action being undertaken.	February 23	BAF0024
Quality Strategy update	There is assurance that the Quality strategy is progressing according to timescales but to note the apparent risk of progress around use of Tendable	Tendable audit in progress and Head of Quality Improvement in post which will impact on achieving milestone within the next reporting note risk around Tendable.	The next report will include more focus on impact issues	May 2023	BAF0024
Community Mental Health Services progress report	Committee received an update report and gave feedback including requesting links to our strategic priorities and national benchmarking.	Good assurance of co-production session with service users, carers and families and multi-disciplinary staff engagement sessions. The report assured the Committee that we are well cited on risks and mitigations.	Future reporting to clarify links to strategic priorities	March 2023	BAF0024 BAF0029
Learning Lessons report	Greater assurance being received from the Clinical Quality and Safety Group AAA report that the Trust is bringing together learning.	The Board that can be assured that the process of gathering learning is now much more sophisticated and can inform practice change.	It was noted that committee now needs to see the impact on practice and the evidence of change.	January 2023	BAF0024 BAF0029
Community Mental Health Annual survey 2021	Committee acknowledged significant progress being made and positive work underway	Assurance that results are similar to other Trusts and that the areas for improvement link back to our community transformation.	Impact of Community Mental health services transformation action work will be realised in future surveys	Recovery transformation quarterly progress reports (and the 2023	BAF0024 BAF0029

				survey (January)	
Quality and Equality Impact assessment report	Report received for information and request made for richer impact analysis for future reporting.	Committee assured that there is a process in place	Future reporting to include the potential quality and equality and inclusion impacts to support Quality Assurance Committee understanding of the level of assurance.	June 2023	BAF0025
Safeguarding Internal Audit report	Limited assurance received relating to recording within clinical teams.	Assurance that the issues raised in that internal audit are on track to being addressed.	Future reporting to safeguarding assurance committee to detail conclusion of issues addressed for onward reporting to QAC.	January 2023	BAF0024
Clinical and Social Care Strategy	Committee received an update on progress being made, in particular with respect to a trauma informed approach.	Assurance that the development plan is being followed.	Future reports to focus on change and impact	April 2023	BAF0024 BAF0029
Quality objectives	Committee received an update on progress but only moderate assurance received.	Moderate assurance Limited assurance that protected characteristics are being captured	Further embedding required in order to show impact on quality (especially around improvements for BAME communities)	February 2023	BAF0024
Annual Equality and Human Rights report	Report received and approved for Board consideration	Issues highlighted about service users (and linked to lack of biographical data: see alert above)	Work to be undertaken on improving collection of personal data. Clinical directorate leaders to support improved performance. Proposal that collection of protected characteristic data to be reported in IPQR.	November 22 TBC	BAF0025
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
The Health and Safety Annual report	Highlighted changes made in response to Committee seeing the draft report last month.	Issues highlighted reflect the key risks to the Trust with respect to H&S	Committee agreed that the report can now proceed to the Board	November 2022	BAF0023

Internal Audits – Action Tracking Report	Committee received and reviewed the report and noted that all QAC actions were on track	The Board can be assured there is oversight and completion of internal audit actions related to the QAC.	Standing item on the QAC workplan	January 2023	BAF0024

BAF Risk Description

BAF.0023	There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of Service Users and staff which may result in avoidable spread of infectious diseases.
BAF.0024	There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action.
BAF.0025	There is a risk of failure to effectively deliver essential environmental improvements including the reduction in ligature anchor points in, inpatient settings (the therapeutics environment programme) at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skilled staff to deliver works to timeframe required resulting in more restrictive care and a poor staff and service user experience and unacceptable service user safety risks.
BAF.0029	There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users.

Quality Assurance Committee (QAC)

CONFIRMED Minutes of the Quality Assurance Committee held on Wednesday 14 September 2022 at 10am. Members accessed via Microsoft Teams Meeting.

Present:	Heather Smith, Non-Executive Director (Chair)	CHAIR
	Dr Mike Hunter, Executive Medical Director	MH
(Members)	Richard Mills, Non-Executive Director	RM
	Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director	OF
	Salli Midgley, Director of Quality	SM
	Anne Dray, Non-Executive Director	AD
In Attendance:	Tania Baxter, Head of Clinical Governance	TB
	Neil Robertson, Director of Operations and Transformation	NR
	Pat Keeling, Director of Strategy	PK
	Sue Barnitt, Head of Clinical Quality Standards	SB
	Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services	Si.B
	Greg Hackney, Head of Service, Crisis, and Emergency	GH
	Christopher Wood, Head of Nursing	CW
	Abiola Allinson, Chief Pharmacist	AA
	Dr Jonathan Mitchell, Clinical Director	JM
	Mark Jones, Head of Performance	MJ
	Grace Kinsey-Oxspring, Deputy Head of Nursing	GK
	Hester Litten, Head of Safeguarding	HL
	Amber Wild, Corporate Assurance Manager	AW
	Sara Whittaker, Chartered Clinical Psychologist	SW
	Jaimee Wylam, Public Health Registrar	JW
	Francesca O'Brine, Corporate Assurance Officer (minutes)	FO

Apologies: Dr Robert Verity, Clinical Director
Linda Wilkinson, Director of Psychological Services & Consultant Clinical Psychologist
Beverley Murphy, Executive Director of Nursing, Professions, and Operations (BM)
Professor Brendan Stone, Associate Non-Executive Director
Amanda Jones, Director of Allied Health Professionals
Robert McFarlan, Clinical Lead
Deborah Lawrenson, Director of Corporate Governance

Minute Ref	Item	Action
QAC22/09/418	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
QAC22/09/419	**Declarations of Interest** None.	
QAC22/09/420	**Minutes of the meeting held on 10 August 2022** The minutes of the meeting held on 10 August 2022 were agreed as an accurate record.	
QAC22/09/421	**Matters Arising** **Back to Good – Requirement 71**	

	The committee received the report from Sue Barnitt and were satisfied with its content.	
QAC22/09/422	**Action Log** Committee received the action log for information. Actions 1 and 2 required updating. Committee agreed this could take place following the meeting. These actions to remain on the action log until October QAC for oversight.*	***ACTION FO/BM**
QAC22/09/423	**Back to Good Reporting – Risk Report** Committee received the report from Sue Barnitt for assurance and strategic consideration. Key issue: • Impact on delivery of programme – lack of evidence submitted to close actions • New process in place: two reminders, escalation to Director of Nursing. 51 escalations currently required MH: • Must highlight as a risk to progress of Back to Good Programme • Assurance required that evidence will be submitted RM • What is the reason for lack of evidence - common themes? Embedded cultural issues? SB: Capacity and workload issues is main cause • Colour coding – confusing, need consistency of RAG rating SM: • Action owners need to communicate where action is embedded and how it will be monitored **Committee received the report and agreed to alert the Board of the risk the organisation is carrying to embedded improvements without the evidence. Committee were assured this also indicated a raising of standards and noted it was positive to see spot checks.**	

QAC22/09/424	**Health and Safety Quarter 1 Report** Committee received the report from Pat Keeling for assurance. Report summary: • Data within report has improved, including Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) data • Triangulation being made between RIDDOR and violence and aggression, and smoking and fire occurrences at Stanage Ward RM: • Continue to be encouraged by progress team is making • Some issues have been a concern for a long time e.g., fire doors • Committee should support team with progress – alert to Board PK: • Increased detail within recent reports can cause increased concern – indication of better understanding of issues AD: • Fire doors – benefit to correlate risks of smoking issues to risks of fire door issues? OF: • Physical assaults remain high • Increased smoking – due to stress and pandemic? • Agree alert to Board SB: • Smoke Free Policy under review • Task and Finish Group being set up to focus on data • Conversations planned with staff and service users to understand challenges faced in clinical setting SM: • Limited assurance from report – mitigation of risks unclear Chair: • Combination of assure and alert • Assurance - improved data and triangulation. More grip of what the issues are • Alert – cross-Trust collaborative approach needed to address issues and support team **Committee agreed to alert Board of the risks.** **Internal Audit Final Report – Health and Safety and Central Alerting System** Committee received the report from Pat Keeling for information. Chair: • Limited Assurance report • Actions will be tracked through Internal Audit Action Tracker	

	Committee noted the information provided in the report.	
QAC22/09/425	**a. Integrated Performance and Quality Report (IPQR)** Committee received the report from Greg Hackney for assurance and strategic consideration. Report summary: • No new risks identified • Risks not fully mitigated were discussed at QAC August 2022 • Paper receiving some amendments before Board • Acute pathway flow – issue remains, particularly use of inappropriate out of area beds • Review of care under Care Programme Approach (CPA) – improving but not at expected standard • Corporate and clinical supervision rates – trying to address issue through Back to Good Programme • Vacancy rates remain static at c11%, ongoing challenge • Demonstrating service user feedback – remains a concern • Inclusion of performance against long-term plan to be in future reports* AD suggested: • Recovery plan final column – include detail of activity for oversight • Areas of interest – include information on what will happen next MH: • Supervision – highly sighted on the issue through Back to Good Programme • Beyond this scope - what is the risk, plan, and confidence in making timely improvements GH responded: • Community team compliance dropped below 40% - assertive effort across leadership team to address this has aided improvement • Combination of issues – reporting and cascaded structure of delivery Chair and MH proposed supervision to go into a recovery plan. MH to discuss with BM.** Chair noted there are multiple issues, but important to highlight new positives coming through: • Reviewing incidents more quickly • Assaults on staff reduced • No A&E breaches in June 2022 **Performance against reviews of care under CPA:** • Five principles defined under Community Mental Health Framework (including key worker instead of care coordinator, delivery and review of care in person-centred way) • Meeting today with Integrated Care Board to define regional interpretation of principles • Overall performance of CPA reviews improving • Annual review cycles. Performance seen to improve this time of year - prepare for trajectory to decline at end of year	***ACTION Jason Rowlands/ Neil Robertson** ****ACTION MH/BM**

	Chair: limited assurance received. GH confirmed for AD regarding monitoring of embeddedness: • November update to committees regarding community mental health transformation GH confirmed for MH: • Managing this in line with performance framework • Trying to improve performance against a measure that is changing **Inappropriate out of area placements:** • Positive steps made to reduce these placements • Workstreams report into out of area hospital beds cost improvement programme • Trajectory not sustained throughout August and September 2022 • Working hard to reduce lengths of stay • Sighted on experience of service users, carers, and families – range of measures to support this • Limited assurance RM • Many risks and issues – must keep trying and supporting teams • Alert to Board – difficult target to reach **Waiting time in relation to allocation of a care coordinator:** • Committee sighted in detail of waiting times at August 2022 meeting • Most actions relate to mitigation of risk whilst people are waiting • Most transformational action: how we consider role of key worker in future • Pilot project with Voluntary, Community and Social Enterprise to help with transformation piece – needs formal consultation CW confirmed for RM: • Range of different reasons for staff turnover • Some staff are concerned about the impact of the transformation on their work SM: • Out of city use and waiting list – two of biggest areas where SHSC receives service user and carer feedback • Need to make work more visible so people can see commitment to improving experience*** Chair to GH: Could speak to Governors. Consider SM's recommendation. **Committee received the report and noted limited assurance. Assured that robust plans are being written but difficulty of implementation is the issue. Cannot be assured of impact. Committee acknowledged areas of improvement and the transparency of reporting.**	*****ACTION GH**
QAC22/09/426	**Clinical Quality and Safety Group Triple A Report** Committee received the report from Salli Midgley for assurance. SM noted that the Learning Lessons Report will go separately to QAC in September 2022 on this occasion.	

	Triple A Report summary: • Areas of group's focus highlighted • Alert: previous concern about sexual safety work plan – new person now in post • Reassuring to see concerns in group are mirrored in improvement plans MH: • BAF 029 maps directly through to report alert. Evidence of good governance **Committee received the report and were assured by the content.**	
QAC22/09/427	**Medicines Safety Progress Report** Committee received the report from Abiola Allinson for assurance. Positives: • Fridge monitoring - systems working Risks and mitigations: • Process issues causing increased stock recording discrepancies – meeting next week to discuss how to improve • Benchmarking (error on page 20 noted – graphs are reversed): SHSC sits in the middle – working with other organisations to review incident reporting and consistent reporting on trends • Discussions with supplier, Boots Pharmacy, around performance management - improvement noted but monitoring continues • Procurement to review contracts to check performance management AA confirmed for RM • Centralised fridge temperature monitoring system - next step is business case. G1 to be added then will put this forward • Cost: c£10-15,000 Chair: MH to raise this to move this forward* SM: • Administration incidents - graphs should point to when Inpatient Competency Framework started. Will give understanding of what the figures indicate** MH: • Benchmarking requires proportionality – work in progress but good first step • Reporting double incidents compared to nearest Trust - what does this mean? Chair: in future reports to include interpretation of what the benchmarking is implying *(to be included in action above – improvements for future reports)**** AA confirmed for OF: • Staff who are involved with administration errors are supported through various levels of conversation, and understanding and reflection sought Chair agreed with OF that although there is positive improvement, we should record our concern that incidents still occur.	***ACTION AA/MH** ****ACTION AA** *****ACTION AA**

	JM: • Report shows lots of data but no change. Increased reporting could have affected data and incidents could have reduced MH: • Clarify in future reports: how many controlled drugs (CDs) incidents there were as a proportion of the times where CDs were administered *(to be included in action above – improvements for future reports)***** **Committee received the report and noted the positive improvements made, including fridge temperatures, and suggested how to improve the report. Committee continue to seek assurance concerning impact on service users and staff.**	******ACTION AA**
QAC22/09/428	**Quality Objectives** Committee received the report from Tania Baxter for assurance. Risks: • Good community leader engagement across Sheffield with Patient and Carer Race Equality Framework (PCREF) - need to take time with this, work underway to rebuild relationships • Number of training sessions staff need to attend – impact of releasing staff for these RM: • How do we measure, compare, and track progress? Need consistency of reporting on progress TB confirmed for AD regarding objective 2: • Four priorities outlined, initially gathering data to understand where the barriers are, then as move forward with objective will look at actions OF: • *Demonstrate improvements in the number of people from BAME communities accessing services* - it's not about numbers per se but improving experience. We can only improve experience by fostering better engagement SM: • Understanding of reasons for not accessing services links to work with PCREF • These are three-year objectives • Do need to understand population • Recording of ethnicity not robust in the organisation, need to work with communities to understand barriers and actions • Year 1 – much broader piece of work is running alongside Chair: reference work that sits under these objectives, e.g., PCREF, for reassurance* **Committee received the report, noted assurance of the objectives outlined but requested further reassurance of the work that is going on to meet the objectives.**	***ACTION TB**
QAC22/09/429	**Safer Staffing Bi-Annual Review and Declaration December to July 2022** Committee received the report from Simon Barnitt for assurance and strategic consideration. Report summary:	

	• Bi-annual report required by National Quality Board • Establishment review completed in December 2021, now approved • Establishment review and safer staffing modelling to be enacted over next few months • Organisation is safely staffed despite not meeting desired numbers of qualified staff • Review of complaints incidents – no incidents identified where patients have been harmed because of staffing levels MH • Difference between compliance with a reporting requirement and how we understand and mitigate risks around recruitment, substantive staffing, and helping staff to flourish professionally • Where is the line between safety and quality? • Consequence of teams not substantively established is progress slows down and length of stay goes up - does this cross threshold of harm? • Can draw a line between these challenges and service user experience AD suggested: • Consider use of a heat map to give picture of staffing levels between departments to improve overview of correlation. Include agency and bank data OF • 338 – *no complaints regarding staffing numbers from service users and carers*. Don't take assurance from that – are we asking the right questions? S.B responded: • No formal complaints relating to quality aspects indicative of staffing numbers RM: • Funding establishment changes are cost neutral – can we be confident to say staff numbers are correct to best practice? JM: • Complicated to give simple answer • Always times in acuity when extra staff needed • Be realistic of staff turnover • Need to understand staffing in context of other organisations SM • Can be assured methodology is robust and in line with other Trusts • Registered nurse numbers - reviewed skill mix, used professional judgement • Used a measurement tool, in some wards higher some lower • At times of critical acuity ward mangers have ability to request further staffing • This report done under old model. Work underway to bring in new model • Harm and incidents/complaints – final stages of Nursing Strategy looking at missed care and implications • Cyclic – this time of year drop in registered nurses on wards **Committee were assured that SHSC are following the methodology required**	

	but expressed concern of what real situation is in terms of aspirational standards of what care should be. This needs to be addressed as a separate issue.	
QAC22/09/430	**Claims and Litigation Annual Report** MH: Report is about processes and stage of completion. Not a quality orientated report. Proposal is that it should be going to Audit and Risk Committee (ARC). Quality and learning lessons aspects relating to claims will be included in reporting to QAC. Move from QAC work plan to ARC work plan* **Committee agreed that this report will go to ARC, not QAC.**	***ACTION FO**
QAC22/09/431	**Corporate Safeguarding Team Annual Report 2021-2022** Committee received the report from Hester Litten for information. HL confirmed for AD that handover of delegated duties to SCC is on the Corporate Risk Register. SM noted that HL has been appointed substantive Head of Safeguarding. **Committee received the report and noted that it provides significant assurance that safeguarding is now well managed at the Trust. Handover to SCC is on the CRR for oversight and monitoring and reports will continue to focus on this.**	
QAC22/09/432	**Ligature and Blind Spot Risk Reduction Process** Committee received the report from Grace Kinsey-Oxspring for assurance and consideration. RM: • Paper highlights issues where more should be done • Alert to Board of risks and that SHSC is progressing with identifying them and taking the work forward SM: • Report illustrates confidence around work on Section 29a, lost sight of ligature work • Ligature anchor point risk assessments complete and robust plan across acute estate • Some areas where work not progressed – alert to board. May be financial implications dependent on reassessment process **Committee received the report and agreed an alert to Board that there are aspects of ligature anchor point and blind spot risk reduction not yet addressed but noted that there is a new group has been formed to address that.**	
QAC22/09/433	**Quality and Assurance Committee Tier 2 Group Effectiveness Self-Assessment Reports** Committee received the reports from the Tier 2 groups for approval. Committee noted: • In the future need an analysis of what the results are saying • Format needs improvement – summary would be more useful	

	• Returns were low, no robust constructive feedback for action AW: reports are going to ARC in October 2022 for assurance. More planned approach in place for next year. **Committee received the reports and noted the suggested improvements to be made going forward.**	
QAC22/09/434	**Quality Related Policies** **Policy Governance – Ratification of Decisions by Policy Governance Group (PGG)** Committee received the report from Amber Wild for ratification. The policies detailed within the report had been through the governance process and the Committee were asked to ratify the recommendations. Committee noted the one policy breach of review date and ratified extensions to review dates. **Committee received the report and approved the recommendations.**	
QAC22/09/435	**Board Assurance Framework (BAF)** Committee received the report from Amber Wild for assurance. Four risks monitored by QAC: • BAF 023 – Committee discussed and agreed updated risk descriptor, current risk score and risk appetite score. Risk doesn't include *caused by* information - AW to take back to BM and update* • BAF 024 – Committee discussed and agreed risk appetite and scoring that remained unchanged • BAF 025 – Committee discussed strategic context for determining risk appetite, and proposal to either separate the risk into Ligature Anchor Point and Therapeutic Environments or adoption of proposed change to current wording. Committee agreed to separate the risk • BAF 029 – Committee discussed and agreed proposed wording and scoring of new risk **Committee received the report and agreed the proposed changes.**	***ACTION AW/BM**
QAC22/09/436	**Corporate Risk Register (CRR)** Committee received the report from Amber Wild for assurance. • Two risks have received updated description • Two risk scores increased • One target score updated **Committee received the report and agreed the changes.**	
QAC22/09/437	**Quality and Assurance Committee Terms of Reference Review** Committee received the report from Amber Wild for approval. • Consistency in language improved • No fundamental changes **Committee received the report and approved the proposed changes.**	
QAC22/09/438	**Internal Audits – Action Tracking Report** Committee received the report from Amber Wild for assurance.	

	• Report provides oversight and assurance of actions • Report will be provided monthly to Committee and actions reviewed one month ahead **Committee received and reviewed the report and confirmed assurance that it will now be received monthly.**	
QAC22/09/439	**CQC Statement of Purpose Annual Review** Committee received the report from Sue Barnitt for approval. Changes: • Addition of Beech registration - move from Wainwright Crescent to Beech • Addition of new headquarters Additional information: • CQC received copies of SHSC Statement of Purpose and is on website • Annual sign off • Process for regular reviews of general managers and heads of service underway to maintain accuracy **Committee received and approved the report.**	
QAC22/09/440	**Updated Terms of Reference** **Committee received the reports for information and approved the updated terms of reference.**	
QAC22/09/441	**Healthwatch Sheffield Annual Report 2021-2022** **Committee received the report for information.**	
QAC22/09/442	**Emerging Quality Risks** Committee received the verbal report from Salli Midgley for assurance. • SHSC is in cycle - August onwards movement of staff out of inpatient settings to progress in careers. Currently minimum staffing not safer staffing • Reviewing ways to support recruitment and retention – against national picture it remains challenging • Minimum staffing means there could be missed care and stressful place to work • A proposal for retaining 10 `off framework` registered nurses has been presented at Executives to provide a short-term intervention whilst new preceptee registered nurses join SHSC. Full induction and training will be provided to mitigate any risks **Committee received the report and agreed to advise the Board.**	
QAC22/09/443	**Any Other Business** None.	
QAC22/09/444	**Final Committee Work Plan** Committee received the final draft of the work plan for information. **Alert, Assure & Advise: Significant issues to report to the Board of Directors** Due to meeting time, the Chair will prepare the Alert, Assure & Advise Report after the meeting. Chair noted the Alerts: • Continued concern about persistent not fully mitigated risks. Robust plans in place to address this but not seeing impact because of other difficult circumstances around them – significant concern regarding progress despite best efforts to address this • IPQR – positive alerts highlighted	

	• Health and Safety - alert and advise. Much improved data and triangulation. Committee continues to be encouraged by progress made by manager and team and good grip on what needs to be done. Progress should be paced up and Committee asked what additional support is required. Alert for a whole Trust approach and request for prioritisation of issues to be addressed that are causing significant concern • Back to Good Programme – assurance that actions are being implemented and increased assurance processes in place. Not clear what risk SHSC is carrying with the embedding of actions due to issues with evidence submission. Alert to Board - pressing issue • Supervisions – continuing concern with problems meeting target. Proposal for recovery plan reporting to Board • Ligature Anchor Point and Blind Spot Risk Reduction – some aspects not yet addressed. New group formed to consider this. Committee will receive further reports **Changes in level of assurance - Board Assurance Framework** Board Assurance Framework updates were discussed and agreed. **Meeting Effectiveness** Chair thanked the Committee for the work that is being done. Comments were invited in the Chat Box. The Committee were asked to consider how the Trust's Values are modelled within the meeting conduct.	

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

Quality Assurance Committee (QAC)

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

Present:	Heather Smith, Non-Executive Director (Chair)	CHAIR
	Dr Mike Hunter, Executive Medical Director	MH
(Members)	Salli Midgley, Director of Quality	SM
	Anne Dray, Non-Executive Director	AD
In Attendance:	Tania Baxter, Head of Clinical Governance	TB
	Edman Kabadeh, Lived Experience Member	EK
	Sue Barnitt, Head of Clinical Quality Standards	SB
	Nicholas Bell, Director of Research Development	NB
	Greg Hackney, Head of Service, Crisis, and Emergency	GH
	Christopher Wood, Head of Nursing	CW
	Dr Jonathan Mitchell, Clinical Director	JM
	Deborah Lawrenson, Director of Corporate Governance	DL
	Mark Jones, Head of Performance	MJ
	Sara Whittaker, Chartered Clinical Psychologist	SW
	Samantha Crosby, Health and Safety Manager	SC
	Francesca O'Brine, Corporate Assurance Officer (minutes)	FO
	Emma Harrison, Executive Assistant	EH

Apologies: Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director
Pat Keeling, Director of Strategy
Abiola Allinson, Chief Pharmacist
Linda Wilkinson, Director of Psychological Services & Consultant Clinical Psychologist
Beverley Murphy, Executive Director of Nursing, Professions, and Operations (BM)
Professor Brendan Stone, Associate Non-Executive Director
Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services
Robert McFarlan, Clinical Lead

Minute Ref	Item	Action
QAC22/10/440	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
QAC22/10/441	**Declarations of Interest** SM: Trustee for Restraint Reduction Network.	
QAC22/10/442	**Minutes of the meeting held on 10 August 2022** The minutes of the meeting held on 10 August 2022 were agreed as an accurate record subject to the following amendments being made: * • *Emerging Quality Risks*, bullet point four, as requested by SM and AD: A proposal for retaining 10 `off framework` registered nurses has been presented at Executives to provide a short-term intervention whilst new preceptee registered nurses join SHSC. Full induction and training will be provided to mitigate any risks • DL requested minutes reflect that she gave apologies	***ACTION FO**

QAC22/10/443	**Matters Arising** **Back to Good – clarification of involvement of carers and families** SB verbal report: • Range of strategy workshops taken place throughout year • Individualised Standard Operating Procedures (SOPs) for wards not developed with carers, but underpinned by feedback with triangle of care principles • Monitoring of SOPs – performance against them to go to newly formed Carer Action Group, impact and challenges to be discussed • Carer Open Door Forum to sit under Carer Action Group	
QAC22/10/444	**Action Log** Committee received the action log for information and agreed to close Action 2.	
QAC22/10/445	**Back to Good Reporting – Full Report** Committee received the report from SB for assurance and strategic consideration. Summary: • Working with clinical services to retrieve evidence and close actions • Aim: 61 closed requirements • August 2022: 11 requirements closed • Requirements in exception: 6 remain • Working with Project Management Office • Risks: involvement of carers and families, and suitability of environments • Supervision improved MH: • Front sheet: Equality, Diversity, and Inclusion (EDI) should be ticked as *Yes, considered*. Back to Good Programme speaks to EDI agenda - will work with team to acknowledge that * • Good to see areas of focus, but consistent gaps in key training relating to patient safety. Committee to be made aware of significant clinical risk SM: • Next report: include table with each ward and its particular area of focus, with mitigation noted for assurance ** DL: • Good progress being made on Tier 2 Reviews of Effectiveness reports • Report writers to use updated cover sheet • Note *N/A* if report has not been previously presented to a committee **Committee received the report and noted significant risks relating to feedback from service users and carers, and that it was a theme throughout several of the QAC reports. Feedback was given on the report. Committee acknowledged greater levels of assurance being secured by the Back to Good Programme Board. On track, but some mitigations put in place to address concerns. Advise Board of progression.**	***ACTION MH** ****ACTION SB**

QAC22/10/446	**Integrated Performance and Quality Report (IPQR)** Committee received the report from GH for assurance and strategic consideration. Summary: • Very long length of stay on acute wards – challenges in August 2022 • Community plans remain a persistent challenge, continue to work through mitigations • Care Programme Approach (CPA) - compliance improving, not yet meeting target • Spend on agency staff concern - inconsistent workforce and quality aspects GH confirmed for AD regarding level of training of agency staff: • Onboarding plan to include all training required on wards • Appointment of 10 full time equivalent staff – will improve consistency of care and control of training • Mitigated by daily staffing huddle SM: • Skillset on wards is being met • Line between offering all training to agency staff, and incentives to encourage other staff to join SHSC • Need to build NHS Bank, more work to do Chair: • Scale of persistent risks is serious: significant waits, flow across acute pathway, CPA reviews (note: South Recovery team improving), supervision rates (note: positive work done on wards), demonstration of service user feedback MH: • Need to show that risks are cumulative SM: • Learning Lessons report highlights impact of risks and the flow through different routes **Committee received the report and noted that the persistent risks were escalated to September 2022 Board and required a different way of working.**	
QAC22/10/447	**Learning Disability Transformation: Clinical Model Progress Report** Committee noted this item was deferred because work plans were out of sync. To be amended outside of the meeting. Next report currently due at January 2023 QAC.	
QAC22/10/448	**Lived Experience and Co-Production Assurance Group Quarter 1 Triple A Report and slides** Committee received the report from SM for assurance. Assure: • Lived Experience posts - appointments: Quality lead and Race Equity Community lead • Finalised policy on working with people who have lived experience • Lived Experience Group - slides presented in accessible format, membership has grown Advise: • Not assured by SOPs, further work on these underway Alerts	

	• Feedback from service users, carers, and families - make best use of intelligence received and be agile with how it is collected. Pay attention to groups of people with protected characteristics, consider if mechanisms are appropriate • Investment in Race Equity work received for 2022 **Committee received the report and noted the positive work underway. Board to be assured of significant progress with the Lived Experience and Co-production implementation plan. Committee noted the alert around service user feedback and will be updated in the next report.**	
QAC22/10/449	**Discussion regarding any necessary amendments to the Board Assurance Framework (BAF)** Committee agreed there were no significant pieces of assurance that would lead to a change in the BAF.	
QAC22/10/450	**Learning Lessons Report Quarter 1** Committee received the report from VL for assurance and strategic consideration. Summary: • Most frequently reported incidents: medication and self-harm • Physical assaults on staff impact provision of care and staff morale • Management of medication incidents – not administration errors, no direct patient harm • Self-harm - very complex process, can lead to use of restrictive practice • Skill mix, staff numbers and therapeutic environments key to patient safety • Waiting to see positive impact of implementation of processes • External work undertaken to aid learning • Violence and Aggression Reduction Group formed via Health and Safety Committee • Ongoing work with Clinical Establishment Review regarding staffing numbers • Pharmacy programme underway to assist in development of competency of non-registered staff in non-administrative tasks • Review of self-harm incidents • Cross cutting themes - long waiting times, lack of available beds, staffing numbers – plans in place to mitigate • 11 serious incidents reported during the quarter VL confirmed for MH: • Good link up with Pharmacy team including daily incident huddle • Digital incidents relating to patient safety e.g., loss of patient records, not included in report Chair: include digital incidents in next report* SM: • Useful for Board to feedback on amount of detail required from reports and its level of inclusion in the IPQR • Report out of sync, will be more aligned next month • Improved report, more to do regarding the responsibility of teams who feed into it, correlation with IPQR, and leaning from themes MH: • Developmental report • There is triangulation with the IPQR, clinical effectiveness and audit programme	***ACTION VL**

	Committee received the report and agreed to advise the Board that the report is much improved. Inclusion of serious incident reporting was a direct response to the Ockenden recommendations. Board to reflect if any more detail is required. For assurance, report must highlight what has changed as a result of learning lessons.	
QAC22/10/451	**Ockenden Report and Paterson Review: SHSC Implementation Plan** Committee received the report from TB for assurance and strategic consideration. Summary: • Committee received 18 recommendations in July 2022 • Recommendations have been aligned to applicable governance groups • TB to oversee implementation of plan • Actions link to existing strategies and pieces of work - will ensure no duplication but separate line of sight for assurance TB confirmed for AD: • 6 monthly updates to QAC • High alerts – sooner than 6 months, possibly as Matters Arising item, as required Committee agreed an exception report would be presented to January 2023 QAC.* **Committee agreed to assure the Board that there is a robust implementation plan in response to the Paterson review and Ockenden report and there is coherence across the piece and the different strategies.**	***ACTION FO - workplan**
QAC22/10/452	**Clinical and Social Care Strategy Progress Report** Committee noted the item was deferred to November 2022 QAC.	
QAC22/10/453	**Board Visits** Committee received the report from SB for assurance and consideration. *Item taken at 10:47am, before Learning Lessons report quarter 1.* Summary: • 42 out 50 visits completed • 24 visits scheduled over quarter 1 and 2, 22 took place • Staff are welcoming the opportunity of the visits • 3 key themes: staffing challenges, impact of delays in recruitment processes, estates and environments people work in • Feedback sheets recommended improvement of quality of data collected • Review of model to include service user feedback from visits MH: • *Executive Board member* to be corrected to *Board member* within report for clarity AD: • Value honesty of teams – need to consider balance, how to enable staff to give feedback and bring in service user and carer feedback • Senior team and junior team presented different feedback SB:	

	• Feedback from staff regarding the visits is part of the planned review • Guidance on visits could go to teams in advance to support experience and opportunity **Committee received the report and acknowledged that good work was being done and was now moving onto the next level. Committee agreed that the team must ensure that the visits were having the right impact.**	
QAC22/10/454	**Draft Health and Safety Annual Report 2021-22** Committee received the draft report from SC for assurance and feedback. Summary: • External consultant drafted report • Health and Safety Committee reviewed report, will review final version in October 2022 • QAC to feedback, final draft to go to QAC November 2022 for approval • Health and Safety Executive (HSE) visit to be included in next quarterly report Committee feedback: • HSE improvement notice to be reflected in cover sheet of report to Board • Be clearer where SHSC is compliant and partially compliant • Amalgamate action plans monitored at QAC • Connect with Policy Governance regarding update of policies • Risk register – explain what moderate rating represents • Highlight fire safety concerns • Assessment of partial compliance of Health and Safety at work Act – make clear how this assessment is made and include timescale for meeting full compliance. *Not yet compliant with requirements of the Act, but will be compliant once policy framework is complete* **Committee received the report and agreed to advise the Board that feedback was given to support the final draft of the report ready for November 2022.**	
QAC22/10/455	**Annual Report – Research, Innovation, Effectiveness, and Improvement Group (RIEIG)** Committee received the report from NB for assurance. Progress: • RIEI Strategy completed • Strategy includes Clinical Effectiveness Framework. Has brought teams together and informed work • More ambitious Clinical Audit Programme • Prioritising national audits, local are ongoing • Quality Improvement – new Head of Improvement starts end of October 2022 SB: • Quality Management System (QMS) will help to identify priorities • Need to use data to inform audit, evaluation, and improvement cycle across different settings and workforces MH: • Work to develop QMS - integrate quality improvement, planning, and control, and gain good assurance • When will this be tangible, visible, and useful to the whole organisation? • Need to give it an identity	

	NB confirmed for MH: • Work to be done with clinical teams regarding audits • Confidence that audits will be completed by end of year NB confirmed for AD: • Continue to keep internal audit informed of which audits SHSC are conducting to avoid duplication SM: • Number of appendices – next time bring together within report and highlight areas of assurance for ease • Record keeping audit – format not necessarily meaningful for staff using day to day • Gaps - audit with outcomes but no action plan – not assured DL suggested: • 46 research projects – bring out key issues in a table to aid understanding of impact Chair: • Assurance paper – focus on detailed outcomes and impact going forward • Lots of activity over the year, important to recognise achievements • Appendices – balance needed **Committee received the report and agreed to advise the Board of the volume of work conducted over year. The annual report summarised the significant step forward in developing the strategy and the start of the impact analysis from this. Committee considered questions about how to raise awareness of the QMS, how to prioritise work in a collaborate way across SHSC, and how to accelerate impact.**	
QAC22/10/456	**Quality Related Policies** **Policy Governance – Ratification of Decisions by Policy Governance Group (PGG)** Committee received the report from DL for ratification. The policies detailed within the report had been through the governance process and the Committee were asked to ratify the recommendations of one updated policy and two extensions to review dates. **Committee received the report and approved the recommendations.**	
QAC22/10/457	**Internal Audits – Action Tracking Report** Committee received the report from DL for assurance. **Committee received and reviewed the report and noted that all QAC actions were on track.**	
QAC22/10/458	**Use of Force Annual Report – For Information** Committee received the report for information.	
QAC22/10/459	**Emerging Quality Risks** **a) Learning from Edenfield** Committee received the report from SM for assurance. • Undercover documentary • Multiple visits conducted but culture not detected • SHSC leaders met to reflect and discuss understanding of cultures in SHSC teams	

	• SHSC have done a significant amount of work on restrictive practice • More work to be done regarding feedback from service users and carers • Advocacy and peer support – area of weakness • Discussed leadership and more work to be done with Freedom to Speak Up and cultural indicators • Fundamental standards visits brought forward • Actions in train but cannot be complacent, must remain alert to recognise if these cultures start to emerge • Piece of work agreed to be shared nationally with Restraint Reduction Network regarding coercion within services Chair and SM: bring brief report to November 2022 QAC* **b) Health and Safety Executive: Improvement Notice for Sharps Instruments in Healthcare** Committee received the verbal report from SM for assurance. • Improvement notice issued • Inspection carried out at Michael Carlisle Centre, specific concerns at Dovedale 1 • Working closely with Health and Safety (H&S) Manager and Infection, Prevention, and Control (IPC) team • Sharps and waste management – sharps monitoring spreads across IPC, H&S, medical devices, and clinical operations – oversight unclear and risks were not fully owned • Requested assessment to ensure this is not occurring in other areas **Committee received the reports and agreed to advise the Board.**	***ACTION FO - workplan**
QAC22/10/460	**Any Other Business** **Infection, Prevention, and Control Committee: options to meet FFP3 compliance** SM: • Relates to fitting of masks, not currently applicable • QAC agreed to stand this down • IPC nurse is trained to deliver this if necessary in the future	
QAC22/10/461	**Final Committee Work Plan** Committee received the work plan for information. **Changes in level of assurance - Board Assurance Framework** Committee agreed none currently. To be reviewed again at the next QAC meeting. **Alert, Assure & Advise: Significant issues to report to the Board of Directors** Alert: • Noted persistent risks and reflected on cumulated risks in terms of service users (waits, flow across acute pathway, CPA reviews, supervision rates, vacancy rates) • Need to strengthen carer and service user feedback, advocacy, and peer support. Seeking robust plan for this going forward to help to assure improvements continue on the right track • Improvement notice from HSE on the use of sharps Advise: • Improved levels of assurance from the Back to Good Programme Board	

	regarding the checking of embedding of actions. Requested more information of mitigation relating to training gaps, particularly agency staff • Progressing well with Board Visits – review how to improve information received and increase engagement with staff • Draft annual Health and Safety report received – committee gave comments including improving the tracking of actions • Learning Lessons report – significant improvement in reporting and inclusion of serious incidents reports. Suggestions for improvements given • RIEIG annual report – summarised significant steps taken in developing the strategy and the start of the impact analysis • Internal Audit Action Tracking report received – nothing major identified • Use of Force annual report received for information • Learning from Edenfield – review undertaken with ongoing reflection. Committee requested regular progress reports Assure: • Lived Experience and Co-Production implementation plan – significant progress being made • Robust implementation plan in response to the Ockenden report pulling together different aspects of work across SHSC and its strategies **Meeting Effectiveness** Committee feedback: • As agenda reduces it allows for more focussed discussion and time to review papers • Effective and supportive meeting. Good triangulation of key issues • Not enough discussion around EDI – one of QAC's objectives for the year, needs to be consistently throughout reports • Committee need to have BAF risks in mind throughout meeting and when reading reports	

Date and time of the next meeting: Wednesday 9 November 2022, 10am to 12:30pm
Format: MS Teams
Apologies to: boardcommittees@shsc.nhs.uk

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Audit and Risk Committee** **Date:** **18/10/2022** **Chair:** **Anne Dray**

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale
Internal Audit Progress Report	Good progress on internal audit, positive alert. Much improved follow up position	Good assurance	Positive alert to Board Next report to ARC January 2023	BoD 23/11/2022 ARC 17/01/2023
Limited Assurance reports: Safeguarding Recruitment	Senior leaders attended meeting to give assurance on reports. Significant risks recorded in BAF	Limited assurance but confirmation of ongoing work to make required improvements and meet deadlines	Alert to Board Safeguarding report to QAC Recruitment report to PC	BoD 23/11/2022 QAC 9/11/2022 PC 8/11/2022

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

Issue	Committee Update	Assurance Received	Action	Timescale
Final Internal Audit report: Data Security and Protection Toolkit (DSPT)	Report received by committee. Committee agreed to support actions to progress work on escalating improvements in training	Good assurance	Advise Board	BoD 23/11/2022
Finance self-assessment – Getting the basics right	Committee approved report for submission	Good assurance	Advise Board of approval from ARC	BoD 23/11/2022
Annual Report and Accounts 2022-23 Draft Plan	Committee were assured by the detailed paper that outlined timings and responsibilities going forward	Good assurance of plan and preparation	Advise Board Timings to be updated once Annual Reporting Manual is received	BoD 23/11/2022
Register of Interests and Register of Hospitality, Sponsorship and Gifts	Committee received the progress report. Not complete, declarations outstanding. Further work to be done	Moderate assurance	Further report to ARC to close 2021-22 in January 2023	ARC 17/01/2023

Single Tender Waivers	Actions taking place but slow progress. Committee noted the need for traction on this	Moderate assurance	Advise Board	BoD 23/11/2022
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Counter Fraud, Bribery, and Corruption report	Committee received report. National Fraud Initiative – SHSC updated and uploaded in advance of deadline	Good assurance	Results end of January 2023 Next report to ARC January 2023	ARC 17/01/2023
KPMG progress report and Value for Money	Committee received verbal reports from KPMG	Good assurance of discussions taking place	Next report to ARC January 2023	ARC 17/01/2023
Monitoring of External Audit actions	Committee received report and noted work undertaken so far	Good assurance	To be received as a standing item at ARC going forward	ARC 17/01/2023
Annual Board Declaration of Emergency Preparedness, Resilience, and Response self-assessment and work plan for 2022-23	Committee received the report. Partially compliant – work underway to be substantially compliant by December 2022. Declaration submitted by deadline	Assured of submission	Advise Board of submission of declaration Next report to ARC January 2023	BoD 23/11/2022 ARC 17/01/2023
Mid-year review on attendance at Board Committees	Committee received the report	Good assurance	Advise Board of receipt of report Circulate to Non-Executive Directors to check for accuracy	BoD 23/11/2022 November 2022
Risk Review proposed next steps	Committee received the report and approved the proposal	Assurance of proposed plan	Advise Board of approval	BoD 23/11/2022
Report on reviews of effectiveness for Tier 2 groups	Committee received the report and acknowledged the progress made. Data and Information Governance Group Terms of Reference approved.	Assurance of progress	Policy Governance Group and Risk Oversight Group reports to go to January 2023 ARC.	ARC 17/01/2023
Report on Monitoring of Action Plans and Third-Party Assurances	Committee received the report and gave feedback	Assured that the report is in progress, more discussions to be had on format and process	Standing item at ARC	ARC 17/01/2023
Annual Claims and Litigation Report 2021-22 - confidential	Committee received the report and noted the ongoing work with Capsticks LLP	Assured of progress	Further report to ARC April 2023	ARC 18/04/2023

Audit and Risk Committee (ARC)

CONFIRMED Minutes of the Audit and Risk Committee held on Tuesday 26 July 2022 at 3pm. Members accessed via Microsoft Teams Meeting.

Present: (Members)	Anne Dray, Non-Executive Director (Chair)	AD
	Richard Mills, Non-Executive Director	RM
In Attendance:	Phillip Easthope, Executive Director of Finance	PE
	Deborah Lawrenson, Director of Corporate Governance	DL
	James Sabin, Deputy Director of Finance	JS
	Matt White, Deputy Director of Finance	MS
	Rashpal Khangura, Director, KPMG	RK
	Leanne Hawkes, Director, 360 Assurance	LH
	Oliver Blake, Auditor, 360 Assurance	OB
	Wendy Fowler, Freedom to Speak Up Guardian (item 07/208)	WF
Apologies:	Lianne Richards, Client Manager, 360 Assurance	

Minute Ref	Item	Action
ARC2022/07/197	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
ARC2022/07/198	**Declarations of Interest** None.	
ARC2022/07/199	**Minutes of the meeting held on 14 June 2022** The minutes of the meeting held on 14 June 2022 were agreed as an accurate record, with the following amendment: Item ARC2022/06/184 Auditors' Annual Report: 5th paragraph: RK confirmed KPMG …….	
ARC2022/07/200	**Matters Arising & Action Log** Members reviewed, agreed and updated the action log.	
ARC2022/07/201	**360 Assurance Internal Audit Progress Report and Plan 2022/23** Committee received the report from LH for assurance. LH provided an update on progress against plan since the last meeting, confirming that two audits had been completed, namely: • Health & Safety Reporting (Including CAS Alerts) – Limited Assurance • Data Security Protection Toolkit – Moderate Assurance Members noted the outcome of these audits and it was agreed that further exploration/clarification was required in terms of the current split responsibilities for health and safety to determine the responsible committee for oversight of agreed actions. Members were assured that arrangements are also being put in place to facilitate the relevant director attending committee to discuss any limited	DL/PK

	assurance reports received. LH noted that two audits from the 21/22 audit plan (Safeguarding Adults & Children and Recruitment) are nearing completion. LH further advised the committee that a request had been received from the Trust to defer the start of the intended Infection Prevention & Control audit to quarter 3/4 due to changes in the IPC Team. Following due consideration, members agreed to the deferral of this audit but requested that the Quality Assurance Committee are made aware and assure themselves that this deferral will not impact or create any additional risk for SHSC. Members were also cognisant of potential impact and risk any further deferrals may have on the capacity of the audit team to complete delivery of the plan in-year and it was confirmed that this is being closely monitored and will be escalated to the Trust as necessary. Confirmed that work on the opening stages of the Head of Internal Audit Opinion Statement have commenced and members noted receipt of the terms of reference for this work. LH confirmed that the Trust's follow up rate for 2022/23 currently stands at 78%. She also advised that the two overdue, low risk, actions identified in the progress report have since been completed and closed, which would improve the rate further. Members welcomed the improved follow up rate and DL provided an assurance on the on-going monitoring process now in place, including operational oversight through to Executive lead. Board committees are also encouraged to agree monitoring arrangements at the time of issue for audit actions under their oversight and include this on the relevant committee work programme upon receipt of the audit reports. The Chair was keen that action is taken to close the 7 outstanding historic actions for the next meeting. **Committee received and noted the report.**	AAA Report PE/BM
ARC2022/07/202	**ISA 260 Report 2021/22** Committee noted receipt of the final ISA 260 Report for the financial year 2021/22 from RK for assurance, which was formally received at the extra-ordinary Board of Directors' meeting held on 29 June 2022 as part of the Annual Report and Accounts approval process. PE advised that an additional fee for the overruns experienced during the year-end audit had been agreed per the report received by members. **Committee received and noted the report.**	
ARC2022/07/203	**Auditors Annual Report 2021/22** Committee received the report from RK for assurance. The report provided: • a summary of the accounts work undertaken by KPMG; • the headline messages as a result of that work; • confirms the audit opinion issued on the 1st July; • confirms the value for money element of the audit work, including summary findings. **Committee received and noted the report.**	
ARC2022/07/204	**Annual Report and Accounts – discussion about learning on the process for the 2021/22 process and submission - verbal** PE advised the committee that as agreed a series of meetings have taken	

	place to identify key areas of learning and what needs to be done differently from the processes in place for the completion and submission of this year's Annual Report and Accounts. He confirmed that a formal report will be prepared on the outcome of these open and honest discussions for receipt at the next ARC meeting, but that key themes identified included: • Clear roles and responsibilities – ownership of deadlines. Not just a Corporate Governance or Finance task. • Oversight and accountability • Ensuring areas/key leads understand the task asked of them – ensure that overview of the ARM and GAM is maintained, including any changes and that these are factored into planning and work programme. • Relationship management between key contacts, ensuring better oversight and early escalation of issues. • Improved and impartial challenge required to ensure issues are understood. • Improved corporate records management. • Prepare for issues – ensure capacity is available at key times of the process. • Functional preparedness. • Understand the evidence. • Address carry-over issues early. A number of factors have been identified as having impacted this year's process including changes within key positions in the finance and governance functions; a lack of regular on-site presence of both parties; as well as an understanding of changes within the audit environment. It has been agreed that all these key areas will be addressed early in the process for 2022/23. RK confirmed that the session had provided a welcome learning opportunity and identified key action areas for both themselves and SHSC. One suggestion being considered to improve everyone's understanding of the year-end audit process is a workshop. It was confirmed that a formal report on the findings of these learning meetings, together with clear actions and timeframe, as well as the plan for 2022/23, will be prepared for the October 2022 ARC meeting. One key area is to commence planning processes much earlier in the year. **The committee noted the outcome of these learning events and the intention to present a paper to the next ARC meeting in October on planning for the Annual Report and Accounts 2022/23. ACTION** **In the meantime, the Chair asked that PE and DL share a file note of this learning to the Board members to assure them of the progress being made to address concerns raised regarding this year's year-end processes.** The Chair thanked everyone for their contribution to these learning events.	PE/DL Oct 22 DL/PE
ARC2022/07/205	**Received outcome of externally facilitated risk review full report post receipt at Board to agree monitoring arrangements** Committee received the report from Deborah Lawrenson for assurance, who confirmed that this is the formal report following the recent Risk Management Review undertaken during May and June. ARC received the initial presentation on findings at their meeting in June. **DL advised that further work is planned regarding risk appetite at the Board Development session in August and a further update and confirmation of next steps will be received at the October ARC meeting.**	DL Oct 22

	ACTION AND NOTE FOR AGENDA **Committee received the report.**	
ARC2022/07/206	**Board Assurance Framework (BAF) 2022/23** Committee received the report from Deborah Lawrenson for assurance. A new element added to the BAF is a section indicating the status of all actions being taken to mitigate BAF risks. DL would appreciate feedback from members regarding this addition. The report provided a summary of the new BAF risks and relevant committee oversight. Members acknowledged the development of this year's BAF and welcomed the additional status section. In order to assist in reviewing the BAF pre-meetings, a specific request was made to include headings on each page. The Chair noted the over-arching monitoring role of ARC when reviewing the BAF. The committee needs to assure itself that where necessary there is a clear escalation of any potential delays in completing mitigating actions. She believed that the additional status element would contribute towards the assurance required. **Committee accepted the report.**	
ARC2022/07/207	**Corporate Risk Register (CRR) 2022/23** Committee received the report from Deborah Lawrenson for assurance. Members reviewed the five risks on the CRR under the stewardship of ARC, including one new risk (4716 - network security) and noted the following: **Risk 4605 – agreed that clarify/agreement was needed on committee responsibility in respect of health and safety matters (ie ARC or QAC). ACTION** Risks 4375 and 4376 – now closed. DL confirmed that the first meeting of the Risk Oversight Group will take place in August. One of the key roles of that group is to monitor the CRR in more depth and confirm and challenge wherever appropriate. It is anticipated that the Risk Oversight Group will report into ARC through an Alert, Advise, Assure (AAA) Report. NED members asked if consideration could be given to incorporating a status update element in the CRR report (as had been introduced into the BAF report). While the intention in the future is to give the format of both these reports more scrutiny, as the CRR is currently produced through the Ulysses system, this will not be possible. **Committee accepted the report.**	DL
ARC2022/07/208	**Freedom to Speak Up Guardian Annual Report** Committee received the report from Wendy Fowler, Freedom to Speak Up Guardian, for assurance. WF advised the report: • Provided an overview of the FTSU activity for the year, focussing on local resolution, responsiveness and organisational learning. • Confirmed a continued commitment to raise the profile of the FTSU Guardian and promote a culture that actively encourages raising concerns.	

	• Identified thematic analysis and learning from FTSU concerns raised during 2021/22. • Provided a planned activity outline for the year 2022/23. Members welcomed the analysis of key themes and learning from the last year, and that work is already underway to address some of the identified themes. Assurances were provided regarding FTSU accessibility and reporting support for staff raising concerns as well as appropriate escalation arrangements for WF as the FTSU Guardian. RM confirmed that as the Non-Executive Director lead for FTSU he is in regular contact with WF. WF advised that since this report was written anticipated guidance from NHS England has now been released and she is working closely with DL on refreshing our FTSU policy. Also, within the next couple of months, the Board of Directors will be undertaking a FTSU self-assessment exercise which will be led by DL supported by WF. **Committee received the report and were duly assured by processes in place throughout the year 2021/22.**	
ARC2022/07/209	**Policy Governance Group AAA Report: Ratification of Decisions by Policy Governance Group** Committee received the report from Deborah Lawrenson for review and ratification. The deferral of the approval of the refreshed Password policy due to quoracy issues was noted. Members recognised the continued positive assurance regarding the processes and controls in place in respect of policy governance. **Committee received the report and endorsed the recommendations made within the report.**	
ARC2022/07/210	**ARC Terms of Reference** Committee received the report from Deborah Lawrenson for approval. DL advised a number of inconsistencies have been identified across the committee terms of reference which are in the process of being eradicated. This may result in a small number of additional minor changes to the version received by members for approval at today's meeting, prior to submission to the Board of Directors as part of the Committee's Annual Report for ratification. DL noted that the as previously discussed, a change had been made within the Quorum Section, in that reference is now made to deputies being able to attend in the absence of the respective Executive Director to maintain quoracy. As discussed earlier in the meeting, members were keen to ensure that the refreshed terms of reference provide clarity on responsible committee for Health & Safety issues; as well as which elements of the Digital Strategy should be overseen by ARC and which fall under the remit of Finance & Performance Committee. DL confirmed that this was noted and would be reflected in the refreshed draft for receipt off-line by committee members for agreement prior to September Board for approval alongside all other committee ToRs. **Committee noted the revised terms of reference and agreed that, in line**	

	with DL's request, a further version should be received off-line for approval following final amendments, prior to submission to the Board of Directors. ACTION	DL/FB

ARC2022/07/211	**Draft Audit and Risk Committee Annual Report** Committee received the report from Deborah Lawrenson for assurance. DL noted that the report outlines the work of the committee over the past year and is received for approval in advance of submission to the Board of Directors. It was also confirmed that going forward it is proposed the preparation of this item be brought forward on the committee work programme to the beginning of quarter 4. **Agreed.** The Chair drew members' attention to the need for specific committee objectives and asked that during the year sufficient consideration is given to identifying appropriate milestone evidence to inform next year's report. **Committee received the report and agreed to include the identification of committee objectives in the AAA report to the Board of Directors. ACTION**	FB
ARC2022/07/212	**i. Data and Information Governance Group (DIGG) – Escalation & Update Report** Committee received the report from Phillip Easthope for assurance. Of note was the recent phishing attack (June 2022) and the report confirms subsequent action taken. Members noted the update provided on each of the specific risks. PE advised members that it has been agreed that the FOI and SARs functions will transfer to the IMST Directorate, under the management of the Chief Digital & Information Officer. Work will now take place to stabilise this function in terms of sufficient management capacity, permanent staffing and the necessary funding. **Committee received the report and noted the updates/mitigation being put in place to address identified issues.** **ii. Data and Information Governance Annual Report, including SIRO and Caldicott Reports 2021/22** Committee received the report from Phillip Easthope for assurance. In terms of ensuring the Annual SIRO Report is received at Board in September for assurance, it was agreed that the combined report would be received together with a different/more specific summary. **Committee received the report and agreed it should be received at September Board Meeting with an updated summary.**	
ARC2022/07/213	**Governance Processes around Action Plans and Third-Party Assurances (ARC priorities 2021/22) - verbal** Per earlier discussion, DL confirmed that the mapping of governance arrangements for key action plans is under way with a view to providing a draft to the Chair of ARC for views by the beginning of September. *Update to add to Action 2 ARC2022/06/194 on action log. Action due to be completed by September.* ***ACTION***	FB
ARC2022/07/214	**Single Tender Waivers** Committee received the report from the Phillip Easthope for information, noting the specific comment regarding level of concern on each waiver and	

	supporting narrative. **Committee received the report.**	

ARC2022/07/215	**Any Other Business** **i. Change in Non-Executive Director Membership** Noted that with effect from October 2022, NED membership for ARC will change. Richard Mills will stand down as an ARC member and Heather Smith and Owen McLellan would join ARC membership.	

ARC2022/07/216	**Meeting Effectiveness**
	Noted that a small number of papers had been received late as a result of challenges within the respective teams and that this had impacted on preparation time.
	
	Members felt it important that consideration be given to the formulation of meeting agendas, ensuring there is sufficient time for discussion and that purpose and decision required is clear. Agreed this would be given consideration outside of the meeting at each agenda setting meeting.
	
	Alert, Assure & Advise: Significant issues to report to the Board of Directors
	Alert:
	• Annual Report & Accounts 2021/22
	
	Assure:
	• Board Assurance Framework
	• Corporate Risk Register
	• Audit & Risk Committee Terms of Reference
	• Audit & Risk Committee Draft Annual Report
	• Data & Information Governance Annual Report, including SIRO and Caldicott Reports 2021/22
	• Policy Governance Group
	  o Deferral of Password Policy
	
	Advise:
	• 360 Assurance Internal Audit Report:
	  o Follow up completion rate
	  o Request to defer IPC audit
	  o Request for clarity on committee responsibilities re H&S matters
	• Freedom to Speak Up Annual Report 2021/22
	
	Changes in level of assurance - Board Assurance Framework
	None.
	
	Agreed Actions
	To be monitored via Committee Action Log.
	
	Review of Committee Timetable/Work Programme
	Committee received the Work Programme for information**.**	

Date and time of the next meeting: Tuesday 18 October 2022, 1:30pm to 3:30pm
Format: MS Teams
Apologies to Francesca O'Brine, Corporate Assurance Officer Francesca.O'Brine@shsc.nhs.uk

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	People Committee	Date:	08/11/2022	Chair:	Heather Smith

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk No
Sickness	Long-term sickness rates have decreased slightly, and short-term sickness rates have increased. The overall sickness rate is at 6.5% which is higher than our target of 5.1%. Concern raised that seasonal sickness could further increase the short-term rate.	Some cases of long-term sickness have been managed in a way that means some people who would have had longer periods of absence are returning to work in a shorter period of time however this can then increase the number of short-term sickness incidents. Areas with low sickness rates are being analysed to see if there are points of learning that could help areas with higher absence rates. The new occupational health contract will take effect from January 2023.	Sickness will continue to be monitored in the IPQR and Workforce dashboard	Ongoing	BAF.0013
Increase in head count/decrease in vacancy rates	There has been a decrease in vacancy rates in some areas however there are still areas with significant resource issues.	The data in the dashboard has confirmed that vacancy rates are decreasing but the data needs to be separated by service line so under - resourced areas can be highlighted.	The next workforce performance dashboard will include data by service line and any further risks identified	Ongoing	BAF.0014
Time to appoint	The time to hire data now shows an average of 59.2 days which is a reduction since the last report.	The data in the dashboard confirmed a decrease since the previous month, however due to a spike in the data in May the overall average remains unchanged since Feb 2022.	The next workforce performance dashboard will include time to hire data by service line and risks will be further identified in the	Ongoing	BAF.0014

		No significant impact yet being seen of actions being taken.	report.		
Staff turnover	Staff turnover is above the 10% target.	Outliers are pushing up the average across the organisation. The committee asked to see further assurance and risks identified in future reports.	The next workforce performance dashboard will include data by service line and risks will be further identified in the workforce dashboard.	Ongoing	BAF.0014
Retention - Leavers reasons	The committee were advised that 53% of leavers are related to retirement and 12% were related to work/life balance.	The dashboard data confirmed the reasons for leaving and will continue to monitor in future reports.	Continued monitoring will take place to provide assurance	Ongoing	BAF.0014
Employee Relations Case Work Data	Case work length has reduced to 15.17 weeks (below target of 22 weeks). There are no 'live' grievances at present.	The dashboard data confirmed weeks that an employee relations case is open has decreased and remain low	Continued monitoring will take place to provide assurance	Ongoing	BAF.0014
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Staff and Wellbeing Report	The committee were advised of the following points: - Our staff survey and pulse surveys indicated more work to be done on Health and Wellbeing - Health and Wellbeing Assurance Group are to provide assurance on improvements in future reports, and would welcome more clinical engagement. - Developing skills to support wellbeing is not on track due to capacity - A lot of wellbeing support is virtual which is not suitable for all staff, so this is being reviewed - Promoting Attendance and Managing absence policy is being reviewed - Options including food banks are being considered to support cost-of-living crisis and staff forums will prioritise options	The actions are being progressed and the committee have assurance of this, however there are delays due to staffing and concerns surrounding the cost-of-living crisis. Impact is therefore difficult to ascertain. The committee approved the recommendation to continue the real living wage for lowest paid staff.	Continued monitoring will take place to provide assurance	Ongoing	BAF.0013

	- The committee approved the recommendation of continuing the real living wage for lowest paid staff.				
Organisational Development	The committee were advised of the following points: - There is evidence to show that the completion rate has increased but that more support needs to be in place to manage the preparation and promotion of the PDR and further quality measures need to be in place. - The 2nd cohort of 'Developing as Leaders' has commenced and learning from cohort 1 has supported development of the programme for cohort 2. - Engagement activity is taking place around the staff survey and pulses.	The committee were asked to note that, at this point, we are near the top of the comparator group for completion of the main survey and just below the average for the bank survey – which was only established this year.	Future reports will consider the trajectory of the BAF and indicate the milestones, how they interlink and how the target scores will be met.	Ongoing	BAF.0013
HEE self-assessment	The committee received the HEE Self-assessment.	This paper presented for information purposes and provided assurance to the committee of where training funding has been invested across the Trust.	The report will be presented to People Committee annually.	Ongoing	BAF.0020
Update on strike action	The committee were advised of the following points: - RCN have concluded their ballot and will have more info 09/11/2022. - Unison will close their ballot on 25/11/2022 - Unite and GMB are still in consultation. - Working with ICS colleagues regarding industrial action planning.	- Industrial action plans are being finalised and there will be a confirmed process with the Board once completed. - It was agreed that an extraordinary meeting may be established to handle the industrial action plans as the next People Committee is in January. - An extraordinary Gold Command has been established on 14/11/2022 to monitor the action - Engagement is taking place with staff to support cover arrangements. - There is a BoD meeting at the end of the month, which will discuss the winter plan with a commentary	Continued monitoring will take place to provide assurance and an extraordinary meeting will be established if required.	Ongoing	BAF.0013

		including industrial action			
Regional and National News	The committee were advised of the following points: - The support in place for the cost-of-living crisis at national, regional, and local level - Health Education England Workforce Planning - Development of South Yorkshire One Workforce People strategy	Report was provided for information, so no assurance was required	This report will be presented at each People Committee to inform members of relevant workforce information	Ongoing	BAF.0014
Health & Safety Annual Report	The committee received the annual Health and Safety report including current position on statutory compliance and H&S management within SHSC.	A Violence and Aggression Reduction Group has been established and will meet in Feb 2023. There are several policies which will need interim reviews which is in progress. Once the policies have been reviewed, there will be full compliance.	Several policies are being reviewed to meet compliance.	January 2023	BAF.0013
Gender Pay Gap Interim Report	The committee received the interim Gender Pay Gap report.	The data in the report shows an improvement in the mean and median gender pay gap and a significant reduction in the median gap.	A report will be shared at People Committee in March which will include the action plan and detail what is driving the gap and what are we doing to resolve it.	March 2023	BAF.0014
Annual Equality and Human Rights Report	The committee received the annual report for Equality and Human Rights of which its main duty is to comply with section 149 of Equality Act 2010.	Work is taking place with communications team to create a view on a page to ensure the information is easily understood and disseminated across the Trust.	A report will be shared with committee in Feb/March 2023	March 2023	BAF0013
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Workforce Performance dashboard	The dashboard has been much improved over the last few months and provides clear data to assure the committee.	The data is very clear and easy to understand. The committee have been able to request additional information which has been built into the dashboard by the workforce team.	N/A	Ongoing	BAF0014

Board Assurance Framework and Corporate Risk Register	The CRR and BAF are reviewed at each meeting, and actions are being moved to controls.	A report is provided at each meeting to continue to provide assurance	N/A	Ongoing	BAF.0013 BAF.0014 BAF.0020

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BAF Risk Description:

BAF.0013	There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing and delivery of services, leading to ineffective interventions; caused by failure to engage with staff in a meaningful way around concerns raised in the staff and pulse surveys as well as through engagement with, and demonstration of the values; and failure to implement demonstrable changes resulting in low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.
BAF.0014	There is a risk of failure to undertake effective workforce planning to support recruiting, attracting and retaining staff to meet current and future needs caused by ineffective workforce planning, insufficiently attractive flexible working offer, competition, limited availability through international recruitment, reluctance of staff to remain in the NHS post Covid19, any national ICS requirements resulting in a negative impact on delivery of our strategic and operational objectives and provision of high-quality safe care.
BAF.0020	There is a risk of failure to enable a paradigm shift in our culture through delivery of the overarching cultural change programme, caused by a lack of engagement in the wide range of leadership activity and opportunities for development provided, inability to adapt and engage to enable organisational change, resulting in failure to improve the culture of the organisation, ineffective leadership development, application of learning, engagement with our values, emergence of closed subcultures and low staff morale which in turn impacts negatively on service quality and service user feedback.

ITEM 03 08/11/2022
CONFIRMED

Sheffield Health and Social Care NHS Foundation Trust

People Committee

Minutes of the People Committee meeting, which was held on Thursday 13th September 2022, via Microsoft Teams Meeting

Members Present:
Heather Smith (HS) Non-Executive Director (voting) and Chair of Committee (Chair)
Caroline Parry (CP) Executive Director of People (voting)
Owen McLellan (OM) Non-Executive Director (voting)
Richard Mills (RM) Non-Executive Director (voting)

Apologies:
Aimee Hatchman (AH) People Systems Lead – Resourcing
Beverley Murphy (BM) Executive Director of Nursing, Professions & Operations (voting)
Deborah Lawrenson (DL) Director of Corporate Governance

In Attendance:
Amber Wild (AW) Corporate Governance Manager
Caroline Greenough (CG) Deputy Lead AHP, Specialist Services
Charlotte Turnbull (CT) Head of Leadership and Organisational Development
Jessica Malone (JM) Corporate Governance Officer (Minutes)
Karen Dickinson (KD) Head of Workforce Development and Training
Liz Johnson (LJ) Head of Equality and Inclusion
Neil Robertson (NR) Director of Clinical Operations and Transformation
Rachel Squires (RS) Peer Recovery Support Worker
Sarah Bawden (SBa) Deputy Director of People
Simon Barnitt (SB) Head of Nursing for Rehab and Specialist Services
Stephen Sellars (SS) Workforce Systems Lead

Min Ref	Item	Action
1/09/22	**Welcome & Apologies** The Chair welcomed everyone to the meeting and apologies were noted.	
2/09/22	**Declaration of interests** No declarations of interest were made.	
3/09/22	**Minutes of the meeting held on 12th July 2022** The minutes of the meeting held on 12th July 2022 were agreed as an accurate record.	
4/09/22	**Matters arising and action log** <u>Action log</u> There are several actions to resolve so it was agreed that JMa and SBa would meet to review the log and ensure an up-to-date version is circulated to committee	

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	members. **Action** JMa and SBa to meet as soon as possible to review the committee action log and circulate a revised copy. <u>Matters arising</u>: <u>Clinical Establishment Review Progress</u> A presentation was shared with the committee which outlined the Clinical Establishment review process and the steps that the Trust will take to achieve this. RM asked about the link between Clinical Establishment Review and Budget setting. SB advised this review related to Inpatient wards only and was related to the Safer Staffing Establishment review that was required by the National Quality Board and NHSE/I. The paper was previously signed off by the Board in December 2021 and has been signed off in Finance last week, where they have been able to achieve a cost neutral position on the new model. This new model will then be used for the budgets for Inpatient Wards from October 2022. CP advised this work triangulates with People Directorate. SB advised the budgets will change from October 2022 and the revision for implementation of the model for band 2 and 3 roles will be by the end of the year with support from Staff Side. The complete model has longer timescale due to training advanced clinical practitioners.	A101
Staff Voice		
5/09/22	**Peer Support Worker Insight** RS was invited to the committee to advise on the work they she is doing as a Peer Support worker in the North Recovery Team. RS explained she has been a Peer Support worker for around 3 years which involves working under the talking team with patients who have emotional sensitivity such as those with BPD or struggle with emotional management and interpersonal management. RS explained that she has lived experience and is a current service user in SPS but that this experience allows her to share what has helped her whilst still respecting that each journey is different for everyone. Currently each service user will have around 12 sessions in which they look at the diagnostic criteria and try to understand how to better manage emotional sensitivities. Each session is tailored to the service users' needs and skills such as Dialectical Behaviour Therapy (DBT), distress tolerance, mindfulness, and emotional regulation are offered. RS explained that there will be a pilot group established in November 2022 which will be a managing and understanding distress group for service users who do not have a care co-ordinator. RS and the team are involved in the Trust Wide development of the Peer Role	

	which will create more structure for staff coming into the role. CP asked if Workforce could provide any support around the Peer Support structure. RS explained there is a real priority to focus on role definition within Peer Support and CG also advised it is important to look to create standard practice for job descriptions, inductions, and training and to also help develop a career pathway to show Peer Support opportunities. It is also vital for there to be wider awareness of the roles across the Trust. CG advised there is a Peer Support Lead post but the funding for this is temporary, so work is ongoing to secure permanent funding. RS advised the roles are full time. RM said it would be good to explore how this role help with academic and personal development. RM asked about the challenges facing the team when working with service users who do not have care co-ordinators. RS explained it has been challenging but there has been good support from manager and a lot of development work has taken place to help staff work within safe boundaries. RM explained he sees that we have a requirement to support Peer Support and need provide training and support for the wellbeing and safety of the service. In order to do this, we need an appropriate structure that the trust is aware of and remains sustainable.	
Performance Monitoring		
6/09/22	**Integrated Performance and Quality Report (IPQR)** The Chair highlighted the following points from the report: <u>Good Performance</u> • Open Serious Incidents & Unreviewed Incidents - Improvement to number of unreviewed incidents and decrease in outstanding SI actions overdue. • Assaults on Staff - Trustwide – low number of Assaults of Staff reported • Long term sickness - Low long-term sickness Trustwide • Supervision - Rehabilitation & Specialist service area meeting target <u>Performance Concern</u> • Sickness Absence – specific to short term sickness and will be further discussed in 07/09/22 • Mandatory training - will be further discussed in 07/09/22 • Supervision - will be further discussed in 07/09/22 <u>Areas of Interest</u> • Headcount/WTE - Increase in staff numbers The Chair advised the same risk around Quality are still prominent IE waiting lists, out of area beds.	
7/09/22	**Workforce Performance Dashboard** SS, SBa, and CP highlighted the following points from the dashboard:	

	• Agency information has been included in the dashboard and Workforce will look at how that data is presented in future reports. • Overall number for case work are still being reduced. Volume of formal case work has decreased and remains lower, which includes time to conclude processes. This means the time invested as well as the numbers have decreased. This shows that the way that problems in the workplace are being managed has shifted, • The number of informal cases for Ethnically diverse staff has decreased and remains low. • Short term sickness is showing as high, especially in areas where there are high numbers of agency staff or vacancies, but work is taking place with the managers of these areas to create a plan for individuals who are on short term sick leave. • There is a reduction in long term absence. Work has been ongoing with managers to manage long term sickness and offer support • Looking at short term absence I order to look to reduce the number of absences and put plans in place for individuals on short term sick leave. • The main causes for short term sickness are showing as “infectious diseases (Covid)” and “Stress/Anxiety”. RM and OM queried the trend of short-term sickness as they anticipate this will increase as we go into winter as Flu and Covid rates may increase, and pressures on the NHS, cost of living may increase stress and anxiety rates. SBa explained that the Flu and Covid vaccination campaign should help mitigate some short-term sickness concerns. SBa also explained that the graph starts from a higher point due to the Omicron outbreak in June/July 2022. NR explained that every year the Trust looks at the Business Continuity Plan for ensure we have ways of backfilling our central crisis services. This was used last year, and points of learning have been taken from that and built into this year’s plan. The Winter plan has been submitted to Sheffield Place to acquire additional resources. SBa asked the committee to ensure they consider the sickness absence figures as a whole as there are cases where staff who would normally have long term sickness are only taking short term sick as they are being better supported during these periods. RM and OM also noted that there wasn’t a consistent message regarding agency usage in this report and the CIP report which is being presented to FPC on Thursday. RM would like to discuss the key factors that need to go into each of these reports. CP explained that work is taking place in the Agency Reduction Project Group and that this will then feed into CIP. CP expects that the same information will in turn be reported into CIP in a future report. OM asked Workforce to look at reporting target agency rates for the next report NR advised that the supervision and appraisal rate is below the target of 90% and wanted to know what action is being taken in these areas. CT explained that they have done a quality audit and the information will be in the November OD report. It is worth noting that even through the focal point window has closed, there are still forms to be processed or uploaded, therefore the figures in this report will increase.	

	The forms have been amended this year and will continue to be reviewed as part of continuous improvement, along with considering feedback sought from surveys. It was noted that the KPI is 90% and NR asked that a figure is garnered for what percentage of PDRs are still being processed and uploaded and if there are any still taking place outside of the focal point window due to the window being extended last year. NR also suggested some communications are sent to managers to ensure remaining PDRs are processed as quickly as possible. RM asked why it takes approximately 4 weeks from a vacancy being created to a position being advertised. SS explained that there could be issues with the authorisation process or the advert which need resolving before the vacancy can be advertised. However, this is something that Workforce are trying to improve over the next 12 months. The Chair asked for the dashboard to include a 12-month rolling graph to track the improvements in the time taken from vacancy creation to advertised position. CP asked to note that the PDR performance reviews are taking place in October which will feed into the OD report. OM asked if the "time to recruit" dashboard could be viewed by executive owner in order to give more accountability to individual areas. The Chair highlighted that the report shows 136 people awaiting their start date even though pre-employment checks have been done. The chair asked if these can be reviewed to urgently provide start dates to these new starters. **Actions** SS to add target agency rates to the dashboard so this can be reported on at subsequent meetings. CT to include position statement of PDRs in the OD report at the next meeting Workforce to arrange for communications to be sent to managers requesting for all PDRs to be uploaded SS to include a 12-month rolling graph to track the improvements in the time taken from vacancy creation to advertised position. SS to look at the "Time to recruit" data and present it by Executive owner. Workforce to look at the 136 people awaiting start dates to see if these can be processed urgently.	A103 A104 A105 A106 A107 A108
People Strategy		
8/09/22	**Refresh of People Strategy – timeline** CP advised the slides demonstrate the planned engagement and summarises the strategy and timeline. From August to September, Workforce have been looking at the Consultation and Engagement arrangements. The Consultation and Engagement plan will be drafted	

	in October and November, with the Policy being drafted in December. It is anticipated that the strategy will then present at Committee and Board between January and March. This work will link in with the National and System ICE Integrated Care system agenda and the Trust's Clinical and Social Care Strategy before going out to the rest of the organisation. **Action** JMa and CP to schedule People Strategy updates into the Work Programme	 A109
People Strategy theme: Equality, Diversity and Inclusion		
9/09/22	**Workforce Race Equality Standard (WRES) Annual Report and Action Plan** LJ advised it is a requirement from the NHS standard contract to produce an annual report and action plan. The points to highlight were: • There was a national decision to separate Bank staff into their own WRES report. This exclusion has impacted on some data in particular the Disparity Ratio the report includes the DR including Bank only and excluding for reference. Bank Staff will have their own staff survey. • Staff Survey results for the WRES indicate a small number of positive but the Survey Results continue to highlight the poor experience of our staff who are ethnically diverse, and our Staff Survey data is consistently below our organisations benchmark comparators. • Disciplinary cases: LJ expressed that this is new cases that have gone into a formal process. LJ wanted to clarify that there was one disciplinary case which involved 3 ethnically diverse staff members which progressed to formal process, if this case had not progressed to formal disciplinary, LJ expected a likelihood figure of 0.55. • The percentage of "Not known" ethnicity is significantly higher than that the 3% benchmark however meetings have been planned with SS to review this. • A benchmark report was conducted in April 2022 and a bespoke report has been created based on benchmarking across peer groups and the region to identify areas which the Trust should work on. These are as stated above, and the Trust has chosen to also include Disciplinary cases. • A risk has been identified which is that the Trust may not meet the target associated with the disparity ratio target, which is 2025. The ratio is now being reported on it quarterly. Mitigating action is highlighted in the report and the committee are advised that they will receive a further update in the EDI report in January 2023 CP explained that the merging of 2 tier 2 assurance groups should provide an opportunity to plan more focused actions around how we can improve the disparity ratio. HS suggested that the data for disparity ratio could be aggregated by executive owner to allow for a more targeted approach in areas. NR asked that mentoring schemes provide further information on racial disparity or if the Trust needs to consider dedicated schemes which would cover this.	

	CT advised that at a recent Leadership session, a section on EDI data was covered which was very well received and provided staff with a safe space to discuss this topic. CP asked that we consider how do we obtain qualitive data to see what difference is being made to staff, to give assurance at this committee that improvements are being made.	
10/09/22	**Workforce Disability Equality Standard (WDES) Annual Report and Action Plan** LJ advised it is a requirement from the NHS standard contract to produce an annual report and action plan. The points to highlight were: • Our data shows a high percentage of people who haven't advised their disability therefore a target has been set of 8% for not known, which LJ is working with SS to assess this target and plan. • A risk has been identified around the experience of staff accessing reasonable adjustments. There are significant issues in obtaining the equipment which staff with disabilities require. • Establishing a task and finish group to look at this issue and working with Staff Network Group in order to provide a further update in the next EDI report. • The disparity ratio is less for WDES than WRES in higher level positions, however, need to review the "not known" figure to ensure this isn't affecting the data. • Funding has been approved from Quality Innovation Fund to develop some digital stories. • Details in the action plan for this report is different to the WRES action plan so we can work more effectively with the Staff Network Group. RM advised a Procurement strategy was recently approved in FPC however doesn't recall issues with procuring adjustment items being mentioned in the strategy and that this will need to be reviewed to see if it can be built into the strategy. OM asked what our labour turnover amongst disabled and minority populations is relative to other colleagues. LJ explained that a deep dive on this has been conducted and the merging of the Workforce Transformation and Recruitment and Retention workstreams would allow for more focus on this topic. CP advised they will work with SS to include a metric to monitor this in the Workforce dashboard. **Action** A metric to monitor staff turnover amongst disabled and minority populations is to be developed and included in the Workforce Dashboard. This will be developed by CP and SS.	A110
11/09/22	**Inclusion and Equality Group – Report** LJ presented a high-level review of EDI progression, which talked to the key points: • Progress is being made in terms of zero tolerance, and data has been provided to assure the committee of the work that is ongoing. A Inclusion	

	and Equality group has been established and reports are being presented around Zero Tolerance. • The SOP for reporting hate incidents has been approved. • The detailed action plan has been provided and there are a few actions which are behind target however LJ assured the committee that there are mitigations in place for these. • An action plan is going to be introduced for the NHS Rainbow Badge phase 2. RM advised that FPC have an outstanding action to agree the EDI KPI timescales. LJ to obtain the timescales of the IPQR metric review in relation to the disparity ration noted in the Inclusion and Equality Group report. **Action** LJ to obtain the timescales of the IPQR metric review in relation to the disparity ration noted in the Inclusion and Equality Group report.	A111
People Strategy theme: Health & Wellbeing		
There are no agenda items this month, however Staff Health and Wellbeing Group report will be considered at the November meeting.		
People Strategy theme: Recruitment & Retention		
12/09/22	**Recruitment and Retention Group – Report** SBa provided an overview of the work which has taken place in the Recruitment and Retention Group since the last meeting: <u>Recruitment and Retention Premium for Band 5 nurses</u> We are proposing a recruitment and retention premia for ALL band 5 nursing staff, in the first two years of employment with us, when below the mid-point. There are 45 preceptors in the pipeline. This is not a change to agenda for change terms and conditions. The business case for this has been presented at BPG. <u>Merging Recruitment and Retention Assurance and Workforce Transformation Assurance Groups.</u> The report also recommends the merging of the recruitment and retention group with the Workforce assurance group, this is in line with the revision to the BAF risk 19 and the opportunity to create greater impact by connecting our workforce development more closely with our recruitment and retention plans. RM advised they would like to see more data surrounding retention in the next report. SBa to work with SS to develop a dashboard which reports on retention levels. SBa mentioned that the delivery plan which was included as an appendix is to cover work up until March 2023. A revised delivery plan will be developed as part of the strategy refresh in April 2023. **Decision** The committee approve the merging of Recruitment and Retention Assurance and Workforce Transformation Assurance Groups. **Actions** SBa to work with SS to develop a dashboard which reports on retention levels.	D001 A112

People Strategy theme: Workforce Transformation		
13/09/22	**Workforce Planning & Transformation Group – Report** KD provided an overview of the work which has taken place in the Workforce Planning & Transformation Group since the last meeting: An education and training subgroup has been established which reports into Workforce assurance. KD advised they are pleased with the improvement of workforce planning. There following areas have made progress: • Formulation of a template which will be used as part of this year's annual business planning timetable • Process and training support for managers to develop their capability and skills in workforce planning and skill mix • SHSC workforce dashboard in continuing. KD explained that BAF risk 14 has been merged with BAF risk 19 and on review of this there will be no amendment to the risk scores at this time. It was confirmed that ESR will be our main source of data in time, however, Workforce reviews need to be actioned first in order to cleanse the data before ESR can be our single data source.	
14/09/22	**Review of risk 0019: Workforce Transformation** Due to Recruitment and Retention Assurance and Workforce Transformation Assurance Groups merging into one group, it also means BAF risks 14 and 19 will merge. A review of this joint BAF risk will be conducted at the next meeting. **Action** JMa to defer this item to the next meeting.	A113
People Strategy theme: OD, Leadership and Talent		
There are no agenda items this month, however Organisational Development Group report and Pulse Survey update will be considered at the November meeting		
Governance		
15/09/22	**People Policies – Ratification of decisions made at PGG** The following decisions made at PGG were ratified by the committee: • Flexible Working Policy HR 021 - PGG approved extension to review date to 31/10/2022 • Mandatory Training Policy HR 036 - Policy was approved by PGG and will be sent to Communications for publication • Performance Development Review (Appraisal) Policy HR 055 – Interim review due to 360Assurance audit - Policy was approved by PGG and will be sent to Communications for publication	
16/09/22	**Reviews of Assurance Groups Effectiveness**	

	Surveys were sent to tier 2 members asking them to advise on meeting effectiveness of their groups. The response rate response was low but there was a theme identified from the data: • Improve connecting the work of the assurance groups and ensure there is clarity on what is required from each assurance group. SBa advised that this has already been addressed and a clear structure has been developed for the tier 2 groups.	
17/09/22	**Review of Board Assurance Framework and Corporate Risk Register** This agenda item was presented by AW as DL was on leave. The report advised there are 3 BAF risks monitored in People Committee and the recommendations by the executive leads are as follows: BAF.0013: In the Board meeting in August, it was recommended that the risk type is to be amended to Workforce and the risk appetite to be amended to between 5-8 (Low). BAF.0014: In the Board meeting in August, it was recommended that the risk appetite is to be amended to 9-12 (Moderate) BAF.0020: In the Board meeting in August, it was recommended that the risk type is to be amended to Workforce risk appetite is to be amended to 9-12 (Moderate) There are no recommendations to amend the Corporate Risk Register. **Decisions** The committee approve the above recommendations to the BAF risk types and appetites.	D002
18/09/22	**Internal Audit Action Tracking** This agenda item was presented by AW as DL was on leave. The progress report provides an update for People Committee on the actions from the following Internal Audit Reports: • Staff Engagement - Governance arrangements • Staff Engagement - Exit interviews The committee is asked to request confirmation the work to meet this medium priority action is in hand and the timeframe within which the evidence required will be provided - for the action to be closed – ideally in advance of the October Audit and Risk Committee paper submission. The chair requested that the responses to the actions are prepared before the meeting in future and that the responsible person(s) are named in the report. CP advised we are ok to close the action around exit interviews but need to remain vigilant to exit interviews and look at ways the information can be gathered and monitored. The chair suggested that exit interview data is looked at in the Recruitment and Retention Group in order to provide assurance. CT advised there is an OD assurance Group in place as well as Staff Engagement	

	Steering group which can provide terms of reference and membership in order to support the closure of the Governance action.	
19/09/22	**People Committee Terms of Reference** The committee approved the track changes and there were no adjustments made.	
20/09/22	**People Committee annual report update** The People Committee Annual Report was shared with members for assurance and approval. It provided 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 main changes include: • 6.1 and the inclusion of the objectives for 2022/23 • Appendix A Terms of Reference – updated membership It was suggested that the report is reviewed every 6 months. JMa and CP will meet to review the current work programme and ensure regular updates are scheduled. **Decision** The committee approve the changes as outlined above. **Action** JMa and CP to meet to review the current work programme and ensure regular updates are scheduled and a revised copy of the programme is circulated to all members.	D003 A114
Other		
21/09/22	**Regional & National updates and news** <u>Pay award</u> CP advised the pay award and impact has caused an issue for some people who have now found they are owing money to the Trust, however support has been put in place to help people with repayment. The pay award is being reviewed to ensure this issue doesn't happen again next year and a review is taking place to look at if we can grant the pay awards in April instead of October in future. <u>Industrial action</u> Ballots for strike action are likely to go ahead. RM asked if there is a contingency plan for strike action. CP advised we are working very closely with Staff Side. RM would like to meet with CP to discuss the reporting pathway for emergency planning of strike action. <u>Robotic process automation (RPA) with NHS provider organisations</u>	

	OM advised this is very relevant in both public and private sectors so would like to ensure the Trust scope the possibilities in this area if funding is available as a long term staffing solution. <u>The NHS Estates and Facilities Workforce Action Plan</u> NR advised there is a Therapeutic Environments Programme and Community Facilities Programme which are looking at how to improve our working environments and these programmes will also consider the benefits of agile working. RM asked that this committee consider any policy announcements that are made from the new Prime Minister and what impacts they might have on workforce.	
22/09/22	**Highlights from the Joint Consultative Forum** CP advised JCF are looking at having a subgroup to monitor strike action and that the next meeting in October 2022.0	
23/09/22	**Any Other Business** None	
24/09/22	**Confirmation of Significant Issues to report to our Board of Directors 16:22** a. <u>Committee members noted the following significant issues to report to Board.</u> **TO ALERT** (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently) • Short term sick leave and concerns about entering winter • Transfer from agency to bank staff is not on track • Our WRES data is still indicative of issues compared to other Trusts. Our improvement focus will be on reducing harassment and abuse from patients and carers and on improving career progression to address the disparity ratio. • A concern has been addressed around staff being able to access procured items to support their disability in the workplace. • Meeting supervision and mandatory training remains a challenge • Time to appoint is at 65.5 days but aiming for 43 days • Long term sickness rates are decreasing • Case work data managed well • HR performance data much improved. **ADVISE** (areas of on-going monitoring where an update has been provided to Committee AND any new developments that will need to be communicated or included in operational delivery) • TRAC data reveals blockages with the recruitment process e.g. issues with agreeing start dates • Incidents of violence and aggression towards staff are reducing in number • Inclusion and Equality Group have developed a KPI Dashboard • International recruitment 20 nurses start Jan • Premium for Band 5 nurses has been approved and work is progressing • Merging of Workforce Transformation and Recruitment and Retention assurance groups has been approved • The BAF risks have been considered • Regional and national news has been shared with the committee **ASSURE** (areas of assurance that Committee has received)	

	• ESR will become the single data source once validation of information has been concluded • Apprenticeship performance and use of levy is progressing well • The work on zero tolerance of hate incidents is progressing with positive assurance of impact b. Review of future work programme and agenda items for the following meeting Committee This was discussed c. Meeting effectiveness the committee were invited to post comments in the chat box	

HS CHECKED 21/10/22 CONFIRMED xx-xx-21

Date and time of next meeting:

Tuesday 8th November 2022, 2:00pm – 4:30pm, via Microsoft Teams Meeting

Apologies to: BoardCommittees@shsc.nhs.uk

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Finance And Performance Committee	Date:	13/10/2022	Chair:	Owen McLellan

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk No
CIP update monthly report	The committee were advised of the progress and risks associated with the Cost Improvement Programme which advised the current CIP forecast outturn us £3.377M but that there are increasing risks to delivery. Agency: The programme is behind plan and has been restructured into 5 workstreams. Out of Area: The programme is reporting an increase against contracted beds which is indicating an overspend. Efficiency Delivery Group: The programme is expected to deliver above target and in excess of £2m.	Agency: Beverley Murphy and Caroline Parry have replanned the agency programme report which will include costings derived from workstream delivery plans. Out of Area: The projected overspend is being reviewed and will be reported in November. Efficiency Delivery Group: The 3-year plan is being reviewed to see if there is any slippage which can be recovered in areas of loss.	A report will come to FPC in November which will provide costings on the agency and staffing CIP Programme as well as further triangulation between the CIP report and Finance Report.	N/A	BAF.0022
Review Board Assurance Framework – Financial Risks	The committee were advised that the target score for BAF.0022 has been updated to ensure if fits with the low appetite score	The paper advised that work is taking place to refine capture of recurrent/non-recurrent detail in budget lines which should be	A new action for "developing mitigating actions to mitigate forecast overspend" will be included in the BAF report in	November and December 2022.	BAF.0021 BAF.0022 BAF.0026 BAF.0027

	which was agreed in August.	complete by December 2022 and will be aligned with budget setting	November. Refinement of capturing recurrent/non-recurrent details in budget lines to be completed by December 2022.		
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Burbage Overspend	The committee were asked to approve a retrospective ask for £403k due to additional works which took place during the Burbage renovation. This was due in part to the original plan to re-cover the roof which when works commenced, it became apparent it needed to be completely replaced.	As this was a retrospective ask, the funds had already been committed but Phillip Easthope confirmed that BPG are looking at reprioritising funds in the Capital Plan if there are financial impacts across the Trust.	The Therapeutic Environments Programme were aware of the additional ask and Beverley Murphy agreed to take an action to ensure that the programme understands its responsibility to monitor, check and challenge the use of Capital. An update to this will be provided at a future FPC meeting.	Update to be given in November FPC.	BAF.0026
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Procurement Strategy Refresh – delivery summary	The committee were advised of the deliverables and key measurables which are highlighted in the Procurement Strategy. Two risks were noted: • Funding of £120k for staffing • Developments to the National system are ongoing	The Procurement strategy will report to BPG (timescale to be determined) and to FPC annually. A benefits review of the £120k investment is to be assessed through QEIAP.	The Procurement strategy is to be scheduled on FPC work Programme once a conversation has taken place with the chair of BPG. The strategy should come to FPC annually to provide an independent update.	November 2022	BAF.0026

BAF Risk Description:

BAF.0021	There is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring ongoing maintenance, inadequate system monitoring, testing and maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents.
BAF.0022	There is a risk that we fail to deliver the break-even position agreed for 2022/23 caused by factors including non-delivery of the financial plan or CIP targets and increased cost pressures resulting in a threat to both our financial sustainability and delivery of our statutory financial duties
BAF.0026	There is a risk of slippage or failure in projects comprising our transformation plans caused by factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity to deliver within the timeframes agreed or availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.
BAF.0027	There is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirement to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs.

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Finance And Performance Committee	Date:	10/11/2022	Chair:	Owen McLellan

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk No
Risk surrounding potential Capital underspend	The committee were advised that the committed forecast spend for the year stands at £10,794k but a significant increase in costs are profiled in the second half of the year. There remains uncertainty in the cost and timings of our big schemes (EPR, 136 suite and phase 3 LAP), which could impact delivery of our forecast.	The committee were assured that the potential capital underspend is being reviewed by CPG and BPG to see if already approved business cases can utilise the funds before the end of the financial year if the big schemes are not in a position to utilise the funds. Smaller schemes will also be progressed to reduce future requirements where possible. The committee was assured that the Trust had a similar position in 2021/22 but by working with CPG and BPG, as a Trust we were able to achieve 100% capital spend.	N/A	Ongoing	BAF.0022
Review of Standing Orders, SFIs & Scheme of Delegation	The committee was made aware of proposed amendments to the paper which was received at FPC in advance of ARC and BoD.	The committee approved the recommendations, but it was noted that further changes will be made to the paper regarding litigation and governance arrangements before it is taken to ARC and BoD.	N/A	Ongoing	BAF.002

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

or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Transformation Portfolio Report – Therapeutic Environments Programme	The committee were advised that there are concerns with funding and what the potential impacts would be if external funding was not secured or less than anticipated.	With the current level of internal funding, the programme is confident that it will be able to build a new inpatient ward of some kind. i.e a smaller scale development of 4 wards and potentially provide for a refurbishment scheme in Older Adults. They have also secured funding for the 136 suite. A business case is being developed and a Strategic Outline Case is to be brought to FPC in January/February 2023 which will explore options.	N/A	Ongoing	BAF.0026
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Finance Report	The committee were advised that the forecast year-to-date deficit is £3.913m with a best-case scenario of £3.6m based on CIP delivery and a worst-case scenario of £4.6m recognising that Local Authority may not pay the 2022/23 management fee. The report showed that cash balance remain healthy and the Trust has no debt concerns.	The issue surrounding the Local Authority refusing to pay the 2022/23 management fee is concerning, even though this is viewed as under contract, However, this has been escalated and the ICB are aware. c£2m of the deficit is due to pay award system allocation and the Trust is to continue to lobby hard for a better deal and progress inflation funding on external contracts.	The Executive team are meeting to discuss finance matters and a report following this meeting is to come back to FPC in December.	Ongoing	BAF.0022
Cost Control and Deficit Reduction Plan	A report was presented which outlined various options for further cost control and the proposed mitigation of the current	The recent NHSI guidance will be reviewed and information of this will be presented within the next finance report.	This will be discussed further in the Executive team meeting. This will also be reviewed in light of the more recent NHSE protocol	Ongoing	BAF.0022

	forecasted deficit of £3.9m.		for changes to in-year revenue financial forcast guidance for ICB Systems and providers not in balance.		
Financial Planning & Reporting Governance Arrangements and Principles	The committee received the annual reports which briefed them on the current return actions as routine business within the Finance directorate.	The report provided assurance to the committee, and it was requested that a monthly update concerning progress on planning is brought to each meeting.	N/A	Ongoing	BAF.0022
Operational Plan Quarterly Update	The committee were assured that the operational plan deliverables are being progressed and risks to delivery are being managed appropriately. The committee asked for an update on strike action – however this report was for up to Q2 so did not include this information.	Concerning strike action, the committee were assured that an update paper will be presented to BoD along with the winter plan and business continuity is being closely monitored in People Committee.	N/A	Ongoing	BAF.0022
Internal Audit Actions Update	The committee received the Internal Audit action update which advised there are currently no open actions being monitored by this committee.	A report is provided at each meeting to continue to provide assurance	N/A	Ongoing	BAF0026
BAF and CRR	The CRR and BAF are reviewed at each meeting, and actions are being moved to controls.	A report is provided at each meeting to continue to provide assurance	N/A	Ongoing	BAF.0021 BAF.0022 BAF.0026 BAF.0027
Delegation of Budgetary Authority Policy	The committee received the recently updated policy which had been approved at Policy Governance Group (PGG)	The policy had been approved at PGG and was brought to committee to support the Review of Standing Orders, SFIs & Scheme of Delegation item.	N/A	N/A	BAF022

BAF Risk Description:

BAF.0021	There is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring ongoing maintenance, inadequate system monitoring, testing and

	maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents.
BAF.0022	There is a risk that we fail to deliver the break-even position agreed for 2022/23 caused by factors including non-delivery of the financial plan or CIP targets and increased cost pressures resulting in a threat to both our financial sustainability and delivery of our statutory financial duties.
BAF.0026	There is a risk of slippage or failure in projects comprising our transformation plans caused by factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity to deliver within the timeframes agreed or availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.
BAF.0027	There is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirement to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs.