Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 July 2022
	Agenda Item:	7

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 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 below.
Key Points:	This report highlights key matters, issues, and risks discussed at committees since the last report in May 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.

The AAA reports presented to Board are attached to this report and include the following:
Quality and Assurance Committee – June, July 2022
Finance and Performance Committee – June, July 2022
Mental Health Legislation Committee – June 2022
Audit and Risk Committee – June 2022
People Committee - July 2022

Minutes are presented to Board after they have been approved by the reporting committee and this reporting cycle to Board includes the following minutes:
Quality and Assurance Committee - May, June 2022
Audit and Risk Committee – April 2022
Mental Health Legislation Committee – March 2022
People Committee – May 2022

Minutes presented to the confidential Board:
Finance and Performance Committee – Extraordinary meeting June 2022

Recommendation for the Board/Committee to consider:

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

To formally note the minute of the committee meetings being present to the confidential Board
To receive the 'Alert, Assure, Advice' committee activity reports within the appendices.

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

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

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

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Quality Assurance Committee** **Date:** **8 June 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
Key risks remain unchanged, some have worsened.	Flow, waiting times, allocation of care coordinators, and CPA reviews remain risks	Recovery plans received for the key risks and QAC were assured of intent, but assurance will come from impact measures. To note significant risks being carried regarding management of the change required, for both staff and service users.	Continue to try to manage the key risks as in previous months. QAC requested more information on the impact of those changes on service user experience.	QAC 13/07/2022

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
Supervision	Supervision has improved overall in terms of volume and compliance, but there are quality issues and issues around clarity of what supervision entails.	Partial assurance	There is a need for more in-depth understanding and clarification of what supervision means for different groups.	QAC 10/08/2022 Back to Good Report
Clinical Quality and Safety Group	The group is bringing together a variety of tools to align to the quality improvement process, and this will have impact.	Significant work underway to address patient safety issues through the Learning Lessons process.	Report to QAC 14/09/2022	QAC 14/09/2022

Draft Quality account	Draft Quality Account received and commented on.	Assurance that report is on track	June Board for final approval	June Board for final approval
Board visits	Visits are increasingly extensive.	Feedback loop and implementation has improved.	Board Visits 6-monthly reporting	QAC 14/12/2022
QAC work plan	New QAC work plan agreed.	More emphasis is given to Tier 2 groups and some reports moved to six-monthly from quarterly.	Different ways of producing reports are being considered so that more time can be spent on issues of most concern.	N/A
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Better Tomorrow dashboard (for learning lessons process)	A Better Tomorrow Dashboard implementation plan was received by the Committee.	The Committee were assured by the timeline and that there is an implementation plan in place.	Progress will be reported on in future meetings.	QAC 14/09/2022
Tendable (audit tool) implementation plan received	• Project Plan with timescales being finalised • Audits around eg Restrictive Practice are key to gaining assurance • Quality Assurance and Quality Improvement is a whole team effort, encouraged by these audits	• Linked to regulatory framework, CQC Back to Good – quality indicators • Aligns with ambitions to be a good to outstanding organisation	To be reported on quarterly through Clinical Quality and Safety Group Report	Quarterly Clinical Quality and Safety Group Report
QEIA: detail on mitigations for the closure of the Health Based Place of Safety	All risks have been mitigated but this issue remains a challenge.	• All risks mitigated, good understanding of risks • Proactively reviewing potential risk areas • Planning – utilisation, capacity, and Standard Operating Procedure	To be reported through IPQRs, then Clinical Quality and Safety Group.	Monthly IPQR, quarterly Clinical Quality and Safety Group Report
Back to Good action plan	Committee received the report for assurance and endorsement.	The plan is being closely monitored and progress is being made	More being done to audit impact	QAC 10/08/2022
IPQR	• Board to be assured that progress is being made on	Good progress being made with -Decreasing length of stay older	N/A	N/A

	a number of issues	adult wards and Forest Close -Waiting times in Early Intervention meeting improvement targets -72 hr follow up by community teams improving -IAPT strong performance – waiting times and recovery rate -Falls decreasing on G1 -Restrictive Practice on G1 and Specialist Services -Low number of seclusions across all wards		
Lived Experience and Co-Production Strategy	An update was received	Progress is being made with the new strategy.	QAC suggested ways for more visible narrative and use of volunteers to enhance work.	QAC 09/11/2022
Medicines Safety	Quarterly report received	Continues to be well monitored with clear actions for improvement. However, the Committee asked for more assurance in future (see next column)	QAC asked for this to be improved to include benchmarking, better trend analysis, and consideration of patient experience.	QAC 14/09/2022
Safeguarding	Significant assurance received	Considerable progress has been made and examples of best practice were demonstrated.	Next reports to QAC 10/08/2022 and 14/12/2022	QAC 10/08/2022 and 14/12/2022
QEIA process	Members were updated on work done.	Process in place to assess impact of CIPS.	Quarterly reporting	10/08/2022
Horizon scanning and the STH CQC Report.	Members received a report on our work with STH concerning the mental health issues mentioned in their CQC report.	These exercises are good indications that the Trust is considering its wider impact on the system.	N/A	N/A

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Quality Assurance Committee** **Date:** **13th July 2022** **Chair:** **Heather Smith**

KEY ITEMS DISCUSSED AT THE MEETING

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

Issue	Committee Update	Assurance Received	Action	Timescale
IPQR key issues	Flow and CPA reviews remain key risks	Limited assurance	Flow: slow but consistent improvements, consolidated in next IPQR – continue to review progress and monitor closely CPA: revised governance structure enacted and in progress, next QAC progress report Nov 2022	Monthly IPQR - QAC 10/08/2022 Monthly IPQR - QAC 10/08/2022 Community MH Services report QAC 09/11/2022
IPQR key issues	Waiting lists remain a key risk, new BAF risk	Limited assurance, significant concern	Further review to QAC and then Board	QAC 14/09/2022 Board 28/09/2022

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
Positives on IPQR	Committee recognised continuing positive work, and that there are now no beds blocked at the Health Based Place of Safety	Significant assurance received. Good progress being made with -Decreasing length of stay older adult wards and Forest Close -Waiting times in Early Intervention meeting improvement targets -72 hr follow up by community teams improving -IAPT strong performance – waiting times and recovery rate	Committee continue to recognise and monitor successes	Monthly IPQR - QAC 10/08/2022

		-Falls decreasing on G1 -Restrictive Practice on G1 and Specialist Services -Low number of seclusions across all wards		
RIE Strategy	Implementation Plan received	Good assurance – progressing to agreed deadline, recommendations approved	Report to QAC 14/12/2022	QAC 14/12/2022
Ockenden response	QAC thoroughly evaluated outcomes of Ockenden Report	Good assurance - recommendations identified to improve ways of working	Action plan to be developed. Report to go to Board.	Board 28/09/2022
New BAF risks	Suggested new BAF risks received and approved	Good assurance that risks identified. QAC noted CRR risks deescalated or removed	Continue to monitor risks through bi-monthly reporting	QAC 14/09/2022
QAC TORs	TORs reviewed and approved	Assurance that TORs are up to date and accurately reflect committee requirements	N/A	N/A annual review, or earlier if necessary

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

Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Community Mental Health Services	QAC received progress report. Constructive suggestions given by members	Good assurance that programme is progressing well	Next QAC report Nov 2022 Clinical models of care and delivery model agreed – slides to QAC Sept 2022	QAC 09/11/2022 QAC 14/09/2022
Learning Disability Service Transformation Model	Committee received report on transformation model. Constructive suggestions given by members	Good assurance that transformation is progressing well	Committee requested that detail of risk and mitigation is enhanced in next paper for further assurance	QAC 12/10/2022
Complaints Annual Report	Complaints responsiveness has improved	Good assurance received from report	Future direction is to increase learning from complaints. Training programme for staff planned – aim to improve experience for complainants	Training August – December 2022
IPC BAF	Committee received report	Good assurance - key risks and mitigations identified in report	Presented quarterly to IPC Committee	Quarterly to IPC Committee
Mortality Annual Report	Committee received annual report	Assurance that the Trust is compliant with national standards for learning from deaths and is engaged in a	Mortality report quarterly to QAC	QAC 10/08/2022

		process of continuous improvement		
MHA review of CPA access and admission pathway Sheffield	Trust is working in partnership with STH and Children's Hospital about crisis care, and are strongly advocating the use of specialists in the assessment process	Good assurance of partnership working	N/A	N/A

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

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

KEY ITEMS DISCUSSED AT THE MEETING

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

Issue	Committee Update	Assurance Received	Action	Timescale
None – June meeting done via e-governance.				

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
Due to annual leave, the June FPC meeting was not quorate. The meeting was therefore held via e-governance.	Essential papers were submitted to members via email, and comments were collated within minutes by the Corporate Governance team.	Reports were received by members via email.	Some agenda items are deferred to the agenda of the July's meeting.	July FPC meeting.
An extraordinary FPC meeting is to be held in order for members to review the Financial position end of year.	The meeting is to go ahead on 14th June 2022 at 12:30pm.	All Board members and FPC voting members have been asked to attend. Anne Dray will Chair, and Phillip Easthope will present.		14th June 2022

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

Issue	Committee Update	Assurance Received	Action	Timescale
None – June meeting done via e-governance.				

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Finance and Performance Committee** **Date:** **14 July 2022** **Chair:** **Richard Mills**

KEY ITEMS DISCUSSED AT THE MEETING

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

Issue	Committee Update	Assurance Received	Action	Timescale
LAP Business Case – Business case for Section 136 suite	The Trust submitted their business case in June 2022.	Response to bid expected imminently.	FPC support the business case subject to further discussions. Further work required developing value for money assessment, currently 0.0. Benefits requires development Revenue consequences need further development, these costs are not financed in the financial plan. Discussions with commissioners	Reporting timescales to FPC to be agreed.
Procurement Strategy	The 3 year Strategy was presented to members.	Procurement strategy aligned to national strategy and developed with engagement of system partners. The document presented was local to the Trust and will be adapted by ICS for other Trusts.	High-level summary of delivery and cost implications to be presented to a future FPC meeting.	October 2022
The new Learning disability community model	Two options were presented to FPC, the minimum requirement and the 'Golden standard'.	Paper on this presented to January 2022 private Board meeting and it is supported by both FPC and QAC.	Final version of the report to be signed off by FPC. Incorporate evidence re narrative	Reporting timescales to FPC to be agreed.

			on benchmarking	
Cost Improvement Plan (CIP)	- Timescales of the CIP are back end loaded and the majority will kick in over last 6 months of the plan - The next stage will consist of making connections between spending plans and savings	- Senior leaders are fully engaged and supportive of the plan. - Work being done quantifying and measuring out of area spend	Monthly reporting to FPC	Monthly reporting to begin from August 2022 FPC meeting.
Substance misuse contract expansion	- Discussions regarding development of service are ongoing with commissioners - Committee expressed support for the work done and requested future involvement.	- Item has also been presented to QAC - A comprehensive service is in place, the bid is for additional funding - This is a National fund but Sheffield City Council have initiated tendering procedures	Future update to FPC requested.	Reporting timescales to FPC to be agreed.

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**
IPQR Report	Out of area and Placement spend continues to be an ongoing area of concern.	Recovery plans in place and monitored via the Quality & Assurance and Finance & Performance Committees	Reporting on the Recovery plans at the two committees has been aligned.	Recovery plans to Quality & Assurance and Finance & Performance Committees in June
Finance Report	Month 2 report reflect the submitted plan at 31st May i.e. £2.7m overspend. A deficit of £329,000 at month 2 was reported and represents a challenge to the revised Breakeven plan	Further discussion re CIP planning including additional paper.	Monitor performance over next few months as CIP develop and analyse impact on run rates. Consider cost control	September 22 FPC meeting.
Recovery Plans	The report was month out of date as June's meeting was done via E-governance.	Transformation is needed in order to remove some of the issues	PE & NR are to review how these are presented to Committees to make them more fit-for-purpose.	Update to September 22 FPC meeting.
Corporate Risk Register	A new risk, risk number 2177, has been added to the register and allocated to FPC.		Placement of Health & Safety risks are going to be reviewed to ensure that they are being	Update to the August 2022 FPC meeting.

			reported to the correct Committees.	

ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Digital Strategy	Assurance received on progress identified	Progress on Key projects including EPR and prioritisation of other areas including Wi-Fi.	Consider update to project tracking and stuck indication and in progress narrative were inconsistent.	Next Quarter update to FPC in October 2022.
Estates Strategy	Good progress reported across many areas: • 7 investment areas are supported in the strategy & 3 enabling projects • Good progress in relation to LAP in single rooms • Fulwood move underway • Strategy planning is going well		Further development of operational planning and integration with capital planning is underway.	Update to September 22 meeting of FPC.

Cost Improvement Programme	The draft programme was presented to FPC.	FPC were assured that significant progress is now being made in this area.	Progress will be reported monthly from the CIP Programme Board to FPC, summary information will continue to be reported in the Finance Report.	Monthly reporting.
Triannual Performance Reviews	FPC were notified that work was ongoing. Supervision data was reported at the last performance review and has improved significantly since then.	The Committee is assured the performance reviews are in place in accordance with the performance framework. Actions are tracked and followed up. Workforce information data needs improvement	The Chair is to raise Workforce information data issues at the May meeting of the People Committee.	People Committee meeting 13/05/22

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Mental Health Legislation Committee** **Date:** **15 June 2022** **Chair:** **Olayinka Monisola Fadahunsi-Oluwole**

KEY ITEMS DISCUSSED AT THE MEETING

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

Issue	Committee Update	Assurance Received	Action	Timescale
Court of Protection issues	Court of Protection processes within the Trust have been inconsistent, which has significant care, legal and reputational implications.	Improvements have recently been made and are included within the MHLC reports.	Monitor impact of improved processes via MHLC	Next review Sept 2022
Delays to works at Maple Ward Gardens	CQC raised concerns following MHA inspection but work has not yet started.	A health and safety recommendation has stated that works cannot start until patients are decanted to another ward. In the interim, access is supervised	SHSC is closely appraising the CQC on timelines for all building works that improve clinical environments and improve patient safety	Next review Sept 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
Mental Health Act Reform and Liberty Protection Safeguards (LPS)	The Government are proposing to reform the Mental Health Act and introduce LPS which could impact on SHSC's systems, processes, responsibilities and resources.	Proposed reforms are being tracked and monitored by the MHLC via regular reporting from the Mental Health Legislation Operational Group (MHLOG).	Continue with current monitoring. Further information to be provided to Board as soon as timescales and impact become clearer.	Next review Sept 2022

Annual Review of Compliance with the Mental Health Act Code of Practice	The Committee was asked by Board to discuss and return a short paper to Board providing the necessary assurance	The Committee discussed and agreed to receive a paper in Sept 2022 for inclusion on the Board agenda also in Sept 2022	Paper to be received	September 2022
Prevention of future death reports from HM Coroner	MHLOG Q4 Report reported that organisational delays had been highlighted within a Prevention of Future Deaths notice from the Coroner.	Updates on Prevention of Future Deaths notices and SHSC's response are provided to MHLC, QAC and the Board.	To track learning and service improvements in reports to MHLC and QAC	Next review Sept 2022
AMHAM update	The role of AMHAMs may be removed with the Mental Health Act reforms but this is not certain.	The Committee requested more assurance on the performance of the AMHAM function.	KPIs for AMHAMs to be developed and included within future reporting. Audit to be undertaken on AMHAM record keeping	Sept 2022
Annual Review of Committee Effectiveness	Self-assessment has been completed by the Committee	The Committee discussed the findings of the self-assessment and agreed these as a basis for the Annual Review of Effectiveness	The Annual Review of Effectiveness will be drafted for review by the Committee	Sept 2022
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Mental Capacity Assessments in Inpatient Wards	MHL Q4 Report.	There has been a significant increase in patients who have had Mental Capacity Assessments when moving from formal to informal patients. Also improvements in recording of the assessments.	Maintain monitoring through MHLC	Next review Sept 2022

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Audit and Risk Committee** **Date:** **14 June 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	Updates received on ongoing audits: *2021/22* • Health and Safety Reporting (including CAS Alerts): Final draft report issued with Limited assurance and is awaiting approval from the Trust to issue the final report. • Safeguarding Adults and Children: Report drafted and exit meeting scheduled. • Recruitment: Testing is being processed and the audit will be concluded as soon as possible. *2022/23* • Data security and protection tool kit: testing almost complete	LR highlighted to members that there are requirements within NHSI guidance for internal audit coverage of 'Improving NHS Financial Sustainability' this year. An initial meeting with NHSI to get an early understanding of what might be required has happened, and PE has agreed to postpone planning of the quarter two schedule until requirements are understood. AD asked what impact this may have on the annual audit plan. LH replied that more guidance is being drafted this week to confirm NHSI expectations and that 360Asurance are inputting into that work. The Trust will be kept informed of the ongoing	Monitoring of audits ongoing	Ongoing - Update planned for receipt at the next meeting.

	• IPC and Estates audits: draft terms of reference supplied to the Trust	discussions.		
Head of Internal Audit Opinion and Annual Report	• Strategic risk management: moderate assurance • Internal Audit plan outturn: significant assurance • Follow up of Internal Audit actions: moderate assurance	The final Head of Internal Audit Opinion was of 'Moderate' assurance which it was noted was unchanged from the position reported to the committee in April.	Recommendations made by the report.	NA
Final Annual Report and Accounts 2021/22	Committee received the report for approval in advance of Board. • It was noted work was ongoing in respect of external audit on the accounts which was not yet finalised and the Annual Report from external audit was also delayed and they advised this may impact on the timing submission of the final documents.	Committee approved the report for submission to Board subject to the changes discussed during the meeting.	As the report was to be submitted on the same day as the June Board meeting, Board members will be asked to submit any material change sufficiently in advance to enable changes to take place. This will be made explicit when papers are circulated.	Extraordinary Public June Board
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Data and Information Governance Group (DIGG) – Escalation & Update Report	• Some of the data security business case development is now part of the planning process • likely that there will be investment in the annual planning process as part of the investments, but this has not formally been agreed	• The request to increase the mandatory training compliance figure in line with the IG compliance figure has been agreed due to concerns with current levels of compliance. Improvements prompted by this change are expected over the upcoming months. • SARS & FOIs need	ARC will continue to monitor identified areas of concern and will escalate as needed.	Ongoing – update to be received in next report

		improved assurance • Unable to confirm 23/24 submission dates but will be able to do so shortly		
Compliance Against Provider Licence Conditions and Self-Certification 2021/22	ARC received the report for assurance, with changes since the document was last received highlighted.		Committee received the report and approved for advancement to Board. A change will be made at the request of Internal Audit to make it clear that the Health & Safety audit is still in progress.	Received at the extraordinary public June Board meeting
Received Outcome of Externally Facilitated Risk Review	External consultant, David Pilsbury, who was commissioned to complete a risk review of the Trust's systems processes, capability and capacity, provided a presentation on the key findings.	The review was positive about a number of areas and outlined areas of potential ongoing and future improvement for example around improving use of data; reviewing the point of escalation to CRR and Board level. The report will support the upcoming BAF review and work around reviewing risk appetite. It was confirmed the first meeting of the Risk Oversight Group is being put in place for late July/early August	The presentation and the full report will be presented to the Board in their June Development meeting	June Development session
Emergency Preparedness Resilience & Response (EPRR) Assurance Framework Update	ICBs (Integrated Care Boards) become legal bodies from 1st July 2022 which will make them Category 1 responders and will be expected to provide leadership in strategic co-ordination if there were to be a major incident. CPR standards – reverting to pre-pandemic requirement and expected to be similar to those in place in 2019.	The data protection security toolkit is almost complete.	Changes will be made to the new On-Call policy but this work has been paused whilst an options paper is considered by the Executive Team. NHS England is introducing a new Health and Command course that all staff with a command role must attend by December 2023, with 75% of staff having attended by March 23.	Following the Exex team decision, the policy will be completed, circulated for consultation, and submitted to PGG and ARC for approval. March 2023

	The Trust's self-assessment will be made available to the CQC (which is a new requirement) and may be required to provide evidence. Data protection security toolkit is almost complete.			
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Ratification of Decisions by Policy Governance Group	PGG met on the 13th May 2022 and they have put to ARC 2 policies for rectification: • Claims Policy - Work is being done with Capsticks • Accessing legal advice - Minor changes have been made to sign posting, and a flowchart has been added. A further review is to be in 6 months.	The policies detailed within the report had been through the governance process.	Committee received the report and endorsed the recommendations made within the report.	
Declarations of Interests, Gifts and Hospitality	Process has begun to call in declarations from relevant staff below Board level	In place for Board and Council of Governors. Procurement team declarations received (detail provided to Internal Audit which will close off an existing IA action).	Work underway to call in declarations below Board level – to be completed	End of Q2
Committee Annual Review of Effectiveness	Annual Review of effectiveness received – most feedback in the agree or strongly agree categories. Will support review of TORs and	The intention is for the self-effectiveness reviews for committees to take place early in Quarter 4 in 2022/23 to enable receipt of the Annual Committee reports at the beginning of Quarter 1 of the new financial	Work plan to be updated to receive self-effectiveness review in January 2023 and the Annual Report from the Committee in April.	Q4

	development of the Annual Report from the Committee to Board due at the next meeting of the committee.	year. .		

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **People Committee** **Date:** **12 July 2022** **Chair:** **Heather Smith**

KEY ITEMS DISCUSSED AT THE MEETING

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

Issue	Committee Update	Assurance Received	Action	Timescale
Supervision	Supervision rates below target.	70% completed compared to the 80% target.		
Mandatory training completion	Completion of mandatory training in safeguarding children, information governance and respect level 2 is not as expected.	Overall target reached.		

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
Health & Safety report – Q4	Violence and aggression at work hasn't progressed as expected.	Back on Health & Safety Committee agenda as new national guidance has been issued.	Further assurance asked for at future People Committee meetings and plan in place to address violence and aggression.	Update to September 2022 People Committee
Organisational Development Group – Update	- Very good progress with the OD action plan - Development of an OD action, impact, and assurance framework	Some actions are having a clear impact on performance indicators such as: - absence rate - casework statistics - positive shift in engagement revealed in the April People Pulse survey	There is work to do on team and talent development, and identifying risks associated with the progress.	Update to September 2022 People Committee

Terms of Reference review	Terms of Reference reviewed and presented to Committee for comment.	People Committee approved the draft.	To be submitted to July's Board meeting for final approval.	
Review of Committee effectiveness	Review completed.	Chair of the People Committee to reflect on the feedback received.	To be submitted to July's Board meeting for final approval.	

ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Staff Health & Wellbeing	Good progress with the health and well-being actions and key indicators, e.g., absent rates are improving.	The Tier two group has very good oversight of the health and wellbeing initiatives and is having a positive impact.		
	The workplace wellbeing offer has been well received by staff.	-Positive impact on staff satisfaction scores - Is part of the overall offer of health and well-being.		

POSITIVE ALERTS (Detail here any areas of positive improvement that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
IPQR	Although sickness is still a concern, there are some positive indications of improvements in this.	- Month on month data is slightly improved. - Short term has increased, long term decreased. - Other organisations have reported continuous increase.		
	Turnover has reduced and recruitment has improved, enabling a steady state in terms of overall headcount.			
Casework Tracker	There is very good progress with the management of Employee Relations cases.	- The number of cases is reducing and are at the lowest on record - Average case length has now declined to SHSC's target level		

Quality Assurance Committee (QAC)

CONFIRMED Minutes of the Quality Assurance Committee held on Wednesday 11 May 2022 at 10am. Members accessed via Microsoft Teams Meeting.

Present: (Members)	Heather Smith, Non-Executive Director (Chair)	CHAIR
	Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director	OF
	Beverley Murphy, Executive Director of Nursing, Professions, and Operations	BM
	Professor Brendan Stone, Associate Non-Executive Director	BS
	Salli Midgley, Director of Quality	SM
	Dr Mike Hunter, Executive Medical Director	MH
In Attendance:	Anne Dray, Non-Executive Director (observer)	AD
	Tania Baxter, Head of Clinical Governance	TB
	Neil Robertson, Director of Operations and Transformation	NR
	Christopher Wood, Head of Nursing	CW
	Dr Jonathan Mitchell, Clinical Director	JM
	Dr Robert Verity, Clinical Director	RV
	Samantha Crosby, Health and Safety Manager	SC
	Vin Lewin, Patient Safety Specialist	VL
	Zoe Sibeko, Head of PMO	ZS
	Dr Dana Wood, Interim IPC Lead	DW
	Nicholas Bell, Director of Research Development	NB
	Maggie Sherlock, NHS Sheffield Clinical Commissioning Group (CCG)	MS
	Linda Wilkinson, Director of Psychological Services & Consultant Clinical Psychologist	LW
	Amber Wild, Corporate Assurance Officer	AW
	Francesca O'Brine, Corporate Assurance Officer, (Minutes)	FO

Apologies: Richard Mills, Non-Executive Director
Deborah Lawrenson, Director of Corporate Governance
Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services
Sue Barnitt, Head of Clinical Quality
Alun Windle, NHS Sheffield Clinical Commissioning Group (CCG)

Minute Ref	Item	Action
QAC22/05/307	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
QAC22/05/308	**Declarations of Interest** Professor Brendan Stone noted his Board membership of Sheffield Flourish.	
QAC22/05/309	**Minutes of the meeting held on 13 April 2022** The minutes of the meeting held on 13 April 2022 were agreed as an accurate record.	
QAC22/05/310	**Matters Arising** These items are for clarification. A full report was not required.	

a) **Learning Disability Service Transformation – timeline for implementation of a new intensive community support service**
Dr Jonathan Mitchell presented this timeline to the Committee for assurance.

The models will be finished by end of May 2022. They then go to the Learning Disability Board and Transformation Board. JM to bring back to QAC and Board of Directors (BoD) - month to be confirmed. ACTION JM

BM noted:

- Modelling outcome and discussions may have implications for staff team
- Highlight to People Committee (PC) or Joint Consultative Forum (JCF)

MH added:

- Business case could not be signed off by end of May 2022 – timeline to be amended
- Need strategic approach to work through Trust 's contribution to what the system requires

The Committee were assured by the timeline presented and will receive the model once it has been through the Learning Disability and Transformation Boards.

b) **South Recovery Team CPA Reviews – Recovery Plan**
Christopher Wood and Dr Robert Verity presented this update to the Committee for assurance. To also be discussed under IPQR item.

BM noted:

- Plan for resolutions required for full assurance
- CW to work on plan and trajectory with Paul Nicholson, General Manager Adult Community Services. Performance Framework to be referenced ACTION CW

The Committee were assured by the update and detail.

c) **Internal Audit Waiting List Data Quality – SPA/EWS Waiting List Data Quality Management Recovery Plan**
Christopher Wood and Dr Robert Verity presented this update to the Committee for assurance.

The Chair told the Committee the reason for the report was to keep track of the progress of audits.

Final plan to go to QAC in August 2022 with impact and narrative for assurance. Report to include information provided by SM on the involvement of Service Users and Carers.

The Committee were assured by the update on progress.

d) **Prevention of Future Deaths March 2022 Response to HM Coroner/Regulation 28**

	Dr Robert Verity presented this report to the Committee for assurance. Committee amendments: • Eliminating wait for assessments – to be answered fully • Improve level of empathy in letter introduction **The Committee were assured by the response and approved the letter with the amendments requested.**	
QAC22/05/311	**Action Log** Committee received the action log for information and noted that all actions had been completed.	
QAC22/05/312	**Back to Good Reporting** Committee received the report from Salli Midgley for assurance and endorsement. Key risks: • Supervision, reviewing incidents, and Mandatory Training – addressing as a team to support action owner to close actions • Tendable – progress and confidence in its delivery Progress made should be celebrated. BM addressed the Committee: • Tendable has the potential to unlock assurance questions • What are the barriers to using platform to its full potential? SM responded: • Plan to review Tendable through Clinical Quality and Safety Group Matters Arising report regarding review of Tendable to QAC after Clinical Quality and Safety Group has met. Date to be confirmed. SM confirmed for BS: • Amanda Jones, Chief Allied Health Professional (AHP) leads on safe and therapeutic environments for care • Trust contracts for specific art therapy projects • SM to put BS in touch with Amanda Jones to discuss work MH questioned: • How can the Committee be assured of the audit of evidence? • Assurance required that the plan is being delivered in a sustainable and embedded way SM answered: • Delivery Group sits under Board • Group works with action owners to understand requirements and risks to delivery • Once actions closed there is review of evidence and final assurance check • Range of Tier 2 Groups monitor improvements and continuation of assurance	ACTION SM

	The Chair noted: • Confident actions are managed and tracked • Assurance needed from future reports - longevity of actions, impact, actions being embedded OF reflected: • Unforeseen circumstances of ill health – good to look outside immediate team to mitigate risk • Delayed leaflet – lack of urgency • Good innovation to consider evening supervision groups • Important to investigate reasons behind sickness absence - often stress-related **Committee received the report and noted the persistent concerns raised and the progress made. More information needed on Tendable. Supervision and Mandatory Training have been identified as risks for too long. Alert to Board – concerns over closing of the loop around assurance process caused by stress on the system. QAC has asked for more detail on how that is working in practice.**	
QAC22/05/313	**Integrated Performance and Quality Report (IPQR)** Committee received the report from Beverley Murphy for assurance. At the April 2022 QAC, Non-Executive Director, Richard Mills, questioned incomplete data from Community Teams. BM responded: There are several small teams that collect data in different ways. Work is underway to establish the most efficient way to collate and present this data. Key risks remain unchanged: • Achieving flow in Acute Adult Inpatient system • CPA Annual Review completion in South Recovery Team • Waiting times for routine assessment – EWS/SPA Proposal for long-standing risks: • Next report - Clinical Services to provide realistic trajectory for change • State if change is considered a possibility or not Positives to note: • G1 ward - reduction in seclusion • Older adults - reduction in length of stay • Rehabilitation and Specialist (R&S) Services - supervision compliance Future agenda item for QAC July 2022 – Substance Misuse Services. Contract expansion in place – QAC to review potential impact on quality. Report now details each individual who did not receive 72 Hour Follow Up. Data quality now improved. BM confirmed for OF regarding the medication incident detailed in the report: • Open reporting culture is being encouraged • Working with Pharmacy to ensure sufficient training	

	MH expressed concern that demand for Memory Services waits could become a new risk. NR responded: • Not new, has been building over time • Isolation caused by the pandemic impacted diagnosis • Service uses *doctor providing diagnosis* approach. Nationally – multi-disciplinary team member makes diagnosis • Reviewing process is a priority. Independent review organised • Service to receive investment later in 2022 to increase staff capacity MH questioned how the Trust would know if there were issues emerging within other services. NR responded: • Trust monitoring all services • Older adults community mental health teams – potential issues arising from discharging patients to create flow RV confirmed for OF: • Sexual incidences on Stanage Ward relates to patients to staff • Male ward, female workforce • Trying to report every incident and improve reporting • Included in Health and Safety Report BM added: • Mechanical restraints - every incident is reviewed • Greater understanding and lower bar for reporting • Will always let CQC know, including where there is good clinical reason **Committee received the report. Recurrent risks must be alerted to the Board. Waiting times (GDC and SAANs) must also still be acknowledged so the Committee remains alert to them. The Chair noted the positives and good results, and congratulated the teams involved.**	
QAC22/05/314	**Community Service Programme Update** Committee received the report from Neil Robertson for assurance. Report summary: • Good leadership – clinical model and positive staff engagement • Next steps – structure to deliver the model • SPA/EWS – moved from Community Mental Health Programme to new Primary Care Mental Health Board • Primary Care Mental Health Board – first meeting today • SPA/EWS - good clinical model, agile, consider how it is delivered • Termination of Social Care contract - outlined timeline of process • Contract – 12 months' notice. Questions and risks identified BS commented: • Fragmented experience of care – how can we know the impact on Service Users? • Community Teams project – how are staff feeling? NR noted: • Staff have contributed at every level • Worked hard to hear and respond to staff concerns • Primary Care Mental Health developments – critical phase for staff	

	engagement CW added: • Growing confidence within teams that Organisation has learnt and adapted • Adopting an agile approach BM requested an alternative phrase to *recovery check-up* is agreed with Service Users, that infers a partnership approach. **Committee received the report. The Chair will discuss at People Committee. The Committee would like to see what the model will look like and feel like for a Service User. Continue with the good work. Impact and comparison data will be required.**	
QAC22/05/315	**Health and Safety Quarter 4 Report** Committee received the report from Samantha Crosby for assurance. BM told the Committee: • RIDDOR – key risk • Clear link needed between the team that manages Ulysses and the Health and Safety Manager • Understanding of actions and delivery timeline required SC confirmed for OF: • Fire doors – long-standing issues, business case submitted • Lone-working – will review risk assessment and report back • Falls older adults – process on floor mats unclear, will link with the lead on Falls • Physical Health Report speaks to Falls **Committee received the report and shared the frustration around lack of progress with fire doors. Escalate to Trust Board as an alert. Progress is also needed with RIDDOR. Legal framework remains amber - highlight which ones are anticipated to go green.**	
QAC22/05/316	**Physical Health Quarter 4 Report** Committee received the report from Salli Midgley on behalf of Sue Barnitt for assurance. Risk update: • Gap in Falls leadership. Physical Health lead nurse has withdrawn • Moving and Handling Back Care adviser needed SM told JM: • Physiotherapy will go through CCG • SHSC physiotherapy will be inputted into inpatient wards SM confirmed for OF: • New Falls form – not previously aligned to best practice guidance, work ongoing • Bed Rails Policy – knowledge gap exists, potential collaboration with Sheffield Teaching Hospitals, active discussions with Physical Health Group Baseline work such as policy and strategy were completed last year. There are	

	areas of good practice - recovery team checks around the physical health of people with severe mental illness. Not demonstrated clearly in report. JM summarised: There was a long way to go, and basics were put in place. Some good examples of development – these need to be embedded and evaluated. Consistency is required to show improvement. RV added: Stanage safety huddle – physical health care of patients was the first discussion. Monitoring is improving across wards. **Committee received the report. Need to be alert to risks around recruitment and Tendable. Good that Trust is looking externally for support. Physical Health is on the Corporate Risk Register – need to ensure that improvement is keenly monitored.**	
QAC22/05/317	**Mortality and Learning from Deaths Quarter 4 Report** Committee received the report from Vin Lewin for assurance. To note: • Higher reviews than deaths in each month – includes reviews of discharges without contact within six months • All deaths of individuals with a Learning Disability reviewed and submitted to LeDer Process • Better Tomorrow Project – dashboard not ready, national issue MH commented: • Pandemic was a stressor in the system - provides information on vulnerabilities across teams • Homeless Assessment and Support Team – reason for change in number of deaths? Analysis and understanding needed to make greater impact through learning OF: Equality, diversity, and inclusion (EDI) analysis is missing on page 3. BM added: • Committee requires specific time frames. Matter Arising – Better Tomorrow timeline • Consideration - difference reviews are making to process is not clear SM: Annual report needs to reflect national learning from LeDer and national work around mortality. **Committee received the report and advised on where assurance is needed in future reports:** • **Trend data linking into national learning** • **Analysis for understanding of impact and impact on practice** • **EDI data to get a sense of impact on different groups** • **Better Tomorrow – clarity on progress**	ACTION VL
QAC22/05/318	**Quality and Equality Impact Assessments (QEIA) Quarter 4 Report** Committee received the report from Zoe Sibeko for assurance. Report summary: • Panel received and approved two QEIAs	

	• EPR QEIA returned to provide further understanding of impact • Closure of Health Based Place of Safety (HBPoS) QEIA - ensure safe staffing levels across acute wards • Quality measures – majority low impact, EPR medium (finances), HBPoS medium (staff morale, reputation) • Work commencing on CIP Improvement Plan – increase in QEIAs BS queried: • HBPoS details on mitigations not clear in report The Chair - Matters Arising for next meeting to provide detail. BM told the Committee: • Future CIPs – if mitigations do not address potential quality impact, panel will not approve them **Committee received the report and were assured by the process. To increase assurance levels the Committee requires reports to include more information on mitigations.**	ACTION ZS
QAC22/05/319	**SHSC Response to Sheffield Adult Crisis Pathway Review** Committee received the report from Dr Robert Verity and Christopher Wood for information. BS asked what the target date is for the Task and Finish Group to map current helpline provision. What will be achieved by then? Significant risk – reaching the right service in a timely way. CW responded: • Single helpline provision • Mapping exercise outcome – recommendations to move forward • Systems are very complex, current system is the best version • Risk arises from complexity of system • Request to improve and enhance system • Task and Finish Group – gain perspective of experience of contacting services during crisis over 24-hour period NR added: • System issue • CCG role and responsibility • Will be a partnership approach BM: Bring back to Committee to close loop on actions proposed and feedback on progress. Date to be confirmed. OF noted that the name *Urgent Helpline* is misleading. NR told the Committee: • Review was triggered by system issues Trust was sighted on • Catalyst to move forward • Note of caution – possible tiered future provision needed due to recruitment challenges **Committee received the report and recognised this piece of work as**	ACTION CW

	important and valuable. QAC were interested in progress and requested feedback on that at an appropriate time.	
QAC22/05/320	**Draft Annual Quality Account 2021/22 (including Quarter 4 Report)** Committee received the draft report from Tania Baxter for assurance and feedback. Report timeline: • Comments deadline - close of 13th May 2022 • Revised version including comments to be sent to QAC members by 20th May 2022 • External providers (CCG, Sheffield Health Watch, Local Authority) comment by 6th June 2022 • Final draft to QAC June 2022 meeting • Final version submitted to June 2022 BoD meeting • Published on Trust website by 30th June 2022 **Committee received the draft report and timeline. QAC members to submit comments by Friday 13th May 2022.**	
QAC22/05/321	**Annual Compliance – Eliminating Mixed Sex Accommodation (EMSA)** Committee received the report from Vin Lewin for assurance. Report summary: • Trust is compliant against standards • Monitored daily • Can escalate easily via Daily Safety Incident Huddle • Link sexual safety incidents into Sexual Safety Group and Safeguarding Team • Development of Standard Operating Procedure underway – transfer of sexually vulnerable patients between single sex accommodation • All sexual safety incidents were reviewed, and action taken **Committee received and approved the report and recommended it to Board.**	
QAC22/05/322	**Research, Innovation, Effectiveness, and Improvement Group (RIEIG) Report** Committee received the report from Nicholas Bell for assurance. Report summary: • Strategy now approved by Board • Implementation plan underway – to QAC in July 2022 • Investment requests in progress • Standards met • Clinical Effectiveness Audit Plan approved at QAC April 2022 BS asked for consideration of monitoring a broader demographic. To include socioeconomic status, for example. NB to look into this. NB confirmed for MH: • Implementation plan will focus on all areas of the strategy • Clinical effectiveness across SHSC - network of 100 research champions could also be effectiveness champions **Committee received the report and noted assurance that plans are on track.**	

	The strategy implementation plan will be brought to QAC July 2022.	
QAC22/05/323	**Infection, Prevention, and Control (IPC) Committee: Summary of alerts, assurances, and advice from Tier 2 group April 2022** Committee received the report from Dana Wood for assurance. Key risks: • Sharps management – issues continue • Waste segregation practices – risk to Organisation (prosecution potential) not staff BS told the Committee that the report gives an alert, assure, advise oversight across the whole IPC agenda. **Committee received the report and noted good assurance for the Board. There is a strong grasp of the key risks, the triangulation of those, and actions to address them.**	
QAC22/05/324	**Quality Related Policies** **Policy Governance – Ratification of Decisions by PGG** Committee received the report from Amber Wild on behalf of Deborah Lawrenson for review and ratification. The policies detailed within the report had been through the governance process and the Committee were asked to ratify the recommendations. The Transition of Young People from CAMHs to Adult Mental Health Services Protocol has now been updated and signed off at Executive level. **Committee received the report and approved the recommendations.**	
QAC22/05/325	**Board Assurance Framework (BAF)** Committee received the report from Amber Wild on behalf of Deborah Lawrenson for assurance. Corporate risk and BAF Risk Review is underway. Report to Audit and Risk Committee in June 2022. Committee agreed to discuss the BAF in detail after the review has taken place. **Committee received the report and approved the recommendations.**	
QAC22/05/326	**Corporate Risk Register (CRR)** Committee received the report from Amber Wild on behalf of Deborah Lawrenson for assurance. Committee agreed to discuss the CRR in detail after the Risk Review has taken place. The Chair told the Committee that the discussion should focus on what improvement is required to change risk ratings. SM advised that risks relating to physical health, Omicron, and complaints have been closed since the report was circulated. **Committee received the report and approved the recommendations.**	
QAC22/05/327	**Emerging Quality Risks** Committee received the verbal report from Beverley Murphy for assurance.	

	Working with Clinical Directorate leadership to discuss how certain patients are presenting and any difficulty in meeting their needs. There is still one person in long-term segregation. More information to be provided to QAC in the coming months. Service Users recognised in the IPQR as having a longer length of stay are reviewed. This should be identified better in the IPQR for clarity. Instability in ward leadership in two acute wards. Working closely with service leaders to address this. Risk is being managed but noted for QAC awareness. **Committee received the report and noted the information shared.**	
QAC22/05/328	**Any Other Business** The Committee discussed the Ockenden Report. SM is reviewing what the Trust needs to learn and consider from this report. An assessment template has been produced. Questions and challenges were selected for people and Committees to answer. QAC to consider: • Should QAC receive a report on serious incidents each quarter with detail of the key issues for scrutiny, oversight, and transparency? • Is QAC listening to Service Users and carers? Is there a senior lived experience director who feeds directly into the Board? FO to send these questions to Committee members giving a one-week deadline for response. Collate and submit responses to BM and SM. SM: full report to QAC July 2022 to give time for a sufficient response.	ACTION FO
QAC22/05/329	**Annual Work Plan** Committee received the report from Beverley Murphy. The report proposes a new Committee Work Plan. The Committee understands that as the Trust went into Special Measures QAC would need to meet monthly and the agenda would be challenging. The change from System Oversight Framework 4 to 3 gives the opportunity to consider working differently going forward. The paper formalises the discussions the Committee has been having. Substantially changed Work Plan to come back to June 2022 QAC. **Committee approved the proposal.** **Alert, Assure & Advise: Significant issues to report to the Board of Directors** **Alert:** • Continue to have persistent and not fully mitigated risks evident in IPQR (flow, CPA reviews in South, waiting times). Requested improvement trajectories and alternative approaches. Higher level Board action may be necessary. This should help and support teams to make the impact everyone is striving to achieve	

- Persistent Health and Safety risks (RIDDOR and fire door safety)
- Issues around Back to Good closure of actions to be aware of

Assure:

- Good progress with several issues within the IPQR
- Trust achieved compliance with EMSA
- IPC – strong grasp of keys risks and issues, the triangulation of those, and actions to address them

Advise:

- Community Transformation Programme is on track. Further output expected going forward. Working in a partnership manner
- QEIA now implemented in a systematic way. Requested continuous review of quality of mitigations
- Sheffield Adult Crisis Pathway - SHSC responded. Valuable and important piece of work. Update requested as work progresses
- Mortality report led to further information about the impact of lessons learnt, trends, and EDI analysis
- Draft Quality Account received, final draft to QAC in June 2022
- RIEIG report received – plans are on track. Intent to be more cognisant of the participant group noted, bearing in mind issues relating to inclusion, and to more clearly articulate clinical effectiveness
- Committee continues to challenge itself around the Ockenden Report and consider implications on the Trust
- Physical Health – still making progress but there is not yet consistency of action across the Trust. Plans in place to address this. Recruitment challenges and issues with the use of Tendable hindering progress, more detail requested

Changes in level of assurance - Board Assurance Framework
No changes reported.

Meeting Effectiveness
The Chair reflected on the meeting as being effective in the context of challenges to raise the bar within a safe and supportive environment. 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 8 June 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 8 June 2022 at 10am. Members accessed via Microsoft Teams Meeting.

Present: (Members)	Heather Smith, Non-Executive Director (Chair)	CHAIR
	Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director	OF
	Professor Brendan Stone, Associate Non-Executive Director	BS
	Salli Midgley, Director of Quality	SM
In Attendance:	Tania Baxter, Head of Clinical Governance	TB
	Caroline Parry, Director of People (until 10:40am)	CP
	Helen Crimlisk, Deputy Medical Director	HC
	Neil Robertson, Director of Operations and Transformation	NR
	Dr Jonathan Mitchell, Clinical Director	JM
	Teresa Clayton, Head of Experience	TC
	Hester Litten, Interim Head of Safeguarding	HL
	Adele Eckhardt, Care Standards Lead	AE
	Shrewti Moerman, Pharmacist	Sh.M
	Caroline Greenough, Deputy Lead AHP	CG
	Vin Lewin, Patient Safety Specialist	VL
	Zoe Sibeko, Head of PMO	ZS
	Sue Barnitt, Head of Clinical Quality Standards	SB
	Adam Butcher, Governor	AB
	Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services	Si.B
	Amber Wild, Corporate Assurance Officer	AW
	Francesca O'Brine, Corporate Assurance Officer, (Minutes)	FO

Apologies: Beverley Murphy, Executive Director of Nursing, Professions, and Operations
Linda Wilkinson, Director of Psychological Services & Consultant Clinical Psychologist
Richard Mills, Non-Executive Director
Maggie Sherlock, NHS Sheffield Clinical Commissioning Group (CCG)
Dr Robert Verity, Clinical Director
Dr Mike Hunter, Executive Medical Director
Deborah Lawrenson, Director of Corporate Governance
Christopher Wood, Head of Nursing
Fleur Blakeman, NHSEI

Minute Ref	Item	Action
QAC22/06/330	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
QAC22/06/331	**Declarations of Interest** Professor Brendan Stone noted his Board membership of Sheffield Flourish.	
QAC22/06/332	**Minutes of the meeting held on 11 May 2022** The minutes of the meeting held on 11 May 2022 were agreed as an accurate record.	

QAC22/06/333	**Matters Arising** These items are for clarification. A full report was not required. **a) STH CQC Report: impact on quality issues around mental health and learning disabilities** Sue Barnitt presented this update to the Committee for assurance, outlining the work we are doing with STH in support of their response to CQC issues. To note: • Lead for Restrictive Practice, Lorena Cain, supporting STH with training and resources JM added: • Important to acknowledge overlap between STH and SHSC's needs and skills • STH also need to develop their own specific training programme SM noted for BS: • Work under way nationally to review implementation of Mental Health Standards with amendments for acute hospitals • Meeting with STH leaders to consider undertaking pilot OF questioned if there could be a business case for shared funding. **The Committee were assured by the report received.** **b) Better Tomorrow Project Dashboard: timeline for implementation** Vin Lewin provided this timeline to the Committee for assurance. (Item received at 11am with Item 9) **The Committee were given further assured by the timeline and that there is an implementation plan in place. Progress will be reported on in future meetings.** **c) QEIA: detail on mitigations for the closure of the Health Based Place of Safety (HBPoS)** Zoe Sibeko presented this to the Committee for assurance. Summary: • All risks mitigated, good understanding of risks • Proactively reviewing potential risk areas • Planning – utilisation, capacity, and Standard Operating Procedure • Data concerning experience using HBPoS as a bed – to be reported through IPQRs, then Clinical Quality and Safety Group **The Committee were assured by the report received and requested that risk alerts are brought to this Committee should they occur.** **d) Tendable Implementation Update** Salli Midgley presented this to the Committee for assurance. To note: • Project Plan with timescales to be finalised by end of week	

	• Request to report on this quarterly through Clinical Quality and Safety Group Report • Linked to regulatory framework, CQC Back to Good – quality indicators • Audits around Restrictive Practice are key in order to provide full assurance • Aligns with ambitions to be a good to outstanding organisation • Quality Assurance and Quality Improvement is a whole team effort, hence the introduction of this system which involves a team approach to audit/checks JM added: • Labour intensive but important • New Electronic Patient Record (EPR) will eventually help staff improve performance with completion and quality. **The Committee were assured by the report received.**	
QAC22/06/334	**Action Log** Committee received the action log for information. The Chair noted that all actions were complete.	
QAC22/06/335	**Back to Good Reporting** Committee received the report from Salli Midgley for assurance and endorsement. SM clarified for OF: • SPA leaflet now available • Doors delayed – highly specialist door, Estates investigating alternative suppliers **Committee received the report and noted strong assurance that progress is being made. The plan is closely monitored for quality impact, and this is improving. Requested that reports focus on this more in future.** a) Supervision Quality and Staff Experience (Item taken at 10:40am) Committee received the report from Simon Barnitt for assurance, on behalf of Linda Wilkinson. To note: • Went to People Committee in May 2022 • There is an improvement in number of supervision sessions taking place and some small improvements to perceived value/quality over the year (however, the sample size was small) • Sense that staff were unclear of differentiation between manager and clinical supervision • Recommendation for directorate review of supervision JM added: • The results do not provide enough insight • A different approach to gathering staff feedback is needed - focus groups suggested • Some areas have good rates of supervision • Understanding of supervision is different across professions **Committee received the report and noted that it is good more supervision is**	

	happening and that there is also a focus on the quality of supervision, although there is clearly work to be done to improve this. Committee supported the idea of focus groups and agreed clarity is needed around terminology. Simon Barnitt will feedback to Linda Wilkinson.	ACTION: SB to feedback to LW
QAC22/06/336	**Integrated Performance and Quality Report (IPQR)** Committee received the report from Salli Midgley for assurance. (Item taken at 10:45am) Chair: • Same top-level risks remain and are proving difficult to move – discussed within recovery plans (see later) • Positives: o Decreasing length of stay older adult wards and Forest Close o Waiting times in Early Intervention meeting improvement targets o 72 hr follow up by community teams improving o IAPT strong performance – waiting times and recovery rate o Falls decreasing on G1 o Restrictive Practice on G1 and Specialist Services o Low number of seclusions across all wards Regarding the patient on Maple Ward, SM confirmed for OF: • Service user is well-known to the Trust • Patient has had robust reviews • Trust continues to endeavour to support improvement in their mental health **Committee received the report, acknowledged the risks to be alerted to Board and were assured by the ongoing positives and progress. The Chair thanked those involved for their work. The Chair requested that future reports highlight 'outliers' e.g., those with long LoS as these can be hidden within averaged data.** **a) Recovery Plan: Unacceptable waiting time to access SPA/EWS** Committee received the report from Neil Robertson for assurance. (Recovery Plan items taken at 10:25am) Report summary: • Issue since 2017 - 800-900 people waiting list • No trajectory included yet because aligning and integrating SPA/EWS with Primary Care Mental Health team • September report will include trajectory • Opportunity to combine resources and utilise further funding **b) Recovery Plan: Inappropriate Out of Area Placements** Committee received the report from Neil Robertson for assurance. Report summary: • Report speaks to robust flow plan to prevent delayed discharges and reduce reliance on beds • Trajectory to March 2023 outlined. Two-year project • Good progress being made with flow plan	ACTION: BM

	c) Recovery Plan: Waiting time for allocation to a care coordinator in recovery services Committee received the report from Neil Robertson for assurance. Risks and mitigations: • Dependent on recruitment in terms of allocating to care coordinator • Risk remains around wait numbers • Review of structure as part of Community Team Clinical Model required • Care coordination opportunity: dismantled as part of abolition of CPA, consider using workforce differently • Primary Care Mental Health development BS noted: • Scale of SPA/EWS transformation should not be underestimated • Risks must be headlined to Board • Similar recruitment risks pertain to SPA/EWS • Must remain vigilant and understand impact on quality of care • Change is challenging for service users and staff. SM added: • Reports do not cover patient experience and impact • Must always be embedded in recovery plans **Committee received the report and noted the amount of work underway. The report was found to be transparent. Patient focus should be embedded into future reports. Board to be alerted to risks, including the impact on staff of this significant change programme. Whilst assured about intent of the improvement plans, it was not yet possible to gain assurance about impact until this is evidenced. These risks remain consistent and of concern.**	ACTION: NR
QAC22/06/337	**Lived Experience and Co-Production Assurance Group Q4 Triple A Report and supporting slides** Committee received the report from Teresa Clayton for assurance. Salli Midgley and Adam Butcher have taken over the chairing of the group. BS noted: • Quality of experience survey – important way to understand the experience of service users • Mandated to do Friends and Family tests – should this data be less prominent in reports? • More emphasis should be placed on surveys and feedback from community settings • Pool of potential volunteers – network of Sheffield university students with experience of using mental health services SM added: • Trust is not getting the best out of Care Opinion – putting a timeline on this for improvement, big piece of work • Co-production standards – acknowledge good work, more to be done • Committed to growing volunteer network this year	

	HC told the Committee: • Narrative data across the wider element of the Trust – collate and make more visible • Narrative data currently collected could go to Care Opinion via volunteers and staff • Good Friends and Family rates – could link to Care Opinion and EPR • Not explored all volunteer options – students, Trust alumni staff, advertising roles • Recruitment of volunteers links to other strategic aims such as workforce **Committee received the report and noted significant progress being made with the strategy. Productive discussion around the ways of bringing experience to the forefront and the potential use of volunteers.**	
QAC22/06/338	**Clinical Quality and Safety Group: Quarter 4 Reporting** Committee received the report from Vin Lewin for assurance. This group will be looking at the implementation plan of the Quality Strategy. Learning Lessons Report: • Preparing for transition to the Patient Safety Incident Response Framework (PSIRF) • PSIRF document to be launched June 2022, implementation from 2023 • Engaging with patient safety partners • Benchmarking work with Rotherham, Doncaster, and South Humber NHS Foundation Trust - more work to do SM added: • Report format and style evolving to be more meaningful for staff **Committee received the report and took assurance from the significant amount of work underway to address patient safety issues. The Clinical Quality and Safety Group report was useful and gave assurance of what is covered within that team.**	
QAC22/06/339	**Medicines Safety Quarterly Report Q4** Committee received the report from Shrewti Moerman for assurance, on behalf of Chief Pharmacist, Abiola Allinson. Risks and mitigations: • Reduction in incidences, Medicines Management continues to be highest • Fridge monitoring – positive downward trajectory, measures working • Stock discrepancies controlled drugs – progress mixed, culture change will take time • Administration errors – working well with nursing team, 3 Task and Finish groups • FP10s – annual audit shows improvement, no incidences, plan to close action HC noted for future reports: • Trends to be made clearer • Need to benchmark against other Trusts, locally or nationally OF was uncomfortable with the continuously reported medication incidences. Benchmarking would be useful to give the Committee some perspective.	

	SM reiterated the need for patient experience and impact on service users to be included within all reports. Sh.M: • Medicines Safety meetings are conducted with the North Mental Health Trusts. Meeting today, will discuss future benchmarking **Committee received the report and acknowledged that attention and hard work has made improvements. Comparisons are required in future reports to understand the level of assurance the reports are giving. Report to include patient experience.**	ACTION: Sh.M
QAC22/06/340	**Corporate Safeguarding Team Q4 Report and Safeguarding Committee 3A Report** Committee received the report from Hester Litten for assurance. Report summary: • Children's' Safeguarding Training – under compliance, working to target areas and support teams • Adults and Prevent Training - increasing each month, aiming for compliance by December 2022 • Safeguarding Supervision acute and PICU wards – some training delayed, possibly due to staffing level challenges • Good feedback on Section 11 and Adult Safeguarding Self-Assessment • Accountability meeting – transparent about challenges and progression made • National recognition from Safeguarding lead around partnership working • Delegated duties and desegregation from Sheffield City Council – discussed at team away day **Committee received the report and gained significant assurance that considerable progress is being made and that the Trust is demonstrating some elements of best practice.**	
QAC22/06/341	**Board Visits Quarterly Report** Committee received the report from Adele Eckhardt for assurance. Report summary: • 11 visits over the last quarter • Common issues – recruitment and staffing • Positive feedback – pathways and partnership working, staff keenness for co-production and sharing good practice and learning • Challenges – timeliness of feedback forms to staff and service users from Board, cancellation monitoring improved • Risks unchanged – ineffective management of process, impacts on transparent culture, not being sighted on challenges of front-line staff **Committee received the report and noted how valuable the visits are. The feedback loop is evident and improving, and the Trust needs to continue to support staff as much as possible.**	
QAC22/06/342	**Annual Quality Account 2021/22 – Draft** Committee received the report from Tania Baxter for assurance and approval. Timeline: • Report is out for formal consultation – CCG, Scrutiny and Overview	

	Committee, and Sheffield Health Watch • Comments to be included in final version • June 2022 Board for final approval • QAC comments due by end of week SM noted for next year's report: • Develop report to be a more inclusive process • Develop organisational report for everybody to consider **Committee received the report and noted the timeline for the account.**	
QAC22/06/343	**Cost Improvement Plans Programme - QEIA** Committee received the report from Zoe Sibeko for assurance, on behalf of Director of Strategy, Pat Keeling. (Item taken at 12pm) • Quality impact assessments undertaken for CIP Programmes • Targets to achieve over a two-year period • New approach – three core areas of focus: Out of Area Placements Project, reduction of agency and bank staff, and an efficiencies workstream • New delivery and governance structures, projects initiated **Committee received the report and were assured of the focus on quality and impact on service users as well as being finance driven.**	
QAC22/06/344	**Quality Related Policies** **Policy Governance – Ratification of Decisions by PGG** The Chair informed the Group that they were not quorate for this item. Quoracy is required to approve the recommendations in the report. FO to circulate the report to the Committee via email after the meeting for ratification. **Post meeting note: Committee received the report via email and approved the recommendations.**	ACTION FO
QAC22/06/345	**Emerging Quality Risks** Committee received the verbal report from Salli Midgley. The Flash Report around an alleged domestic homicide was highlighted to the Committee. **Committee received the report and noted the information shared.**	
QAC22/06/346	**Any Other Business** The Chair notified the Committee that the QAC Self-Assessment Questionnaire which informs the Annual Report on Committee Effectiveness will be circulated via email following the meeting. Committee were asked to complete it and return it by the deadline detailed within the email. FO to circulate the questionnaire and collate the results for the report.	ACTION FO
QAC22/06/347	**Annual Work Plan** Committee received the new work plan from Salli Midgley for approval. (Item taken at 11:45am)	

Aims:

- Reduce report writing burden and streamline content
- Ensure QAC receive assurance
- Effective use of Tier 2 groups
- Use of AAA reporting for focussed reporting
- Quarterly reports where work is stable and robust – change to detailed six-monthly reporting, interim quarterly AAA report, and slides on key risks
- Strategies – six-monthly

Feedback and questions are welcomed.

Committee comments:

- Direction welcomed - tension between assurance and burden of report writing acknowledged
- Patient experience could be a compulsory element of AAA report template
- Mechanism for picking up concerns in the interim required – Matters Arising to be utilised for this purpose
- Progress from previous report should be made clear, tweak template to facilitate this
- Reduction in report writing will allow for more work to be done in the interim and more visible progress

SM added:

- Work with report authors to support with new expectations

Chair:

- AAA reports from Tier 2 groups need more data in them for assurance

Committee approved the new work plan in principle and agreed to trial it.

Alert, Assure & Advise: Significant issues to report to the Board of Directors

Alert:

- We continue to try to manage the key risks as in previous months, some remain unchanged, others have worsened:
    - Flow, waiting times, allocation of care coordinators, and CPA reviews
    - Recovery plans received and QAC were assured of intent, but significant risks being carried regarding management of change required
    - QAC requested more information on the impact of those changes on service user experience

Assure:

- Better Tomorrow dashboard received
- Tendable implementation plan received
- Risk around the Health Based Place of Safety mitigated, challenge remains
- Back to Good action plan being closely monitored, more being done to audit impact

- Good progress with
    - Decreasing length of stay older adult wards and Forest Close
    - Waiting times in Early Intervention meeting improvement targets
    - 72 hr follow up by community teams improving
    - IAPT strong performance – waiting times and recovery rate
    - Falls decreasing on G1
    - Restrictive Practice on G1 and Specialist Services
    - Low number of seclusions across all wards

- Progress made with Lived Experience and Co-Production Strategy, QAC suggested ways for more visible narrative and use of volunteers to enhance work
- Medicines Safety – continues to be well monitored with clear actions for improvement. QAC asked for this to be elevated to include benchmarking, better trend analysis, and consideration of patient experience
- Safeguarding – significant assurance received, considerable progress made, demonstrating examples of best practice
- QEIA process in place to assess impact of CIPS

Advise:

- Supervision has improved overall in terms of volume and compliance, but quality issues and issues around clarity of what supervision entails remain. Focus groups recommended and need for more in-depth understanding of what supervision means for different groups
- Clinical Quality and Safety Group bringing together a variety of tools to align to quality improvement process, and this should have impact. Significant work underway to address patient safety issues through the Learning Lessons process
- Draft Quality Account received and commented on
- Board visits increasingly extensive and feedback loop and implementation is improved
- New QAC work plan agreed. More emphasis on Tier 2 groups, and looking at different ways of producing reports so that more time is spent on issues of most concern
- The Board is advised that there are good indications that the Trust is horizon scanning and considering its wider impact on the system e.g. the work being done with STH on their CQC report.

Changes in level of assurance - Board Assurance Framework
No changes reported, report to come to next QAC. There will be a reformulated set of risks as they have been under review.

Meeting Effectiveness
Patient experience was discussed and considered throughout the meeting. There are some areas that the Trust has made considerable progress on. 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 13 July 2022, 10am to 12:30pm
Format: MS Teams
Apologies to Francesca O'Brine, Corporate Assurance Officer
Francesca.O'Brine@shsc.nhs.uk

Audit and Risk Committee (ARC)

CONFIRMED Minutes of the Audit and Risk Committee held on Tuesday 19 April 2022 at 1:30pm. Members accessed via Microsoft Teams Meeting.

Present: (Members)
Anne Dray, Non-Executive Director (Chair)
Phillip Easthope, Executive Director of Finance
Richard Mills, Non-Executive Director

In Attendance:
Beverley Murphy, Executive Director of Nursing, Professions and Operations
Matt White, Deputy Director of Finance
Deborah Lawrenson, Director of Corporate Governance
Susan Rudd, Interim Director of Corporate Governance
Matthew Moore, Senior Manager, KPMG
Leanne Hawkes, Director, 360Assurance
Lianne Richards, Client Manager, 360Assurance
Chris Taylor, NHS Anti-Crime Specialist, 360Assurance
Francesca O'Brine, Corporate Assurance Officer, (Minutes)

Apologies: Rashpal Khangura, Director, KPMG

Minute Ref	Item	Action
	Welcome & Apologies The Chair welcomed everyone to the meeting and noted the apologies.	
ARC2022/04/147	**Declarations of Interest** None.	
ARC2022/04/148	**Minutes of the meeting held on 18 January 2022** The minutes of the meeting held on 18 January 2022 were agreed as an accurate record.	
ARC2022/04/149	**Matters Arising & Action Log** Members reviewed and agreed the action log. ARC2022/01/0140 – On agenda, mark as complete. ARC2022/01/0135 – On agenda, mark as complete. ARC2022/01/0144b – Committee agreed change of meeting date to 14/06/2022. May 2022 meeting not scheduled. Susan Rudd and Deborah Lawrenson confirmed that Non-Executive Director, Heather Smith to cover Richard Mills, ensuring quoracy. ARC2022/01/0129 – Report is on agenda and includes Covid Risk Register as an appendix. Mark as complete.	

	ARC2022/01/0134 – On agenda, mark as complete. ARC2021/07/091 – Susan Rudd confirmed the Board Assurance Framework (BAF) discussion is on the agenda for the June 2022 Board Development Session. Mark as complete.	
ARC2022/04/150	**360 Assurance Internal Audit Progress Report** Committee received the report from Lianne Richards for assurance. Report summary: • Four final reports issued - two Limited Assurance (Procurement and Waiting Lists), two Significant Assurance (Incident Management and Ledger and Financial Reporting) • Three ongoing audits from 2021/22 Plan - Health and Safety audit at draft report stage, testing in progress for recruitment and safeguarding review • 2022/23 Plan – preparatory work for Data Security and Protection Toolkit (DSPT) audit started, plan submitted to Committee for approval, will take forward Q1 work • Head of Internal Audit Opinion issued - Moderate Assurance overall • 2021/22 Follow Up Rate - 46% first Follow Up, 72% overall • Procurement Report - areas of non-compliance with policy, Head of Procurement working to strengthen arrangements. Declarations of Interest – needed for all tender exercises, actions agreed and taken forward • Waiting List Data Quality and Management Report (SPA/EWS) – wait for first contact, waiting lists for being triaged and initial assessment maintained on Insight. Follow Up lists managed on Excel spreadsheet – errors, blank fields, and duplication found, no guidance for list maintenance, waiting lists not held on Insight not reported in Trust waiting list data, no process for measuring and monitoring impact of waiting times on Service Users Beverley Murphy told the Committee that the Service Manager was active in vocalising concerns. Positive to see a demonstration of an open and transparent reporting culture. Phillip Easthope confirmed: • Verbal update on the Procurement Strategy at next Finance and Performance Committee (FPC) • Actions in place to improve Procurement – planning, purchase order usage, waivers • Result this year disappointing, should be aiming for 90% achievement of full Follow Up for Significant Assurance • Need oversight across Committees and operationally, and to strengthen governance Richard Mills added that the Committee needed to assure itself that internal audit reports go to the relevant Committee in time to influence them. Phillip Easthope confirmed the Procurement Audit was belatedly signed off at the beginning of 2022. Will go to next FPC. Timeline of audits is variable - flexibility between governance leads is required. Leanne Hawkes clarified:	

	• First Follow Up should be 75%, SHSC 46% • This year organisations still impacted by Covid19 and CQC inspections, so re-assessed as an overall rating of 90% gives Significant Assurance • SHSC overall rate is 72%, Moderate Assurance • Be clear of process to improve Deborah Lawrenson took an action to review what is required to ensure deadlines are met for the next period of time. Discuss with Phillip Easthope. **360Assurance Interim Head of Internal Audit Opinion** Committee received the report from Lianne Richards for assurance. Report Summary: • Moderate assurance overall – Strategic Risk Management (Moderate Assurance), individual audit assignments (Significant Assurance), Follow Up (Moderate Assurance) Phillip Easthope told the Committee: • Trust has improved on individual assignments, overall Strategic Risk Management remained the same • Trust should consider whether the rating reflects where the Organisation is today Leanne Hawkes noted: • Improvement is recognised, Trust is on a positive trajectory • BAF – regular reporting seen in year, more about the quality • Focus on - effective management of risk, closing actions, discussing content at Board **Committee received the report and agreed it was a fair reflection of the current position and the progress made.** **360Assurance 2022/23 Internal Audit Plan** Committee received the report from Lianne Richards for review. Report Summary: • Follows on from January 2022 ARC meeting paper • Phillip Easthope and Executive colleagues have prioritised list of potential audits • Appendix A1 - Full Audit Plan, Appendix A2 – Exclusions • 196 audit days Phillip Easthope added: • Scope of Risk Management piece to be finalised, changes will be minimal • Final number of days to be no more than 200 Lianne Richards confirmed that any changes will be highlighted to the Committee. **Committee approved the planned coverage.**	ACTION DL

	Draft Counter Fraud Work Plan 2022/23 Committee received the report from Chris Taylor for review. Report Summary: • Plan developed to comply with new Counter Fraud Standards • Items 6, 8 and 10 moved from amber to green ratings. Work completed on new Counter Fraud Authority (CFA) system, CLUE • One item remains red rated – Fraud Risk. Trust must now manage its own fraud risk in line with its own policy. Big piece of work, Trust will be supported. Reply to inherent risk assessment received – this will be reviewed, and rating updated Chris Taylor confirmed for the Chair: • The Plan included cyber/email risk - scored 20 • Continue to raise awareness because it will always be a risk Phillip Easthope added: • Trust to note the changing timing of DSPT to comply with national timescales, it's normally completed for Year End. We need to recognise the annual programme doesn't have assurance around DSPT this year. Board noted a gap in assurance re cyber security, so we need to consider how we are reporting to Board effectively. • Paper indicates still a work in progress working to new deadlines • Full assurance piece to July 2022 ARC **Committee noted the report for information and approved the Plan for 60 days.**	
ARC2022/04/151	**Committee noted receipt of the 360Assurance Internal Audit Charter for information. It is provided to the Committee annually alongside the Plan.**	
ARC2022/04/152	**Accounting Policies & Financial Reporting Manual 2021/22 Update** Committee received the report from Matt White for assurance, information, and approval. Report Summary: • Report details method and means of preparing the annual accounts • IFRS 16 to be considered – live from April 2022, before accounts prepared • No changes in preparation from previous year • Any changes will be brought to Committee with the final accounts **Committee approved the report.**	
ARC2022/04/153	**Annual Governance Statement 2021/22 First Draft** Committee received the report from Susan Rudd for review. Report Summary: • Based on the model as included in Foundation Trust Reporting Manual • Gaps remain, e.g., Information Governance, and to be included in next draft • Comments to go to new Director of Corporate Governance, Deborah Lawrenson and Head of Communications, Holly Cubitt by end of April 2022	

	• Next draft first week of May 2022 Beverley Murphy's job title to be corrected. **Committee received the report and noted the update.**	
ARC2022/04/154	**Preparation of Financial Accounts 2021/22 – Going Concern** Committee received the report from Matt White for approval. Report Summary: • Report formalises confirmation that accounts were prepared on a Going Concern basis • Minimal changes - some narrative amended, no directional changes **Committee approved the report and endorsed the recommendation to Board.**	
ARC2022/04/155	**Draft Accounts and Related Issues - Verbal** Committee received the verbal report from Matt White for assurance. Report Summary: • Deadline changed – caused difficulty in presenting draft accounts • First submission - c£1.3M surplus for this year, subject to audit and final checks • £1.3M is lower end of forecast. Full review, then provide assurance to FPC • Late changes – Gift of Time, annual leave accruals, Local Authority gave late notice of their contract • Lots of activity around Estates – finalising Leaving Fulwood **Committee noted assurance and receipt of the report and update.**	
ARC2022/04/156	**Annual Report and Accounts 2021/22 First Draft** Committee received the report from Susan Rudd for assurance. Report Summary: • Report shows progress to date - place holders marked in yellow • Chief Executive and Chair statements under review and awaiting comment • Green Plan section, Equality report, and technical tables to be included • Comments required by end of April 2022, will return to ARC June 2022 • External Audit have viewed first draft, will liaise regarding any compliance issues. Compliance table completed **Committee noted assurance and receipt of the report.**	
ARC2022/04/157	**Losses and Special Payments Full Year Report** Committee received the report from Matt White for assurance. Report Summary: • Total c£58,000 with 71 cases occurring, reduction in value from last six years • Most reduction is on damage to Estate. Potential reasons to monitor and understand - reduction in restrictive practice and use of seclusion results in less damage to property, and significant closures during Ligature Anchor Point (LAP) work	

	Committee noted assurance received.	
ARC2022/04/158	**Material Estimates 2021/22** Committee received the report from Matt White for assurance. Report Summary: • Report provides overview of estimates the Trust are using in the final accounts process • Primarily concerned with assets and provisions • Some driven by national regulations and rules • Full revaluation of Estates completed this year – due to LAP work and sale of Fulwood House **Committee reviewed and endorsed methodology and recommended ratification by Board.**	
ARC2022/04/159	**KPMG Progress and Value for Money (VFM) Update Report** Matthew Moore presented this report to the Committee for assurance, on behalf of Rashpal Khangura. Report Summary: • Audit – planning and interim visit almost complete. Following up on payroll evidence • VFM – information about early part of the year received post-submission of paper. Will provide update when final report is written • Understanding the follow up from CQC, ensuring statements reflect arrangements reported on • Concerns – time it took to retrieve information. To do with process of working with CQC. Information now received KPMG will liaise with Deborah Lawrenson and Phillip Easthope around timescales. **Committee noted assurance and receipt of the report.**	
ARC2022/04/160	**Emergency Preparedness Resilience & Response (EPRR) Assurance Framework Update** Committee received the report from Beverley Murphy for assurance. Report Summary: • Report sets out Trust's EPRR and is in the ARC Work Plan • Details progress to date with National Standards • Trust remains substantially compliant, three areas being tracked closely, one Standard may not be met (DSPT) – risks and mitigations associated with this are understood • Covid19 Risk Register included as an appendix as per the Committee's request. Will continue to be included. It is a live register, reflects changes in guidance and infection rates, reviewed twice to four times per month • Recommendation - Committee considers report and level of assurance within it **Committee noted a good level of assurance and encouragement of progress given by this report.**	
ARC2022/04/161	**Board Assurance Framework (BAF)**	

	Committee received the report from Susan Rudd for assurance. Report Summary: • Independent review of risk systems – as part of transition from system operating framework Category 4 to 3, Trust received funding to review risk management systems and processes • Review started, 10 days allocated for May 2022, discussions underway with consultant • Will be beneficial to Board to Ward • Initial report of risk management review to go to June 2022 Board. To ARC in July 2022 – for Committee Work Plan The Chair had compared the BAF Report to July 2021. Reassuring comparison, but has the Trust moved far enough on the items with greater gaps? Is the Committee content with the targets? The review should assist with these questions. **Committee noted the review timetable and assurance from the content of the report.**	
ARC2022/04/162	**Corporate Risk Register (CRR)** Committee received this verbal report from Susan Rudd for assurance. Capacity issues caused challenges in circulating this paper to Committee ahead of the meeting. Available to view on Google Drive at point of item presentation. Will be circulated to internal and external auditors. Any additional comments received from Committee post-meeting to be incorporated as such within the notes. Report Summary: • Five closed risks, one new regarding compliance with Information Governance, changes to risks • Focus on static nature of older risks • Committee to review and feedback any comments • Reporting to Board and Committees continues to take place Phillip Easthope noted: • Static Risk 4121 – previously agreed this risk was to be reviewed now we are experiencing a reduced number of incidents. Subsequently we experienced a significant document loss incident, documents now recovered but this negated reviewing the risk and lowering the score. • Assurance given that risks are monitored at relevant sub-groups and mitigating action is taken. Deborah Lawrenson added: • Effective risk conversations taking place throughout Committees • Chairs summarising and referring to relevant risks • More focussed discussion about BAF at Committees – detail and content rather than process Phillip Easthope confirmed, regarding Risk 4375, there are risks relating to: • Paper-based documents currently stored at Fulwood House will be compromised. Concerns of storage of paperwork at President Park - overseen by the Data and Information Governance Group (DIGG),	

	mitigation managed by Leaving Fulwood project. Leaving Fulwood record – overseen by Leaving Fulwood project, reporting into DIGG • Leaving Fulwood Group provided positive verbal reassurance report at DIGG, and full assurance paper to be submitted to next meeting The Chair told the Committee: • Risk 4483 – discussed during the Counter Fraud Work Plan item, relating to emails and phishing as a key element of the Plan for the coming year • Risk 2177 – priority to assign risk to a monitoring committee • DSPT and Insight changes – picked up through DIGG **Committee noted comments received on ARC risks for assurance. At the next meeting an update on the monitoring committee assigned to Risk 2177 is required.**	ACTION DL
ARC2022/04/163	**Ratification of Decisions by Policy Governance Group** Committee received the report from Susan Rudd for ratification. The following items had been through the governance process and the Committee were asked to ratify the recommendations: • Intellectual Property Management Policy FIN 003 – Extension to Review Date. Extension due to the decision to move the policy to the Corporate Governance policy portfolio • Emergency Preparedness, Resilience and Response Policy OPS 003 • Data and Information Security Policy IMST 003 Internal Audit recommendation to formalise within the Policy Framework that the Trust follows the standard that all policy review periods are no longer than three years - complete. Committee approved this update to the framework. **Committee received the report and approved the recommendations and amendment to the Policy Framework.**	
ARC2022/04/164	**Annual Report on Policy Management** Committee received the report from Susan Rudd for review. Report Summary: • Report details activity of the Group • All meetings were quorate • Where members have not attended, they have deputised • Policy management was very effective throughout 2021-22 • Many extensions – these were scrutinised, and rationale considered highly reasonable **Committee noted the report and its content.**	
ARC2022/04/165	**Self-Assessment Questionnaire Update – Verbal (Item 21) & Annual Review of Meeting Effectiveness (Item 26) combined** Committee received these reports from Susan Rudd for review and awareness. Report Summary: • Proposal to use same questionnaire as last year, based on Healthcare Financial Model Association (HFMA) framework, facilitates comparison of last year's results	

	• Will go out after this meeting • Consistent questionnaire across Committees • Committee requested to approve of set of questions in report **Committee noted the reports and approved the sets of questions proposed.**	
ARC2022/04/166	**Data and Information Governance Group (DIGG) – Escalation & Update Report** Committee received the report from Phillip Easthope for assurance. Report Summary: • Items for escalation – focus on progress towards DSPT. Detail in paper about DIGG's work and understanding on progress to date regarding cyber security included for Committee's assurance. More able to give some level of assurance to Board • Plan – DIGG provides quarterly report into ARC. Annual report at next ARC from Senior Information Risk Owner (SIRO) and Caldicott. Then to Board • Will improve and complete the sightedness of the governance from team through to Board • Concerns regarding Freedom of Information Act (FOIs) and Subject Access Requests (SARs) detailed in report including improvements needed over next two quarters (increasing accountability and supporting long-term change in responsibility) • FOI and SARs reports go to DIGG. Not assured by compliance, acknowledged that significant change needed and work underway • DSPT Mandatory Training compliance concerns – ARC to forward to People Committee (PC) via AAA Report to Board. Executive-led Group – update on DSPT including Mandatory Training routinely reported on, will be discussed, and escalated accordingly **Committee noted the report content. Alert to Board - DSPT Mandatory Training targets to be escalated to the next PC.**	
ARC2022/04/167	**Compliance Against Provider Licence Conditions** Committee received the report from Susan Rudd for approval. Report Summary: • Initial review on compliance against licence conditions listed • Last year Trust unable to declare compliance against first two conditions • Initial assessment against each condition attached within paper • Recommending declaration of compliance against all three conditions **Committee reviewed and approved the recommendation that the Trust is compliant against all three conditions. Recommended and alert to Board for final approval.**	
ARC2022/04/168	**Single Tender Waivers – to receive Single Tender Waivers issued since last meeting** Committee received the report from Phillip Easthope for information. Report Summary: • Need to improve proactive planning	

	• Trust has cleared capital allocation for the first time – some in response to slippage or receipt of additional funding, e.g., EPR • Has created the need to pull some schemes forward • Overall, no significant concerns • Some long-standing issues – aware of and have been discussed • Consultancy used to improve governance, and put training in place Richard Mills noted that as the Procurement Strategy improves this should assist with the Estate items and longer-term arrangements. **The Committee noted the report for information. The rationale was acknowledged and the need for improved proactivity agreed. It is positive that the Trust has been able to use money rather than lose it. It has been an extraordinary time for the Trust over the last two years. ARC to advise the Board.**	
ARC2022/04/169	**Terms of Reference Annual Review** Committee received the report from Susan Rudd for awareness. Report Summary: • Current Terms of Reference been in use for a year • No recommendations for amendments • Committee are asked for opinion • Membership is three NEDs – Committee is one NED short Committee agreed that if the meeting is held virtually that it is deemed to be at the Trust Headquarters. **Committee noted awareness of the review and agreed its content pending the amendment to the meeting location.**	
ARC2022/04/170	**Any Other Business** Governor, Steve Hible, has not been able to attend any of the ARC meetings and has now relinquished his role as Governor observer.	
ARC2022/04/171	**a) Meeting Effectiveness** • One or two papers missing • Meeting ran at pace and a lot covered • Crossing between Committees - areas of weakness consistent, now much better sighted on risks, getting closer to resolving long-standing cultural issues • Effective meeting, paper issues, actions to take away regarding assurance. Timing of meeting to be considered – challenging since it has been brought forward • Timing of next year's meeting to be decided at June 2022 ARC – May and June 2023 to be considered **b) Alert, Assure & Advise: Significant issues to report to the Board of Directors** Alert: • Internal Audit Progress Report and Internal Audit Opinion and comments around Follow Ups – areas of focus for 2022/23 • DSPT – concerns highlighted on Counter Fraud and DIGG papers	ACTION ARC members

	• Provider Licence Conditions compliance – Board to approve Assure: • Remaining agenda items Advise: • Accounting and annual reports – recommended for Board approval in June • KPMG Progress Report - information now submitted and they are working on VFM. Communication continues, to ensure draft is completed to time • BAF – good improvement this year, it is moving, work (setting baseline and taking forward to next year) to be discussed with BoD in June • Risk Oversight Group – reporting into ARC, did not meet in April 2022, will be included in discussions with consultant for independent review of risk management, important to have overview **c) Changes in level of assurance - Board Assurance Framework** None **d) Agreed Actions** To be monitored via Committee Action Log **e) Review of Committee Timetable/Work Programme** As part of the process of the Review of Committee Effectiveness - questionnaire to be circulated after meeting. Next meeting - main areas of focus for next year.	

Date and time of the next meeting: Tuesday 14 June 2022, 10am to 12pm
Format: MS Teams
Apologies to Francesca O'Brine, Corporate Assurance Officer
Francesca.O'Brine@shsc.nhs.uk

Mental Health Legislation Committee

CONFIRMED Minutes of the Mental Health Legislation Committee held on Wednesday 16 March 2022 at 11:30am. Members accessed via Microsoft Teams Meeting.

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

In Attendance:
Richard Mills, Non-Executive Director
Lorena Cain, Nurse Consultant and Restrictive Practice Lead
Jamie Middleton, Head of Mental Health Legislation
Dr Jonathan Mitchell, Clinical Director
Tallyn Gray, Human Rights Officer
Simon Barnitt, Head of Nursing
Neil Robertson, Director of Operations and Transformation
Helen Crimlisk, Consultant Psychiatrist and Deputy Medical Director
Adam Butcher, Governor (observer)
Francesca O'Brine, Corporate Assurance Officer, (Minutes)

Apologies:
Dr Robert Verity, Clinical Director
Hester Litten, Head of Safeguarding

Minute Ref	Item	Action
MHLC22/03/45	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
MHLC22/03/46	**Declarations of Interest** None.	
MHLC22/03/47	**Minutes of the meeting held on 15 December 2021** The minutes of the meeting held on 15 December 2021 were agreed as an accurate record.	
MHLC22/03/48	**Matters Arising** None.	
MHLC22/03/49	**Action Log** The Chair confirmed that all actions were complete.	
MHLC22/03/50	**Mental Health Legislation Operational Group** Committee received the reports from Jamie Middleton for assurance. a) MHL Q3 Report Report highlights: • Significant improvement (from 65% to 95%) in Mental Capacity Assessments undertaken when patients are moved from formal detention to informal patients	

- Mental Health Legislation mandatory training trajectories achieved

Key risks and issues:

- Continued downward trend over the last three quarters regarding completion of Capacity Assessment Tool (CAT-1) assessments
- Explanation of patient's rights – currently at 94%. Should be 100% as it is a statutory requirement
- Eleven occasions within quarter three where wards had not submitted data. Assurance of compliance with the Mental Health Act cannot be given. Endcliffe Ward are the lowest achievers
- Continued low levels of achievement of S 136 assessment within three hours
- Continued relative high levels of occasions where the Health Based Place of Safety is closed
- Increase in Mental Health related incidents moving towards the upper control limit of the chart. Moderate impact incidents have been mostly bed related
- Court of Protection has a legal power to require the Trust to prepare a variety of reports. The Trust does not have a formal process in place to manage and give oversight of these

Managing compliance with legislation will always carry significant risk as non-compliance could lead to the Trust facing legal action. Current significant risks include the Section 49 Court of Protection. There is a lot of work underway to address this. A new oversight group is being implemented. Managers are being contacted regarding CAT-1 assessment forms and bitesize training is in development.

Susan Rudd noted that the Committee should consider if any risks highlighted within the paper are to be included in the Corporate Risk Register (CRR).

Dr Mike Hunter advised that the balance is towards risk. There are several significant process gaps that are more evident on Acute inpatient wards and PICU, particularly on PICU on Endcliffe Ward:

- Issue regarding the reading of rights to detained patients, and of people who are on community treatment orders
- Issues relating to communication of the second opinion of appointed doctor decisions, and correct certification of medicine

Salli Midgley added that there is additional risk with the Health Based Place of Safety regarding the quality of the environment and using it as a ward bed**.**

Neil Robertson noted:

- The work required on Endcliffe Ward is recognised
- A development plan is in place and there is now a substantive ward manager in post
- A Standard Operating Procedure (SOP) regarding minimisation of Health Based Place of Safety beds repurposed for acute admission has been signed off

Jamie Middleton confirmed for the Chair that it is possible that assessment forms were not being completed because there were many people involved

	in the admission of an individual. Neil Robertson and Dr Mike Hunter agreed that the Committee take an action to ensure clear process is in place and an audit cycle. Neil Robertson to take this action to the triumvirate. Dr Mike Hunter told the Committee that individuals in psychiatric wards are either detained under the Mental Health Act, are there voluntarily because they have capacity to consent to admission, or they are there on the grounds of mental capacity because they do not have capacity to consent to admission. Unless forms are completed consistently at the point of admission the question of consent is unclear. This is the part of the process which needs to be improved. b) Key Performance Indicators (KPIs) – approach, consultation, and recommendation Report summary: • KPIs have been reviewed using Code of Practice requirements, national best practice recommendations, and previous CQC inspections • Individual issues have been risk assessed to prioritise those that are high risk • Final recommendation is for eighteen core categories with four exceptions. Other significant issues are on a phase two to limit the level of initial change Key risks: • Risk that the wrong set of KPIs are chosen • Risk of too much data collected • Data is not available or inaccurate • It is important to identify where there are gaps, and that work is driven by practice rather than the system Dr Mike Hunter told the Committee that the judgement part of choosing KPIs was important. This is a technical paper detailing the process of selection. The assurance required is that this process has led the Trust to a workable set of initial KPIs, including a group by exception, and a further group for future implementation. This will be kept under review. The recommendation is that the KPIs are agreed on that basis. Salli Midgley noted that monitoring Seclusion through the Mental Health Legislation Operational Group and the Restrictive Practice Group causes a risk of duplication. Jamie Middleton agreed that it therefore would not be included within the first tranche. Jamie Middleton confirmed for the Chair: • Benchmarking is challenging because some KPIs are included due to issues and improvements specific to the Organisation and commitments to the CQC • Service User engagement was not utilised regarding the KPIs. Many are KPIs are legislative based so there is little room for movement. Some KPIs fill gaps where monitoring should already be in place	ACTION NR

	Jamie Middleton agreed with Lorena Cain that there will be some benchmarking carried out around ethnicity. This should be interlinked with other pieces of work within the Trust. **Committee received the reports and noted that the balance was towards risk. The Committee will advise the Board of Directors that the initial KPIs have been agreed.**	
MHLC22/03/51	**Least Restrictive Practice Oversight Group** a) LRP Q3 Report Committee received the report from Lorena Cain for assurance. Report highlights: • Document outlines the three-year strategy work plan progress report, supported by the Programme Management Office (PMO) • Procurement of transport action was at risk at quarter 2 but is no longer at risk in quarter 3. Service specification is drafted, under review, and currently with the CCG • Full review of RESPECT Training completed. Resource impact to be identified. The plan is to go live in July 2022 • Significant improvement in Dashboards • Improved engagement with Action Owners and teams Key risks and mitigation: • The Trust are compliant with the National Data Set Version 5. Further step taken to review data quality internally and a plan is in place because omissions have been identified • RESEPCT Training compliance risk is ongoing. It is linked to a CQC action. Recovery plan agreed to end of June 2022 and is on track • Rapid Tranquillisation Training Review was not progressed during quarter 3. Progressed during Q4 • Training Needs analysis is no longer a risk – workplan reviewed and areas of training that will influence culture and reduction in restrictive practice identified • Personal Safety Plans to be moved to Health and Safety Committee • Collaboration with the Police regarding body-worn cameras • Seclusion Audits The Trust must be mindful of associating numbers with targets because this is not always meaningful. Barriers faced so far have been changes in leadership and staffing capacity. Salli Midgley added that Year 1 consisted of baseline work including the model, policy and procedure, and consideration of co-production. Years 2 and 3 will be concerned with measuring progress. Work such as changing the approach and language when evaluating data will continue in order to improve culture. Teams have been asked to make their own pledge for Year 2. Salli Midgley confirmed for Jamie Middleton that whilst there is a quality objective around race equality which aligns with the Patient and Carer Race Equality Framework (PCREF), discussions are underway regarding bringing work around	

	protected characteristics into the Least Restrictive Practice work. **The Committee received assurance regarding reduced use of seclusion. The strategy update provided a combination of assurance and reassurance. There is a possibility of differences between quarter three reporting and what is happening in the present and included in more recent reports.** b) Use of Force Implementation Plan Update Salli Midgley presented this report to the Committee for assurance. Summary of alerts: • Consistency of Seclusion Audits and adherence to the Code of Practice • Risk for staff and patients regarding how the Trust searches patients • The updated Personal Search Policy will not be ready for March 2022 but consultation is underway with Clinical teams. Training is reliant on another organisation • Blanket Restriction Register must be aligned to the Trust Policy regarding its review Dr Mike Hunter advised the Committee: • The Use of Force Act is about Organisational responsibility for the use of force and dates to 2018 • Code of Practice for the Use of Force Act is due to be implemented from the end of March 2022 Salli Midgley noted the actions: • The updated Seclusion Policy is to go to Policy Governance Group (PGG) on 28th March 2022 • Use of body-worn cameras by the Police - memorandum of understanding underway. SHSC stopped using body-worn cameras six months ago, but the Police are required to use them • Co-produced leaflet and digital applications with information on Use of Force for Service Users, carers, and staff is in development **The Committee received a combination of assurance and reassurance that the Trust are on track for the delivery of the Code of Practice for the Use of Force Act. Specific work to be completed and to advise the Board of relate to policy, Police using body-worn cameras and the Trust's decision making, and information giving. The Committee will review the success of going live from the beginning of April 2022 at the June 2022 MHLC meeting.**	
MHLC22/03/52	**Human Rights Framework** a) Human Rights Training Update Committee received the report from Tallyn Gray for assurance and information. Report highlights and activity: • British Institute for Human Rights (BIHR) requested that the Trust run the Practice Lead element of the training programme from Sept 2022 onwards and further co-production workshops prior to this • Training was developed through the research phase and co-production phases	

	• Working with partners at BIHR to roll out the training programme in Year 1. First training scheduled for Monday 21st March 2022 • The use of Service User's voices and individuals with lived experience is a central dynamic to the programme. Timeframes of co-production has been highlighted as a challenge • Collaboration with the Least Restrictive Practice Group and the Blanket Restrictions Register • Task and Finish Groups and consultation relating to areas of Trust policy • Engaging with third sector organisations such as Sheffield Flourish, Sheffield African Caribbean Mental Health Association (SACMHA), and Sheffield Voices. Tallyn Gray responded to Richard Mill's question. As Human Rights legal compliance is a public sector requirement, Human Rights law will impact everything that the Trust does. Issues would be raised through Freedom to Speak up or the Complaints procedure. Salli Midgley added that Complaints go out to the triumvirate ensuring Clinical scrutiny and identification of Human Rights issues. Practice Leads are also key in terms of Freedom to Speak Up. Jamie Middleton and Tallyn Gray are also contacted directly regarding Human Rights complaints and Human Rights issues raised by the CQC. Tallyn Gray confirmed for the Chair that in terms of co-production, it takes time to build working relationships and trust. There is a necessity to balance working towards meaningful co-production and timescales needing to be more flexible to accommodate this. **Committee received the report and were assured by the update on progress.** b) Mental Health Act Code of Practice Equality and Human Rights Policy NPCS 010 Committee received the report from Jamie Middleton for assurance and information. The Trust is currently working to improve governance relating to the Mental Health Act Code of Practice. There is a requirement that the Mental Health Act Code of Practice Equality and Human Rights Policy must be reviewed annually by the Board or equivalent. The version presented has been through previous governance frameworks, and the Quality Assurance Committee. It is now being brought to this Committee's attention. An early review of the policy has been deemed necessary to update certain information and make it more applicable to how Trust services now run. Dr Mike Hunter noted the required actions: • Annual review process of the policy to be included in the Committee Work Plan • Early revision of the policy to be completed by Quarter 2, July, August, September. Revision to include change in the named Executive Lead, and expansion of Section 7.3 Health Inequalities. **Committee received the report, acknowledged the Mental Health Act Code of**	ACTION MH/JM ACTION JM

	Practice Equality and Human Rights Policy, and approved the recommendation for an early review.	
MHLC22/03/53	**MHLC Related Policies** Committee received the report for ratification. Susan Rudd reported that the following item had been through the governance process and the Committee were asked to ratify the recommendation: • Associate Mental Health Act Managers (AMHAMs) Policy NPCS 012 - Extension to Review Date to 30th June 2022 **Committee received the report and approved the recommendation.**	
MHLC22/03/54	**Board Assurance Framework (BAF)** Susan Rudd assured the Committee that there were no Board Assurance Framework Risks aligned to the Mental Health Legislation Committee.	
MHLC22/03/55	**Corporate Risk Register (CRR)** Committee received the report from Susan Rudd for assurance. Risks for review: • Risk 4672 – risk that service users whose liberty is restricted by the Mental Health Act are not being able to access a fair legal hearing caused by the lack of comprehensive Wi-Fi in some of the Trust's locations resulting in reputation damage and litigation against the Trust. Recommendation of de-escalation following discussion by the Mental Health Legislation Operational Group • Risk 4739 – risk that the Trust will not be in a position to discharge its statutory responsibilities under the forthcoming Liberty Protection Safeguards (LPS) when they are introduced on 01/04/2022. Recommendation of de-escalation because the anticipated legislation will not come into force in the near future **Committee received the report and approved the recommendations to reduce the risks.**	
MHLC22/03/56	**Any Other Business** Dr Mike Hunter and Jamie Middleton suggested to the Committee that the time of future meetings should be altered to align with Trust Values and staff wellbeing in connection with lunch breaks. Action to review this against the Corporate Calendar in collaboration with the Director of Corporate Governance.	ACTION MH
MHLC22/03/57	a) <u>Annual Work Plan</u> Committee received the workplan for information. The annual policy review is to be included. b) <u>Significant issues to report to the Board of Directors (Alert, Assure & Advise)</u> Dr Mike Hunter assured the Committee that the Alert, Assure & Advise Report will be presented verbally to the Board of Directors (BoD) on 23rd March 2022 due to the turnaround of meetings. A written version will be submitted to the subsequent Public BoD meeting in May 2022. c) <u>Changes in level of assurance (Board Assurance Framework)</u> None. d) <u>Meeting Effectiveness</u> The Chair thanked the Committee for their contributions and closed the meeting.	

Date and time of the next meeting: Wednesday 15 June 2022, *time TBC*
Format: MS Teams
Apologies to Francesca O'Brine, Corporate Assurance Officer
Francesca.O'Brine@shsc.nhs.uk

ITEM 3, 12-07-22
CONFIRMED

Sheffield Health and Social Care NHS Foundation Trust

People Committee

Minutes of the People Committee meeting held on Friday 13th May 2022, via teleconference

Members Present:

Heather Smith	Non-Executive Director (voting) and Chair of Committee (the Chair)
Richard Mills	Non-Executive Director (voting)
Anne Dray	Non-Executive Director (voting)
Caroline Parry	Executive Director of People (voting)
Deborah Lawrenson	Director of Corporate Governance

Apologies:

Emma Highfield	Head of Nursing for Older Adults and Acute Inpatient Services
Beverley Murphy	Executive Director of Nursing, Professions & Operations (voting)
Liz Friend	Governor
Deborah Cundey	Service Development Manager
Aimee Hatchman	People Systems Lead – Resourcing
Karen Dickinson	Head of Workforce Development and Training

In Attendance:

Catherine Draper	Psychotherapist / Staff Governor
Charlotte Turnbull	Head of Leadership and Organisational Development
Simon Barnitt	Head of Nursing for Rehab and Specialist Services (SBar)
Sarah Bawden	Deputy Director of People
Wendy Fowler	Freedom to Speak Up Guardian (for item 12/05/22)
Sally Hockey	HR Business Partner
Liz Johnson	Head of Equality and Inclusion
Victoria Racher	Workforce Systems Manager
Neil Robertson	Director of Clinical Operations and Transformation
Amber Wild	Corporate Governance Manager
Emily Allan	Corporate Assurance Officer (Minutes)

Min Ref	Item	Action
1/05/22	**Welcome & Apologies** The Chair welcomed everyone to the meeting and apologies were noted.	
2/05/22	**Declaration of interests** No declarations of interest were made.	
3/05/22	**Minutes of the meeting held on 8th March 2022** The minutes of the meeting held on 8th March 2022 were agreed as an accurate record.	
4/05/22	**Matters arising and action log** <u>Action log</u>: Members reviewed and approved the action log.	

Proud to care in Sheffield

	Matters arising: *i. Completion of People delivery plan* Members were unable to review the People Delivery Plan as the document presented was unusable due to problems encountered in its conversion from Word to PDF. Discussion referred to July's meeting. Action: Circulate the Excel version of the People Delivery Plan to members.	EA
Staff Voice		
5/05/22	**Recruitment and Retention Group report** SB presented the report which recommended that PC approve in principle a retainment premium for Band 5 nursing staff and focused on retention as requested in the March 22 meeting of the PC. • The Recruitment and retention assurance group have done a detailed analysis of leavers data • Work is being commissioned to identify the main reasons for staff leaving • Assurance groups are working to the People Promise themes, meaning that the Trust is aligned with national and ICS programmes • Work-life balance has emerged as a main reason given by staff for leaving, and this links to a wider piece of OD work looking at engagement and leadership development • There is an aging workforce in some areas and the Trust is considering how this should influence strategies • A proposed retainment premium is predicted to retain Band 5 nurses for an additional 2.5 years. The proposal is made as part of the agenda for change terms and conditions and is being benchmarked against ICS colleagues. RM said that an escalating situation with RDASH should be avoided and suggested unifying retention premium terms and conditions. He added that staff communications need to be carefully considered. NR agreed that a partnership approach is key, as sovereign decision making is a risk. RM asked if the Trust was recovering money paid to international staff if they leave early and SB replied that employment contracts do not include a 'tie in'. Recent press has highlighted that some NHS Trusts are recovering the full cost of recruitment, but this is not something that SHSC has any interest in doing. CP said that recruitment challenges were being seen across the System and are not unique to the Trust. She asked if the physicality the role was having an impact on the retention of Healthcare support workers, and SBar said not as training was given to staff. The main reason for leaving given by qualified staff is for promotion. Engagement with local communities and building development pathways were key, SBar suggested that the Trust consider offering more Band 7 opportunities to Band 5 nursing staff as the premium, not additional money. CP said that the Service Delivery Group had discussed what the premium offer should be, and that the issue will be looked at further in the June ICS Human Resources Director meeting. AD asked if any retention issues identified were unique to the Trust. SB reassured members that the Trust is working across the ICS on Healthcare Support Workers, international recruitment and the well-being aspects. Many indicators are not unique to the Trust and are being seen across Sheffield. The Recruitment and Retention Delivery Plan clearly sets out the Trust's priorities for 2022/23, one of which is International Recruitment, and resource is in place to complete the plan.	

	The Committee supported the Retainment Premium in principle but asked for more ICS level information. Action: A paper on the retention of physician associates in relation to new roles will be presented by Karen Dickinson, Helen Crimlisk and Nick Bell at the July PC meeting.	SB, KD & Helen Crimlisk
Deep Dive: Recruitment and Retention BAF risk 0014 The Chair asked members to discuss if a full articulation of the risk and the actions had been taken and the following observations were made: • Many of the actions seemed to be behind and some had no quantification. The use of clear actions and timescales were suggested • 12th May 22 Finance and Performance Committee (FPC) meeting highlighted a gap in Workforce data. SB gave assurance that a full set of data had been presented to PC today. The workforce team has been severely depleted with a long-term sickness and vacancies, but teams are working together to ensure full IPQR data. • Members agreed that the current 'Green' status of the risk was correct, as actions are showing intent • Members agreed that the current risk score was accurate Action: Add considering if all proposed actions will achieve target risk level onto the agenda of the Recruitment & Retention Group and have an iterative discussion on this topic. Action: Attend a Recruitment & Retention Group meeting and lead an agenda item on the impact of the Cost Improvement Programme on risk 0014.		SB NR
Performance Monitoring		
6/05/22	**Integrated Performance and Quality Report (IPQR)** The Chair highlighted the three key quality risks. Issue have not changed since the last PC meeting and they are: • Flow and the movement of people through the system • CPA reviews and South Recovery teams (paper received at the May 22 meeting of the Quality and Assurance Committee (QAC)) • Waiting times Positive improvements have been made: • The reduction of length of stay in the older adult wards and Forest Close • Very strong performance by IAPT • The decrease in restrictive processes and the use of seclusions on G1 • Increase in supervision compliance in some areas	
7/05/22	**HR Performance Dashboard** VR presented a progress update. • Long term sickness is reducing in line with the peak from COVID, but short term sickness levels are increasing • Work done by managers and the HR team to reduce time taken to close episodes of sickness has improved data quality • There remains a high staff turnover, although there is a slight improvement of 1.8% from the previous month. • There has been a 2% point reduction in vacancies since January 22. • A workforce profile is being developed with the intention of being able to identify staff approaching retirement age. • There is a strong pipeline of healthcare support workers and nurses.	

	Members requested more narrative to support data, clear communication of key messages and consistency month-on-month in the content of future reporting. Action: Investigate the amount and format of data submitted to high level committees and Board.	VR & DL
People Strategy theme: OD, Leadership and Talent		
8/05/22	**Supervisions Update** LW highlighted to members key findings from the supervisions survey, which had focused on staff experience and quality. • 141 respondents took part in the survey • Workshops held in 2020 and 2021 developed questions for the survey • Supervisions are happening more regularly for an hour, in a private space and with the same supervisor • Supervision rates have improved since 2021 but are still variable across services • There are completion issues on the acute wards. A clear plan is in place to improve this trajectory however • Results showed: - that staff feel a better balance of challenge and support which is benefiting clinical work - Staff leaving the organisation is leading to inconsistencies in supervision - Staff value the expertise of supervisors, the skills and opportunity for development - Some staff reported feeling it was difficult to establish a good relationship with their supervisor, and that confidential information discussed would be repeated within the team - Some supervisees reported feeling pressure from the supervisor DL asked that the report make it clear where the Trust is against the CQC notice. The report recommended that a bigger piece of work is done to triangulate data with other data (e.g. Staff Survey results). The Committee supported this proposal.	
People Strategy theme: Equality, Diversity and Inclusion		
9/05/22	**Inclusion and Equality Group – high level review of EDI progression** LJ gave the following highlights: • SHSC are currently trialling the updated NHS Equality Delivery System framework along with several other NHS organisations, following discussion with the Chair of the Inclusion and Equality group it is proposed that the work of the group focuses around the three domains of the NHS Equality Delivery System (EDS) • Benchmarking analysis on the staff survey has been done • A breakdown of who completed the staff survey was given: - The number of people who completed the survey with a disability and long term health condition has doubled - The number of people completing the survey from ethnically diverse groups has also increased. Results from this group are universally lower than other groups - A higher percentage of men completed the survey - 4.6% of the staff survey responses were from the lesbian, gay, bisexual staff group, which is in line with the percentage of people in the organization who identify as LGBT - There was an over representation in staff under 40 years of age, and a under representation of staff over 40	

	Action: Future report to include impact assessments on improvement changes made. DL suggested that overdue action items are reported early in the report with a narrative. Members asked for the report to give more information on what interim actions are being done to counter-act the findings of the Staff Survey. These messages can then be clearly communicated to the Board. Action: Review feedback given by PC and include suggestions made by members in future reporting.	LJ LJ & NR
People Strategy theme: Workforce Transformation		
10/05/22	**Workforce Planning and Transformation Group - Report** The Committee received the report. CP gave an overview of highlights from the report: • Progress has been made around the workforce planning framework which has been supported by some funding received from the CQC • Workshop held in April 2022 looking at developing the dashboard and framework • An action plan is being developed and the first draft will be in place by the end of July 2022 RM asked how the work was linked to the ICS and if the Trust was able to have a significant impact on the workforce planning across the system. CP replied that the Trust has contributed to populating the ICS dashboard, and that work will align with what is needed at an ICS level. Action: Produce a paragraph on how the Trust is utilising the apprenticeship levy as a 'Matters Arising' update for the July 22 PC meeting.	KD
Workforce Transformation BAF risk 0019 The Chair asked if a review of the BAF risk rating was needed. CP replied that work is in progress, but that the framework for the dashboard is currently in draft and therefore unable to demonstrate impact. It was agreed to review progress again in the July and September 2022 PC meetings.		
People Strategy theme: OD, Leadership and Talent		
11/05/22	**Staff Survey 20/21 update** CT presented the report Key points: • A full analysis of results has been done • There are plans to re-instate the Big Conversation • Staff Survey results are snapshot in time and a benchmark • Improving staff engagement and experience is now the focus of work, and will be throughout the next year RM commented that this is the 4th year of negative results, which is a risk, and that cultural change is needed. He asked what monitoring was being done between the yearly staff survey. CT responded work was in the early stages and is being structured on the organisational action plan. SH added that the People Pulse is done 3 times a year and will be used to track progress. April's results are not yet available, and January's shared the same themes as the Staff Survey.	

	AD asked for assurance to be given that conversations regarding Staff Survey results were happening throughout the organisation. CT said that reporting would be part of the action plan and will mirror the IPQR. CP said that the Trust was one of the bottom performers in this area on an ICS level and that it needs to take ownership of this. Reporting is being done through the ICS, and the Trust is sharing good practice and learning with other organisations. Staff feedback will also be sought via Board and Exec site visits. The Chair requested that more information regarding monitoring impact be given at future meetings.	
12/05/22	**Freedom to Speak Up Report – Annual Report** WF presented an overview of the report: • Substantial progress in embedding freedom to speak up within the organization thanks to the manager training • Half of the people who have used the service report feeling that their issue is resolved, the other half report that their issue is un-resolved or only part resolved • Communication is key as it is often the reason behind many issues • The system is being strengthened. Clinical concerns are tracked the by the IPQR report, which makes the system much more robust RM is the FTSU guardian on the Board, and there is regular engagement between the Guardian, the CEO and the Chair of the Board. WF is now part of the Corporate Governance team and DL offered her ongoing support. The Committee accepted the report and members made suggestions of how FTSU could link with other areas, such as the Staff Survey.	
Governance		
13/05/22	**People Directorate (HR) Policies** The Committee approved two extensions and one ratification as recommended by the Policy Governance Group.	
14/05/22	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)** DL presented the Board Assurance Framework and Corporate Risk Register to the Committee and gave the following overview: • The risks have not been updated • Risks will be updated to include comments from today's meeting for the May 22 meeting of the Board • DL and CP have a meeting later in May to have a detailed look at risks and actions for 22/23 The Chair reflected that the biggest issue appeared to be the attraction and retention of staff, and that culture underpinned many risks. AW confirmed that access to Ulysses had been improved and encouraged all risk owners to attempt to use it.	
Other		
16/05/22	**Highlights from the Joint Consultative Forum (JCF)** CP gave members a verbal update:	

	• There has been a decrease in the number of formal cases due to informal interventions and changes the disciplinary policy in terms of checking points are starting to take effect • Presentations on expense rates and cost of living pressures has been offered to staff and was well received by Staffside • The CMHT dispute has only a couple of more points to address Action: Provide an update for QAC on how the Community reorganisation is being received by staff.	CP
17/05/22	**Any Other Business** None	
18/05/22	**Confirmation of Significant Issues to report to our Board of Directors** Committee members noted the following significant issues to report to Board. **TO ALERT** (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently) • Short term sickness levels continue to be of concern • The outcome of the Staff Supervision Survey • Completion of mandatory training • Concerns about what analysis of the staff survey was saying about the experience of diverse staff groups **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) • 2 percentage point reduction in vacancies since January 22 • The Committee received the annual Freedom to Speak Up Report • The Committee approved in principle the recommendation to Board for a retention bonus for Band 5 nurses **ASSURE** (areas of assurance that Committee has received) • Good progress made with the Governance structure for EDI across the Trust • Significant progress made with workforce planning methodology • The results of the Staff Survey have been received	

HS CHECKED **19-05-22** **Date and time of next meeting:**

CONFIRMED **12-07-22** **Tuesday 12th July 2022, 2:00pm – 4:30pm, via teleconference**

Apologies to: Emily Allan, Corporate Assurance Officer

Emily.allan@shsc.nhs.uk