Board of Directors - Public

SUMMARY REPORT	Meeting Date:	28 September 2022
	Agenda Item:	07

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

Summary of key points in report

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

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

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

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

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

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

Quality and Assurance Committee:
AAA reports from August 2022, September 2022
Minutes from July 2022, August 2022

Mental Health Legislation Committee:
AAA Report from September 2022 with appendix - Assurance of compliance with the requirement of the MHA Code of Practice to review the Equality and Human Rights Policy NPCS 010
Minutes from June 2022

Audit and Risk Committee – June 2022.
AAA Report from July 2022
Minutes from June 2022

People Committee:
AAA Report from September 2022
Minutes from July 2022

Finance and Performance Committee: (to be presented to confidential Board of Directors)
AAA Report from August 2022, September 2022
Minutes from May 2022, July 2022, August 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***	
Sustainability	*Yes*		*No*	***X***	

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Quality Assurance Committee (QAC)** **Date:** **10/08/2022** **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
Waiting Lists	Waiting lists across several community services are an enduring (and significant) risk. Committee considered a full report about waiting lists, noted significant assurance around positive improvements where seen and transformational service redesign solutions where proposed. However, these actions are unlikely to be sufficiently impactful for all services to avoid the potential risk for harm and the potential for regulatory action.	Low assurance – significant risk of potential risk for harm and regulatory action.	The Committee asked that a Board discussion on this considers all possible options and requested regular updates.	Board of Directors (BoD) 28/09/2022
Flow across Acute pathway	Flow across the acute pathway remains a risk. There are some improvements to be seen but not yet the confidence that these are sustainable.	Low assurance – remains a risk	Issue remains under scrutiny – monthly Integrated Performance and Quality Report (IPQR) to QAC	QAC 14/09/2022
Care Programme Approach (CPA) reviews	CPA reviews (another enduring risk) remain lower than expected,	Low assurance – remains a risk	Issue remains under scrutiny – monthly IPQR to QAC	QAC 14/09/2022

	with particular concerns about performance in the South Recovery team (76% completion compared to an improved 90% in the North Recovery team).			
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	The Committee asked questions about the progress with e-rostering; queried lower rates of training in corporate services; restrictive practice on Burbage; and noted the risks around flu/Covid19/Out of Area (OOA) beds in the winter months to come. Supervision rates are not consistently meeting SHSC standards. The number of suitably trained staff on duty at any one time requires improvement (more detail requested for the next meeting). Some mandatory training is not yet meeting the Trust's standard, with Immediate Life Support causing particular concern due to the pass rate. The Committee asked that Board note the positive improvements reported in the IPQR e.g.	Reassurance of improvement and progress in some areas. Limited assurance of ongoing issues.	IPQR remains a monthly report to QAC.	QAC 14/09/2022

	• no inappropriate OOA beds for older people since December 2021 • 72 hour follow up has shown improvement for 4 consecutive months • use of rapid tranquilisation on G1 continues the improvement trajectory seen in past reports			
Safer Staffing	The Committee received a verbal report on Safer Staffing and the proposed changes in skill mix across the wards, with a written report expected next month.	Good assurance and encouragement received from verbal report on progress of model.	Full written assurance report to next QAC meeting.	QAC 14/09/2022
Research, Innovation, Effectiveness, and Improvement Group	The Committee received a quarterly report from the Research, Innovation, Effectiveness, and Improvement Group. A different approach to this report was requested for the future, focussing on quality improvement activity, impact etc rather than process, a better approach to understanding best practice standards and also the outcomes of clinical audits should be shared.	Limited assurance noted from report content.	Report writer to use feedback provided by Committee in next report to give better assurance. Annual report to QAC October 2022, progress report January 2023.	QAC 12/10/2022 QAC 11/01/2023
Board Assurance	The Committee considered the	Good assurance that new risks	Committee agreed to discuss	QAC 14/09/2022

Framework (BAF) and Corporate Risk Register (CRR)	newly formulated BAF risks and the CRR.	were agreed at Board.	BAF and CRR in detail at September 2022 QAC. QAC agenda to be arranged around BAF risks – Committee to discuss risks throughout meeting agendas.	
Annual Report on Committee Effectiveness and Objective Setting 2022-23	The Annual Report on Committee Effectiveness was presented and discussion about the Committee's key objectives for next year will be taken forward.	Good assurance on progress Committee has made in year. Committee agreed to reduce meetings to ten per year unless essentials items come up in the interim.	Minor amendments to be made to report before Board in September 2022.	BoD 28/09/2022
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Infection, Prevention, and Control (IPC) Annual Report	The Committee received the IPC Annual Report and were assured that there was good oversight of issues and clear identification of risks and mitigations (e.g., sharps and waste management practice; staff not consistently BBE) and expected improvement in future reports.	Good assurance noted from level of attention being given to IPC.	QAC recognise mitigation in place but noted still some risks – these to be addressed in next report.	QAC 08/02/2023
Physical Health Progress Report	The Committee received the Quarter 1 Physical Health Progress Report. This is an improving picture with good oversight of areas. Tendable is being used more frequently and the Committee requested that future reports identify outcomes of these audits and actions being implemented to secure	Good assurance of oversight of areas to be improved and the progress made.	Outcomes of audits and actions being implemented to be included in next report for further assurance.	QAC 08/02/2023

	improvement.			
Mortality Quarterly Report	The Trust has a robust Mortality Review system in place. However, the Committee asked for increased assurance reporting around learning and changes implemented as a result. A re-think was requested with how all our 'learning opportunity' processes could be combined e.g., service user feedback, incident reporting and investigation, complaints, mortality reviews.	Good assurance that robust mortality review system is in place. Limited assurance of learning and impact.	Next quarterly report to QAC November 2022 to include assurance of learning and impact.	QAC 09/11/2022

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Quality and Assurance Committee (QAC)	Date:	14/09/2022	Chair:	Heather Smith

KEY ITEMS DISCUSSED AT THE MEETING					
TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Persistent risks: • Waiting lists • Care Programme Approach review writing • Allocation of a care coordinator in Recovery teams • Inappropriate out of area (OOA) placements	Committee have continued concern with persistent, not fully mitigated risks. Recovery plan progress reports to address issues received. Assured that intent was appropriate and effort significant, not assured of impact of actions and improving position in any of the three areas. Implications for OOA Cost Improvement Plan target	Limited assurance of impact of actions and improvement of position	Alert to Board	BoD 28/09/2022	24 29
Health and Safety Report	Assurance: much improved data and triangulation, grip team has on understanding of improvements needed noted Limited assurance: progress of issues, particularly fire and safety	Assurance of understanding of issues, but limited assurance of progress	Committee requested issues to be listed as priorities and cross-Trust approach taken to resolve at pace	BoD 28/09/2022 QAC 12/10/2022	23
Back to Good Programme	Assurance that actions progressing and spot checks underway Clarity needed on risks Trust carries regarding embedding improvement actions due to	Assurance of progress with actions, but limited assurance of risk to Trust	Alert to Board	BoD 28/09/2022	24 25

	issues with evidence submission				
Supervision	Continued concern regarding problems with meeting supervision target	Limited assurance	Alert to Board – Committee propose Recovery Plan reportable to Board	BoD 28/09/2022	24
Ligature and Blind Spot Risk Reduction improvement work	Not all risks reduced or in scope. New group formed to address this	Moderate assurance	Alert to Board	BoD 28/09/2022	23 24
Integrated Performance and Quality Report (IPQR)	Positive movement in IPQR recognised. New improvements: • Reviewing incidents more quickly • Assaults on staff significantly declined • No A&E breaches in June 2022	Good assurance	Positive alert to Board QAC monthly reporting	BoD 28/09/2022 QAC 12/10/2022	-

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

Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Safer Staffing	Committee were advised of emerging risk of safe staffing on wards – proposed resolution to use agency staff being formulated	Moderate assurance	May need to be elevated to alert to Board if solution unsuccessful	QAC 08/02/2023	24
Quality Objectives	Work underway to address relevant issues, clarity of risks to future progress	Moderate assurance	More assurance evidence to be included in future reports. Request to link work to ongoing development in other projects e.g., Patient and Carer Race Equality Framework	QAC 09/11/2022	24
IPQR	Committee highlighted gap in IPQR: progress being made against long-term plan to be addressed in future reports	Good assurance	To be included in next monthly IPQR report to QAC	QAC 12/10/2022	24 29
Tier 2 Group/Committee Self-Assessment Reports and updated Terms of Reference	Committee received and reviewed the reports and terms of reference from all Tier 2 Groups/Committees reporting into QAC. New annual objectives for QAC also agreed	Good assurance	Submit to Audit and Risk Committee (ARC)	ARC 18/10/2022	-

Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	Committee discussed and agreed newly formulated risks in BAF and ratified changes in CRR	Good assurance	Bi-monthly QAC items	QAC 09/11/2022	-
Internal Audits – Action Tracker Report	Committee received report and tracked compliance with actions from internal audit reports. Committee reviewed new internal audit Limited Assurance report on Central Alerting Systems	Good assurance from improved oversight	Monthly standing item now on agenda and work plan	QAC 12/10/2022	23
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Safer Staffing	Committee received report and were assured of compliance with safer staffing national criteria	Moderate assurance	Committee emphasised importance that aspirations extend beyond standard to ensure richer staffing structure providing effective and compassionate care	QAC 08/02/2023	24
Medicines Safety	Assured that Medicines Safety Group have clear line of sight on actions needed to improve management of controlled drugs. Concern remains regarding impact of incidents. Assurance sought that staff and service users are supported and reflection is appropriate. Fridge temperature management has improved	Good assurance	6-monthly reporting to QAC	QAC 12/04/2023	24
Annual Safeguarding Report	Committee received report and were significantly assured that area is now well led at SHSC	Significant assurance	6-monthly reporting to QAC	QAC 11/01/2023	24

BAF Risk Description

BAF.0023	There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of Service Users and staff

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

Quality Assurance Committee (QAC)

CONFIRMED Minutes of the Quality Assurance Committee held on Wednesday 13 July 2022 at 10am. Members accessed via Microsoft Teams Meeting.

Present: (Members)	Heather Smith, Non-Executive Director (Chair)	CHAIR
	Beverley Murphy, Executive Director of Nursing, Professions, and Operations	BM
	Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director	OF
	Richard Mills, Non-Executive Director	RM
	Dr Mike Hunter, Executive Medical Director	MH
	Professor Brendan Stone, Associate Non-Executive Director	BS
	Salli Midgley, Director of Quality *(for item 13 only, minute reference QAC22/07/349)*	SM
In Attendance:	Tania Baxter, Head of Clinical Governance	TB
	Dr Jonathan Mitchell, Clinical Director	JM
	Deborah Lawrenson, Director of Corporate Governance	DL
	Michelle Horspool, Deputy Director, Research	MHP
	Christopher Wood, Head of Nursing	CW
	Des Francis, Complaints Manager	DF
	Greg Hackney, Head of Service, Crisis, and Emergency	GH
	Dr Hassan Mahmood, Clinical Director and Consultant Psychiatrist, Learning Disabilities	HM
	Vin Lewin, Patient Safety Specialist	VL
	Francesca O'Brine, Corporate Assurance Officer (minutes)	FO

Apologies: Alun Windle, CCG
Amanda Jones, Director of AHP
Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services
Sue Barnitt, Head of Clinical Quality Standards
Fleur Blakeman, NHSEI
Dr Robert Verity, Clinical Director
Maggie Sherlock, CCG
Linda Wilkinson, Director of Psychological Services & Consultant Clinical Psychologist

Minute Ref	Item	Action
QAC22/07/348	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies. Beverley Murphy welcomed new Clinical Director and Consultant Psychiatrist, Learning Disabilities, Hassan Mahmood, to the Trust and committee, and members introduced themselves.	
QAC22/07/349	**Declarations of Interest** Professor Brendan Stone noted his Board membership of Sheffield Flourish.	
QAC22/07/350	**Minutes of the meeting held on 8 June 2022**	

	The minutes of the meeting held on 8 June 2022 were agreed as an accurate record.	
QAC22/07/351	**Matters Arising** None.	
QAC22/07/352	**Action Log** Committee received the action log for information. The Chair noted the two items in orange had a September 2022 target date. The remaining items were complete.	
QAC22/07/353	**Integrated Performance and Quality Report (IPQR)** Committee received the report from Beverley Murphy for assurance. The key risks remain static: • Flow through inpatient unit, acute and crisis – numbers of people being treated away from home too high. Fallen slightly, slow but consistent improvements – more sustainable. Continue to review progress • Performance against standards for Care Programme Approach (CPA) – started to improve. Further discussion during next agenda item • Waiting time in community services – biggest concern. Gender Dysphoria Clinic - greatest risk but assessment function only. Case load too high. Future full QAC and Board agenda item required * RM: Demand for mental health services - continuing to rise or stabilising at a higher level? BM: • Crisis has increased - made changes over last six months • Increased demand not entirely due to Covid19 • Local nuances combined with local crisis additional response hindering progress BM confirmed for OF: • Patient on Maple Ward: several reviews conducted - clear formulation of care needs, diagnosis being reassessed • Patient on Endcliffe Ward: long term segregation ended 4th July Chair requested Matters Arising at next QAC for assurance and oversight of patient with longest length of stay. ** *post meeting note – BM and HS agreed this would be added as an item under IPQR item at August QAC* Specialist Triage, Assessment and Referral Team (START) services – BM confirmed for MH: • Significant change in caseload stability • During Covid19 less people dropped out of services • Unstable system • Substance Misuse Contract Expansion Report – FPC July, QAC August Assaults on service users, exception in May – BM clarified for MH: • Charts now used consistently in performance reviews • Every variation is identified and understood • G1 – either no harm or minimal harm • Forest Close – complicated circumstances – well sighted on issues **Committee received the report and noted ongoing concern regarding flow and**	* ACTION FO (agenda item) ** ACTION BM

	CPA reviews – report to Board signs of improvement and monitored closely. Waiting lists considered a significant concern - new Board Assurance Framework (BAF) risk. Further review requested at QAC and Board. **Committee recognised the positive outcomes in other areas on the IPQR and the hard work involved. New improvement noted – no bed blocking at Health Based Place of Safety. Also commented that Supervision should be closely monitored (also monitored at People Committee).**	

QAC22/07/354	**Community Mental Health Services Progress Report**
	Committee received the report from Greg Hackney for assurance.
	
	Revised governance structure enacted:
	• Primary Care Transformation
	  o Project initiation document agreed
	  o Sheffield programme road map received
	  o Programme board on track but in infancy
	  o Clinical models of care and delivery model agreed - request to send slides to September QAC *
	• Care Programme Approach
	  o Nationally no clear implementation guide for personalised care and support plans (definitions of care, timescales)
	  o Mitigation – met as an Integrated Care System to review
	  o Risks – addressing needs of workforce, new Electronic Patient Record, financial impact
	
	BM:
	• Additional risk – potential for insufficient lack of impact from work undertaken
	• Change to structure and process - date for implementation far in the future. Waiting times unacceptable and need to be focussed on. Note mitigations in report
	• Incorrect language used – replace *check up*
	• Good to see measures of success
	• Mobilisation - how do we get to a position of being agile as things progress?
	
	MH:
	• Triangulation with Clinical and Social Care Strategy – 2nd year priority is evidence-led and person-centred outcome measures
	
	RM:
	• Complex issues, report showing right direction
	• Engaging the workforce is key
	
	GH confirmed for BS:
	• Personality disorders not highlighted - national move towards renaming diagnosis to Complex PTSD/Complex Trauma
	
	OF:
	• Service user feedback - *fair and equitable service to all putting Equity, Diversity, and Inclusion (EDI) at the forefront* should be added
	• EDI should be at forefront of reports
	
	CW:
		* ACTION FO (agenda item)

	• Experience of change is as important as the outcome • Positive experience of transformation will help to achieve sustainable change Chair summarised for next report: * • Note early success points, as this is a rolling process of change/improvement • Build on risk section and mitigation for assurance • Include equality measures and issues **Committee received the report and were assured by the progress.**	* ACTION GH/NR
QAC22/07/355	**Infection, Prevention, and Control (IPC) Board Assurance Framework** Committee received the report from Beverley Murphy for assurance. Report summary: • 2020-21 nationally introduced IPC BAF due to Covid19 • SHSC continuing use - enhances understanding of gaps in controls • For assurance at QAC, presented quarterly to IPC Committee meeting RM: • Positive to see work on ventilation • Rate of emerging variants and infections – assurance needed on how this can continue to be governed OF: • EDI not reflected in cover sheet and not detailed enough in report Chair requested this is brought out in future reports. * **Committee received the report and noted assurance given from the content.**	* ACTION BM
QAC22/07/356	**Learning Disability Service Transformation Model** Committee received the report from Dr Hassan Mahmood for assurance. Proposal for new model: • One learning disability team, currently two teams • Standard and community offers in multiple pathways • Increase in service's working hours • Hub referral • More responsive and effective model, focussed on patient safety and team approach • Consistent application of national agendas • Focus on outcome measures – co-production to meet needs of diverse Sheffield communities • Build relationships within wider system • QAC asked to approve paper before submission to Board BS told committee that HM initiated multi-cultural Stopping Over-Medication of People with a Learning Disability, Autism, or both, with Psychotropic Medicines (STOMP), Birmingham. HM confirmed for BS: • New model will focus on consistent personalised care - finer details to be developed	

	• Multi-cultural STOMP, Sheffield, in progress OF: • High level of reassurance from report that inequality will be addressed head on Chair requested that the risk and mitigation section is enhanced in future reports for assurance. * **Committee received the report and noted a high level of optimism and assurance for the proposed model and plans.**	* ACTION HM
QAC22/07/357	**RIE Strategy Implementation Plan** Committee received the report from Michelle Horspool for assurance and were asked to approve the recommendations made. Summary: • Ongoing work – bringing together Clinical and Social Care Strategy evidence-led theme with RIE Strategy • Workshops with other enabling strategies to consider co-dependencies • Risk around resource continues • Lived experience research partnership now established BM told the committee that every clinical operational policy should reference the standards for what is recognised nationally and in best practice specialist groups as being effective and quality care. MHP: • Clinical Effectiveness Framework is in year two of the plan BM: • Needs to be paced up – risk to quality of care MH: • Agree with BM comments • Networking approach – utilise 90 research champions from across services as clinical effectiveness champions Chair requested this to be directly addressed in the next report. * OF: • Reassured that the SHSC anti-racism statement underpins the strategy. **Committee received the report and approved the direction of implementation and date for completion.**	* ACTION MHP
QAC22/07/358	**Complaints Annual Report 2021-22** Committee received the report from Tania Baxter and Des Francis for assurance. DF summarised: • Key focus o Learning from complaints – themes emerging o Utilising Ulysses to identify learning o Agile mindset sessions underway including with the executive team • Aims o Emphasise to complainants: we are listening and working to improve o Work more closely with service users o Staff need to feel confident in dealing with complaints – training programme in place for August – December 2022	

	○ Correspond with complainants more regularly • Plan over next year ○ Further training sessions ○ Conduct survey with training provider, Patient Association – take learning points to improve service ○ Invite service users to collaborate – learn about complainants to inform improvement work ○ Experts by experience key to development ○ Investigation panel – complaints tracker is monitored across SHSC OF: • Assured that complaints panel has diversity • Important that everyone feels they can come forward DF confirmed for RM: • SHSC work closely with the Sheffield Teaching Hospital Patient Advice and Liaison Service team BS: • Reassured - key message is about learning • Institutional-level learning also critical • NEDs should receive agile mindset training BM: • Need to be actively looking at protected characteristics in reporting • For ongoing assurance of improvement - median and longest completion periods to be included as a chart in future reports * MH: • Complaints is a statutory process – might work for some people more than others • Improvements in accessibility and support needed • Democratic co-production key to learning **Committee received the report and were assured by the improvements made and the plans in place.** The Chair noted that the SHSC response to Speak Up Work paper was there for committee's information.	* ACTION DF/TB
QAC22/07/359	**Mortality Annual Report** Committee received the report from Vin Lewin for assurance. Assurance: • SHSC meet National Quality Board standards • Organisation working at pace, making required improvements to system • Examples of learning from reviewing deaths over 2021-22 detailed • Policy reviewed; short review date applied due to imminent major changes • Collaborated in development of Mortality Dashboard Risks: • Team capacity to develop work RM noted the importance that the work SHSC does with the Homeless Assessment	

	and Support Team (HAST) and substance misuse is communicated more widely.
	
	MH:
	• Excess drug-related deaths were closely linked to the time of the first Covid19 lockdown, but not linked to Covid19 virus infection – during period of process control in START
	• Learning from work with START and HAST
	  o Covid19 lockdown more associated with people using drugs alone – high risk
	  o Pick-up arrangements meant people were holding more Methadone to reduce contact during Covid19
	  o Most excess substance misuse deaths due to alcohol – more likely to lead to long term deaths. Opiate-related deaths – more likely to lead to sudden deaths. During Covid19 the concurrent use of alcohol and other drugs alongside opiates increased due to stress response
	
	VL:
	• Collaborative piece of work in progress - working with families who have lost loved ones
	• Clinical internal audit started to review contact with families and identify learning
	MH:
	• Scope for a more integrated approach
	
	BM:
	• Last two years – significant improvement work
	• Focussed on engagement with the service user's family and answering their questions
	• Different sets of questions emerged to inform reviews
	
	Committee received the report and were assured that SHSC are compliant with the national standards for learning from deaths and are engaged in a process of continuous improvement.	

QAC22/07/360	**Ockenden Report and Paterson Review – SHSC Self-Assessment** Committee received the report from Salli Midgley for information and assurance. Approach: • Staff and people with lived experience were asked to consider questions and offer challenge • Key themes collated • Assurance and limited assurance identified • Recommendations for improvement made • QAC to consider and approve recommendations • More work to do before it goes to Board and is taken forward **Committee received the report and approved the recommendations. There is a lot of work to be done and so prioritisation is important. This needs to be brought back to QAC in the future to close the loop and give assurance.**	
QAC22/07/361	**July 2022 Preventing Future Deaths (PFD) response re: MG** Committee received the report from Tania Baxter for information and assurance. • Letter was sent to coroner by due date (11th July 2022)	* ACTION

	• Final letter to be circulated to committee * • Four actions highlighted to coroner in draft letter. Fifth added –training session to be developed on forensic sections of Mental Health Act • Final version more action-focussed MH: • EDI section should acknowledge EDI aspect TB noted next steps: • Flowchart to monitor PFDs • Actions inputted onto Ulysses system for tracking • Live PFD action plans brought to weekly investigation panel meeting until completed • Report PFD actions clearly in IPQRs to give QAC assurance ** **Committee received the report and noted the next steps for assurance.**	TB/FO ** ACTION TB
QAC22/07/362	**Quality Related Policies** **Policy Governance – Ratification of Decisions by Policy Governance Group (PGG)** Committee received the report from Deborah Lawrenson for ratification. The policies detailed within the report had been through the governance process and the Committee were asked to ratify the recommendations. Committee noted that one policy was extended, and one policy was deferred due to PGG's quoracy issues. **Committee received the report and approved the recommendations.**	
QAC22/07/363	**Board Assurance Framework** Committee received the report from Deborah Lawrenson for assurance. • June session to review 2022-23 risks • Feedback from Board members received • Descriptions of risks to be overseen by QAC – final comments requested from committee • Scoring and gaps in controls – assurance detailed in report Chair: • Need more clarity on which actions would lead to risk reduction • Evaluate agendas on an ongoing basis to link with BAF – Chair and BM to discuss approach to doing this * **Committee received the report, were assured by the content and no further feedback was given.**	* ACTION HS/BM
QAC22/07/364	**Corporate Risk Register** Committee received the report from Deborah Lawrenson for assurance. Chair noted: • Safeguarding risk rating reduced – assurance received of ongoing work • Three risks closed - o Complaints will not be responded to in a timely manner – evidence to the contrary, therefore closure of risk o Risk of physical harm to service users due to absence of physical health monitoring – discussed at QAC for assurance, therefore closure o Progress with Back to Good hindered due to Omicron variant -	

	considered to be closed **Committee received the report and were assured by the improvements.**	
QAC22/07/365	**Self-Assessment Review of Committee Effectiveness** Committee received the report from Deborah Lawrenson for approval. • Future format to be reviewed – include space for commentary • Good response from committee members • Committee to receive the QAC annual report on effectiveness August 2022 from BM Chair: • Committee to set a series of objectives for the year * **Committee received the report and noted the themes. The Chair thanked the committee for their positive feedback.**	* ACTION HS/BM
QAC22/07/366	**QAC Terms of Reference (TOR) Review** Committee received the report from Deborah Lawrenson for approval. • Quorum section – detail included regarding deputies • Governance structure to be added in * • CCG removed from attendee list • QAC asked to approve TORs BM: • Once approved – meeting invitations to be amended to reflect changes to attendee list ** **Committee received the report and approved the TORs subject to the addition of the governance structure.**	*ACTION FO **ACTION FO
QAC22/07/367	**Emerging Quality Risks** Committee received the verbal report from Beverley Murphy for assurance. • Committee to be aware of the impact of living with Covid19 on services - as communities have opened up staff across a range of services have contracted Covid19 • Absence of coherent data on staffing levels is impeding management of the risk in terms of pace and efficiency • Most recent regional public health update estimated upcoming peak to be 10% of April 2022 peak • Annual leave could add to the issue • Quality of data continues to be raised at People Committee and may be put forward as a BAF risk **Committee received the report and noted the information shared.**	
QAC22/07/368	**Any Other Business** - MHA review of CYP access and admission pathway Sheffield (verbal report) BM: • Report received from the Sheffield Patient-Led Assessments of Care Environment review by the CQC of the care of children and young people in crisis	

	• SHSC has engaged with Sheffield Teaching Hospital (STH), Children's Hospital, and CCG in planning a response • No actions specific to SHSC • SHSC's partnership working has been recognised by CQC and reported to regional Chief Nurse - assure the Board • SHSC is advocating the use of a specialist in the assessment process, as per the code of practice, supporting the view of Approved Mental Health Professionals that this is best practice	
QAC22/07/369	**Annual Work Plan** Committee noted the workplan. Six-monthly reports are now highlighted in green. Workplan reflects evolving nature of the committee in a staged approach. Colour key to be added to workplan * Deferred items to include explanation of deferral ** **Alert, Assure & Advise: Significant issues to report to the Board of Directors** **Alert:** • Flow, CPA reviews – some signs of improvement seen, hope they will be consolidated in the next IPQR • Waiting lists continue to be significant cause for concern – new BAF risk, paper to go to Board after it has been to QAC **Assure:** • Community Service Programme progressing well • Learning Disability transformation progressing well, constructive suggestions were made • Complaints responsiveness has improved, future direction is to increase learning from complaints. Training programme for staff and effort to improve experience for complainants • IPC BAF - identified key risks and mitigations • Mortality Report – SHSC is compliant with national standards for learning from deaths and engaged in a process of continuous improvement • Working in partnership with STH and Children's Hospital about crisis care and we are strongly advocating the use of specialists in the assessment process **Advise:** • Positives and improvement in some IPQR measures • RIE Strategy – progressing to an agreed deadline • Thoroughly evaluated outcomes of Ockenden Report and identified recommendations to improve ways of working • Received suggested new BAF risks and noted CRR risks that have been deescalated or removed • Approved review of Terms of Reference	* ACTION FO ** ACTION FO

	Changes in level of assurance - Board Assurance Framework BAF discussed in agenda item. No changes in assurance noted. **Meeting Effectiveness** The Chair thanked everyone for their ongoing hard work and noted that language was now consistent across reports. 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 10 August 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 10 August 2022 at 10am. Members accessed via Microsoft Teams Meeting.

Present:	Heather Smith, Non-Executive Director (Chair)	CHAIR
	Beverley Murphy, Executive Director of Nursing, Professions, and Operations	BM
(Members)	Richard Mills, Non-Executive Director	RM
	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
	Helen Crimlisk, Deputy Medical Director	HC
	Neil Robertson, Director of Operations and Transformation	NR
	Michelle Horspool, Deputy Director of Research	MH
	Sue Barnitt, Head of Clinical Quality Standards	SB
	Jillian Singleton, Infection, Prevention, and Control Nurse	JS
	Simon Barnitt, Head of Nursing, Rehabilitation and Specialist Services	Si.B
	Deborah Lawrenson, Director of Corporate Governance	DL
	Dr Robert Verity, Clinical Director	RV
	Greg Hackney, Head of Service, Crisis, and Emergency	GH
	Emma Harrison, Executive Assistant	EH

Apologies: Christopher Wood, Head of Nursing
Linda Wilkinson, Director of Psychological Services & Consultant Clinical Psychologist
Vin Lewin, Patient Safety Specialist
Dr Jonathan Mitchell, Clinical Director
Dr Mike Hunter, Executive Medical Director (MH)

Minute Ref	Item	Action
QAC22/08/394	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
QAC22/08/395	**Declarations of Interest** Professor Brendan Stone noted his Board membership of Sheffield Flourish.	
QAC22/08/396	**Minutes of the meeting held on 13 July 2022** The minutes of the meeting held on 13 July 2022 were agreed as an accurate record.	
QAC22/08/397	**Matters Arising** The chair noted that the matters arising from the 13 July 2022 meeting were detailed on the action log.	
QAC22/08/398	**Action Log** Committee received the action log for information.	

	Action QAC22/07/361 (b) – BM noted: • BM to check and conclude if action is complete*	***ACTION BM/FO**
QAC22/08/399	**Back to Good Reporting – Full Report (risks for escalation and full report for assurance)** Committee received the report from Sue Barnitt for assurance and endorsement. Full report provides: • Comprehensive overview of risks in exception • Progress and position on open actions, detail of completed actions • Onward reporting of closed actions Risk: • Lack of evidence submission to support closure of actions Mitigation: • Recommendation for new process of escalation and discussion • From 01/09/2022: actions are not marked as *complete awaiting approval* if suitable evidence not received Requirements in exception: • Training, Supervision, Blanket Restrictions, Staffing, Carers • Training and Supervision – impacted by staff vacancies, capacity, sickness • Team is working with managers at ward level Assurances: • Requirements with one action have been closed at pace • Improved position with Dovedale 2 data BS asked regarding Requirement 71: • How many Standard Operating Procedures (SOPs) are outstanding? • Have the four Acute and PICU SOPs been received? The Chair requested a Matters Arising paragraph at September QAC to answer these and include reference to monitoring of engagement with carers and families. * SM confirmed for RM: • Safeguarding Level 3 training below target on most Acute wards • Courses delivered by local authority - training offered is good quality, issue is participation BM asked SB to include in the report what the impact of the risks highlighted, such as staffing, would be and how this is mitigated. SiB added regarding safer staffing: • Briefing template introduced for when under requirement for qualified nurses • Template asks about patient complaints, management, wellbeing issues, incidents • Reports are then sent to BM and SM and discussed with CCG HC added in terms of safer staffing: establishment focusses only on nurses – how can we ensure other staff on wards are brought in to reduce impact on care and nurses? Not enough conjoined work. BM noted: • Is the Trust being ambitious enough in involving carers and families?	***ACTION SB**

	• How do we know and measure that we are making a difference? • Need for Quality team to lead and move this forward Trust-wide SM added: • Back to Good Board purpose is to deliver regulatory actions • Issues discussed (staffing, carers) sits in work of business-as-usual groups The Chair noted that the expectation was that SB would feedback to the relevant group, not necessarily through the Back to Good Board. **Committee received the report and reflected the rich discussion that was had:** • **Wanting more clarification on the involvement of carers and families - ask the relevant group to have more ambition and review what is measured for impact**** • **Safeguarding training - satisfaction with training provider was clarified, established that the key is to find ways to get staff booked on** • **Safer staffing - impacts of this discussed and how it could be enhanced by looking at other groups beyond the nursing groups**	****ACTION SB**
QAC22/08/400	**a. Integrated Performance and Quality Report (IPQR)** Committee received the report from Beverley Murphy for assurance. Highest risk areas: • Waits – paper on agenda • Flow across Acute pathway – some indication might be starting to improve, number of people out of city and away from home has reduced, remains under scrutiny • Care Programme Approach reviews – remains lower than expected in some teams • Supervision rates – not consistently to standard, improvement on some wards but not all • Vacancy rates – changes not quick enough, risks associated with not inducting influx of September/October registrants in a way that leads to retention • Rounded approach to quality of care The number of improvements is increasing and becoming more diverse. New Board Assurance Framework (BAF) risks confirmed for QAC via Board of Directors meeting – working with Performance team to better demonstrate risks and improvements and concerns in line with these. RM added concerns: • Reduction in out of area placements encouraging but note caution regarding Autumn/Winter • Can we be assured e-Rostering will start in September? • Sickness rate good – caution ahead of Winter and potential new Covid19 variant and Southern Hemisphere flu virus • Mandatory training – lowest level within corporate staff – BM to feedback to Executive colleagues* HC regarding CPA reviews: • Concern for some time and not moving forward. In the process of being replaced – do staff feel it is no longer a responsibility?	***ACTION BM**

BM added:

- Out of area placements - GH is linking with Leicestershire Partnership NHS Trust on this, their good practice has been nationally showcased
- E-Rostering critical and must remain a focus. Question around resourcing and pace
- Sickness – should expect and prepare for another wave of Covid related absence. Implementing new guidance as it is received

BM assured of:

- Maple Ward restrictive practice – BM and MH monthly meeting with both clinical directors – sighted and questioning of what care is provided. Specifics driving restrictive practice are understood.
- Catastrophic incidents – small number so small increase can appear larger than it is. No trend in this area.
- Missing persons – were sighted on those two incidents.

Committee received the report, and the Chair acknowledged the areas of improvement:

- **No inappropriate use of out of area beds for older adults since December 2021**
- **Flow is appearing to improve**
- **72 hour waiting standard has shown positive performance for four consecutive months**
- **Use of rapid tranquillisation on G1 continues to improve**

b. Understanding of the waits for care and treatment across SHSC community services

Committee received the report from Greg Hackney for assurance.

GH emphasised that there are nuances in the risks associated with each service.

Single Point of Access (SPA):

- Since 2018 c1000 people on waiting list - 385 waiting for triage, 727 waiting for comprehensive assessment
- Transforming SPA and Emotional Wellbeing Service (EWS) under Primary and Community Mental Health Transformation Programme
- Incremental changes needed – revising triage and assessment function with Voluntary, Community and Social Enterprise (VCSE) and Primary Care Sheffield
- Committee is requested to support with transformation

Recovery Service:

- Core community mental health service in Sheffield – 195 newly referred people waiting to access service, 493 people waiting for reallocation
- Significant risk
- Plan to transform service

Sheffield Eating Disorder Service:

- Working in partnership with All-Age Pathway to streamline access
- 23 people waiting – Trust is within clinical standards for waiting times
- Investment not currently required

- Work needed regarding efficiency

Sheffield Autism and Neurodevelopmental Service (SAANS):

- Comprehensive service offer, two pathways – Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD)
- Significant rise in referral since April 2020 – reflected nationally
- c3000 people waiting for ADHD assessment
- Nearly 2000 people waiting for ASD assessment
- Working with CCG on transformation

Gender Identity Clinic (GIC) service:

- c1700 people waiting for assessment – reflected nationally, service commissioned by NHS England
- Issues relating to staff vacancies
- Investment required from NHS England to meet demand

Perinatal Mental Health Service:

- Performance improvements
- Investment expected through Mental Health Investment Standard in 2023
- Internal work required to improve pathway – not significant risk

Specialist Psychotherapy Service:

- Internal access to service waiting list
- Inefficiencies to address
- Need to strengthen psychotherapy offer across other SHSC services

Community Learning Disability Team:

- 184 people waiting to access professional pathways within the service
- Urgent access to help is offered within 24 hours if required
- Service under transformation to offer community-based intensive support
- Additional request for investment not anticipated
- Engaged in regional discussion regarding requirements for regionally accessed inpatient facility

RM told the Committee it was one of the best papers presented to the Trust:

- Open and upfront about issues, clearly showing how many are historic
- Good to note incremental and transformational change
- Vast service re-design - if successfully implemented will be significant improvement
- Encouraging - gives element of assurance

RM noted:

- How best to present level of change to CQC?
- SPA/EWS assessment process form – challenge for QAC is how to monitor and get feedback
- Recovery Team – was there feedback from 2nd August event?
- Should some risks be on Corporate Risk Register (CRR)?
- How to ensure Neurodiversity Summit gets traction?
- Sickness and vacancies in GIC concerning
- Perinatal Mental Health Service improvements encouraging
- Estates issues regarding Specialist Psychotherapy – part of Leaving Fulwood and significant risk?

HC regarding comprehensive assessments:

- Same information should not be asked for repeatedly
- Is stratification of data possible to identify who has had a comprehensive assessment previously?
- New people - consider prioritising them?

HC regarding SAANS:

- Need to think very differently
- Incidents of autism in population: c2%, ADHD: c2% - currently standalone service for assessments
- Some assessment requests arise due to an issue – dealing with/investigating issue rather than assessment might mitigate that

All links to staff wellbeing – concerning how many teams are struggling.

BS:

- Report includes focus on race and ethnicity, and social and economic disadvantage – needs to be broadened out so QAC and Board understand impact on, and vulnerability to, mental illness
- Reports need more reference to national picture. Pessimistic about mental health services nationally
- GIC – *plans to expedite moves towards transition by not requiring complex co-morbidity formulations* – concerning
- SPA/EWS – planning to use Insight to develop a time limited assessment and intervention pathway – want waiting lists to reduce but not for quality to suffer

OF:

- Good that Equality, Diversity, and Inclusion (EDI) recorded as major consideration
- Important that waiting list for Autism and ADHD being benchmarked

BM regarding Board's support of the team with strategic action:

- Need to engage with strategic partners and commissioners at Integrated Care System level to understand funding per capita weighted to population and demographics
- Want to move costs out of inpatient services and invest in the community services
- Reduction in reliance on agency staff will take time
- Historically, mental health service funding minimal compared to Acute services, we are seeing the impact of this
- Business of Board is to ensure engagement in strategic conversations to bring about change

GH responded to the Committee:

- How regulators are informed of change is being carefully considered
- Duplication in assessment process – plans to reform and work with Primary Care Sheffield
- Recovery Service event feedback – actions agreed including request for temporary resource
- Transition to adult services - Trust is in line with clinical standards
- SAANs already recorded on CRR
- SAANs – co-morbidity issues are picked up by Crisis services
- Specialist Psychotherapy Service and Sheffield Eating Disorder Service to

	be relocated • GIC – agree caution needed relating to moving people along pathway too quickly, work with NHS England GH: requirements will differ between services. Examples: • SAANS - conversations with CCG: holding Neurodiversity Summit to work towards tangible actions • GIC – conversations with NHS England: funding needed NR added: • SPA/EWS – investment/resource question critical, opportunity to streamline service and combine resource with Primary Care Sheffield • SAANS – high level of expertise required to support change management and transformation. Integrated Care Boards – shared opportunities? • GIC challenges - very prescribed pathway, medically orientated assessment process, four-year wait for surgery • Duplication of assessments – also due to policy and culture of risk aversion • Patient and Carer Race Equality Framework (PCREF) and work with VCSE a priority **Committee received the report and emphasised that the Board was fully supportive of the team and grateful for their work. The report will go to Board in September.** **c. Long lengths of stay** Committee received the verbal report from Beverley Murphy for assurance. • Need for understanding around longest length of stay discussed at Board • IPQR is a public paper – individuals must not be identifiable • Monthly process working with clinical directors to understand issues including length of stay **Committee received the verbal report and noted that for assurance it was important for QAC to be kept broadly up to date on long lengths of stay and the minutes not to share personally identifiable data.**	
QAC22/08/401	**Infection, Prevention, and Control (IPC) Annual Report** Committee received the report from Beverley Murphy for assurance. The report is a summation of the detailed quarterly assurance reports to QAC from across the year. Reporting frequency will now reduce to an annual and mid-year report only. Risks remain unchanged: • Compliance with Bare Below the Elbows • Fundamental standards of hand hygiene • Some risks mitigated in-year – detailed in report front sheet BM clarified for RM and OF regarding issues with sharps and waste management: • Historically a risk for mental health teams across many services • SHSC invested in training and understanding for Matrons and Ward Managers over last 12 months • Newly appointed IPC nurses bringing refreshed approach	

	Committee received the report and were assured by the level of attention being given to IPC. QAC recognise the mitigation in place but noted there are still some risks and seek to see those being addressed in the next report.	
QAC22/08/402	**Physical Health Progress Report** Committee received the report from Sue Barnitt for assurance. Overview: • Now recruited to key roles: Lead for Physical Health and Moving and Handling • Risk - limited access to falls data, gap analysis and work plan included in report • All 360Assurance actions now complete • Key Performance Indicators will go to Physical Health Management Group for oversight • Centralised equipment store available for services to hire additional items when needed • Physical health audits on Tendable – further work to do SM: • Actions that will be taken following audits and impact of changes should be noted clearly in future reports* SB clarified for SM that the End of Life Policy being developed is for community end of life care. An inpatient End of Life Policy already exists. **Committee received the report and noted good assurance of oversight of the areas to be improved and the progress made. Further assurance is sought regarding the actions following audits.**	***ACTION SB**
QAC22/08/403	**Mortality Quarterly Report** Committee received the report from Sue Barnitt for assurance, on behalf of Patient Safety Specialist, Vin Lewin. Overview: • 100% of deaths reported internally were subjected to mortality review • Undertaken random sample of deaths reported • All deaths of people with a Learning Disability and Autism reported via appropriate reporting processes • Learning from completed reviews was disseminated to Learning Disability team • Fully compliant with National Quality Board standards for learning from deaths • Work with Better Tomorrow continues – aiming to use dashboard in Quarter 2 • Ongoing work in teams to identify spikes in death rates, and work with Specialist Triage, Assessment and Referral Team and Homeless Assessment and Support Team to review these Chair summarised SM and BM's concerns with the report: • QAC requires increased assurance around focus on learning, changes implemented, impact for service users, input from families and carers SM added that supporting authors with report writing could be key. Presenting data and the learning within reports is a skill. BM and SM to discuss development of this.* We should move to a report that demonstrates the lessons we have	***ACTION**

	learnt, the change in practice and the impact for people who use services. This report would then be supported by the data from reports such as mortality report. **Committee received the report and noted assurance that a robust mortality review system is in place. QAC requested more assurance of learning and impact in future reports.**	**BM/SM**
QAC22/08/404	**Quality Objectives** Progress with quality priorities 2022-23 *Report deferred to September 2022 QAC – report not available, not competed as required by the author.*	
QAC22/08/405	**Safer Staffing Mid-Year Review** Committee received the verbal report from Simon Barnitt for assurance. A full written report will be received by QAC in September 2022. Overview of process: • Annual requirement of National Quality Board to review staffing to ensure it is safe • Method: evidence-based toolkit, professional judgement, and data and quality metrics • Submitted to Board January 2022 • Skill mix for each clinical area reviewed and model designed • Submitted to Finance for costing - worked to remain cost neutral whilst improving skill mix • Model should ensure career pathway on wards, increase retention and ability to have skilled staff out of hours, reduce incidents, reduce bank and agency spend • Budget is almost complete – model can then be implemented **Committee were assured and encouraged by the verbal report and will receive the full written report and proposal at the next QAC meeting.**	
QAC22/08/406	**Claims and Litigation Annual Report** *Report deferred to September 2022 QAC – data not available from external Claims management, Capsticks.*	
QAC22/08/407	**Safeguarding Annual Report** *Report deferred to September 2022 QAC to ensure Safeguarding Assurance Committee received it first.*	
QAC22/08/408	**Quality and Equality Impact Assessments (QEIA) Quarterly Report** *Report deferred to next quarter – no QEIAs to report on.*	
QAC22/08/409	**Research, Innovation, Effectiveness, and Improvement Group Quarterly Report** Committee received the report from Michelle Horspool on behalf of Nick bell, Director of Research Development, for assurance. Risks remain the same as previous quarter. BM: • Not enough assurance received from these reports on the standards of care pathways • Approach to ensure all teams understand standard in terms of best practice, national audits, National Institute for Health and Care Excellence not clear • Resource not being utilised or progressed • Receipt of completed clinical audits is on QAC work plan – these results should be included within the report	

	MH: • Meeting is set up to discuss how teams are delivering against guidance • Detail of projects and clinical audits will be included in future The Chair noted the need for the report to show quality impact. HC: • Connectivity is not coming through **Committee received the report and noted the lack of assurance received from its content.**	
QAC22/08/410	**Substance Misuse Contract Expansion – meeting quality standards and understanding the potential risks due to expansion** Committee received the report from Neil Robertson for consideration. • SHSC have the whole contract, awarded in 2019 • National Drug Strategy released 2021 with commitment to more investment to increase treatment opportunities. NHS England resource regarding gambling • Awarding of resource currently in legal process to understand if it is tendering • QAC August 2022 presented with the paper that went to Finance and Performance Committee • Paper to come back to QAC once flows on resource are more clearly understood **Committee received the report and noted that the paper will return to QAC once there is more information.**	
QAC22/08/411	**Quality Related Policies** **Policy Governance – Ratification of Decisions by Policy Governance Group (PGG)** Committee received the report from Deborah Lawrenson for ratification. The policies detailed within the report had been through the governance process and the Committee were asked to ratify the recommendations. **Committee received the report and approved the recommendations.**	
QAC22/08/412	**Board Assurance Framework (BAF)** Committee received the report from Deborah Lawrenson for assurance. The Chair noted this is the first time the Committee has seen the new QAC BAF risks. The risks were agreed at Board July 2022. BM will display the agenda to make clear the risks so that the committee can make the links between information presented and the BAF risks. Committee will discuss risk ratings during the meeting. *(Action already on action log for September 2022 QAC).* **Committee received the report, noted the new QAC BAF risks, and agreed to discuss further at the next meeting.**	
QAC22/08/413	**Corporate Risk Register (CRR)** Committee received the report from Deborah Lawrenson for assurance.	

	BM told the Committee that the risks had not changed since July 2022. As above, to be discussed further at September 2022 QAC. **Committee received the report and agreed to discuss further at the next meeting.**	
QAC22/08/414	**Annual Report on Committee Effectiveness and Objective Setting 2022-23** Committee received the report from Beverley Murphy for assurance. BM: • RM stated as left Committee January 2022 – to be corrected • Feedback has been carefully considered • Committee need to consider objectives going forward • Frequency of meetings: o August difficult month o Consider either no August meeting or hold meeting slot for most important issues relating to risk o No December meeting agreed in July 2022 updated Terms of Reference – QAC to decide if in a position to reduce to 10 meetings per year • BS attendance to be corrected to 6/6 meetings in year (joined October 2021) DL to send BM a table to include in the report before it goes to Board in September regarding areas for the committee to monitor as assigned by NHS England.* Proposed Committee objectives: • Focus on waits and care in intervening period • Support of Tier 2 committees to operate as effectively as possible • Ensure everything the Committee does is linked to key risks to quality across the organisation • Develop Committee culture of participation to encourage a diverse range of voices Members provided feedback: BS agreed with the need for broader participation but noted how intrinsic BM's comments are. DL: • Very engaged committee that has powerful debates SM: • Opportunity to support in the development of committee member's participation beyond report writing RM: • Important for the wider Trust to be made aware of the work and discussions that take place at Board sub-committee meetings Chair: • Themes such as ensuring EDI of population health, service user involvement, quality improvement, and learning could be linked to the objectives, higher on the agenda, and included in all papers HC: • Staff attending sub-committee meetings is key to enhancing learning and development SM:	***ACTION DL/BM**

	• Agenda item recordings could be placed on Jarvis to allow Tier 2 group members and wider staff to observe the meeting more easily DL regarding Terms of Reference (TORs): • Agreed with Board a check across all TORs to ensure consistency in language – in progress **Committee received the report and agreed that the meeting frequency should reduce to ten meetings. If an essential item comes up, then an extraordinary meeting will be called. August and December meeting dates to remain in the calendar for this reason.**	
QAC22/08/415	**Emerging Quality Risks** Committee received the verbal report from Beverley Murphy for assurance. Committee previously received information regarding the approach to PCREF. Resourcing needs to be reviewed to facilitate delivery against priorities. Delivering PCREF is instrumental to EDI. RM added: • Adastra cyber-attack - SHSC not affected as do not use those systems • Other parts of Acute system under extreme pressure, for example Ambulance services • Cost of living crisis rapidly rising up the agenda – most Trade Unions out to ballot on industrial action **Committee received the report and noted the information shared.**	
QAC22/08/416	**Any Other Business** None – meeting frequency discussed under the *Annual Report on Committee Effectiveness and Objective Setting 2022-23* agenda item.	
QAC22/08/417	**Annual Work Plan** Committee received the work plan for information. **Alert, Assure & Advise: Significant issues to report to the Board of Directors** Due to meeting time, the Chair will prepare the Alert, Assure & Advise Report after the meeting. **Changes in level of assurance - Board Assurance Framework** Committee agreed to discuss the new BAF risks at the September 2022 QAC meeting. **Meeting Effectiveness** Chair thanked the Committee for the work that is being done. Comments were invited in the Chat Box. The Committee were asked to consider how the Trust's Values are modelled within the meeting conduct.	

Date and time of the next meeting: Wednesday 14 September 2022, 10am to 12:30pm
Format: MS Teams
Apologies to Francesca O'Brine, Corporate Assurance Officer
Francesca.O'Brine@shsc.nhs.uk

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	Mental Health Legislation Committee	Date:	21/09/2022	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**	**BAF Risk No**
Least Restrictive Practice Oversight Group	Committee received the quarter one and annual report and expressed concern that CCTV was in use in specific inpatient areas. Assured that this is in accordance with the existing SHSC recording policy but that work is under way to update the policy to reflect the requirements of human rights legislation.	Limited assurance	Alert to Board MHLC quarterly report	BoD 28/09/2022 MHLC 07/12/2022	24 25
Mental Health Legislation Operational Group	Committee were concerned that delays in access to beds following Mental Health Act assessment remains a prominent mental health legislation incident. Committee received the quarter one report and whilst assured that SHSC is compliant overall for mandatory training and all timescales for Section 49 Capacity Act met, there is significant further work to do with specific inpatient teams to improve mental health legislation	Limited assurance	Alert to Board MHLC quarterly report	BoD 28/09/2022 MHLC 07/12/2022	24

	mandatory training compliance				
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
MHA Code of Practice requirement to review the Equality and Human Rights Policy NPCS 010	Committee received the report and were assured of compliance with the requirement.	Good assurance	The summary report is appended to this document for Board's review	BoD 28/09/2022	24
Mental Health Bill	Committee received the report and advise the Board that training, service provision, enhanced oversight of workforce, and the impact on people with a learning disability were discussed and reflected on.	Moderate assurance	Advise Board	BoD 28/09/2022	24 29
Human Rights Training	Committee received the quarterly Human Rights Training report and noted progress.	Good assurance	Quarterly report to MHLC	MHLC 07/12/2022	24
MHLC Annual Report and Tier 2 Effectiveness Reports	Reports were received and approved by the Committee. Committee is relatively young and has made progress and development over the year	Good assurance	Advise Board	BoD 28/09/2022	24 25
MHLC Terms of Reference	Committee reviewed and approved its Terms of Reference	Good assurance	Advise Board	BoD 28/09/2022	24
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Least Restrictive Practice Oversight Group	Committee were assured that SHSC was compliant with Use of Force Act recording with the exception of G1, where there is an ongoing issue regarding recording physical contact to facilitate self-care. Committee noted that there has been an overall reduction in rates of seclusion in SHSC.	Good assurance	MHLC quarterly report	MHLC 07/12/2022	24 25

BAF Risk Description

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

Appendix 1: MHA Code of Practice requirement to review the Equality and Human Rights Policy NPCS 010

Mental Health Legislation Committee

SUMMARY REPORT	Meeting Date:	21.9.22
	Agenda Item:	7

Report Title:	**Assurance of compliance with the requirement of the MHA Code of Practice to review the Equality and Human Rights Policy NPCS 010**	
Author(s):	Jamie Middleton, Head of Mental Health Legislation	
Accountable Director:	Mike Hunter, Executive Medical Director	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	
	Date:	
Key Points recommendations to or previously agreed at:	N/A	

Summary of key points in report

Section 118 Mental Health Act 1983 (as amended) (MHA) requires the Secretary of State to produce an accompanying Code of Practice to the Act. Hospital managers (amongst others) have a legal duty to take the Code into account when discharging functions of the MHA.

Part of the MHA Code of Practice is known as 'Annex B'. Annex B sets out a range of policies, procedures and/or expectations which hospital managers should have or follow. Paragraph 3.15 of the Code stipulates that providers must have a human rights and equality policy in place in respect of the Act and that this should be reviewed by Board (or equivalent) at least annually.

The Trust has a Mental Health Act Code of Practice Equality and Human Rights Policy (NPCS010) in place. This policy is in date and is available on the Trust's intranet system, 'Jarvis'. The policy has a scheduled review date of 30.11.2023. The policy has been through the Trust's policy governance process having been approved by Policy Governance Group on 9.11.20, and ratified by Quality Assurance Committee (QAC) on 23.11.20 (the MHLC was not in place at that date).

On 16.3.22, the Policy was presented to the MHLC where it was both received and acknowledged. The need for the policy to be reviewed at Board level (or equivalent) was added to the work plan.

This paper has been produced, to meet the requirement set out in the Code that the Equality and Human Rights Policy, where Committee is asked to receive this report and be assured that the required policy remains in place. It is recommended, again to meet what is set out in the Code, that this is then reported to the Trust Board as part of the assurance reporting.

Recommendation for the group to consider:							
Consider for Action		**Approval**		**Assurance**	✓	**Information**	
Committee is asked to receive this report and be assured that the required policy is in place, It is recommended that this assurance is escalated to the Board so the requirement within the MHA Code of Practice is complied with.							

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

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission	*Yes*	✓	*No*		Responsive Well-led Effective
IG Governance Toolkit	*Yes*		*No*	✓	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*	✓	*No*		
Financial (revenue &capital)	*Yes*	✓	*No*		*No financial implications identified*
OD/Workforce	*Yes*	✓	*No*		
Equality, Diversity & Inclusion	*Yes*	✓	*No*		*Please complete section 4.2 in the content of your report*
Legal	*Yes*	✓	*No*		

Mental Health Legislation Committee

CONFIRMED Minutes of the Mental Health Legislation Committee held on Wednesday 15 June 2022 at 11:30am. Members accessed via Microsoft Teams Meeting.

Present:	Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director (Chair)	CHAIR
(Members)	Heather Smith, Non-Executive Director	HS
	Dr Mike Hunter, Executive Medical Director	MH
	Salli Midgley, Director of Quality	SM
	Deborah Lawrenson, Director of Corporate Governance	DL
In Attendance:	Jamie Middleton, Head of Mental Health Legislation	JM
	Dr Jonathan Mitchell, Clinical Director	Jo.M
	Tallyn Gray, Human Rights Officer	TG
	Adam Butcher, Patient Advice and Liaison Service (PALS) and Patient and Public Involvement (PPI) Manager	AB
	Amber Wild, Corporate Assurance Manager, (Minutes)	AW
Apologies:	Simon Barnitt, Head of Nursing	
	Dr Robert Verity, Clinical Director	
	Lorena Cain, Restrictive Practice Lead	

Minute Ref	Item	Action
MHLC15/06/01	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies. Jonathan Mitchell, Consultant is present to represent clinical directors	
MHLC15/06/02	**Declarations of Interest** SM declared an interest as Trustee for the Restraint Reduction network.	
MHLC15/06/03	**Minutes of the meeting held on 16 March 20212** The minutes of the meeting held on 16 March 2022 were agreed as an accurate record.	
MHLC15/06/04	**Matters Arising** None	
MHLC15/06/05	**Action Log** • MHLC22/03/50 (2.) relating to the Human Rights Act: JM confirmed that this action is not due until September. • MHLC22/03/50 (2.) in relation to MHA Code of Practice, and Equality and Human Rights Policy: MH confirmed that the Code of Practice compliance standard will be part of the annual cycle of workplan. It has been agreed to take a short paper back to MHLC in September and then to Board in September to advise that the Code of Practice compliance standard has been reviewed by MHLC	

MHLC15/06/06	**Least Restrictive Practice (LRP) Oversight Group** SM provided a summary, on behalf of Lorena Cain on LRP Q4 report and Use of Force Update: a) LRP Q4 Report 3 alerts are highlighted from the group last month: • Use of CCTV – there remains incomplete governance around its utilisation and there is a current review of relevant policies underway. • Assaults on staff – including difficulties with implementation of the no smoking policy on inpatient wards. There is work underway to support staff with safe and therapeutic implementation of the policy. • Inconsistent response of staff alarms at Michael Carlisle Centre - this has been addressed and the work has been completed. • All concerns raised at the last MHLC meeting have been addressed. b) Use of Force Update • The Use of Force update has been completed. • The leaflet has gone for printing but has not yet been distributed and it is expected to be available by the end of this month • Easyread work has been passed to Sheffield Voices to take forward • There is an ongoing long term segregation at the Longley Centre – this is an unusual event and Executive Clinical Directors have oversight of this. An additional risk for committee to note, which has not been added to the report, is in relation to the move from Fulwood: • no training base has been agreed for respect training and there are 2 months left to finalise this. • Proactive work is ongoing with estates colleagues to identify a training space. The committee acknowledged the good work that is going on in relation to the Use of Force leaflet and discussed: • The leaflet will be available in Easyread for service users and accessible to all wards across the organisation • There will be a clear process of how this is going to be used – the co-production work on the leaflet has been strong and the development of a SOP has been incorporated in this work to ensure understanding of its implementation. • This is a co-produced leaflet that has been signed off following wide consultation over 6 months • Wider compositions for accessibility such as different language, different cognition and user formats should be considered In relation to the risk of rising assaults on staff the following discussion was held: • Work is being done in conjunction with the Health and Safety group, and Samantha Crosby (Health and Safety lead) is aware of what is being done • The Violence reduction standards work was published in December 2020 • The rise in incidents is in relation to one inpatient ward • The smoke-free environment work requires a clinical focus due to the implementation of the policy • There are differing approaches across wards to implementing the smoke-free environment • Pete Stewart, QUIT lead, is involved in a specific piece of work that is looking at how the wards should implement the smoke-free environments to ensure a consistent approach	

	In relation to least restrictive practice the following was discussed: • Quality Assurance Committee received the Back to Good report last week and paid particular attention to the completing of the tenable audit in connection with seclusion. The Back to Good report will be going to the next meeting of the Board • The Least Restrictive Practice report covers Quarter 4 and does not align with the Back to Good report which has a more current report and demonstrates progress. • The Use of Force annual report is being written in line with other annual reports, such as safeguarding and IPC. • The Least Restrictive Practice strategy has a 3-year plan – there has been significant progress made in year one which has been detailed in the report. Overall, the use of restrictive practice is reducing with the use of safe wards, the removal of a seclusion room and more personalised care aligned to individual service users Action: discussion to confirm timelines of when to present to the Use of Force Annual Report to MHLC and Board – OFO, MH, SM, DL AB asked if the plan will be presented to service users groups again, SM said that there was a specialist group set up to work with the coproduction of the plan. The Chair queried the Trust's use of CCTV on wards. SM confirmed that the use of CCTV in inpatient settings is permitted so long as appropriate policy and governance is in place. A risk has been identified in this area and there is work being done to understand where CCTV is being used and how it is impacting on Human Rights. The Chair asked what funding was in place for Respect training. SM responded that the planned training had been reviewed and will roll out from July 2022. Additional trainers have been recruited and a business case submitted for the funding for these posts. Action: All formats of the Use of Force booklet will be considered to ensure the broader accessibility and inclusivity of its use and this will be incorporated into the next report to MHLC. LC update members on the production of the booklet in accessible formats to the next meeting.	OFO, MH, SM & DL LC
MHLC15/06/07	**Mental Health Legislation (MHL) Operational Group** Committee received the reports from Jamie Middleton for assurance. a) MHL Q4 Report • Included within the report was additional information that had been added in response to previous discussion at MHLC regarding certain KPIs • Positives: - The Trust has been complaint with the MHL mandatory training - Low levels of use of the short-term holding powers - Significant increase in patients who have had Mental Capacity Assessments when moving from formal to informal patients • Key points: - Risk identified regarding the access to Maple Ward gardens, as this was raised by CQC a year ago. This will not be resolved until the until the ward decants - Section 17 leave – Audit is difficult as data must be manually checked, and the whole policy is being rewritten.	

- Data reporting remains inconsistent
- Court of Protection processes within the Trust have been weak which has significant legal and reputational implications. Improvements have recently been made and are included within the report.
- The Committee noted the Trust's response to a Prevention of Future Deaths letter from the Coroner

HS asked for an Equality analysis and a Patient Experience section to be included within the report as well as clearer risk analysis.

MH highlighted that the evidence in this report satisfied one of the previous actions regarding mental capacity recording.

MH commented that the Section 49 and Court of Protection issues should be an alert for the board and included within corporate risk planning

MH said that Board members attending this meeting should note that the issue of delays highlighted within the Prevention of Future Deaths notice from the Coroner (Regulation 28 Notice) had been raised at this forum.

The Chair noted that staffing levels may be impacting on patient leave and asked if this should be advice/alert. JM responded that reporting methods can be misleading as reporting categories can be subject to staff interpretation. Staff are being reminded how to use categories, and quality assessments of Section 17 breaches are planned.

The Chair asked what legal implementations there were surrounding the delays to works at Maple Ward. Major construction is needed, and a health and safety assessment has recommended that work cannot be done whilst patients are in residence. The Trust is closely engaged with the CQC in relation to timelines for the completion of all building works that will improve patient safety.

b) Liberty Protection Safeguards (LPS) Consultation (for Committee approval)

JM presented and asked members to approve the Trust's feedback before submission.

- Government formal consultation process is still ongoing in relation to the new proposed new code of practice for the Mental Capacity Act and new code for Liberty Protection Safeguards
- Public and organisations are invited to contribute, which consists of 25 questions in an online format.

MH said that JM had consulted appropriately across SHSC and has captured what people are saying. If Members are assured that this has be done sufficiently, feedback will be submitted as one respondent, and the Board will be advised of this.

c) Horizon Scanning Report

Key points:

- Mental Health Act Reform
  - Proposals have been formally announced to parliament during recent Queen's speech
  - Reform proposed at this point is for a complete overhaul which would have a significant impact on Mental Health services. Reforms may change however

	- Timeline is not clear, but the proposals will have to go through the parliamentary processes which could take more than a year - Funding is an issue as if reform does go ahead, a spending review is likely • LPS - Has been through parliament and is running to a different timescale to MHA reform - Possible implications for the Trust: o New legal duties and legal responsibilities, similar to Local Authorities, and would mean that the Trust would be completing LPS authorisations o a new role – approved AMCP (Approved Mental Capacity professional), a local central team to deal with referrals, and an out of hours service. Meetings are taking place between NHSE and neighbouring Trusts to look at how this may work o Assessments to take up to 21 days o ICS input is needed to support local structures DL noted that: • The new AMCP is an addition to the paper presented • A briefing on the Queens speech had been delivered to the Board in their May 22 meeting • The Board had received a Prevention of Future Death Report alert and will receive an update in the learning lessons report that goes to QAC moving forward MH notified members that he had received a Board action asking for more information regarding the impact of Supervised Community treatment. Action: Incorporate response within September 2022 MHL update for Board.	MH, DL
MHLC15/06/08	**Human Rights Framework** Committee received the report from Tallyn Gray for assurance and information. The report gave a detailed update of progress made since it was last presented to the Committee. Three risks have been identified: • Incomplete engagement of Service Users in the upcoming co-production workshop • A lack of staff engagement – significant non-mandatory training programme of 10.5 days spread over 10 weeks • Concern that the number of people going through the training won't be high enough DL asked what was being done to mitigate theses identified risks. TG responded that work is being done to advertise the workshop via Sheffield networks such as the Sunrise Group, Flourish, Disability Sheffield and Carers link. The Communications team are also assisting with promotion via Social Media outlets. Action: share with governors to reach out to their networks for support.	AW & TG
MHLC15/06/09	**AMHAMs** Committee received the report from Jamie Middleton for assurance.	

	• This is the first time that the report is being presented to committee and is a work in progress • Associate Mental Health Act Managers (AMHAMs) have the legal powers to discharge patients from their detentions as an autonomous decision-maker, independent from line management of the Trust. • Currently there are 15 AMHAMs working with the Trust, and this is to increase • Mental Health Act reform is proposing that the AMHAMs role is abolished as the Government is concerned that, nationally, there are very few people who are discharged by them. No patients have been discharged by the AMHAMs in Sheffield over the last year • It is a difficult time locally and nationally for AMHAMs as they feel devalued by proposed changes. • AMHAMs work remotely but want to have face-to-face hearings again • Going forward reporting to MHLC needs to include more training and supervision/appraisal data, and there is work to do around the assurance and quality assurance of their decisions Jo.M commented that the rate of discharge from tribunals is very low too, and said that the AMHAMs appear to be using the criteria appropriately. MH suggested that quality and assurance be highlighted with further iterations of the report. HS asked what measures could be used to enable the Trust to feel assured that the role is being carried out effectively. JM responded that specific measures are hard to identify as AMHAMs are autonomous, independent decision makers. He suggested that the number of adjournments and length of time to hearings could be possible measures. Action: To agree KPI's and include them in future reporting and to instruct an audit to be done on AMHAM record keeping. Update to be given at next MHLC meeting. Action: The Trust chair will be in the quarterly engagement meetings with AMHAM supported by MH and JM.	JM & MH JM & MH
MHLC15/06/10	**Annual Review of Committee Effectiveness** Committee received the report presented by Deborah Lawrenson for review and approval. • The questionnaire had been compiled from a template of questions used in previous year reviews. • There is a need to improve as some disagreement, in particular the third-party assurance question within the Committee Focus section • Committee effectiveness section also has several 'Disagree' responses, and DL confirmed that the Board is the governing body and that it receives AAA reports from this Committee • Committee engagement section is more positive but does show a need to be clearer about relationships with other committees. The committee's annual report to the Board will include examples of where the committee has made an active difference • Committee leadership section regarding the Chair also included some 'Disagree' comments • JM noted that the Chair was new, and the questionnaire did not reflect that.	

	There is a lot to take in and everyone is learning • MH added that the comments should be taken for understanding and development, working together in support of the Committee's progress and effectiveness • DL reminded members that it is still a fairly new Committee having had only four meetings so far Action: Meet to reflect on responses received and incorporate within the Committee's Annual Report of Effectiveness.	DL, MH & OFO
MHLC15/06/11	**TORs for groups feeding into MHLC** Committee received the report from DL for review and approval. • Section 49 Oversight Group - the Section 49 Group is a new group which has been set up to report into the Mental Health Legislation Operational Group - The aim of the Group is to strengthen Section 49 processes - The group will provide rigour and means of testing when to seek legal advice and support writing reports The Chair highlighted that meetings were held "as and when needed" and asked if they could be made more regular. DL responded that the group was fluid, for example, it would meet when Court action is required, and that a schedule of set meetings would not suit the work that it does. • MHLOG - ToR reviewed to ensure that it is fit for purpose **Committee Approved the report.**	
MHLC15/06/12	~~**TORs for MHLC**~~ *TORs are being updated and will be circulated for approval via e-Governance after the meeting ideally to be approved by Bod in July*	
MHLC15/06/13	**Ratification of Decisions by Policy Governance Group** Committee received the report from DL 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. **Committee received the report and approved the recommendations.**	
MHLC15/06/14	**Board Assurance Framework (BAF) – Verbal report** DL assured the Committee that there were no Board Assurance Framework Risks aligned to the Mental Health Legislation Committee. Action: Check that there are no other MHL-related risks across the organisation that need to be captured within the revised BAF.	JM & AW
MHLC15/06/15	**Corporate Risk Register (CRR) – Verbal report** DL reported that two MHLC risks were deescalated from the CRR at the last committee meeting and that a new risk regarding S49 and the Court of Protection would be added following discussion at MHLC today.	
MHLC15/06/16	**Any Other Business**	

	None.	
MHLC15/06/17	**a) <u>Annual Work Plan</u>** Committee received the workplan for information. **b) <u>Significant issues to report to the Board of Directors (Alert, Assure & Advise)</u>** **Alert** • Court of Protection issues • Delays to works at Maple Ward Gardens • Human Rights Framework update – Training **Advise** • Mental Health Act and LPS Reform • Mental Health Legislation Operational Group and prevention of future death reports. • AMHAM update • Annual Review of Committee Effectiveness **Assure** • Mental Capacity Assessments **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 21 September 2022, 11:30am to 1:30pm
Format: MS Teams
Apologies to Francesca O'Brine, Corporate Assurance Officer: <u>Francesca.O'Brine@shsc.nhs.uk</u>

Audit and Risk Committee (ARC)

CONFIRMED Minutes of the Audit and Risk Committee held on Tuesday 14 June 2022 at 10:00am. Members accessed via Microsoft Teams Meeting.

Present:	Anne Dray, Non-Executive Director (Chair)
(Members)	
	Heather Smith, Non-Executive Director (on behalf of Richard Mills)
In Attendance:	Jan Ditheridge, CEO Phillip Easthope, Executive Director of Finance Matt White, Deputy Director of Finance Deborah Lawrenson, Director of Corporate Governance Rashpal Khangura, Director, KPMG Leanne Hawkes, Director, 360Assurance Lianne Richards, Client Manager, 360Assurance
	Chris Taylor, NHS Anti-Crime Specialist, 360Assurance
	Emily Allan, Corporate Assurance Officer, (Minutes) Amber Wild, Corporate Assurance Manager Matthew Moore, Audit Manager, KPMG David Pilsbury, Consultant Terry Geraghty, Emergency Planning Manager

Apologies: Richard Mills, Non-Executive Director
Beverley Murphy, Executive Director of Nursing, Professions and Operations

Minute Ref	Item	Action
ARC2022/06/172	**Welcome & Apologies** The Chair welcomed everyone to the meeting and noted the apologies.	
ARC2022/06/173	**Declarations of Interest** None.	
ARC2022/06/174	**Minutes of the meeting held on 19 April 2022** The minutes of the meeting held on 19 April 2022 were agreed as an accurate record.	
ARC2022/06/175	**Matters Arising & Action Log** Members reviewed and agreed the action log.	
ARC2022/06/176	**360 Assurance Internal Audit Progress Report 2021/22** Committee received the report from Lianne Richards for assurance. LR gave the following updates 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 • IPC and Estates audits: draft terms of reference supplied to the Trust 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 discussions. **360Assurance Final Head of Internal Audit Opinion and Annual Report 2021/22** Committee received the report from Lianne Richards for assurance. LR informed members that the report was largely unchanged since the previous version presented in the April meeting of ARC, and that the score remains at Moderate. **Committee received the reports and noted their content.**	
ARC2022/06/177	**Counter Fraud Annual Report 2021/22** Committee received the report from Chris Taylor for assurance. • The report aims to comply with the Government standards account for fraud as adopted by the NHS Counter Fraud Authority, and it contains a copy of the annual submission • There are significant changes from last year's position, as a lot of work has gone in to achieving green across the board • Improvement work was finalized prior to submission PE asked where the Trust compares within benchmarking. CT responded that the Trust was in a good position, however, inconsistencies in approach between Trusts make comparisons difficult. AD asked how the work had impacted the corporate risk register. MW responded that two risks had been added onto the register because of the work done in this area. **Committee acknowledged the sign off and submission of the report.**	
ARC2022/06/178	**Compliance Against Provider Licence Conditions and Self-Certification 2021/22** Committee received the report from Deborah Lawrenson for assurance, and she highlighted changes made since the last meeting. **Committee received the report and approved for advancement to Board.**	
ARC2022/06/179	**Annual Governance Statement 2021/22 Final Draft**	

	Committee received the report from Deborah Lawrenson. She gave the factual update that the Health & Safety audit is still in progress and a change made to the document in respect of this at the request of Internal Audit. **Committee received the report and approved for advancement to Board.**	
ARC2022/06/180	**Final Annual Report and Accounts 2021/22** Committee received the report from Deborah Lawrenson and Phillip Easthope for approval in advance of Board changes since receipt of the last version were outlined It was noted work was ongoing in respect of external audit on the accounts and was not yet finalised. DL advised the committee that the report is going to the 22 June 2022 Board meeting for approval, and that documents need to be submitted on the same day and therefore any final changes from Board members would be required in advance of this. JD suggested that, due to this tight timeframe, that Board members are asked to submit any material change requests by a set date prior to the meeting and that the deadline for final feedback to be received, is made explicit when papers are circulated. **Committee approved the report for submission to Board subject to the changes discussed during the meeting.**	
ARC2022/06/181	~~**Annual Report 2021/22 – Final draft for approval**~~ *This item was combined with agenda item above.*	
ARC2022/06/182	**Analytical Review 2021/22** Committee received the report from Matt White for assurance. **Committee noted acceptance and approved the report.**	
ARC2022/06/183	**ISA 260 Report 2021/22** Rashpal Khangura and Matthew Moore highlighted to members that they were presenting an update on work currently underway. Key areas have been identified via significant risk flagged in the audit plan: • *Payroll* – Delays in evidence submission have resulted in changes to the audit approach. • *Treatment of Fulwood house through the accounts* – The auditors have received the initial management paper and are now comfortable with the value of the asset held for sale at year end. Queries regarding how the valuation has been reached are being investigated alongside benchmarks. • *Expenditure recognitions* - There have been more challenges this year than in previous years in gaining evidence information. This has now been resolved. • *Management overriding controls* – This is a significant risk area. Issues regarding journal completeness are now resolved and supporting evidence is being received. • *Local Government Pension Scheme* - An estimation of the rate of return will be included within the final ISA260. The Actuary will base their estimates rates of return on this information. The auditor has calculated that the actual rate of return was 2.8% out, which equates to £700,000 The ISA260 is to be updated with account information. The committee was advised by RK that a delay to finalisation was possible and this may impact on	

	the Trust meeting the 22 June submission deadline. PE asked that clarity on the latest position be given in the next few days, noting that although the risk of delay was low, he would need to be advising NHSE/I of any issues before the end of the week. The Chair noted KPMG's caution over submission timescales, expressing concern if this were to result in a delay. She confirmed it was important to continue to strive for submission on the 22 June and this would be the focus for the Trust. She asked when KPMG would be able to advise on their definitive position. RK confirmed he would confirm the position later that week. The Chair asked for confirmation of the approval route of the Annual Report and Accounts were there to be potential for a delay and what the repercussions of this might be. PE re-confirmed he would contact NHSE/I by the end of the week if there is to be a delay with submission and advised there were a number of organisations who would be submitting late and he did not envisage there would be repercussions – however he confirmed he would keep the Chair of the committee updated on discussions with them. Members noted items discussed and delegated approval authority of the ISA260 report to the Chair, a NED, PE and the CEO. Action: PE to organise approval of the final ISA260 report when received from KPMG. **Committee noted information discussed at the meeting and delegated authority to approve the final ISA260 report as to be organised by PE.**	PE
ARC2022/06/184	**Auditors Annual Report** Committee received the draft report from Rashpal Khangura for assurance. • The report will be finalised after audit opinion is gained and will include a summary of the ISA260 within its introduction. • 3 key lines of inquiry have been identified: - Financial Sustainability - Governance - Improving economy, efficiency, and effectiveness • A risk assessment had been completed and 1 key risk had been identified regarding the economy, efficiency and effectiveness • The financial environment is predicted to become more challenging • ICS online from 1st July 2022 which may add a different dynamic to the environment (e.g. potential new processes and working with partners in different ways) • The Auditors confirmed there had been no issues this year that would lead to them raising a significant weakness in respect of governance arrangements • Significant weaknesses were present in relation to the trust failure to achieve statutory and regulatory requirements throughout the year though it was recognised improvements had been made and recognised through the movement on the CQC and SOF ratings • There were VFM issues in 2021/22 but improvements are expected within 22/23 The Chair asked if the reference to internal consultation was referring to a KPMG internal process or to a process within the Trust. RK confirmed this	

	related to internal processes he was required to go through at KPMG, and that this is standard procedure when a significant weakness has been identified. JD stressed the importance of differentiating between progress with well led and the audit opinion as expressed (which related to an additional issue arising at the start of the financial year), when discussing this with the Board noting strengthened processes and controls are now in place in the organisation and the Trust is on track with its planned response to the issues raised through the CQC. RK confirmed KPMG recognise the Trust has made significant progress in response to historic issues, and there is evidence to demonstrate the significant changes made, however, the auditors are required to take the whole financial year under review into consideration when determining the end of year audit opinion. PE added that the Trust had an opportunity to outline the improvement journey and emphasise improvements in governance and reporting. Significant issues are not expected in 2022/23. RK confirmed that the final report will be provided for submission to the Board. **Committee noted receipt of the report.**	
ARC2022/06/185	~~**Draft Management Letter of Representation**~~ *This paper was received and considered as part of the Accounts.*	
ARC2022/06/186	**Emergency Preparedness Resilience & Response (EPRR) Assurance Framework Update** Committee received the report from Terry Geraghty for assurance. TG highlighted the following: • ICBs (Integrated Care Boards) become legal bodies from 1st July 2022 which will make them Category 1 responders • If there was to be a major incident, ICBs would be expected to provide some leadership into strategic coordination • Work is being done looking at what 'On call' will involve and key members of staff • 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 next year • CPR standards: - Now reverting back to pre-pandemic requirements - The Trust are expecting them to be very similar to 2019 standards - A significant difference is that self-assessments will be made available to CQC, who may request evidence • Data protection security toolkit is almost complete **Committee noted the content of the report and members agreed to advise the Board of the Category 1 change.**	
ARC2022/06/187	**Update on declaration of Interests Exercise & to Receive the Register of Interests & Hospitality, Sponsorship & Gifts** Committee received the verbal update from Deborah Lawrenson for assurance. She confirmed declarations are in place for Board and the Council of Governors and work is underway to call in declarations below Board level with declarations already received from Procurement (detail is being provided to internal audit to close off an existing action). The Head of Corporate Assurance is leading this	

	work and will engage with HR to capture changes to the contact list used in 2021 with a view to capturing all declarations by the end of Quarter 2. **Committee noted the position as stated.**	
ARC2022/06/188	**Received Outcome of Externally Facilitated Risk Review** Committee received and welcomed the report for assurance and Deborah Lawrenson introduced the item explaining the report had been commissioned by the Trust to look at the Trust's systems, processes, capacity and capability around risk to support future planning and ongoing improvements. She welcomed external consultant David Pilsbury who talked through a slide presentation (which would also be received at Board), and confirmed his full report would be available for receipt at the June Board Development session. HS asked for confirmation of what was recommended in relation to the Ulysses system, data sets and reporting. DP explained feedback from staff had been mixed in terms of the usability of the system. There is a lack of confidence in some aspects of data and the Trust is not currently utilising data as fully as it could in its reporting and this was an area he recommended be explored. DL noted that the Trust currently escalates risks of 12 and above onto the Corporate Risk Register and Board Assurance Framework and asked for DP's view on whether this was the appropriate level or if the escalation point for the BAF should be higher. DP responded that the Trust is identifying and reporting on more information than other organisations because it is reporting at this level and advised raising it. He added there are examples in other organisations where different risk appetite is used for separate priorities which may also be an area to consider. DL confirmed further discussions on risk appetite were planned at the Board and this was an area which would also be explored through the new Risk Oversight Group. **Committee noted receipt of the report**	
ARC2022/06/189	**Board Assurance Framework (BAF) 2021/22 end of year update** Committee received the report from Deborah Lawrenson for assurance. • The top 3 risks are: - 0025 - the provision of safe therapeutic environments - 0023 - COVID-19 - 0014 - attracting and retaining staff in a very competitive environment • It was confirmed further risks may be escalated because of discussions to be held that day at FPC, for example around the financial position for 2022/23 and through discussions taking place to review and revise risks for the BAF 2022/23 due for initial discussion at the June Board Development session and then Committees and Board for approval in July. **Committee accepted the report.**	
ARC2022/06/190	**Corporate Risk Register (CRR) 2021/22 end of year update** Committee received the report from Deborah Lawrenson for assurance. DL stated that the register is a live document and that movement is reported to Committee. Four risks have been removed from the register, and the review is ongoing. **Committee noted changes and received the report.**	
ARC2022/06/191	**Ratification of Decisions by Policy Governance Group**	

	Committee received the report from Deborah Lawrenson for review and ratification. PGG met on the 13th May 2022 – two policies were presented for ratification: • Claims Policy – following work by the new Director of Corporate Governance and Capsticks (claims service) • Accessing legal advice - Minor changes have been made to support sign posting, and a flowchart has been added. A further review may take place during 2022/23. The policies detailed within the report had been through the governance process and the Committee were asked to ratify the recommendations. **Committee received the report and endorsed the recommendations made within the report.**	
ARC2022/06/192	**Annual Committee Effectiveness Self-Assessment Report** Committee received the report from Deborah Lawrenson for assurance. • Responses received were generally either 'Agree' or 'Strongly agree' and feedback will support generation of the Annual Report from the Committee to the Board and the review of the Terms of Reference due for receipt at the next meeting. • Theintention 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 year. . Action – Work plan to be updated to receive self-effectiveness review in January 2023 and the Annual Report from the Committee in April. **Committee accepted the report.**	EA
ARC2022/06/193	**Data and Information Governance Group (DIGG) – Escalation & Update Report** Committee received the report from Phillip Easthope for assurance. PE highlighted the following areas from the 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 • SARS & FOIs need improved assurance • Unable to confirm 23/24 submission dates but will be able to do so shortly **Committee noted the concerns raised within the report. Members agreed that ARC will continue to monitor the concerns and will escalate them to the Board.**	
ARC2022/06/194	**Governance Processes around Action Plans (ARC priorities 2021/22)** Committee received the verbal report from the Chair for assurance.	

	• Last year ARC discussed as an objective for 2021/22 to determine how action plans within the Trust are tracked • Feedback received from the CQC stated that the Trust had an action plan for Firshill but it had not been completed. There was a risk that other action plans might not be completed • There should be a clear line of sight from the Board through committees to action plans • ARC wishes to have assurance that the Board is aware of all action plans and their state of completion. Action – Discussions to take place with the Director of Strategy and PMO with regard to mapping the monitoring arrangements for action plans in order to bring a report back to the Committee.	DL
ARC2022/06/195	**Any Other Business** None	
ARC2022/06/196	**Meeting Effectiveness** Recognised late submission of some papers which impacted on preparation time. It was noted by DL work will take place between the Trust and the Auditors on the planning for the Annual Report and Accounts for 2022/23 which is expected to address this. **Alert, Assure & Advise: Significant issues to report to the Board of Directors** *Alert:* • Internal Audit Progress Report • Head of Internal Audit Opinion and Annual Report *Assure:* • Ratification of Decisions by Policy Governance Group *Advise***:** • Data and Information Governance Group (DIGG) – Escalation & Update Report • Compliance Against Provider Licence Conditions and Self-Certification 2021/22 • Received Outcome of Externally Facilitated Risk Review • Final Annual Report 2021/22 – Final Annual Accounts 2021/22 • Emergency Preparedness Resilience & Response (EPRR) Assurance Framework Update **Changes in level of assurance - Board Assurance Framework** None. BAF review is ongoing and ARC will be kept informed. **Agreed Actions** To be monitored via Committee Action Log. **Review of Committee Timetable/Work Programme** Committee received the Work Programme for information. July meeting: • Risk management strategy moved to October to give sufficient time to reflect on the outcome of the risk review. • TOR – will be received in July • Tier 2 Committee reporting – moved from June to October to allow time for review. DL will share with members prior to this date for their input.	

	• Annual reports from Committees moved to October. Shared offline prior to this date to support ongoing reporting to the Board. • MHLC Annual report – to confirm if this will go straight to Board. **Action:** Mike Hunter to be asked to confirm if the MHLC Annual report timing for receipt of the report and if this should go via Audit Committee or straight to Board. **Action:** Workplan to be updated to ensure original & deferred dates are noted	EA/FO FO

Date and time of the next meeting: Tuesday 26 July 2022, 3pm to 5pm
Format: MS Teams
Apologies to Francesca O'Brine, Corporate Assurance Officer
Francesca.O'Brine@shsc.nhs.uk

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee: **Audit and Risk Committee** **Date:** **26 July 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**
Annual Report & Accounts 2021/22	Discussion regarding learning on the 2021/22 process and submission	Reflective meetings now held with all those involved in the process.	Actions and timelines agreed in preparation for 2022/23 submission.	To be received at **October** Audit & Risk Committee meeting.
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
360 Assurance Internal Audit Progress Report	Follow up completion rate noted at 78%.	Committee welcomed this improved position and were assured by the steps being taken to maintain it.	Continued monitoring through regular discussion at Executive Directors Meetings.	Further update to be received at part of IA progress report at October's meeting.
	Request to defer Infection Prevention & Control audit to Q3/4 due to changes within the IPC team.		Committee agreed deferral on the basis that the Quality Assurance Committee provide their assurance that this deferral will not pose any additional risk/ impact.	
	Clarity to be sought on committee responsibilities in respect of Health & Safety matters and associated assurance reporting.		Director of Corporate Governance in conjunction with ARC & QAC Chairs and lead Execs	

Freedom to Speak Up Annual Report 2021/22	Report received outlining FTSU activity for the year, including key themes and activity. Planned activity for 2022/23 also noted.	Assurance received re • FTSU Guardian accessibility and reporting for staff to raise concerns. • Support and accessibility for escalation arrangements in place for FTSU Guardian. • Themes and learning.		
ASSURE (Detail here any areas of assurance that the Committee has received)				
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**
Board Assurance Framework / Corporate Risk Register	Committee discussed and approved reviewed BAF & CRR.	Assurance received re processes and development of updated BAF/CRR across committees. Assured regarding development plan going forward.		
Audit & Risk Committee Terms of Reference	Amended terms of reference received.	Noted that further minor amendments were necessary.	Terms of reference to be updated and changes advised to members via email for approval prior to receipt at Board of Directors in September in conjunction with the Committee Annual Reports.	September 2022
Audit & Risk Committee Draft Annual Report	Committee received and approved draft Annual Report.	Inclusion of four committee specific objectives for the coming year noted.		
Data & Information Governance Annual Report, including SIRO and Caldicott Reports 2021/22	Annual Report received and noted.	Assurance received against the Information Governance requirements place on SHSC, particularly in relation to the Data Security Protection Toolkit. Also, assurance regarding plans		

		to address areas where current standards are not yet met and the actions required to adopt a more strategic approach to information governance and cyber security in the future.		
Policy Governance Group	Noted deferral of Password Policy.	Continued positive assurance re process and controls of policy governance.		
360 Assurance Annual Report and Auditors Annual Report	Committee received the final report for assurance	Members were assured that arrangements are being put in place to facilitate the relevant director attending committee to discuss any limited assurance reports received.		

COMMITTEE ALERT, ADVICE, ASSURANCE REPORT TO BOARD

Committee:	People Committee	Date:	13/09/2022	Chair:	Heather Smith

KEY ITEMS DISCUSSED AT THE MEETING					
TO ALERT (Alert the Committee/Board to areas of non-compliance or matters that need addressing urgently)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
Workforce Race Equality Standard (WRES) data	There are issues of concern in our race equality data compared to other trusts, for example the proportionality of promoted posts	The focus will be on harassment and abuse from patients and carers, and for career progression to improve the disparity ratio.	A paper will be presented to November People Committee with a status update on the disparity ratio.	November 2022	20
Supervision and Mandatory Training	Meeting supervision and mandatory training remains a challenge	A communication to managers was proposed to ensure all PDRs are processed which would in turn improve supervision and MT figures.	Workforce team to arrange for a communication to be circulated regarding uploading of PDRs including supervision and Mandatory training	November 2022	20
Short Term Sickness	Short term sickness rates have increased and there is a concern that they will continue to increase over the winter period	Flu and Covid vaccination campaign to mitigate associated absence. Some cases of long-term sickness have been managed in a way that means some people who would have had longer periods of absence are returning to work in a shorter period of time however this can then increase the number of short-term sickness incidents.	Short-term sickness will continue to be monitored in the IPQR and Workforce dashboard to provide the committee with assurance	Ongoing	13
ADVISE (Detail here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)					

Issue	Committee Update	Assurance Received	Action	Timescale	BAF Risk No
Time to appoint	Currently is at 65.5 days but target is 45 days	It was suggested that a metric to monitor individual areas would be beneficial and allow senior leaders to have more input into reducing the time to appoint	Workforce team to look at time to appoint metric by Directorate to monitor more closely.	November 2022	14
Violence and Aggression	The rates are decreasing across the Trust.	A Standard Operating Procedure for reporting Hate Incidents has been approved and a detailed action plan has been developed.	Hate incident metric will be monitored in subsequent reports	Ongoing	20
Inclusion and Equality Group	A KPI dashboard has been created	The timescales for the EDI KPIs will be advised and planned into the People Committee Work Programme to provide further assurance through the year.	Timescales are to be planned into the work programme in order to provide the committee with regular assurance of the data.	Ongoing	20
International recruitment	On track to recruit to target of 20 nurses, offers made to 15 to date.	Funding in place and offers made to 15 nurses.	Further updates will be presented to People committee from the Recruitment and Retention Assurance group.	Ongoing	14
Band 5 Recruitment and Retention Premia (RRP)	RRP for Band 5 nurse has been agreed within agenda for change guidance, and work is progressing	The proposal has been discussed at the Service Delivery Group and the Business Planning Group.	Further updates will be presented to People committee from the Recruitment and Retention Assurance group.	Ongoing	14
Workforce transformation and Recruitment and Retention Assurance groups	The Workforce Transformation and Recruitment and Retention Assurance groups will merge in order to enable strategic assurance, and better alignment of actions to support effective workforce planning and recruitment and retention.	The group will provide focussed reporting to mitigate BAF 14 and delivery of our people plan.	The new assurance group Terms of Reference to be agreed, and work programme is being reviewed to include a schedule for reporting for this group	November 2022	14
Board Assurance Framework(BAF) and Corporate Risk Register (CRR)	The committee considered the BAF and CRRs.	The risk types and appetites were reviewed and updated in line with the BOD recommendations form August 2022.	This is a standing agenda item within People Committee.	Ongoing	13, 14, 20
Conversion from Agency to Bank Staff	The conversion of agency staff to Bank staff lower than anticipated	Work is taking place in the Agency Reduction Project	Tier 2 groups will continue to report into People Committee	Ongoing	14

		Group with workstream actions to reduce agency spend, reporting into the Cost Improvement Programme.	with regular updates		
Workforce Disability Equality Standard (WDES) data	Concern has been raised around the issues with the process of accessing practical reasonable adjustments including procurement of equipment for staff with disabilities	Committee noted the development of the Procurement strategy and to include this area as part of the review	A task and finish group of key stakeholders is in place including representation from procurement	November 2022	20
ASSURE (Detail here any areas of assurance that the Committee has received)					
Issue	**Committee Update**	**Assurance Received**	**Action**	**Timescale**	**BAF Risk No**
ESR/single data point	ESR will become the single data source once validation of information has been concluded	Validation of the data within ESR needs to be completed and then ESR can be used as a single source for data reporting.	No specific actions stated in the meeting	Ongoing	14
Apprenticeships	Apprenticeship performance and use of levy is progressing well	Further updates will be presented to People committee as part of the Workforce transformation and Recruitment and Retention Assurance group.	No specific actions stated in the meeting	Ongoing	14
Long-term sickness	This rate for long-term sickness is decreasing	The data in the dashboard demonstrated a decrease in the number of cases.	Continued monitoring will take place to provide assurance	Ongoing	13
Case Work Data	The volume of case work has reduced and remains low.	The dashboard data confirmed case work numbers have decreased and remain low	Continued monitoring will take place to provide assurance	Ongoing	20
HR Performance Data	The data presented is much more qualitative and allowed the committee to see assurance in the areas it reported on.	The dashboard data is improving and will continue to develop and include additional metrics as appropriate to enable assurance	Continued monitoring will take place to provide assurance	Ongoing	14

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BAF Risk Description:

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

ITEM 3, 13-09-22
CONFIRMED

Sheffield Health and Social Care NHS Foundation Trust

People Committee

Minutes of the People Committee meeting held on Tuesday 12th July 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:	
Karen Dickinson	Head of Workforce Development and Training
Victoria Racher	HR Workforce Systems and information manager
Amber Wild	Corporate Governance Manager
Liz Johnson	Head of Equality and Inclusion
Simon Barnitt	Head of Nursing

In Attendance:	
Samantha Cosby	Health & Safety Manager
Sara Whittaker	Chartered Clinical Psychologist
Charlotte Turnbull	Head of Leadership and Organisational Development
Sarah Bawden	Deputy Director of People
Neil Robertson	Director of Clinical Operations and Transformation
Emily Allan	Corporate Assurance Officer (Minutes)

Min Ref	Item	Action
1/07/22	**Welcome & Apologies** The Chair welcomed everyone to the meeting and apologies were noted.	
2/07/22	**Declaration of interests** No declarations of interest were made.	
3/07/22	**Minutes of the meeting held on 13th May 2022** The minutes of the meeting held on 13th May 2022 were agreed as an accurate record.	
4/07/22	**Matters arising and action log** <u>Action log</u>: Members reviewed the action log: • Reconciliation of the IPQR and the People Performance Dashboard: CP reported that issues are fully sighted on, and that the Chief Digital Information Officer is now in post • Attend a Recruitment & Retention Group meeting and lead an agenda item on the impact of the Cost Improvement Programme on risk 0014: - NR reported that there is a piece of work currently ongoing which is looking at agency CIP	

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	- This is also linked to the vacancy work and the Clinical establishment review (on today's agenda) - Good outputs from Nursing recruitment - 15 offers to international nurses have been made Members approved the action log but emphasised that updates and timescales were needed prior to meeting paper circulation. <u>Matters arising</u>: *i. Apprenticeship levy* Members asked for this to be re-presented at the next meeting with additional information on: - progress/performance data - context and benefits to Trust - Assurance around use of the levy and that it is being made best use of - success outcomes - Any risks Action: Decide on format of presentation for the September PC meeting agenda – another 'Matters arising' item, within the Workforce Transformation agenda item or a specific agenda item.	CP & KD
Staff Voice		
5/07/22	~~**Peer Support Worker Insight**~~ Deferred to September 2022 meeting due to staff availability.	
Performance Monitoring		
6/07/22	**Integrated Performance and Quality Report (IPQR)** Victoria Racher was unable to present due to sickness. Sarah Bowden presented in her place and gave the following overview. • Sickness performance - Continued concern regarding the levels of sickness within the organisation - Month on month performance however has slightly improved - Llong term sickness has decreased - Too early to confirm this as a positive trend due to seasonal cycles and a new wave of COVID - Sickness performance is encouraging however as other similar organisations have reported continuous increases - Additional resource in supporting managers in managing sickness & training on supervision has been allocated • Training and Supervising compliance - Areas of concern for the Trust - Active work streams to support improvement ongoing in these areas - Face-to-face training is the area of most concern, as people are reporting being unable to attend in-person. Work is being done to transfer online • PDR - Completion window very recently completed, and a data check is needed - The vast majority are usually completed within the window but September 'mop up' sessions have gone ahead in previous years AD highlighted that the reports had conflicting sickness trends. SB responded that the	

	Trust has not hit its target which is a concern, however, performance is better than expected. The date on which the reports are run impacts the data produced, which is an issue as reports run at different points of the month. Work is being done to try and bring the reporting together. AD said that the right clear message is needed for the Board and that the use of targets needs to be consistent through the report. RM suggested that the sickness level for infectious disease be shown separately to show the ongoing impact of the Covid pandemic. **The Chair acknowledged the good work on long term sickness management and the impact of this. However, data integrity and consistency of reporting is an increasing risk and needs to be addressed.**	
7/07/22	**Caseworker Tracker** Victoria Racher was unable to present due to sickness. Sarah Bowden presented in her place. SB highlighted the overlap of the HR Performance Dashboard and IPQR so therefore focused her presentation on the Caseworker Tracker: • Two years ago the Trust had 70 active cases. This has reduced to 15 • The average case length is declining and the 22 week target has been achieved and only 7 cases are in breach (will be included in the reporting for the next PC meeting). CP thanked the team effort which had gone into the work to make this significant improvement. The Chair said that this positive news would be reported to the Board.	
Health & Safety		
8/07/22	**Health & Safety report – Q4** Samantha Cosby highlighted key findings to members: • Violence and aggression at work has not progressed as expected and is back on the Health and Safety Committee agenda as new national guidance has been issued. This allows for more focus and further progression • Staff survey results for this are slightly lower than last year The Chair said that the Committee would advise the Board that more progress is needed on the violence and aggression towards staff action. DL reminded members that identifying timescales within reports is critical. She said that an Annual report to Board needed, as well as training for Board members. Action: Produce an annual report for Board NR asked if the right clinical engagement was in place regarding the violence and aggression work and offered his support in this area. The Committee supported this proposal.	DL & SC
People Strategy theme: Equality, Diversity and Inclusion		
Gender Pay Gap Report, WRES Annual Report & Action Plan and WDES Annual Report & Action Plan due at September 2022 meeting.		
People Strategy theme: Health & Wellbeing		
9/07/22	**Staff Health & Wellbeing Group - Report**	

	The Committee received the report and Sarah Bowden gave the following overview: • There has been a move to describing the work of the assurance group more as providing an oversight of the system • There is a significant offer for wellbeing • The Health and well-being framework has been piloted with NHSEI and benchmarking has been done The Chair commented that the paper gave a good oversight of all the initiatives and how Tier 2 groups are working. She highlighted that KPIs are positive and that they give good assurance. NR informed members that he has received positive feedback from the system regarding what the Trust is doing and, in comparison to partners, this offer stands out. CP asked about engagement of people in relation to the Staff survey and the big conversation. SB responded that closer work with staff engagement plans will form part of the wellbeing system. CT commented that engagement work in Health & wellbeing never stops as people's lives change, and that the Trust's repeated messages are a sign of strength. RM noted the change sessions being delivered as part of the move to Centre Court and asked how staff are managing with the move. SB said that this will be brought back to PC at a later date as the Change and engagement review is being done imminently, and the transition is expected to continue after the move. Good communications and a strong project management has resulted in very connected work. AD said that the report reads well but asked what evidence there was. SB responded that the role of national guardians and champions will be picked up with ICB to ensure the right levels of support are achieved, and that data allows for good benchmarking and partnership working in this area. CP informed PC members that the training for the Trust's 24 Mental Health first aiders is on hold. She asked what impact these roles are having and if staff are aware of the resource. The Committee agreed that it could assure the Board of the good progress made in this area, although the benchmarking data will be helpful going forwards. Trying to balance breadth of offer with those actions that have most impact needs to be kept in mind.	
10/07/22	**Workplace Wellbeing Annual Report** The Committee received the report. Sara Whittaker gave an overview of highlights from the report: • The contract with Trust is for 120 clients, but up to 180 have been received in previous years. 167 have been received this year which down on previous years • In addition, the year the Trust has offered an urgent response type service which has seen around 100 staff members • A proactive piece of work offering some reflective practice well-being is being piloted with a Child protection team • A measure of impact: levels of reported anxiety reduced from 80/83% to 72/79% NR asked if the Trust should be working with people longer term as employers or whether it should be referring people to other resources, such as IAPTS. SW replied	

	that the Trust does recommend the use of IAPTS and self-help apps. Clinical staff reluctant to access IAPTS services, as it's seen as a resource for service users. A range of options is therefore needed, including an occupational offer. SW informed members that she would like to look at contracting levels as well as proactively looking at other areas of development. CP responded that this would be looked at as part of a cost benefit analysis and links with work being done to reduce agency spend. The Committee agreed that it would assure the Board that the workplace well-being offer includes some positive impact measures and that it is an effective part of the Trust's overall Health and Well-being provision.	

Deep Dive: Health and Safety BAF risk

SB stated that BAF risk 0013 had been considered within the Health and Wellbeing report presented to this meeting. Controls and Assurances are constantly being reviewed, and the action plan is on track. Maximising engagement is needed to improve controls. Work is to be done which will involve environment and leadership actions becoming controls. The risk score of 12 is accurate, and sickness improvements are not significant enough to warrant a change.

DL notified members that 2022/23 descriptors have been updated. She reminded attendees that updates are needed to show progress, and all actions on the BAF need milestone targets. SB commented that there are some engagement actions which now need to be included.

The Chair commented that this was a useful oversight of the risk and controls in place, with further work planned.

People Strategy theme: Recruitment & Retention		
Recruitment and Retention Group reported on each January, May & September.		
People Strategy theme: Workforce Transformation		
Workforce Planning & Transformation Group reported on each January, May & September		
People Strategy theme: OD, Leadership and Talent		
11/07/22	**Organisational Development Group - Update** Charlotte Turnbull presented the report to members. Key points: • Vacancies still apparent within the team • Staff survey and level of engagement activity positive • Big ticket items, e.g. Leadership development, in place RM commented that the report indicates progress in an historically challenging area, and asked CT for her reflections as a new member of staff. CT said that now she has been able to work with a wider range of groups of staff through away days etc, she is confident that the proposed 'Big conversation' activity exploring cultural issues will be an importance piece of work for SHSC. Staff are still showing negative feelings regarding changes that happened in 2015/17, and Staff side and key senior managers have voiced their commitment in engaging with and supporting this work. AD asked how what CT's team does incorporates the Trust's QI systems. CT responded that the OD part of People Directorate is already working with the QI team on incorporating improvement as a focus on Cohort 2 of the in-house leadership programme and we will work collectively on engagement between managers and how best to support them on delivery and improvement. Once OD Team is fully in place,	

	they will work across SHSC to triangulate data from the Staff Survey, performance team and improvement team to identity more efficiently identify 'high-need teams' and to work them and their leaders. DL asked how learning from high performing areas will be used to improve performance of other areas. CT responded that 'Achievable inspiration' has started. An engagement calendar is being mapped out with Communications to give leaders an idea of activity across the year to engage with e.g. Health & Wellbeing, EDI etc. Themes on away-days and leaders calls will help give leaders and managers ideas around things they can improve on and there has already been success on having SHSC staff speak about their successes and challenges on staff engagement and other topics on the leaders call etc. CP commented that it was helpful to see everything in one place. She had recently attended the final day of the Team SHSC: Developing as leaders, the SHC in-house leadership programme. CP reported that there was a positive atmosphere, and that people were keen to engage, take learning back to their teams and to be part of designing and delivering the next cohort. DL said that it was very positive to see on track items in the summary update. She asked if the grey areas were any areas of concern. CT replied that once resource is in place, she is confident that this will improve. CT identified the following risk areas at this stage of the development of the OD offer: • Commitment from the top – on-going active senior sponsorship is essential • Release time - commitment to release staff to invest in the development and delivery of OD offers eg the Developing as leaders programme, plus participate in them • Culture - bringing together the different threads of addressing our 'heritage of hurt', and our aims of a just and learning culture and compassionate and inclusive leadership will be key to advancing our culture work. A board workshop on culture is being planned. The Chair asked for risks to be reported on in future meetings and commented that progress reporting and showing positive messages would be helpful. Action: Include key risks within future reporting.	CT
OD, Leadership and Talent BAF risk 0020: The Committee accepted the risk rating. A Deep dive into this risk will be done at the next meeting incorporating CT's work.		
Governance		
12/07/22	**People Policies – Ratification of decisions made at PGG** The Committee approved ratifications as recommended by the Policy Governance Group.	
13/07/22	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)** Deborah Lawrenson presented the BAF and CRR to the Committee and gave the following overview: • BAF - Members were asked to approve descriptors, risks, scoring and to give feedback - The June Board development session looked at BAF risk descriptors - Presented to PC today is the updated framework - Risk appetite will be looked at in the August Board meeting.	

	- Further work to done on controls, assurances and milestones RM asked if the Trust is considering replacing the Ulysses system due to the recent issues encountered, and DL replied that teams are making best use of the technology available and that there is no appetite for introducing a new system. She gave assurance that recent issues regarding permissions have now been resolved. AD said that she was happy with the descriptions, but that the committee needs to be confident that actions are 'gap closing'. DL responded that the BAF is now being updated. Committee were happy to merge the biggest risks of Workforce planning/recruitment and retention. Action: Meet to update BAF • CRR - 7 risks are allocated to PC - 6 of these risks are unchanged from the previous meeting - 1 new risk – 4896 – employing/re-employing individuals who give incorrect information. Has a risk score of 12 and was added in response to an audit recommendation regarding controls. Action: Include more context regarding risk 4896 and report at September's meeting	SB, CP, AW & DL SB & DL
14/07/22	**Terms of Reference review** Deborah Lawrenson presented the reviewed Terms of Reference to the Committee and gave the following overview: • Head of Nursing role has been added as a member • Attendee section now includes current titles • Deputies may attend and count towards Quorum • Hierarchy diagram added Action: Head of Nursing to be added to attendees list. Approval given for submission to the Board.	EA
15/07/22	**Review of Committee effectiveness** Deborah Lawrenson presented the reviewed Review of Committee effectiveness report to the Committee and gave the following overview: • The report included results of a Questionnaire which was circulated to attendees • Disagree scores received in flow to other committees, clear information to governing body (confirmation that PC reports to Board) and environment RM asked that the questionnaire is reviewed as it does not capture the nuances of PC. AD suggested that a comments section is added and that separating the views of members and attendees would be helpful. CP observed the quick turnaround of the review and asked if a minimum response rate should be imposed as was very low this year. DL said that no minimum had been set but that she would expect voting members to respond. Future questionnaires will be circulated in Q4 for reporting to April 23 Board. The Chair commented that it would be an improvement to receive more feedback next year and that she would take on board the feedback given.	

16/07/22	**People Committee Annual Review – Draft** CP presented the drafted People Committee Annual Review to the Committee and asked for any feedback. The Chair asked that the report highlights how Tier 2 committees report into PC. DL said that she would give detailed feedback to CP outside of meeting, but that section 6.1 regarding objectives needed more detail. The Chair commented that, bearing in mind some recent feedback from an external consultant, we should try to ensure that Committees receive overviews of auditable evidence and that Tier 2 groups are where detailed action plans are reviewed and assessed. She also suggested that consideration is given to how evidencing our annual objectives is achieved.	
Other		
17/07/22	**Highlights from the Joint Consultative Forum (JCF)** Caroline Parry gave members a verbal update: • 'Normal' T&Cs to apply to absence from July (had been temporarily amended during the Covid Pandemic). On the agenda to discussed at Staff Side, and the HR advisory team are working on this • Webinars on changes to the Pension framework will be offered. The Pension service will be writing to effected staff but the Trust is considering what can be done at a local level • The Trust still does not know what the pay award is. Government updates continue to be monitored • Regarding change projects, Staffside are sufficiently involved, and members feel as though they are being consulted • Reviewing the change process in relation to effectiveness and learning • Deborah Butterworth gave update regarding those social work staff moving back to the Local Authority. It is a Council process, and the Trust is working in partnership with the Council. The impact on morale is a corporate Risk RM recognised the amount of additional work created in the moving of social workers back to the Council. He suggested that the pay award and the impact of the current political climate be put on the agenda of a future PC meeting, and that the Trust needs to continue to support staff through the national Covid sickness T&Cs changes. CP gave assurance that her team would continue to work with staffside and support staff. 10 members of staff are currently off work with long COVID.	
18/07/22	**Any Other Business** None	
19/07/22	**Confirmation of Significant Issues to report to our Board of Directors** a. 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) • Supervision rates are below target • Completion of mandatory training is below expected rates in a limited number of training programmes **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) • Health & Safety matters – more work to be done on the action about supporting staff regarding violence and aggression • Good progress reported with the OD action plan • The Terms of Reference has been reviewed and PC have agreed the draft	

	• Committee effectiveness report received by PC **ASSURE** (areas of assurance that Committee has received) • Good progress with Health & Wellbeing offer **POSITIVE ALERT** (areas of positive improvement) • Although sickness performance remains a concern, improvements are being recorded in this area b. Review of future work programme and agenda items for the following meeting: AD reminded attendees that audit actions must be monitored and closed and asked if audits needed to be included on the work programme. The Chair highlighted that some audits recommendations are due at the end of the summer, and that this should be reflected within the Work programme. Action: Discuss how audits should be included within the work programme during the PC pre-planning meeting.	CP/HS/EA

HS CHECKED **26/07/22**

CONFIRMED **xx-xx-21**

Date and time of next meeting:

Tuesday 13th September 2022, 2:00pm – 4:30pm, via teleconference

Apologies to: BoardCommittees@shsc.nhs.uk