BOARD OF DIRECTORS MEETING (Open)

Date: 12th April 2017 **Item Ref:** 20

TITLE OF PAPER	Quality Assurance Committee Summary Report to the Board of Directors in respect of Significant Issues
TO BE PRESENTED BY	Mr Mervyn Thomas, Chair, Quality Assurance Committee Non-Executive Director
ACTION REQUIRED	For assurance
OUTCOME	To report items of significance discussed at Quality Assurance Committee on 27th March 2017
TIMETABLE FOR DECISION	To be discussed at April's Board of Directors meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Minutes of the Committee
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	Trust Board Assurance Framework – 4.3 NHS Audit Framework
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Timely Reporting to the Board of Directors
CONSIDERATION OF LEGAL ISSUES	None identified.

Author of Report	Mervyn Thomas
Designation	Chair, Quality Assurance Committee (Non-Executive Director)
Date of Report	April 2017

Sheffield City Council

NHS
Sheffield Health and Social Care
NHS Foundation Trust

SUMMARY REPORT

Report to: Board of Directors

Date: 12th April 2017

Subject: Quality Assurance Committee
Summary Report to the Board of Directors in respect of Significant Issues

Presented by: Mervyn Thomas, Chair, Quality Assurance Committee

Author: Tania Baxter, Head of Clinical Governance

1. Purpose

To report to the Board of Directors, items of significance discussed at the Quality Assurance Committee meeting held on 27th March 2017.

2. Summary

Board members will receive the minutes of the Quality Assurance Committee held on 27th March in April. However, the meeting is reviewed and the Committee agreed by means of this report to notify the Board of Directors of the following significant issues.

Restrictive Practice
This report provided data on restraints, seclusions and length of seclusion across the Trust over the past 3 years and outlined the plan for the full implementation of Safer Wards over the next 6 months. The Committee requested regular updates of the oversight of this implementation.

Mental Health Act (MHA) Inspection and Governance Arrangements
These reports detailed the findings from recent inspections at Forest Close and Burbage Ward and the plans that had been developed to address any shortcomings in compliance.

A revised governance structure that will provide more effective governance arrangements across the Mental Health Act and Mental Capacity Act was presented. This will strengthen assurance to ensure that staff are well trained and aware of the legislation requirements so that practice is safe and lawful.

Quality Impact Assessment (QIA) Update
A revised QIA procedure was presented that describes the arrangements for ensuring that all service development and growth plans, CIPs and decisions to disinvest, withdraw or stop providing a service are assessed and monitored in terms of their potential impact on the quality of care.

Incident Management Quarterly Report
This report provided information on incidents across the Trust from 1st October 2016 to 31st December 2016 and the findings that came out of serious incident investigations and reviews of care that were undertaken.

Mortality Procedures
New national procedures for reporting and learning from mortality were published in March 2017. The Committee was appraised of the requirements within this to develop a mortality policy, nominate a Non-Executive Director champion and ensure quarterly reporting both to the Board of Directors and nationally. This will be brought to a future Board of Directors meeting.

Safety Strategy
The Committee was advised that discussions at Executive Director level had commenced in relation to the potential development of a safety strategy for the Trust. This will be discussed at the Board of Directors meeting.

3. Actions

For the Board of Directors to note the issues raised and receive assurance the Quality Assurance Committee take appropriate action.

4. Contact Details

Mervyn Thomas, Chair of Quality Assurance Committee

Quality Assurance Committee (QAC)

Minutes of the Quality Assurance Committee of the Sheffield Health and Social Care NHS Foundation Trust , held on Monday 27th February 2017 at 1pm in Rivelin Boardroom, Old SHSC Headquarters, Fulwood, Sheffield S10 3TH

Present :

1.	Mervyn Thomas	Non Executive Director, Chair
2.	Sue Rogers	Non Executive Director
3.	Richard Mills	Non Executive Director
4.	Clive Clarke	Deputy Chief Executive/Director of Operations
5.	Liz Lightbown	Executive Director of Nursing, Professions & Care Standards
6.	Dr Mike Hunter	Medical Director

In Attendance

7.	Kevan Taylor	Chief Executive
8.	Giz Sangha	Deputy Chief Nurse
9.	Dr Jonathan Mitchell	Associate Medical Director
10.	Tania Baxter	Head of Clinical Governance
11.	Jane Harriman	Deputy Chief Nurse, NHS Sheffield CCG
12.	Sharon Sims	PA to Deputy Chief Executive (Notes)
13.	Katie Ballands	PA to Medical Director (Observer)

Apologies

14.	Phillip Easthope	Executive Director of Finance
15.	Margaret Saunders	Director of Corporate Governance (Board Secretary)

No	Item	Action
	Welcome & Apologies: The Chair welcomed everyone to the meeting and noted apologies.	
1/2/17	**Declarations of Interest** There were no new declarations of interest.	
2/2/17	**Minutes of the meeting held on 23rd January 2017** The minutes of the meeting held on 23rd January 2017 were agreed as an accurate record.	
3/2/17	**Matters Arising & Action Log** <u>3/1/17 Matters Arising – 8/12/16 Mortality Review refers</u> Dr Hunter reported a visit to Bradford, had been organised for March to look at how they run their mortality review group. The Trust's weekly Mortality Review Group, to review all known individuals to the Trust who had died in the week	

preceding, had commenced.

i Action Log
Members reviewed and amended the action log accordingly.

ii Committee work programme
The Chair reported he had met with Dr Hunter and Ms Baxter to review the work programme for the Committee based on the Terms of Reference. A schedule had been produced and would be transposed onto the corporate template, available from Ms Saunders. MH/TB

Mr Clarke questioned the proposal and rationale for continuing with monthly meetings, mindful that August and December in the past had been cancelled. The Chair reported he would be guided on frequency. Dr Hunter reported quality and safety were key areas to focus on over the next 12 months and proposed the schedule is unchanged. Mr Taylor referenced the CQC domains and the needed to strengthened this area. Members supported the rationale for retaining monthly meetings. Ms Lightbown suggested Dr Hunter and herself schedule a "time out" session at the end of March to review the purpose of items and agree a system of prioritisation and leads for items on the agenda. LL/MH

General Governance Arrangements

4/1/17 CQUIN Monitoring/Oversight

Members received the CQUIN Scheme update for Quarter 3. Dr Hunter updated members.

Indicator N1(c) - Flu vaccination for frontline staff. He noted 22% of healthcare workers had been vaccinated in the recent campaign, against a target of 75%. The Trust had not been achieved this CQUIN and would loose circa £179K. Further work on new approaches to focus on behavioural change and influence would support next years' campaign.

Indicator L2 - Care Planning Standards CQUIN had not been achieved. The Trust had not ensured all Home Treatment service users had received a copy of their care plan or their family offered care and support. In negotiation with NHSSCCG it had been agreed that if the Trust achieved 50% in Quarter 4 it would deliver the CQUIN. Dr Hunter reported it was on track to achieve this.

Indicator L5 - Carers assessment CQUIN indicated non achievement. The Trust were required to offer Carers Assessments and those approached become the denominator for the target. Dr Hunter reported the Trust over achieved on offering, and failed to deliver on completion. Discussions with NHSSCCG were on-going and Mr Clarke noted that additional resource had been put in place to progress the completion of assessments. Mrs Rogers raised concern in relation to the delivery of carers needs if they required input or funding resources from local authority or NHSSCCG. Dr Mitchell responded, the majority of carers needs are met by sharing information or signposting to appropriate organisation, service or team. He noted that in some instances the offer is made for an assessment and often the appointment is not taken up.

Ms Lightbown asked it outcomes of Carers assessments could be shared, and whether needs were provided. Dr Mitchell responded, audit plans were being

finalised, the Clinical Effectiveness Group could look at including this area.

Mr Mills asked for clarity in relation to financial planning and non achievement of CQUINS. Mr Clarke responded a level of under achievement had been factored into the plans.

The Chair reported the Committee had received the report for information.

5/2/17 Minutes from Committees

i Service User Safety Group (Dec 2016)

The Committee received the notes for information.

Safety and Excellence in Patient Care

6/2/17 Safety Dashboard

Members received for Safety Dashboard.

Dr Hunter highlighted key points from the report, noting a steady increase in number deaths, The Trust now had to report and review all deaths. Natural cause in the majority of cases had been attributed to the increase and he had not been concerned by the rise.

At the request of the Committee the missing persons data had been separated to identify detained and multi detained patients.

There had been a number of serious incidents across the Trust in January 2017 requiring a review of care, these included: a number of suicides; death by natural cause as an in-patient; missing person found deceased; fire on an in-patient ward, an overdose, a staff assault and three low level medicines errors which had been escalated as a trend. Dr Hunter noted a similar in-depth review had been applied in September 2016 when more than the average, but not excessive number of suicides had occurred across directorates.

Mr Mills asked if there were measures to monitor variances on serious incidents as there appear to be more. Dr Hunter responded, the reporting process had changed during 2015, there had been a sufficient time period to implement control limits.

Ms Harriman queried the significant rise on the infection control chart. Ms Sangha responded the increase had been attributed to category changes, coupled with an increase in reporting.

Mr Thomas referred to the Falls chart and noted there had been a single fall categorised as major, and felt the focus on training had appeared beneficial.

7/2/17 Service User Engagement (SUSEG) Strategy Implementation Plan

The Chair reported the Trust had chosen service user engagement as a quality indicator and the implementation plan to support the strategy was welcomed by the Committee.

Dr Hunter noted the strategy had been ratified by the Board in July 2016. Following consultation and agreement with service users, the draft plan had

	been presented to this Committee in October 2016. The revised version outlined some practical steps to support a move forward. Two new appointments would be made to support the work programme of the implementation plan. He noted the quality improvement team had supported the work of the service user engagement group through a period of sickness absence. Partnership working with the Patient Opinion Service, a non profit making organisation would enable the Trust to seek feedback. Mrs Rogers asked how the Trust's Values Based Recruitment and service user involvement would be reviewed and audited and when it would be embedded. Dr Hunter responded SUSEG would review, holding itself to account. Mrs Rogers asked if the plan would be shared with Council of Governors. The action log included a progress update of the plan to the Council of Governors in October 2017. Ms Baxter noted the Board of Directors would receive the plan in March 2017, she suggested Council of Governors receive a version following Board, to appraise them of the plan prior to receiving an update in October. Mr Mills supported the development of the plan and asked that all dates are populated including when an action had been completed. Ms Lightbown, as a member of Business Planning Group (BPG) asked for clarity on the green rating and assurance there had been service user involvement/engagement on all proposals or business cases, mindful the business case templates were under review. Ms Baxter noted more would be undertaken on this area and the green rating suggested plans were in place and a date would be added, with the suggested of changing to an amber rating. The new team member would support the project, new systems and processes would need time to embed. Ms Harriman asked for clarity on the role of NHSSCCG at SUSEG. Ms Baxter responded, the group would be looking for someone with a role in quality and patient care. Ms Lightbown asked for an inclusion under the SUEMU actions. To ensure an expert by experience was a member of the mock inspection/peer review team in line with regulatory compliance testing. Mr Clarke noted any resource to support an expert by experience on each mock inspection would need to be costed and taken through the appropriate process for approval. The Chair would support presentation to the Board, with a caveat that dates are included in the action plans.	MH/TB
8/2/17	**Eliminating Mixed Sex Accommodation (EMSA) Declaration of Compliance Statement 2017** Members received a revised EMSA declaration of compliance report following receipt at Executive Directors Group. Ms Lightbown noted the Trust are required annually to make a declaration of compliance to the Department of Health. The report presented at this Committee would be presented to the Board in March 2017. She reported the Trust declared they were minimally compliant and explained the configuration of the in-patient areas; The Trust had twelve in-patient wards, six single sex/separate areas and fully complaint, Forest Lodge (2), Forest Close (3)	

	and PICU (en-suite and separate areas). The challenges for maintaining EMSA compliance are on the mixed sex wards, Burgage, Stanage, Maple and Dovedale due to building infrastructure, some wards had single gender areas, facilities or dormitories, which are only accessible via all access main thoroughfares. The ward mangers have to continually review bedroom allocation based on admissions to ensure gender separation and access to facilities to comply with EMSA. There are a number of key elements to monitor compliance including noting in patient records on admission to a mixed sex ward, the Quality and Dignity survey undertaken by service users and the annual Patient Led Assessment of Care and Environment (PLACE) survey. A new electronic system to record service user responses and views had been applied to link with the care records. The Trust were 95% compliant. The Senior Nurse for EMSA liaises with ward staff and NHSSCCG, sets up bi-annual visits and undertakes periodic audits of the care records. The Service and Clinical Director had also been asked to submit proposals for how the wards could improve and ensure compliance with EMSA and operational issues. Ms Lightbown reported no breaches and could assure Committee the Trust were minimally compliant. Mr Taylor noted the Care Quality Commission (CQC) had reported the Trust to be in breach of EMSA, in their initial findings, which would be challenged. Ms Harriman noted NHSSCCG would wait for the outcome of the CQC report. The Committee noted and supported Ms Lightbown's explanation for minimal compliance and would recommend the report to Board of Directors.	
9/2/17	**Quarterly 3 Reports** i <u>Eliminating Mixed Sex Accommodation (EMSA)</u> Members received the EMSA Quarter 3 report. Ms Sangha reported noted the Trust were minimally compliant in the quarter. Challenges are faced on every admission onto a mixed sex ward to ensure the allocation of bedrooms and bathroom facilities and the access routes do not breach regulations. The CQC had reported concerns on some areas including Bungalow 3 at Forest Close, Ms Sangha reported the space was used for activities only, having in the past been considered for use as step down beds. The Chair noted his concern that in order to comply with EMSA service users could be asked to move bedrooms, he asked if there had been any feedback. He also noted the importance of ensuring ward reconfiguration and new capital projects addressed these issues. Mr Taylor reported he did not recall signing off any complaints in relation to breaches in EMSA compliance, and would as the Head of Corporate Affairs to corroborate this.	KT
	ii <u>Safeguarding Children</u> Members received the Safeguarding Children Quarter 3 report. Ms Sangha reported detailed action plans linked to different organisations had been included in the report. She noted significant progress had been made in	

relation to training compliance, as outlined on chart (6.2.1).

Ms Sangha noted the Trust had been asked to review its attendance at child protection conferences., often requests were late or the name of the parent had been omitted making cross reference and identification of service user and responsible team difficult. Systems were improving and a CMHT Specialist Social Worker had been appointed to work across the Trust

The report included details of the current audit programme, written in conjunction with the safeguarding children lead from NHSSCCG.

Mrs Rogers noted she felt more assured with the improvement in training compliance.

The Chair noted the Committee had been asked to agree the Terms of Reference and submission of information to the Truth Project. The Committee agreed to support the requests.

iii Safeguarding Adults

Members received Safeguarding Adults Quarter 3 report. Ms Sangha reported, in line with the Safeguarding Children, the inclusion of detailed action plans. She also noted the increase in safeguarding adult training compliance. A new training plan would be delivered from April to incorporate both children and adult elements, child exploitation and modern slavery. The Trust are looking at linking with other Trusts in relation to policies and delivery of training.

Ms Lightbown referenced a letter from NHS England to Chief Executives (4.2.5) with a recommendation that each Trust had one executive covering both prevent and safeguarding. Ms Lightbown noted prevent had moved from the HR Director to her portfolio and prevent reporting would be incorporated into future safeguarding reports. Data suggested that the Trust and Sheffield had low reporting on prevent issues, the Trust would review the assessment questions and Dr Rhodri Hannan would lead on prevent and work with front line staff to raise awareness and develop a training package.

The Chair noted the Committee had been asked to agree the Terms of Reference and submission of information to the Truth Project. The Committee agreed to support the requests.

iv Infection, Prevention & Control

Members received the Infection, Prevention & Control report for Quarter 3. Ms Sangha reported training compliance had increased.

The Chair asked if Clover group had any specific issues, Ms Sangha responded, there were no significant concerns, root cause analysis had been undertaken in the past following C-Diff outbreaks and the Microbiologist had worked with them on some projects and data collection.

The categorisation of infections had increased eg: reporting eye infection had lead to an increase in reporting for the Trust.

The Chair noted the report had been received for assurance, the Committee were assured.

	v Quality Impact Assessment Members received the Quality Impact Assessment for Quarter 3. Ms Lightbown reported all areas where on track. She noted following evaluation the risk linked to Community mental health staffing had been upgraded to moderate. The Chair noted the report had been received for assurance, the Committee were assured.	
	vi Mental Health Act Committee Members received the Mental Health Act Committee Quarter 3 report. Ms Lightbown reported the head of mental health legislation had commenced in post in January 2017. Future reporting would focus on performance, to give this Committee assurance on a number of areas including, implementation of the code of practice, monitoring CQC visits and following up actions. The weekly compliance audit is monitored by the team to identify any omissions, which are feedback to ward managers. Significant improvements had been made following the introduction of a weekly audit. A monthly report is presented to the MH Act Committee and EDG receive quarterly updates. A monthly community treatment order audit had also been introduced, monitored and shared with MH Act Committee Mrs Rogers queried the number of detained patients in the data on Pg 8, Ms Lightbown clarified the number was cumulative and she would ensure future reporting was clear. Dr Hunter reported the total number of detained patients would be around 80% of total admissions. The Chair noted the report contained a lot of detail down to ward level enabling further investigation of any areas of concern. The Chair asked for clarity on blanket restricted practice, and how this would be stopped. Ms Lightbown responded there was variation in relation to the definition of restricted practice by the CQC and front line staff. Graham Hinchcliffe Interim Care Standards Manager had organised a session on blanket restrictions on 24th March 2017. This will be delivered by Dr Paul Gilluley, Head of Forensic Services, East London NHS Foundation Trust. The Trust's policy and practice would be updated following this session. Ms Lightbown noted restrictions could be applied if the correct process was follwed. Different inspectors may interpret each restriction differently. She used the example of a blanket restriction for searches of patients returning from unescorted leave in forensic services, the rationale for this is patient safety. Mr Taylor reported the Trust had picked this up with CQC in the factual accuracy checking. The Chair noted the report had been received for assurance, the Committee were assured.	
	vii Quarter – Clinical Effectiveness Group Members received the Clinical Effectiveness Group Quarter 3 report. Dr	

	Hunter reported this Committee had concerns in relation to the frequency of meetings of the Clinical Effectiveness Group. He noted the group were now meeting regularly and progressing through their work programme, attendance had also improved. There had been a focus on ensuring all NICE Guidelines were implemented. The Chair noted the report had been received for assurance, the Committee were assured.	
10/2/17	**Porterbrook Clinic Review** Members received the findings of an internal review of Porterbrook Clinic. Dr Hunter reported, following concerns a review had been commissioned on the relationship and sexuality service at Porterbrook Clinic. The areas of concern included waiting times, practice cleanliness, budgetary management and sustainability of training programmes. He noted the service had recently moved into a new directorate, he had visited and felt assured that the areas of concern were being addressed. Commissioners were in discussion with the Trust on future provision of the service. Mr Mills noted Dr Hunter's assurance. He asked when Commissioners would make a decision on the service. Dr Hunter had not been given a date and would report back. Ms Harriman responded, Robert Carter, NHSSCCG's commissioning team would have more information. Mrs Rogers noted the change in assurance and reduction in waiting times. Mr Taylor noted the turnaround of the service, and advised Committee an internal review would be undertaken to ascertain how the service got to the position it did. The Chair reported the Committee had received the report and were assured that improvements had been made.	MH
11/2/17	Committee assurance The Committee agreed the following should be included on the Significant Issues Report to the Board in March 2017. • Porterbrook Clinic Review • Clinical Effectiveness Group – improvements • Service User Engagement Strategy Implementation Plan • EMSA Compliance • MHA Committee Q3 update • Safe Guarding Q3 Report – increase in training compliance	

Date and time of the next meeting
Monday 27th March 2017 at 1pm in Rivelin Boardroom
Apologies to Katie Ballands, PA to Medical Director Katie.ballands@shsc.nhs.uk