Board of Directors – Open

Minutes of the 109th Board of Directors Meeting of Sheffield Health and Social Care NHS Foundation Trust, held on Wednesday, 13 December 2017, in the Tudor Boardroom, Old Fulwood Road, Sheffield, S10 3TG

Present:

1. Ms. Jayne Brown, Chair
2. Mrs. Sue Rogers, Non-Executive Director/Vice Chair, Chair of Workforce & Organisation Development Committee
3. Mr. Kevan Taylor, Chief Executive
4. Mrs. Ann Stanley, Non-Executive Director, Chair of Audit Committee
5. Mr. Richard Mills, Non-Executive Director, Chair of Finance & Investment Committee
6. Mr Mervyn Thomas, Non-Executive Director, Chair of Quality Assurance Committee and Interim Chair of Audit Committee
7. Cllr. Olivia Blake, Non-Executive Director
8. Mr. Clive Clarke, Deputy Chief Executive/Operations Director
9. Mr. Phillip Easthope, Executive Director of Finance
10. Ms. Liz Lightbown, Executive Director of Nursing, Professions & Care Standards
11. Dr. Mike Hunter, Executive Medical Director

In Attendance:

12. Ms. Margaret Saunders, Director of Corporate Governance (Board Secretary)
13. Mr. Dean Wilson, Director of Human Resources (HR)
14. Mrs. Sharon Sims, Personal Assistant to Deputy Chief Executive (Minutes)

Public Gallery:

Ms B Critchlow, Carer Governor
Mr. A. Sharp, Staff Governor
Mr. J Buston, Public Governor
Ms R Farmer
Ms D Smith

	Item	Action
	Welcome & Apologies: The Chair welcomed members of Sheffield Health and Social Care NHS Foundation Trust Board and those in attendance. Apologies were noted and the meeting was quorate.	
	Positive Practice Awards The Chair welcomed team members from Community Enhancing Recovery Team (CERT), Respite Services (Wainwright Crescent) and the Quality Improvement team. All had been nominated in three different categories, representatives from each team had attended the Positive Practice Awards ceremony in Blackpool. All teams received a highly commended award.	

	Mr. Taylor reported he was proud to have attended the awards ceremony, and enjoyed the evening. All teams had been nominated in their respective categories and all had received a highly commended award. Mr Taylor believed by receiving awards in three different categories it highlighted the diversity within the Trust. He gave a brief synopsis of each service, noting CERT were a relatively new service and had established itself as a socially inclusive provider service. Wainwright Crescent, a well established service offering step up/down facilities supporting the transition of service users through in-patient services and also offering respite. The establishment of the Quality Improvement Team has been a significant change for the Trust, embedding quality improvement methodology had contributed to enhancing the Trust's culture. The Board showed their appreciation in the usual way.. The Chair believed Council of Governors (CoG) would benefit from hearing team stories and suggested time was scheduled for a future CoG meeting.	MS
1/12/17	**Declarations of Interest:** Cllr Blake declared an interest in any issues relating to the Trust's Partnership Agreement with the Local Authority, however, it was determined that these were non-pecuniary and would not require Cllr Blake to leave the meeting during discussion relating to these items. No further declarations were made.	
2/12/17	**Minutes of the Board of Directors Meeting Held on 8 November 2017** The minutes of the Open Board of Directors meeting held on 8 November 2017 were agreed as an accurate record and with the following amendment signed off by the Chair accordingly. Amendment: 8i/11/17 Service Performance: *Correction to name: Stevens*	
3/12/17	**Matters Arising** <u>4/11/17 7i/9/17 Service Performance Dashboard period 31 July 2017 refers</u> Mr Easthope reported the zero rating for Early Intervention Psychosis (EIP) had occurred as a result of one month at zero having been reported twice. A review of calculations going forward will be undertaken. <u>7/11/17 Risk Management Strategy 2017 refers</u> Ms Saunders reported as requested, an executive summary had been drafted to support the Strategy and would be circulated to members following the meeting, and noted the Risk Appetite session was scheduled for 28 February 2018. <u>8i/11/17 Service Performance refers</u> Mr Clarke referred to the minute in relation to the Trust's NHS Improvement segmentation rating, and reported he had been in conversation with Mr Andrew Morgan, the Trust's Relationship Manager at NHSI, for clarity on why the Trust had not transferred to Segment 1 as a result of receiving a Care Quality Commission rating of good. Mr Morgan advised the move had not occurred as NHSI wished to continue to monitor the lower than expected Early Intervention in Psychosis (EIP) returns and these would reviewed in December 2017.	

	8ii/11/17 Safer Staffing Report refers Dr Hunter reported CoG would at their meeting in February 2018 receive a report profiling the role of the Associate Physicians. 10/11/17 Board Assurance Framework refers Ms Saunders reported the Board Committee Terms of Reference (ToR) were in draft, meetings had progressed with the committee chairs to review and agree. 11/11/17 PLACE Outcomes Report 2017 refers Mr Easthope referred to the minute relating to organisational food and noted he had received a briefing and would circulate to members.	
4/12/17	**Action Log** Members reviewed and amended the action log accordingly. 16ii/7/17 Associate Mental Health Act Managers Q4 Report refers A thank you letter would be forwarded to the AMHAM's. 17/11/17 CEO Update Hospital Services Review refers Confirmation the Board will receive a presentation on the Hospital Services Review in February 2018. 20/11/17 AOB Patient Safety Event refers Confirmation the Board will receive a presentation on Southern Health from a representative from Mazars.	MS (B/F) MH(B/F)
	Strategy	
5/12/17	**Carers Strategy Implementation - Moving forward** The Chair reported a number of Governors had expressed concerns and asked for assurance there would be consistency in delivering the implementation plan to support the strategy following the return to a substantive post of the individual assigned as the carers lead. The Chair had asked Mr. Wilson to present an update focusing on the progress against the objectives set out in the implementation plan, as approved by the Board in April 2016 and the way forward. Mr. Wilson reported the paper outlined the context alongside plans for implementation and delivery. He noted progress against delivery of the implementation plan had stalled noting the Carers Strategy Implementation Group (CSIG) had not met for a number of months, a further date had been scheduled for 9 January 2018. A number of key points were highlighted from the report: The implementation of the strategy commenced early 2017, there have been continued discussions within the Executive Directors Group (EDG) in relation to governance arrangements and reporting structure. Considerable work has been undertaken in the background and he noted Pam Allen, Carers Strategy Lead had won an award for her work.	

	The majority of the duties under the Care Act (2014) align to Local Authority jurisdiction, notwithstanding the Trust has been involved and received a Commissioning for Quality and Innovation target (CQUIN), and significant efforts were focused on carers assessments. The Trust had also been involved in the development of the citywide Carers Strategy. The CSIG will discuss the next steps, Mr Wilson noted fourteen of the twenty one objectives had been achieved, a number of the remaining objectives would require CSIG decisions. There has been city wide engagement with a number of stakeholders attended CSIG meetings. Progress had been made within Community Mental Health Teams (CMHT) and material and resources available for people undertaking a caring role. The reported concluded with an assessment to date. Mrs. Rogers noted the progress update had given some assurance that work had progressed despite the lack of CSIG meetings. She would like EDG to confirm the executive lead for implementation of the strategy, and to agree the governance and reporting arrangements to a Board committee. She noted there were a number of gaps in the Key Performance Indicators (KPI's) and believed these would be addressed through CSIG. The delivery plan detailed specifics for each directorates, she asked for clarity on who would have an over arching view. Mr. Wilson responded, he believed CSIG would develop the KPI's. The directorates will be expected to bring their delivery plans back into CSIG, Mr. Taylor noted the changes in the clinical directorate restructure and CMHT reconfiguration and corporate were integral factors in the delivery of the Strategy. Mr. Mills, supported the points Mrs Rogers had made, he believed a message from the Board was required to reiterate the support for carers and to acknowledge the contribution they make to the Trust. He welcomed the suggestion that each clinical area develop and drive their delivery plans. He also sought clarity on where the overall management co-ordination, governance and responsibility sits within the Trust and believed resource should be identified to support an advocacy role, but recognised this was an operational decision for EDG. He believed the CoG would raise further points at their next meeting. Cllr. Blake, also sought clarity of the governance arrangements, she noted there were three city wide partnership groups and asked how the Trust were now engaging with them and who was representing the Trust. Mr Wilson responded a new representative had not been identified and was not able to confirm if attendance at meetings had been maintained in the intervening period. Mr. Thomas believed carers may not have been given sufficient attention, he noted there had been commitment to service user engagement alongside emotional and financial investment by the Board. The parallel between service users and carers should be recognised. Mr. Taylor, responded to Mr. Thomas' comment in relation to parallels and noted issues had been historic and cultural within mental health services which needs to be reflected on and addressed to move forward successfully He believed it was timely to refocus perspectives and acknowledge the roles of carers, which will be challenging.	

	Dr Hunter believed there is a drive within the quality agenda in the oversight of this work and to enhance existing links between quality and operations to ensure delivery . The Chair, believed there was general consensus from Board to raise the profile of carer engagement, and use this forum as a launchpad and share with the CoG at the next meeting. She noted the Non Executive Directors (NEDs) expected the Executive team to agree the organisational structure and governance to support progress of the Strategy and report back to Board the decision. The NEDs would focus on ensuring the delivery objectives of the strategy are met, she acknowledged there had been slippage and expected Board to receive a progress update in March 2018. Mrs. Stanley, agreed with Cllr. Blake that partnership working is key to success and believed there was now a gap. Mr Taylor gave assurance that, in the interim, Mr Wilson would ensure the Trust is represented at key external partnership meetings. Cllr. Blake reminded members that the week of 11 June 2018 had been dedicated as Carers week.	DW DW (B/F 3/18)
	Performance Management	
6/12/17	**Service Performance** i <u>Service Performance Dashboard for the period ending 31 October 2017</u> Members received the service performance dashboard for the period ending 31 October 2017 for information and assurance. A number of key areas were highlighted: A new addition includes the reporting of segmentation and KPI's across the Accountable Care System (ACS). It had now been confirmed by NHS Improvement (NHSI) that the Trust are in Segment 2, there had been a expectation the Trust would move into Segment 1, following Care Quality Commission (CQC) rating of Good. Mr. Eastshope noted subsequently the ACS has issued a dashboard and suite of KPI's for monitoring the success of ACS. One key success criteria with a national profile is commencement of treatment within two weeks in the EIP with a target of 53%. The Trust year to date is 43%, he noted this KPI was preventing the move to Segment 1. There is an expectation this would rise in the next period and an updated status and narrative on actions would be provided. Mr Clarke reported, Mr Andrew Morgan, NHSI Relationship Manager had not initially shared this or indicated this was the reason the Trust had not moved to Segment 1. Following conversations Mr Clarke reported the NHSI evaluation group met monthly and NHSI would review the Trust in January 2018, provided the Trust achieve the EIP target over two consecutive months. NHSI had not raised this issue earlier. The Chair asked if other Trust's had experienced similar experiences and if there was consistency as it was not believed the Trust was an outlier.	

Mr Taylor, believed the Trust should manage NHSI constructively, and ensure an early outcome to decisions on segmentation. Mr Easthope added two months monitoring period was consistent with the performance oversight framework.

Dr. Hunter reported he was pleased the discussion was being held in an open board session, and there was openness and transparency in relation to discussions the Trust has had and continue to have with NHSI. Mr Mills, believed the CoG should be informed of the Trust's status in relation to segmentation at their next meeting.

On-going key reporting exceptions for year to date.

- Bed occupancy continues to remain high with additional monitoring, year to date performance remains amber for the year
- Delayed discharges are a key KPI across the system, continued monitoring and reporting, to note October 2017 had seen an improvement. Further narrative included on the IAPT target, to note slight improvement, the additional resource is expected to have further impact in the coming months
- The 7 day follow sustained strong performance and will continue to be monitored
- A slight dip in Annual Care Planning Approach (CPA), an expectation of the Community Mental Health Team reconfiguration, continued monitoring to evidence and seek assurance once the reconfiguration is embedded into February/March 2018
- Continued reporting on Clover dashboard indicators, an outstanding action in relation to comparisons for access waiting times will be addressed through a benchmark exercise across the city and reported to the Joint Executive Board (JEB) for Primary Care.

Overall the financial performance is strong and on plan, for year to date and forecast outturn no key issues to report.

Mrs. Stanley, asked a question relating to bed occupancy noting the narrative of the possible impact on CMHT reconfiguration, she welcomed this statement, noting discussions regarding this issue had taken place during the sign off of the project. She welcomed the reassurance that this did not appear to be impacting on the service and asked how this was being monitored. Dr. Hunter reported bed occupancy was reported daily, information is also shared on potential admissions to ensure flow and management across the system. Mrs. Stanley asked if the change in the supporting structures had impacted, noting this was often of concern to service users.

Mr. Clarke responded the system was exceptionally busy and of concern, mindful of the reconfiguration and directorate changes there were demands on all areas. Daily and weekly bed management meetings occur with representatives from in-patient, home treatment and CMHT. He noted members of the executive team are visiting services/wards regularly to evaluate and support where necessary. He believed the system was manageable and each area is being evaluated. Mrs. Stanley requested this narrative is included in the report to give additional assurance.

	Dr. Hunter believed the current demands in the system were a side effect in the effort to manage and ensure a consistency in quality and safety in patient care. He noted data around admissions, bed occupancy and length of stay etc. were assuring. Ms Lightbown noted re-admission rates could be included as they are recorded. To support the organisation changes EDG had agreed to commission two mobilisation leads to work collaboratively with quality improvement and care standards to develop a suite of metrics and impact assessments to inform an integrated performance dashboard to be used to benchmark changes and outcomes at service user, team and pathway level. This will include referrals, waiting lists, CMHT Survey indicators and regulatory standards. Mr. Mills recognised the challenges within the system, noting Mr. Clarke's comment on careful bed management and Dr. Hunter's belief it is progression to achieving consistency in quality and safety of service users. From his perspective for assurance, he would like to understand what the Board can do to support. He noted the financial report would be discussed in the confidential session and whether there were resources to support short term. He was mindful changes caused impacts and asked if pressures had intensified over previous years. Dr. Hunter quoted figures for 2012 noting occupancy had been at 120% with bed nights circa 4,000 and usage out of area placements. He reiterated the two types of pressures, one being supporting services through transition and secondly the pressures due to the nature of the service, which has been evidenced as normal operating. Mr. Clarke noted recourses have always been managed, he believed the Board had been supportive, team managers and directorate leads have been asked what additional short-term support is required in the interim period. The change agenda is the additional factor that has affected operations. However evidence suggests that these services long term will see improvement this has been compounded with the clinical directorate leadership reorganisation and executives continue to support both. Mr. Easthope noted the change had been both critical and significant and affected all parts of the system, and staff were reporting heightened levels of stress and anxiety. He added in a recent survey Sheffield had been reported as the second most stressed city in the country. Mr. Taylor reported all northern ACS's were reporting similar pressures, he noted all trust's operated different pathway models with varying bed numbers. The Trust cannot assume the model alone is the cause for pressure. The Trust is managing the local change agenda which needs to progress, the dis-benefits on not changing were becoming obvious and believed the degree of change was one that was required. The change agenda is an essential element to drive forward quality. Mrs. Rogers believed she had received a level of assurance from the debate. Mr. Mills acknowledged the strong financial position and noted, due to the timings of meetings the Finance and Investment Committee (FIC) had yet to scrutinise the information. A number of detailed questions would be raised in the confidential session. Mr. Mills noted the steps that had been made in relation to improvements at Darnall (Clover). Mr Easthope responded, progress would continue.	

	Mrs. Rogers noted her concerns the on responsiveness of IAPT (moving to recovery). Dr. Hunter responded it was a regionally observable affect, noting it was possibly linked to IAPT accommodating people with more complex needs, which may limit success and acknowledged the potential redesign the existing approach if required to ensure attendances for additional complexities are available. Mr. Thomas asked for clarity on the meaning of moving to recovery, Dr Hunter responded, IAPT utilised a number of operationally designed outcome scales. Mrs. Rogers noted the percentage for those absent without leave (AWOL) and asked for clarity of what 51% related to. Dr. Hunter responded it related to 51% the total episodes were reported AWOL. Mrs. Rogers noted staff turnover had increased due to known transfer of services, she sought clarity on the rationale for increasing the target range when the transfers were known fact. Mr. Wilson responded the target range would be reviewed, to align with NHSI benchmarking information. The Chair added a number of targets were nationally imposed and she would not expect targets to move unnecessarily or as a result of non achievement. Mrs. Rogers made reference to the decline in the number of service users in employment. Mrs. Stanley sought clarity on what the turnover in the workforce report was conveying, if it included the service changes, as it did not reflect actual attrition. She asked if the Trust were losing staff. Mr. Wilson responded the report was an overarching report for Board, a detailed report is presented to Workforce and Organisation Development Committee (WODC). Mrs. Rogers queried whether the number of assaults on staff was comparable with other Trusts. She noted the Trust's results are published in the performance report, accessible in the public domain and asked if other trusts data was available. Dr. Hunter responded the Trust did not benchmark well in this area, he attributed this to good reporting, noting a significant number were minor incidents. He reported the Restricted Intervention Project Group have been tasked with looking at assaults on staff alongside incidents of restraints and seclusions to identify correlations. Mr. Clarke noted benchmarking data was available. The Chair noted the sound financial position and performance of the finance team. Mr Easthope responded the operational managers had fully supported the team. The Board received the report for information and were assurance.	
	ii Safer Staffing Report for periods ending 31 October 2017 Members received the safer staffing report for the period ending 31 October 2017 for information and assurance. The Chair noted a number of concerns had been raised following receipt of the September 2017 report, and asked if there had been any significant changes.	

	Ms Lightbown noted progress had been made, completion of a deep dive on Rehabilitation and Forensic wards had resulted in improvements to management rate and recruitment to funded establishment in both areas. The next steps will be to review Maple Ward and Learning Disabilities, specifically looking at the rate of management and use of the health rostering safe care module. Higher occupancy was reported during October 2017 at the Michael Carlisle Centre with challenges in relation to recruitment remaining across acute directorate. It was noted following a recruitment drive, new nurses would be joining the Trust between January and March 2018. Dr. Hunter reported medical staffing remained static. From February 2018, Health Education England, Yorkshire and the Humber expect Trusts to intensify their on-call rotas currently for middle grade doctors and higher trainees, at not more than a 1:10 rota. The Trust does not have sufficient trainees to meet this requirement, attributed to recruitment difficulties in psychiatry which is recognised nationally. Alternative models for on-call arrangements were being discussed with the Consultant Psychiatrists was pleased with the response from his colleagues to support a new on-call model. Mrs. Stanley noted significant improvements in reporting. She referenced the narrative on staff assaults and asked whether the number of incidents that had occurred on Maple Ward had any correlation to the 136 Suite. Ms. Lightbown responded as the 136 Suite was located on Maple Ward, there was a direct correlation. Mrs. Rogers noted staffing wards at night appeared less problematic and asked if staff could be moved between day and night shift. Ms. Lightbown responded this was possible, mindful the majority of activity occurs during day shifts and noted there had been an increase in admissions during out of hours. Robust rota management was a key factor and ensuring all staff are competent and trained to work with a diverse client groups Dr. Hunter reported broad system wide changes had an impact. Cambridge and Peterborough NHS FT, which had accelerated the local r CMHT reconfiguration, had reported a reduction in the use of 136 Suite, attributed to more timely care and believed reduced use of the 136 Suite would result in a decline in assaults. Mr. Mills reported Ms. Lightbown had indicated in previous meetings that in 2018 more accurate establishment data and asked when this would be provided. Ms Lightbown responded a group had been convened to start to consider this issue, noting information is currently available from multiple sources. The aim is to collate and analyse the information and review each ward in depth, Maple Ward and the Assessment and Treatment Service (ATS) will be the first focus. The review will include: rota management, reviewing contracted hours, resource and establishment required to meet the changing patient profiles. The group will consist of representatives from Finance, HR, Operations, Corporate Nursing & Professions and IMST. She anticipated the review would be undertaken within twelve months and would like to share progress at a Board Development Session. Mr. Mills believed the information could support future strategic planning.	

	The Chair echoed Mrs. Stanley's comments that the report had significantly improved. Ms.Lightbown responded reports are produced using the Allocate system and the quality of reporting will improve as it is developed. Members received the report and were assured.	LL/MS
	Governance	
7/12/17	**Register of Sealings** Members received the Register of Sealings for approval and assurance. Ms. Saunders presented the report, noting the Board receive the report on a six monthly cycle. Board approved the report and the Chair will sign off the report accordingly.	
8/12/17	**Introduction of Enhanced Disclosure and Barring Service (DBS) check for Governors** The Chair reported the paper received for discussion, could, depending on the outcome of the Board discussion be shared with CoG at their next meeting on 14 December 2017. The Chair spoke openly and believed there may be controversy whichever decision the Board was to take. She noted there were a number of reviews and investigations taking place relating to historical events, the outcome of these were awaited. She believed one recommendation would be for the Trust to DBS check CoG members. Feedback to the CoG should include details regarding the content of an enhanced check, clarity on its purpose and the context in which consideration is given should an issue arise, mindful of vulnerable people. Ms. Saunders reported the paper was a proposal to strengthen governance processes for the Trust's Governors. She noted the introduction of three yearly DBS checks would be in line with the practice undertaken in other Trusts, in conjunction with the introduction of Governor DBS checks, the Trust will also launch a new Governor identify badge. The Chair asked for clarity on resourcing the checks. Ms. Saunders responded the Trust would identity funding. Mr. Thomas supported the proposal to DBS check Governors, he believed there could be heightened anxiety, possibly from a number Governors regarding the introduction and asked for assurance that there would be sensitivity to ensure the right message is relayed, that the check is confidential with a process to address any issues identified, particularly relating to an elected Governor. He believed the introduction of new badges would cause a different issue and would need to be managed rationally and sensitively. The Chair responded, the DBS checks are "a must be done", further conversations regarding introduction of new identify badges will be held at the CoG meeting. Mrs. Rogers reported DBS checks were now commonplace, for employment and personal activities where contact with young and/or vulnerable people occurred. The message to Governors should be DBS checks are standard	

practice and should not inhibit anyone from applying to be a Governor. In relation to the new badge she believed a photograph should be included.

Mr. Mills concurred with the views of Mrs. Rogers, anyone working with vulnerable groups would be required to undertake a DBS check. He asked for clarity on the decision making process if an issue required further investigation, who would progress and whether individuals could appeal. He added a number of organisations set their own criteria for automatic barring. The Chair responded, these questions could be taken into the CoG meeting. In relation to the introduction of new ID badges, Mr. Mills noted there had been misuse and therefore doing nothing was not an option for the Trust, he believed there may be Governors who would be interested in supporting the redesign.

Cllr. Blake supported the comments made by other NEDs.

Mr. Wilson reported he had undertaken checks for various groups ,and all checks would now come under a single bureau. He reported all criminal convictions, noting there was no time limit, would appear on a DBS check. He added that in addition, and following the Soham Murders intelligence collated as part of an investigation is included on enhanced DBS checks. He reported that all staff undertake a check, there is also a contractual obligation for staff to notify their line manager of any criminal convictions whilst in employment. Non disclosure is a disciplinary offence. The results of the check are released to the individual, two weeks prior to the Trust receiving on-line access rights. Any offence on a DBS check would be referred to Mr. Clarke and himself for further evaluation, which has on a number of occasions required a face to face meeting. He noted the evaluation was a fair process, and there were staff working in the Trust who had spent convictions. The Chair asked Mr. Wilson to attend the CoG meeting to answer questions and allay fears.

Mr. Mills noted there were four different levels of checks, and suggested an explanation of each and which one the Trust would use may be beneficial to Governors.

Mr. Taylor reported he had DBS checked a large number of people involved in sports clubs, he noted checks were required for people driving teams to matches, and therefore believed that checks were required for Governors. He believed there needed to be clarity on the process and felt that any check for a Governor that identified convictions must be seen by Ms. Brown in her capacity as Trust Chair.
(Ref: Policy - Criminal Records Checking, Disclosure and Barring (DBS) Service Policy & Procedure. (Jan 2018) Any disclosure would be reviewed by the Director of Corporate Governance (Board Secretary), A Safeguarding Representative and the Trust Chair

Mr. Taylor believed there was strong emotions amongst the Governors in relation to the change in ID badges. He noted NHS staff have a different contractual and governance arrangement as part of the contract of employment, and the Trust's assurance to service users, than that of the role of a Governor. The position and role are significantly different. He was mindful that the view of a number of Governors was that one individual had abused their position, which will result in change for all.

	The Chair asked if members supported recommendations in the report, it was noted all were in agreement, she believed the discussion with CoG needed to be open and transparent.	
9/12/17	**Corporate Calendar** Ms. Saunders, presented a proposal to members, noting following discussion in a number different forums during 2017, there had been a suggestion to review the frequency and purpose of the monthly sessions, currently scheduled as Board of Director meetings . The proposal suggested a combination of formal board meetings and strategic/development sessions, reducing formal meetings from eleven to seven, she noted historically a meeting had not been held in August, the remaining four sessions would focus on strategy and development. The schedule had been devised to ensure critical Board business would not be compromised. eg: year end and planning. A caveat could be included in relation to calling an additional formal open meeting if necessary. The Chair asked members for their views, the proposal was for discussion. Mrs. Stanley welcomed the introduction of a strategy to enable the Board the opportunity to develop and contribute to the production of a strategy. She asked for clarity on timing of the strategy sessions, and for assurance there were no key items requiring discussion or sign off in open Board in March. She noted there was a quarterly reporting dominance in Committees which may impact the purpose of November's meeting. She would also like to have seen the external reporting deadlines in the appendix. The Chair added whatever members decided in relation to changes or frequency, the business of the Board was the priority. Mr. Easthope gave positive reassurance to FIC and Board in relation to signing off the financial plan perspective and primarily needs to meet internal timescales as much as those of the external regulator, and agreed with Mrs. Stanley's comments in the schedule. Mr. Thomas reported he was not comfortable with the proposal, and unsure what problem it was solving, he believed it allowed more time for strategy and felt this could be achieved by managing the Board differently. He believed there would be a reduction in transparency as a number of strategic items had been discussed in open Board. If the strategy sessions were closed and used for deliberation, they would also be on a formal board meeting agenda, noting there may be wide gaps due to timing of the formal meetings and could therefore delay progression. The Chair was unsure, but felt during previous discussion it had been muted to reduce to nine open board meetings. Mr. Thomas reported he had reviewed the schedule of neighbouring Trusts, noting one Board met bi-monthly (Non foundation trust status), his conclusion was the model of monthly meetings appeared to work for other Trusts. Mrs. Rogers disagreed with the proposal and believed it would show a risk in the lack of contact, understanding and keeping up to date, a lack of being aware of the pressures on executive colleagues. She believed there were too	

	many gaps, noting the loss of a third of public meetings and accountability. She appreciated the requirement for development, noting they had been valuable, mindful of time pressures of members. Alternatives to accommodate strategy and development sessions could be further explored. Mr. Mills believed the proposal did not manifestly make the case for change and would require something more significant and comprehensive to suggest a major change. He was not totally opposed to reducing the number of open meetings, and would not be unhappy reducing to nine, if the remaining closed sessions were used appropriately and more effectively. The quid pro quo would be to review the meetings and use the time more effectively. Each Board Committee have a comprehensive work plan, with a set agenda, sharing the agenda planning for the Board, would identify any gaps and therefore a rationale for not having a meeting at specific times of the year eg: August. He noted there had been valuable work achieved over the previous Board meetings, however the agenda had been light in content, and was this the best use of time. The NEDs should hold the Executives to account in relation to the agenda content of Board meetings, he added he would welcome more strategy sessions, and realised the practicalities of scheduling requires further exploration. Cllr. Blake reported she understood the views of Mrs. Rogers and Mr. Thomas, and felt there needed to be more of a focus on strategy and agreed that the last few meetings had been light on strategy. She believed reducing to nine Open Board meetings would ensure continuity of business and address the points raised by Mrs. Stanley and Mr. Mills. Mr. Clarke reported the proposal was discussed at EDG, and noted strategic development had been a key driver in proposing change of use of Board time, NEDs had feedback they wished to be engaged at early stages of development, a change in use of the Board's time would allow for focused in-depth discussion and to engage fully with the NED's at the early stages. The Chair believed this was still the views of the NED's. Mr. Easthope reported he supported the proposal, he believed it did not take away the transparency of the Trust, and there had been no suggestion that decisions or scheme of delegation is changed. The time could be used better from a business perspective, reducing to nine could be a good starting point during a transitional period. Further consideration would be required, if the Board required post quarterly reporting, he added there would need to be a meeting in August and the Board dates bought forward a week. An improvement from his perspective, and to support the running of the Trust would be frequent dedicated time for strategic development and planning, increasing contact between NED's and Exec, leads to improved decision making and overall running of the Trust. The Chair noted comments made and believed the next steps were for the Board to receive a paper to include the following: alignment of the business to the volume of activity, the rationale for the case for change, her personal view was that there was a case for change to reduce Open meetings, her preference would be nine and the transparency of reporting. It would be helpful to see a number of options for the Board to consider and make an informed decision. The Chair suggested Audit Committee receive the paper in the first instance.	MS (Apr 18)

	Board Stakeholder Relations & Partnerships	
10/12/17	**Chair's Update** The Chair reported the Council of Governors would receive a proposal to extend the terms of office of Mrs. Rogers and Mr. Thomas to 31 March 2018, to enable the two months of shadowing for the new NED appointments, she was also mindful of the significant projects over the next three month period. The NED posts had attracted fifty-seven applications, a significant number are of a very high quality and the recruitment panel will be meeting to undertake the shortlisting exercise. Mr. Thomas, in his capacity at interim Chair of Audit Committee and the Chair had attended an event for Audit Committee Chairs. She noted this had built on an early session attended by Mrs. Stanley as Chair of Audit Committee. The ACS had organised a workshop to share thinking on future governance arrangements and the management of decision making albeit nothing had been determined to date. The Chair had attended an event on 4 December 2017, "Working Together" focusing on Black, Minority and Ethnic (BME) staff in the Trust, she noted the talent, enthusiasm and commitment from staff who had shared their stories, career journeys and development of themselves as individuals. Three Governors had requested a one to one session, with meetings held to discuss their particular issues and feedback. This facility may potentially be extended to service users. Mr. Mills noted there had been heightened national media activity in relation to NHS pressures and the Autumn Statement, he asked if there had been any discussion by Chairs. The Chair responded, the Sheffield Chairs had met The Chair reported she had been elected to represent the Chairs' of Mental Health Trusts to the Board of Trustees of NHS Providers.	
11/12/17	**Governor's & Membership Matters** Members received and noted the update on membership and Governor activity for information.	
	Executive Management Updates	
12/12/17	**Chief Executive's Update** Mr. Taylor asked Mr. Wilson to update on the Doctors in Training Programme. Mr. Wilson reported the Trust were one of twelve pilot sites as part of the national streamlining group, they had identified a number of key areas of focus. "Doctors in Training" an initiative for developing junior doctors in Trusts, collaborative working with Medical staffing. Mr. Wilson reported the Trust were in 2nd cohort of the NHS Improvement Retention Programme. Ms. Lightbown, Ms, Sangha, Deputy Chief Nurse and Ms. Parry, Deputy HR Director were involved in the project. The Trust had already started to review recruitment and retention internally, and would now be involved from a national perspective.	

	Mr Easthope updated members on the Leaving Fulwood Project, noting key issues from the discussion at EDG. The project had been delayed, due to circumstances beyond the control of the Trust, attributed to the interdependence of Health Services Communications Network (HSCN), formally known as N3 and noted there were national delays to infrastructure and specification. The conclusion from discussion at EDG was this was a significant emerging issue and following a robust risk assessment concluded it would be detrimental to the Trust to move to a location that could not support the infrastructure. Any building previously occupied by an NHS organisations would probably have N3. EDG considered the risks and did acknowledge the national infrastructure had previously been delayed. The Trust has put itself forward as a pilot for the new infrastructure and will include detailed conversations at system level to ensure the Trust is in a better position should there be further delay. A review will be undertaken on the specification in relation to telecoms infrastructure and datacentre. The Options Appraisal will be re-evaluated and the recommendation is to delay the move until Quarter 3-4 2018/19, this equates to a six month delay. Mrs. Rogers asked for confirmation that the delay moving from the Fulwood site was due to technical IMST issues and did not affect staff. Mr. Easthope confirmed staff had relocated to NHS buildings which supported IMST requirements. Mr. Mills supported Mr. Easthope's rationale for the delay in moving from Fulwood, noting the risks of moving to a non NHS site, A progress report was requested which could formally be shared, as an audit trail, for FIC and and/or Board of Directors. Mr. Easthope prior to any other governance routes wished to update the Board on the Acute Care Reconfiguration Phase 2. He reported EDG had received a number of reports. The historical case and narrative had been received to support the business case and with the addition of narrative from a clinical perspective would also be presented to FIC. The outline of options in the business case had been shared with EDG, the key purpose of this was to agree the do minimal option, a requirement from NHS I and within guidelines of the Treasury manual. EDG were unable to sign this off and raised concerns in relation to access of external space and minimal bedroom size. Due to the delay in receipt of the outline business case, this coupled with the do minimal option not agreed by EDG, Mr. Easthope would be deferring the report to Business Planning Group on 19 December 2017, therefore there would be further delays, with the business case unavailable for FIC in January 2018 or the Board in February 2018. New Regulations had been published in relation to Section 135 and 136. Mr. Clarke had met with South Yorkshire Police and South Yorkshire Ambulance Service, and a new escalation policy had been produced. The Trust are compliant with the new regulations.	PE CC (date)

	It was reported the A & E Liaison service had extended its operating hours to cover 24/7. The Board welcomed this achievement. The Access Hub will go live at Netherthope House on Monday 19 December 2017. This will be the core for mental health teams operating Monday to Friday 9am to 5pm, the building will remain open 24/7 and become the access point to services. Mr. Taylor requested a formal update to Board in relation to the contractual arrangements with the Trust and Sheffield City Council. Noting the Trust will move from the current contracting arrangements of commissioner provider split, to a single investment plan and target for Sheffield moving into 2018. Mr. Taylor reported Mr. Clarke had on his behalf attended a meeting with the Chief Executive of South Yorkshire Housing, further meetings are planned for January 2018 and a Board to Board scheduled for April 2018. Mr Clarke reported there was £20m available from Winter Pressure monies allocated to mental health providers, the Trust had submitted a bid for £200k to support capacity in the Single Point of Access (SPA), out of hours home treatment, Wainwright Crescent and Crisis House, with a small element in Child and Adolescent Mental Health (CAMHS) in collaboration with Sheffield Children's' Hospital NHS FT (SCHFT). Mr. Taylor reported a Rule 28 had been served on the Trust by the Coroner, following the death of a minor who was in transition between CAMHS and the Trust. There was collaboration working with SCHFT and an exec to exec meeting had been organised for mid January 2018. Mr Clarke reported there had been extensive in relation to employment, a number of bids had been submitted in relation to employment opportunities to support services users. Mr. Mills believed this was an important work for the Trust noting he had attended a Sheffield Hallam seminar on homelessness, employment and the impact of Department of Work and Pensions (DWP) sanctions, which may impact on the mental health services, and housing.	
	Reports for Information and Assurance	
13/12/17	**Quarter 2 Reports** **i.** Infection, Prevention and Control **ii.** Mental Health Act Committee **iii.** Mental Capacity Act and Deprivation of Liberty Steering Group The above reports were received for information, it was reported they had been presented to Quality Assurance Committee (QAC) Mr Thomas, in his capacity as Chair of QAC noted they had all been discussed in Committee.	
14/12/17	**Learning from Deaths – Mortality Dashboard** Dr. Hunter reported there was a requirement to have a policy in place by September and to have presented a paper to Board by the end of Quarter 3. He added the Trust were already reporting at the QAC.	

	The final version of the dashboard had been omitted from the papers and would be circulated to members. Mr. Thomas added there had been a robust discussion at Quality Assurance Committee.	MH (MA Feb)
15/12/17	**Board Committees** **a) Quality Assurance Committee (QAC)** Members received the minutes of the meeting held on 23 October 2017 and the Significant Issues Report from the meeting held on 27 November 2017. Mr Thomas noted the Committee had received the Quality Improvement and Assurance (QIA) Strategy, there was a consensus that the QIA Strategy required a refresh and Dr. Hunter would lead this.	MH
16/12/17	**Any Other Urgent Business** Mr. Mills noted Terry Proudfoot had been appointed as a NED for South Yorkshire Housing Association. The Chair responded she would share this information with CoG.	
17/12/17 18/12/17	**Chief Executive's Announcement of Confidential Business** *The Chief Executive announced the commencement of confidential business in accordance with the published agenda* **Chair's Announcement to Exclude Members of the Public and the Press from the Remainder of the Meeting** *In accordance with Standing Order 3.1 of the Board of Directors' Standing Orders, members of the public and press were excluded from the remainder of the meeting for reasons of confidentiality and business sensitivity of matters to be discussed.*	