BOARD OF DIRECTORS MEETING (Open)

Date: 11 July 2018 **Item Ref:** 19i

TITLE OF PAPER	**Quality Assurance Committee Summary Report to the Board of Directors in respect of Significant Issues**
TO BE PRESENTED BY	Ms Sandie Keene, Chair, Quality Assurance Committee Non-Executive Director
ACTION REQUIRED	For assurance
OUTCOME	To report items of significance discussed at Quality Assurance Committee on 20th June 2018
TIMETABLE FOR DECISION	To be discussed at July's Board of Directors meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Minutes of the Committee
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION+	Strategic Aim: Value for Money Strategic Objective: We will provide sustainable services through ensuring value for money, reducing waste and unproductive time for staff BAF Risk No: A401ii BAF Risk Description: Trust governance systems are not Sufficiently embedded
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Timely Reporting to the Board of Directors
CONSIDERATION OF LEGAL ISSUES	None identified.

Author of Report	Sandie Keene
Designation	Chair, Quality Assurance Committee (Non-Executive Director)
Date of Report	June 2018

SUMMARY REPORT

Report to: Board of Directors

Date: 11July 2018

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

Presented by: Sandie Keene, Chair, Quality Assurance Committee

Author: Mike Hunter, Executive Medical Director

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1. Purpose

To report to the Board of Directors, items of significance discussed at the Quality Assurance Committee meeting held on 20 June 2018.

2. Summary

Board members will receive the minutes of the Quality Assurance Committee held on 20th June in September. 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.

Safety Dashboard

The Safety Dashboard was presented and the committee discussed the potential likelihood that there will be a statistical reduction in the number of falls incidents which will be reflected in the lowering of the control limits. The Committee questioned the apparent increase in the number of self-harm incidents recorded in May 2018 and asked for this to be looked into. The numbers of restraints together with the training and skill mix of staff has recently emerged as an area of concern.

Service User Safety Group Effectiveness Report

The Committee received this report and acknowledged the assurance provided by it. The Committee requested that future reports highlighted assurance on serious incident action plans.

360 Assurance Audit – Nutrition and Hydration Compliance Follow-up

The Committee received assurance that all the actions required from the Internal Audit report on nutrition and hydration had been completed.

Eliminating Mixed Sex Accommodation (EMSA)

The Committee received this report which outlined the various guidance that surrounds this issue. The challenges and risks involved in moving to single sex or remaining mixed sex were discussed at length. An amended report will be provided to the Executive Directors Group in June for presentation to July's Board of Directors meeting.

3. Actions

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

4. Contact Details

Sandie Keene, Chair of Quality Assurance Committee.

Quality Assurance Committee (QAC)

Minutes of the meeting of the Quality Assurance Committee of the Sheffield Health and Social Care NHS Foundation Trust, held on Tuesday 22 May 2018 at 1.00 pm in Committee Room 1, Fulwood Tower Block, Old Fulwood Road, Sheffield S10 3TH

Present:

1.	Sandie Keene	Non-Executive Director, Chair
2.	Richard Mills	Non-Executive Director
3.	Dr Mike Hunter	Executive Medical Director
4.	Liz Lightbown	Executive Director of Nursing, Professions & Care Standards

In Attendance:

5.	Tania Baxter	Head of Clinical Governance
6.	Giz Sangha	Deputy Chief Nurse
7.	Jane Harriman	Deputy Chief Nurse, NHS Sheffield CCG
8.	Andrea Wilson	Director of Quality
9.	Margaret Saunders	Director of Corporate Governance (Board Secretary)
10.	Jonathan Mitchell,	Associate Medical Director for Quality
11.	Marthie Farmer	PA to Medical Director (Notes)

Apologies:

12.	Laura Serrant	Non-Executive Director
13.	Clive Clarke	Deputy Chief Executive/Director of Operations

Minute	Item	Lead
	Welcome & Apologies The Chair welcomed everyone to the meeting and noted the apologies.	
1)	**Declarations of Interest** There were no new declarations of interest declared.	
2)	**Minutes of the meeting held on 23rd April 2018** The minutes of the meeting held on 23rd April 2018 were agreed as an accurate record subject to the following amendment: **5) Regulation Dashboard** ○ Dr Hunter provided a briefing on the staff survey figures. Ms Harriman advised that detailed information was not required; however requested a copy of the Action Plan following the staff survey. It was noted. This work was being managed by a number of areas, but it was felt it would be a mistake to solely consider this an HR issue. **The remainder of the minutes remained unchanged and were accepted as an accurate record.**	

3) Matters Arising & Action Log

Matters Arising:

7) Service User Engagement Quarterly Assurance Report incorporating the Strategy Refresh

Dr Hunter provided an overview on the Quality and Dignity Survey and advised that there has been a month on month increase between February and April 2018. Recruitment is underway for a role to support the development of scale and pace with the completion of the survey.

Action Log

EMSA Plan (Eliminating Mixed Sex Accommodation)

The Committee discussed the annual declaration that had been presented to the Board of Directors. Further discussions on EMSA are ongoing and a report will be brought back to this Committee in June 2018, which will be presented to the Board of Directors in July 2018.

Members reviewed and updated the action log accordingly.

Safety and Excellence in Patient Care

4) Safety Dashboard

The safety dashboard was received for noting and the following key areas were highlighted:

- There has been a reduction on assaults on staff at Firshill Rise (Learning Disability In-patient Unit); this supports the narrative received from the service in April.
- The Committee discussed reporting dates and the impact that this potentially has on the dashboard. The figures contained within the dashboard are completely refreshed each month.

The Committee was assured by this report.

5) Mortality Quarterly Review Report

Dr Hunter gave an overview of the Trust's Mortality processes and an explanation of what was contained within the report presented.

The Committee was informed that a National LeDer report was published in April 2018 which reported that over 1000 deaths had been reported into LeDer, but analysis had only been done on around 100 of these. Dr Hunter discussed the need to consider incorporating historic LeDer learning points into the Trust's report as an alternative to continually reporting 'zero' due to LeDer time lags.

The Committee discussed the removal of mortality data from the Quarterly Incident Management Reports to ensure that reporting is synchronised more effectively.

The Structured Judgement Review (SJR) process enables us to rate our care as 'good', 'adequate' or 'poor'. The 9 mental health trusts in the North (The Northern Alliance) made a decision not to report preventable deaths due to the complexities surrounding this within mental health. The SJR process has led us to conclude that care rated as 'good' or 'adequate' would not be seen as a 'preventable' death. A case judged as 'poor' care would require further assessment to determine if this was 'preventable' or not. The learning from SJRs is taken through the Service User Safety Group and into clinical operations through the Patient Safety and Experience Group to ensure changes in practice are implemented.

Richard Mills asked if we could have a consistent way that SJR's are recorded suggesting it did not have to have a rating in the same way as the others. This may give the Committee a way of demonstrating that quality improvements are being made.

Liz Lightbown commented on the need to ensure escalation to the appropriate accountable Executive Director and line manager when professional practice is highlighted as an issue.

Dr Hunter thanked the Committee for a very helpful discussion and undertook to do two things:

1) Update the report by way of closing the loop and finding the right balance between the information required to assure without doing Operational Management.

2) Ensuring mortality processes are reviewed to outline escalation processed into Operational Management where practise concerns are highlighted.

Tania Baxter gave feedback on the SJR training that the Trust had recently hosted which was seen as very useful.

The Chair summarised this discussion item in terms of the three main things below:

1. Improving the report to strengthen our sightedness on actions and the impact of our learning and becoming more of a learning organisation.
2. Marrying more together the operational ownership and the governance through looking at processes.
3. Developing a Standard Operating Procedure and Escalation process which will further strengthen the Committee's assurance on this.

The Committee was assured by this report.

6) CQUINs – Quarterly Progress Report

Dr Hunter gave feedback on this report and of the key areas;

We are halfway through a two year program of national determinacy and can report our achievement for 2017/2018.

1a) Improvement of health and wellbeing of NHS staff.
This indicator was not achieved based on the staff survey results.

	The Trust has a narrative around how we are responding to this. **1b) Healthy food for NHS staff, visitors and patients** This indicator was achieved. **1c) Improving the uptake of flu vaccinations for front line staff within providers** This achieved 57.6% against a target of 70%. **2a) Cardio metabolic assessment and treatment for patients with psychoses.** Inpatient performance was good achieving 100% against a target of 90%. The Early Intervention in Psychosis (EIS) service's performance was disappointing achieving 11% against 90%. However, results had slightly improved from the previous year. There is confidence that this improvement will continue. **2b) Collaboration with primary care clinicians** This indicator was not achieved. Clinicians are not necessarily using the tools that have been provided on Insight, preferring to write a traditional letter, which does not contain all the requirements of the CQUIN. Clinical operations are putting arrangements in place to improve performance in this area. **3) Improving Services for People with Mental Health Problems that Present to A&E** This indicator was partially achieved, with an 18.3% reduction being attained against the target of 20%. This is a joint CQUIN between SHSC and Sheffield Teaching Hospitals NHS Foundation Trust and progress made is a step in the right direction. **4) Transitions out of Children and Young People's Mental Health Services (CYPMHS)** This indicator was achieved. **5) Preventing ill health by risky behaviours – alcohol and tobacco.** The Trust over-performed against some targets and under performed in others. Elements of this remain problematic. Chris Wood, Associate Clinical Director for the Crisis and Emergency Care Network, is working on the wider system re alcohol screening, which remains low.	
7)	**Draft Quality Report** Dr Hunter informed the Committee of the changes that had been made, following the previous presentation of this at April's meeting, and advised that HealthWatch had made some useful comments within their response on the Report, which was included within this final version. Figures had been updated to provide year-end data. Clarification on what the acronym 'SAANS' stood for was provided and subsequently amended in the report. (SAANS is the Sheffield Adult Autism and Neurodevelopmental Service).	

	Page 9 of the report refers to the percentage of people who are recorded on the case register for people with a learning disability, meaning that 52% of people on the register have had a physical health check through their GP. The Chair requested a change to page 32 which stated "three reportable breaches on two separate occasions…". This is to be amended to read "three reportable breaches on Dovedale Ward…". Work is underway that will provide the structural solutions on these breaches at Dovedale. There have been no reportable breaches on Burbage and Stanage Wards in 2017/2018. Dr Hunter confirmed that the information reported on page 34 was correct and that this was included within the quarterly Incident Management Reports presented to this Committee. Amendments were also requested to page 33 and 34 regarding the MCA/ DoLS training figures which should read March 2018 and January 2018 respectively. Dr Hunter assured the Committee that the triangulation of issues that were raised by HealthWatch would be brought back by way of a dashboard to this committee in July and further assurance around the progress on the Quality and Dignity survey would be reported under matters arising at the next meeting. It was brought to the attention of the Committee that the feedback from the external auditors would be incorporated into this report, following Thursday's Audit Committee. The committee was assured by this report.	MH
8)	**Annual Assurance Report** This report is a positive and accurate reflection that evidences the Committee as being well attended and that it is taking its responsibilities and accountability and assurance roll very seriously. Reports are being analysed and critically understood on how they can be used to support managers and operational staff in terms of improving the services and not only being assured. Liz Lightbown requested that other items, such as the Mental Health Act and Mental Capacity Act, safeguarding, care standards and nutrition and hydration were incorporated in terms of the work of the Committee in reviewing its effectiveness against its Terms of Reference. Tania Baxter will meet with Giz Sangha to add a few bullet points to the report before it goes to the Audit Committee on Thursday. The report was approved subject to the above amendments.	
9)	**Clinical Effectiveness Group Quarterly Assurance Report** Dr Hunter reported on the work of the Clinical Effectiveness Group, i.e. the clinical audit programme, our implementation of new NICE guidelines, our baseline audits against NICE guidance and our plans for implementation.	

	Meetings are well attended and the Clinical Effectiveness Group is growing in maturity. A self-assessment was done on the effectiveness of the Group and the key areas where the Group was not assured were in relation to outcome measures and understanding patient experience in the organisation. For this reason the Group concluded that overall it was not assured it can provide the EDG with a strategic vision of Clinical Effectiveness. A meeting is taking place next week on the pace and scale of gaining greater assurance around patient experience and it is hoped the actions from the Internal Audit report, that draws attention to this, can be completed which will enable the Clinical Effectiveness Group to change its self-assessment to a level of assurance which will assure the Quality Assurance Committee and the Board of Directors. Dr Hunter reported that on how to increase pace and scale would be brought back to the meeting as an action on the action log for next time as to the progress made on: 1) Care Opinion stories and responses. 2) More family and friends surveys being completed. 3) More quality and dignity surveys. Commitment was given to ensure the integration of work due to statutory legislation e.g. safeguarding and the Mental Health Act, as we have got people that actually understand peoples' experience in terms of this and the same can be done for safeguarding. The Committee was assured by this report.	MH
10)	**MCA/DoLs Quarter 4 Performance Report** Liz Lightbown highlighted the key points within the Quarter 4 report: The report is coming to the Committee for assurance and is very detailed due to there being no formal reporting through the organisation in the last financial year, in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Going forward in this financial year (2018/2019) with effect from Quarter 2 the Mental Health Act and Mental Capacity Act governance arrangements will come together to form one report as the Mental Health Legislation Governance System. An overarching policy to the MCA and DoLS has been audited and is in place now providing support in relation to practise at the frontline as the guidance given was not consistent. The Head of Mental Health Legislation and the Associate Director of Patient Safety are working to develop the relevant guidance/guidelines for a Standard Operating Procedure. Training uptake levels has significantly improved and the Head of Mental Health Act Legislation, Anne Cook, and Anita Winter as the Operational	

	Lead for the MCA are getting staff through the training. Practice development forums continue to run. In terms of Insight, there has been significant development work undertaken in collaboration with IMST colleagues, and all forms are now available. The DoLS register is now a central repository for recording DoLS applications and their authorisations. A summit is taking place to raise awareness in getting the Local Authority to take action and respond to outstanding DoLS applications. The Chair enquired as to whether an Internal Audit could be rebooked in relation to the mechanisms that are linked to the statistics around the 25% of service users that are having a form opened, with the expectation that this should be 90%. Liz Lightbown confirmed that that there is some fundamental misunderstanding on the assessment and it was discussed that capacity starting with 90% is the wrong way around, as capacity is assumed. Mental Capacity Act consent forms still need some work to be done in terms of the forms not being completed following admission. A report on the Capacity to Consent Forms will be coming back to the Committee, once the analysis and understanding is completed. This will be added to the forward planner and a date established. The Chair stated it could have been a bit stronger in terms of capacity because it is assumed in every instance and therefore the figure of 90% is being challenged or questioned with the audit approach which just sets out the Trust's position. The Committee was assured by this report.	LL
11)	**Infection Prevention and Control Quarter 4 Report** Giz Sangha highlighted the key points of the report. In previous quarterly reports, some issues had been identified. Hand hygiene training has improved to 96% in quarter 3 with the difference being the starters and leavers. We are working with the Microbiologist on the infections that are reoccurring in the organisation to ensure that during an infection outbreak that the wards remain open. In this quarter 38% of the total number of admissions were screened than in the last quarter this was 36%. However, admissions and discharge rates do change. Audits on the cleanliness of our units has declined due to a number of housekeepers that have moved jobs and some that have resigned, but new employees have started and an improvement should be seen in the next quarter. This is being monitored by the Hotel Services Manager and the IPC	

	team. The IPC Conference was postponed this year due to the move of the headquarters and that it is to be launched with the prelaunch of the new services to happen at the new building. Richard Mills suggested that the report should provide information on when the conference was going to be held. The Chair stated she wanted to receive and accept the report but reflected that a quarter is a long time. She requested that it appears as a matter arising at the next meeting to gain assurance on the April figure and to ensure that the Committee gets 100% return on the audit information requested. A concern about the effectiveness and completion of Physical Health Assessments was raised.	GS
12)	**Mental Health Act Monitoring Visits Quarter 4** Liz Lightbown highlighted the key points of the report: This is the final report for the Mental Health Act Committee for quarter 4. Highlights in terms of the Internal Audit report for part 2 significant assurances were achieved and the action was to establish a dashboard for the collation of the weekly compliance audits. Mental Health Act Breach Incidents – There has been a significant increase in March due to the process that is starting to embed and more people are aware of it and are actually doing it. There has been a reduction in incidents involving missing patients / patients Absent Without Leave (AWOL). MHA Training – Training levels has reached 86% which is above the trust compliance rate of 80%. Training is being developed and improved and good feedback has been received on the quality and content of the training. Protocol for the Allocation of the Responsible Clinician (RC) – Development of the Protocol for the Allocation of the RC has caused some confusion around the arrangement of the protocol, which needs to be put into place to support the Code and the implementation of the rota for Section 12 doctors. Mental Health Act Committee Membership – Reviewed amended and updated in line with reconfiguration of operational services. The Trust's Monitoring of the Mental Health Act – working closely with IMST and is now in a position to start doing that in effect from the forthcoming year. In terms of section 5(2) – shows an appropriate use of Section5(2) as over 77 of people are subject to Section 2 and are going on to be sectioned. CTO's - we have seen some improvements during quarter 4 in terms of the number of people without consent to treatment forms decreasing.	

There has been an increase in people on Section 4 during quarter 4, as we are not leaving people waiting for a second opinion, when they already have authorisation.

Benchmarking Trends – Benchmarking Tends in terms of readmission rates shows there has been an increase for the last financial year (2017/2018).

The services of the Head of Mental Health Legislation is needed around Section 4 and the use of Section 4 as there is an increase and patients are admitted who are sectioned under Section 3 and an apparent increase in Emergency Re-Admissions. LL

13. Mental Health Act Monitoring Visits Quarter 4

- Unannounced Mental Health Act inspections are now being called Mental Health Monitoring Visits from the CQC for inpatients on our wards.
- The Trust has not had any unannounced visits during quarter 4.
- Update in terms of the outstanding open things for the wards previously inspected, we have 4 wards were we have got EMSA actions which are amber and the Committee is aware to why this is the case.
- Completion for Dovedale Ward is due this month, which has gone beyond April.
- In terms of quarter 4 for the seclusion reviews on Maple and Endcliffe Wards, this has been sorted and the blanket restriction on Endcliffe Ward has been completed.
- The completion of 8 actions are being monitored at ward level and at the Mental Health Act Committee and are reporting to the Senior Operations for Performance and Governance Meeting to close the loop.
- On Stanage Ward, the comment about the “shabby garden” is in relation to the garden on the outdoors and is relates to the fence which is not to the required standard, as people can get under it.
- The blanket restrictions on Endcliffe have been dealt with by the ratification of the policy and will come to the Policy Governance Group in quarter 1. Practice has stayed the same but has now been covered off in policy terms.

Evaluation / Forward Planner

17) Confirmation of significant issues to report to the Board of Directors

The Committee agreed the following should be included in the Significant Issues Report to the Board in June 2018:

- Safety Dashboards
- Mortality Quarterly Assurance Report - Review and the Committee’s

strengthened additions. ○ The Clinical Effectiveness Self-Assessment with the focus on the outcomes and experience in terms of areas to develop in the triangulation. ○ MCA /DoLS issues and the fact that we are looking at the delays and expiry of the DoLS applications and the issues about capacity and consent and have asked for a further report to keep an eye on the development of this. ○ Environmental cleanliness and the fact that we are monitoring it and have requested reporting back on compliance issues, particularly in quarter 4. ○ The readmissions rate and the concerns that we have regarding this. ○ Understanding the percentage of people with a learning disability with an annual health check for the people the Trust is in touch with. Items for Annual Planner: ○ Further reports on mortality in terms of the new way of linking in the information. ○ Clinical Effectiveness action plan regarding patient experience in June. ○ Mental Health Act Report on the analysis of readmissions to be agreed on when it's going to be done. ○ There will be no meeting in August. December's meeting will be looked at and brought forward.	
CLOSE	

Date and time of the next meeting

Wednesday 20th June 2018 at 10.00 am (NB revised date and time)
Rivelin Boardroom, Fulwood Tudor Building

Apologies to PA to Medical Director