# BOARD OF DIRECTORS MEETING (Open)

**Date:** 12 September 2018 **Item Ref:** 20i a-b

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| **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 the Quality Assurance Committee on 23rd July 2018 |
| **TIMETABLE FOR DECISION** | To be discussed at September'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<br>Strategic Objective: We will provide sustainable services through ensuring value for money, reducing waste and unproductive time for staff<br>BAF Risk No: A401ii<br>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. |

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

# SUMMARY REPORT

**Report to:** Board of Directors

**Date:** 12 September 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 23rd July 2018.

**2. Summary**

Board members will receive the minutes of the Quality Assurance Committee held on 23rd July in October 2018. 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.

**Eliminating Mixed Sex Accommodation (EMSA)**

The Committee noted the Board of Directors' endorsement of the Trust's compliance statement in this matter and noted that this will be closely monitored on a quarterly basis, with the first quarterly report due to come to the Quality Assurance Committee in September 2018.

**Safety Dashboard**

The Safety Dashboard was received and the Committee discussed the triangulation between restraints and assaults and noted that further work is being done on this.

**Safeguarding Adults and Children - Quarter 4 Report**

The Committee received the quarter 4 reports and acknowledged the assurance provided within them. The Committee requested the Deputy Chief Nurse to look at where the safeguarding concerns are coming from, ie whether they are from family, the community, the environment or Trust activities and also to look further into the transitions work.

**CMHT Annual Survey Action Plan**

The Committee received a progress update on the action plan resulting from the CMHT annual survey, which made recommendations as to the future performance management and governance of the plan. The Committee requested two deep dives – one to be received in November regarding waiting times and the second on CMHT triangulation and the totality of the picture, to be received in January. It was also acknowledged that the Executive Directors will be doing further work on the annual staff survey and the implications for quality to ensure there is a clear link between the staff survey, quality and to clarify who is leading on what.

**Research and Innovation Quarterly Assurance Report**

The Committee received this report and acknowledged the assurance provided by it. The Committee agreed for the Research and Innovation Group to meet quarterly, instead of bi-monthly and to provide bi-annual assurance to the Committee.

**Quality Assurance Proposals including Improving the Balance Between Inpatient and Community Service Metrics**

Quality assurance proposals were presented to the Committee and the comprehensiveness on what we need to know for assurance was discussed, alongside a new performance dashboard which is under development alongside operations, quality and IMST, with some clarification needed about priorities and timescales.

**Complaints Performance Report – Quarter 4**

The Committee received the quarterly report and acknowledged the assurance provided by it. The complaint response rate was reported at 23% within this quarter. The Committee requested developments to the report to show how complaints are feeding into the triangulation of the assessment of quality.

## 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 the 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 Wednesday 20 June 2018 at 10.00am in Committee Room 2, Fulwood Tower Block, Old Fulwood Road, Sheffield S10 3TH

**Present:**

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| 1. | Sandie Keene | Non-Executive Director, Chair (SK) |
| 2. | Anne Stanley | Non-Executive Director (AS) |
| 3. | Dr Mike Hunter | Executive Medical Director (MH) |
| 4. | Liz Lightbown | Executive Director of Nursing, Professions & Care Standards (LL) |

**In Attendance:**

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| 5. | Tania Baxter | Head of Clinical Governance (TB) |
| 6. | Jane Harriman | Deputy Chief Nurse, NHS Sheffield CCG (JH) |
| 7. | Andrea Wilson | Director of Quality (AW) |
| 8. | Clive Clarke | Deputy Chief Executive/Director of Operations (CC) |
| 9. | Marthie Farmer | PA to Medical Director (Notes) (MF) |

**Apologies:**

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| 10. | Laura Serrant | Non-Executive Director (LS) |
| 11. | Richard Mills | Non-Executive Director (RM) |
| 12. | Giz Sangha | Deputy Chief Nurse (GS) |
| 13. | Margaret Saunders | Director of Corporate Governance (Board Secretary) (MS) |
| 14. | Jonathan Mitchell | Associate Medical Director for Quality (JM) |

| Minute | Item | Lead |
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| | **Welcome & Apologies**<br><br>The Chair welcomed everyone to the meeting and noted the apologies. | |
| **1)** | **Declarations of Interest**<br><br>There were no new declarations of interest declared. | |
| **2)** | **Minutes of the meeting held on 22nd May 2018**<br><br>The minutes of the meeting held on 22nd May 2018 were agreed as an accurate record subject to the following amendment:<br><br>**10) MCA/DoLs Quarter 4 Performance Report**<br><br>○ Action point under Item 12 Mental Health Act Monitoring Visits Quarter 4 "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" had been incorrectly allocated and was therefore reallocated to Liz Lightbown. | |

**12) Mental Health Act Monitoring Visits Quarter 4**

- Action point was added to this item assigned to Liz Lightbown.

**The remainder of the minutes remained unchanged and were accepted as an accurate record.**

**3) Matters Arising & Action Log**

Matters Arising:

**7) Draft Quality Report**
Dr Hunter confirmed the issues that were raised by Healthwatch is on the forward planner and will be brought back to this Committee in the presentation by Andrea Wilson in July 2018.

**12) Mental Health Act Monitoring Visits Quarter 4**
Liz Lightbown updated the Committee on the issue raised in relation to the figure of 90% Capacity Act Consent Forms contained in the previous report. Anne Cook had provided an explanation which had been issued to members and attendees by email as a post meeting note.

**11) Infection Prevention and Control Quarter 4 Report**
Liz Lightbown confirmed that completion of Environmental Cleanliness Audits at the end of May 2018 was at 100%. Gaps in April 2018 have now been escalated to the Director of Estates and Facilities and the Clinical Operational Services for ongoing monitoring and assurance.

**12) Mental Health Act Monitoring Visits Quarter 4**
An apparent significant increase in re-admissions in last month's report had been reviewed and it appears that an error had occurred in the dataset. This meant that instead of a quarterly total being generated, the cumulative annual figure had been presented.
The Committee was given assurance that there was no increase, however work is being undertaken on this issue and Anne Cook will provide feedback on this at July's meeting. **LL**

Action Log

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:

In the latter part of the calendar year there has been an improvement in the use of restraints, (a decrease) although the completion of post incident reviews has not been carried out consistently and work is ongoing to improve this across the inpatient areas.

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| | The Trust needs to ensure it has sufficient numbers of RESPECT trained staff on every shift and if for any reason, beyond our immediate control, there isn't a plan to achieve this between Stanage and Burbage Wards, this is reported promptly to enable the Trust to fulfil our responsibilities safely.<br><br>Operational Links into Operational Services around this issue is key and has already been addressed as part of the draft action plan developed following the CQC unannounced inspections. This can also be taken to the Clinical Operations Performance and Governance Meeting as a governance issue that needs to be addressed.<br><br>The Chair suggested that the Clinical Operational Group make their reporting more granular in terms of the skill mix of the staffing on the ward, as well as the number of agency and number of people in each category that have had RESPECT training. This issue has been escalated to the Director of Clinical Operations, the Deputy Director of Nursing for Clinical Operations and the Associate Clinical Director as they would be writing the action plan. It was requested that the plan be brought back to the Quality Assurance Committee.<br><br>The Chair noted an apparent increase in incidents of self- harm for the month of May 2018. Further analysis will be undertaken and feedback given as a matter arising at next month's meeting.<br><br>Feedback on the structure and content of the report was given and it was requested that anything outside the control limits on the dashboards could be clearly noted within the summary and a similar statement to note if all indicators are within the limits.<br><br>Analysis of the data available to us on the number of falls suggests that the downward trend has continued over consecutive months and that we are close to having evidence of a significant positive change.<br><br>The Committee was assured by this report. | **CC**<br><br>**MH** |
| **5)** | **Incident Management Quarterly Report**<br><br>Dr Hunter gave feedback on this report and of the key areas.<br><br>Incidents reported relating to availability of resources is showing an increase within our community services and is now the second most common incident being reported. This will need to be closely monitored going forwards.<br><br>Benchmarking from the National Reporting Learning System, based on our organisational characteristics and how many incidents we have reported, suggests we are reporting appropriately, and are a low risk of under-reporting.<br><br>The investigation into the incident at Clover City Practice was initially undertaken as a Significant Event Analysis instead of a Serious Incident Investigation (SI). This now been addressed and is being investigated as an SI. | |

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| | The Committee discussed whether there was a theme coming out of report and suggested the analysis was missing and what actions are going to be taken to loop back as assurance for the Committee. This could then be compared with the next set of information to the Committee.<br><br>Feedback on the report was given and it was suggested that the report could be improved by keeping the level of detail as it is but strengthening the summary of information and clearly describing the key messages.<br><br>There is reference to a homicide at point 1.3. It was noted that subsequently to the incident being reported, the Police have not made any charges in relation to this incident and it should therefore no longer be classified as a potential homicide. A Review of Care on the individuals' involved is now being undertaken in line with Trust policy. The Board needs to be informed that it is now been determined that it is not a homicide.<br><br>Further comments were made about the need for analysis and the linking of actions taken and feedback within this report. It was also noted that there was connectivity between this report and the Service User Safety Group Annual Effectiveness Report.<br><br>The Committee was assured by this report. | **MH** |
| **6)** | **Service User Safety Group (SUSG) Annual Effectiveness Report**<br><br>Dr Hunter gave feedback on this report and of the key areas.<br><br>He reported that the Group has been meeting regularly, has fulfilled its function and is well attended.<br><br>The Group has identified and appropriately escalated relevant issues, for example around restrictive practices.<br><br>It is expected that next year's report will be a more structured self-assessment that will be checked against the Terms of Reference to ensure that the group has fulfilled its responsibilities in relation to their specific areas of responsibility.<br><br>The Group reports to the Executive Directors Group (EDG) with assurance being given to this Committee.<br><br>It was noted that Clinical Operational Services are accountable to the Executive and the Executive is accountable to the Board. There needs to be assurance that information is provided and that Clinical Operational Services are accountable in ensuring that all appropriate actions are undertaken to enable this Committee to provide full assurance to the Board.<br><br>The Committee was assured by this report with suggested developments within the presentation and content of the report. | |
| **7)** | **360 Assurance Audit – Nutrition and Hydration Compliance Follow-up**<br><br>The Committee confirmed compliance and was assured by this report. | |

**8) Eliminating Mixed Sex Accommodation Report (EMSA)**

Clive Clarke provided an overview of this report and highlighted 3 issues in the report:

- There is a confusing element as to potentially conflicting guidance in relation to our compliance.
- Issues discussed regarding safety on our wards and what the safety requirements are. It is being managed at the moment by offering clients the opportunity to state their preference on admission and during their stay. There has not been any breach on Stanage and Burbage Wards during 2017/2018.
- Out of Town Placements present more of a safety risk than managing the current situation, as our service users are not within our span of control when placed elsewhere.

Recommendation: The Committee noted the recommendation in the paper, namely that until we have reached the medium term solution (ACR2) we will continue as currently managed and review it on an annual basis in line with the requirement to make our annual compliance statement.

Based on analysis of our recent bed usage, to comply with CQC requirements around EMSA, we would have to be able to hold 13 vacant beds to manage the variation in gender specific requirements.

There have been breaches on 3 occasions by people passing other gender bedrooms.

It was noted that if the Trust is not CQC compliant, this could present risk or repercussions to the Trust, i.e. the CQC could issue an enforcement notice, as this is a repeat breach form the 2016 comprehensive inspection.

It was suggested that there needs to be comment within the report about what our safety data is showing us and if the data is directly linked to EMSA or gender related incidents. In addition, we need to see what our incidents relate to and why we are saying that they are manageable, proportionate and not excessive. The Committee needs to have the confidence to support these recommendations and that we are confident that the sexual safety issues on Stanage and Burbage Wards are within acceptable limits and benchmarked reasonably.

There is also a need to have a commitment to ongoing monitoring of service user experience and feedback around their feelings of safety on the wards so that we can add to our review of compliance feedback as assurance to the Board.

The Chair requested that the report offers more clarity about the relevant legislation and guidance quoted and how they are applied in the Trust. With the CQC visit in two weeks and the report in March 2016 that gave us the requirement, but what is not clear is the governance timeline as to what happened between March 2016 and now. The Chair requested that all information relating to the audit trail of decision making by the Trust in relation to the EMSA issue be included in the report with particular attention to the decision not to move to single sex wards, having previously agreed to do so.

With the CQC Well Led Review in two weeks' time, clarity around this would be useful. We need clarity in the articulation of the difference in being compliant with the CQC requirement for a fixed specification by gender of bedrooms on the one side and having an EMSA breach on the other when a female walks past a male bedroom to use the bathrooms. It was queried if this can only be achieved by having the variable allocation of rooms according to gender and is our position reasonable and safe?

The Chair requested that the duplication within the report be removed to have a crisper report in terms of what the issues are.

The Chair requested changes to the order of the Recommendations within the report on page 15.

Proposed changes to bullets points on page 15 are as follows:

EDG/QAC is requested to:

- Acknowledge the challenges and risks associated with any decision to move to gender specific at this moment in time.
- Acknowledge the current performance of the Trust in relation to acute adult admissions in comparison with other organisations within the benchmarking group.
- Note the minimal EMSA breaches over the past 12 months on Dovedale Ward and have now been addressed and that there have not been any on Stanage and Burbage Wards.
- Note that the current means of mitigating patient safety risks through effective processes and procedures.
- Consider the alternative options detailed to address EMSA compliance and the resulting risks.

Clinical Operations recommends:

- that Stanage and Burbage remain as mixed sex wards and the Trust response to the EMSA requirements are met by the Acute Care Reconfiguration recently adopted outline Business Case Phase 2 at the Longley Centre is completed 2020/1.
- this position is reviewed on an annual basis with the CQC, with particular note of the data to the activity patient experience and safety indicators and are being monitored quarterly at the Quality Assurance Committee which will continue to issue a compliance statement against the DOH requirements.

The report was approved subject to the above amendments and will then pass through EDG on 28th June 2018 and then be added to the Board agenda for 11th July 2018. — CC

Copy of approved EDG paper to be sent to the Chair. — CC

**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 July:

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| ○ Safety Dashboards – The restraint and the training and skill mix of nursing staff number issues that has recently emerged, as well as the self-harm investigations being followed up to why and where and the positive step change on falls.<br>○ Service User Safety Group Annual Effectiveness Report – Committee has seen and acknowledges effectiveness and development linked to action planning and assurance.<br>○ 360 Assurance Audit – Nutrition and Hydration Compliance Follow Up has achieved compliance with the actions and is 100% compliant.<br>○ Eliminating Mixed Sex Accommodation Report – amendments have been recorded.<br><br>Items for Annual Planner:<br>○ Safeguarding reports not being brought to the meeting and reason for it. Reports have been done and will be at the next meeting in July 2018.<br>○ CMHT Annual Action Plan – Progress update and has been deferred from June's meeting to July's meeting.<br>○ Complaints Management Annual Assurance Report – 2017/2018 has been scheduled for September 2018. The Chair requested if this could be moved forward to the July 2018 meeting.<br>○ Annual Infection Prevention and Control Report to be added to the Forward Planner and Agenda for July's Meeting.<br>○ Agreed action from last Committee meeting where Anne Cook will be presenting a report on the re-admission rates to be added to July's Meeting.<br>○ It would be helpful if the title of the reports are reflected on the annual planner and not described as annual assurance reports as they are performance reports that come at a quarter and recording which quarter it is.<br>○ Annual Planner to be revised. | LL<br><br>CC<br><br>MS<br><br>LL<br><br>LL<br><br>MF<br><br>MF |
| **CLOSE** | |

**Date and time of the next meeting**
**Monday 23rd July 2018 at 1.00 pm – 3:00pm**
**Rivelin Boardroom, Fulwood Tudor Building**

*Apologies to PA to Medical Director*