Board of Directors – Public

UNCONFIRMED Minutes of the Public Board of Directors held from 9:30am on Wednesday 24 July 2024 at Centre Court and via MS Teams

Present: (voting)	Sharon Mays, Chair (SM) Salma Yasmeen, Chief Executive (SY) Heather Smith, Non-Executive Director, Deputy Chair (HS) Anne Dray, Non-Executive Director, Senior Independent Director (AD) Mark Dundon, Non-Executive Director (MD) Owen McLellan, Non-Executive Director (OMcL) Olayinka Monisola Fadahunsi-Oluwole, Non-Executive Director (OFO) Phillip Easthope, Executive Director of Finance (PE) Salli Midgley, Executive Director of Nursing, Quality and Professions (SMi) Caroline Parry, Executive Director of People (CP)
In Attendance: (non-voting)	Prof. Brendan Stone, Associate Non-Executive Director (BS) James Drury, Director of Strategy (JD) Neil Robertson, Director of Operations (NR) Deborah Lawrenson, Director of Corporate Governance (Board Secretary) (DL)
Other attendees:	Dr Jonathan Mitchell, Clinical Medical Director (Deputising for Dr Helen Crimlisk) (JM) Amber Wild, Head of Corporate Assurance (AW) Holly Cubitt, Head of Communications (HCu) Parya Rostami, Head of Continuous Improvement (PR) for item 12 Abiola Allinson, Chief Pharmacist for item 15 Liz Johnson, Head of Equality and Inclusion for item 21
Apologies:	Dr Helen Crimlisk, Interim Medical Director (HC)

Min Ref:	Item
PBoD 24/07/24 Item 1	**Welcome and Apologies** The Chair welcomed the Board and observers to the meeting. Apologies were noted from Dr Helen Crimlisk. Dr Jonthan Mitchell who was deputising for the Interim Medical Director was welcomed to the meeting.
PBoD 24/07/24 Item 2	**Declarations of Interest** None specifically noted over and above the regular formal declarations of interests made by Board members.
PBoD 24/07/24 Item 3	**Minutes of the Public Board of Directors meetings** The Board **approved** the minutes of the public Board of Directors meeting held on 22 May 2024 as a true and accurate record, following amendments to be made to correct the spelling of Owen McLellan's name in the attendance list.
PBoD 24/07/24 Item 4	**Matters arising and action Log** The Board approved closure of actions as indicated on the actions log and noted the following additional updates: • **Action 4 -** relating to cyber security – It was confirmed assurance had been provided to Audit and Risk Committee (ARC) on compliance with patching and updates received through the Digital Assurance Group report and Data Protection audits; and the risk in relation to system security (whilst Insight is still running and prior to implementation of the new electronic patient record) is covered on the Board Assurance Framework and on the Corporate Risk Register. It was noted a

	new Information and Cyber Security group is being established reporting into Audit and Risk Committee. The Terms of Reference for this will be received by ARC, offline, in August and the committee has requested a written report to provide assurance around Cyber Security for the October 2024 meeting. It was noted there is a new requirement as part of the Emergency Preparedness Response and Resilience (EPRR) reporting that a deep dive on cyber security takes place which needs to be completed by October 2024. This will be received as part of the October reporting at ARC. **Note for ARC forward plan.** • **Action 5** - relating to clarity on the SAANS service data – it was confirmed further work is required to ensure that the timeline of the IPQR reporting reflects an accurate data position and it was agreed that this process would be reviewed for the IPQR reports received in September **Action PE/NR**.
PBoD 24/07/24 Item 5	**Questions from Governors and members of the public** There were no questions received.
PBoD 24/07/24 Item 6	**Chairs Report** The Chair provided an update noting the following key matters: • Board of Director changes - the Executive Director of Nursing, Quality and Professions will be moving to a new role at Greater Manchester NHS Foundation Trust at the end of September 2024 and the Director of Corporate Governance will be retiring at the end of October 2024. The Board thanked them both for their service and congratulated them on their next steps. Recruitment is underway for their replacements. • A board development session took place in June on health inequalities. • The annual Fit and Proper Persons Test declaration for the Board of Directors was made on time with appropriate declarations made. • Successful governor elections have taken place with due diligence underway. • Long Service awards have taken place and were well received. • The Mental Health and Learning Disability Collaborative have confirmed Toby Lewis, Chief Executive of RDASH as lead Chief Executive for a further year. • The Chair and Director of Operations hosted a positive visit from the Chair of the Integrated Care Board to the Health Based Place of Safety, Endcliffe and Maple wards.
PBoD 24/07/24 Item 7	**Chief Executive's Report** Salma Yasmeen (SY), Chief Executive drew attention to the following matters: • The changing context in which the Trust is operating following the elections. SY has written to newly elected members of parliament for Sheffield. The new Secretary of State for Health has made a strong commitment to three key areas – commitment to investment in community and primary care, use of digital and technology to transform services and a focus on prevention and early health. • The Pathways to Employment Commission report launched in July 2024 chaired by the Right Honourable Alan Milburn. It was positive to hear about recommendations centred around supporting those who are economically inactive, with far reaching implications nationally and an opportunity for the region to lead the way in this. Discussions are taking place around the potential for South Yorkshire to be used as a test site for driving forward the recommendations. The report will be shared with Board members and the Executive Team will be reviewing recommendations in order to take forward those related to NHS providers for reflection in the strategy refresh in the autumn. • The Nursing and Midwifery Council (NMC) have shared the outcome of an independent culture review they have commissioned. There is learning in this for all who work in health and care services around addressing inequalities and the Executive Director of Nursing has written to our staff to confirm the Trust will be reviewing and reflecting on the recommendations. SM commended the Chief Executive's contribution to the Pathways to Employment work. BS commended plans to review the approach to receipt of service user, carer and staff voices at the Board and suggested consideration be given to a co-produced approach in this, reflecting on how daunting it can be for some of those presenting their stories to the Board. Discussion took place in

	which a number of suggestions were made including use of videos (where appropriate) and consideration of next steps which will be taken forward by the Executive Director of Nursing, Quality and Professions working with the Director of Strategy and executive colleagues. **To note and take forward.** OMcL asked for an update on progress with the settlement of pay awards for junior doctors. PE confirmed this was not yet known but would have an impact on Trust finances when confirmed. HS asked if anything further had been confirmed with regard to apprenticeships following the election. CP confirmed conversations had begun but there was no further update at that point in time. MD asked, given the priority outlined by the Secretary of State for Health around digital transformation, if the organisation is ready to mobilise in response to opportunities as they emerge suggesting, where there is potential for accessing funds to improve efficiency. JD confirmed that the Trust ensures it is ready to respond proactively in developing ideas and in managing relationships, submitting proposals where it is able to do so. HS asked if the Trust had programmes of work ready to roll out if investment became available. JD explained national initiatives would generally take place through the Integrated Care Boards, but the Trust could seek out and establish relationships with those on national programmes to support readiness to respond. PE confirmed organisations regularly submit their position in terms of digital maturity which includes detail on the development of Electronic Patient Records (EPRs), and it will be through that process that investment will be prioritised. SY stressed the need for the Trust to be clear about its digital journey beyond EPR and SM noted there are some trusts without EPRs in place. SY confirmed proposals are under development by the Trust's EPR advisor around potential innovations for clinical care pathways however she was conscious of capacity and the need to focus currently on successful and safe delivery of the new EPR system.
PBoD 24/07/24 Item 8	**Board Committee Activity Reports** The Board received and noted updates provided through the Alert, Advise and Assure (AAA) reports from the Board assurance committee chairs for meetings held in June and July 2024. The following key matters were drawn to the attention of the Board: <u>Quality Assurance Committee (QAC)</u> – Heather Smith (HS) Chair of the committee drew attention to the following: • Waiting lists for ADHD and Gender services – services are continuing to experience high demand; recovery plans are received through QAC. National work is taking place and locally hosted by NHSE, on gender services which is encouraging in terms of finding system solutions. • Waiting lists have improved for Long Term Neurological conditions (LTNC) and autism services. • Access to crisis services remains challenging. • The rise in falls reported previously has reduced with successful use of safety huddles. • High levels of acuity have resulted in an increased need for 1:1 observations – the committee discussed innovative work taking place in delegating work to nurses around 1:1s which is encouraging. • There are concerns around some persistent issues with medication management that requires a leadership approach. Also see separate agenda item on the controlled drugs annual report. • There has been an increase in reporting of sexual safety incidents which is positive and is enabling plans to be put in place to address issues. • Positive feedback has been received from patients about the new 111 service with further work taking place around formal collection of data. <u>People Committee (PC)</u> – HS who chaired PC in July on behalf of the committee Chair Mark Dundon (MD) drew attention to the following: • Supervision and mandatory training levels remain an issue with insufficient traction being made – this has been an alert for three years and requires further action. Salma Yasmeen (SY) confirmed this is discussed at EMT which has delegated oversight to the Operational Management Group. Neil Robertson (NR) suggested a different approach is required around having a data driven

escalation process which will be discussed at OMG and weekly data received should support this and Caroline Parry (CP) confirmed the new self-service system should ease reporting. SY suggested messaging be reflected in the Cascade. Phillip Easthope (PE) provided assurance discussion on this issue had been a strong theme and push to directorates in the performance meetings. Through this it was evident there was some concern around the level of confidence in deliverability, reporting and recording on the system and the executive have pushed back on that. CP provided assurance there is a clear policy in place, supported with communication, around what can be counted as supervision including regular 1:1s but further testing of understanding of this will take place with managers. SM reminded colleagues performance in supervision and training also has an impact on the 'well led' CQC category and asked that actions being taken to address this continue to be flagged through the People Committee AAA report to Board.

It was agreed that clarity will be provided in future AAA reports on specific clinical and corporate staff areas in relation to mandatory training and supervision compliance **Action**: CP

- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) – despite a net increase in the number of ethnically diverse staff in senior roles since 2021 the clinical disparity ratio remains high and therefore, we are not yet seeing the desired level of impact of actions. There has also been an increase in the number of ethnically diverse staff entering disciplinary processes which is disappointing given work which has taken place and there remain issues around disabled people accessing reasonable adjustments despite work in place. Note separate agenda item.

Finance and Performance Committee (FPC) – Owen McLellan (OMcL) Chair of the committee drew attention to the following:

- The end of month 2 position – which demonstrated an increase in out of area activity compared to March/April. The year-to-date position at this point in time was on plan but the forecast was for a £1.419m overspend given anticipated savings through spot bed purchases was not expected to take place as quickly as expected.
- The month 3 position shows a further increase in out of area usage.
- The committee was assured around arrangements in place for weekly financial review of the value improvement programme with £4.5m delivered out of the £7.2m plan, however the committee have asked for further assurance around grip and control on the management of out of area spend.
- With regard to 'bad debt' the committee have asked that prioritisation be given to addressing the largest of these with the partner organisations.
- Good discussion has taken place on transformation programmes with the Learning Disabilities model agreed and expected to now be in place by January 2025 following recruitment to posts with a further review planned in September.

OMcL noted vacancy controls had been raised in a number of discussions across board assurance committees and it had been confirmed with the executive team this was not negatively impacting on delivery of value improvement. He suggested this needed to be clarified in the narrative in the papers coming through board assurance committees.

SM advised the Board the Council of Governors received a presentation on finances from OMcL and PE and had asked for a briefing on reasons for the increase in planned deficit which is under development.

HS noted risks related to fire doors and work underway which had not been raised in the AAA reports from either Quality Assurance Committee or People Committee which oversee Health and Safety or through Finance and Performance Committee which might also pick up issues through the transformation or capital programmes work. She suggested clarity be given on which elements should feed into the AAA reports for matters covered by more than one committee.

SM noted HFMA guidance suggests the chairs of the assurance committees should meet once a year and a process for doing so is being put in place led by the chair of the Audit and Risk Committee. This will reflect on the issues raised around areas of split responsibility.

Mental Health Legislation Committee - Olayinka Monisola Fadahunsi-Oluwole (OFO) Chair of the committee drew attention to the following:

- An increase in the number of pregnant service users being admitted which brings complexity and challenge in relation to restrictive practice and care planning.
- Compliance for RESPECT training is below the 80% due to capacity within the training team, low sign-up rates and lack of attendance by staff due to staffing difficulties.
- An action plan is in place to improve working with advocacy and to address concerns raised.
- Concerns about prolonged inappropriate use of the Health Based Place of Safety.
- The committee has asked for further assurance around actions and timescales for improving compliance with S132/s132A (provision of information to patients which is variable)
- The numbers of Associate Mental Health Act Managers (AMHAMs) remain lower than required, however some new managers are in the process of being onboarded.

SM asked if the issues around peri natal services have been escalated and SY confirmed providers are being asked to ensure there are robust pathways into primary mental health teams. SMi confirmed escalation has taken place through Integrated Care Board chief nurses and discussed with Sheffield Teaching Hospital. She confirmed there has been an increase and there were issues around the criteria used to access services which requires clarification, and this has been escalated. She assured the Board work is taking place to look at how the Trust wraps around care but a broader review of peri natal service provision is required. SY asked if community services were working effectively in supporting addressing issues and improving parity. SMi confirmed that all admissions were appropriate and had required a peri-natal, mental health bed. SM suggested this be raised again at the Mental Health, Learning Disability and Autism collaborative. SMi noted the Deputy Director of Nursing who is experienced in this service area is working on this and suggested that a clear narrative will be taken through the collaborative.

HS noted a large number of alerts had been raised from MHLC in the AAA report and asked OFO if she considered there to be an increase in issues, or if she was assured progress is being made. OFO confirmed awareness had risen, which was positive, with progress limited in some areas due to limitations around technology, but she was assured things are moving in the right direction and human rights training is being embedded.

Audit and Risk Committee (ARC) – Anne Dray (AD) Chair of the committee drew attention to the following:

- Clinical record keeping improvements are required but the committee was encouraged by action taking place which will be overseen at QAC.
- Positive alerts were received around the internal and external auditors reports and on production of the Annual Report and Accounts 2023/24 with teams commended from both the Trust and the auditors for good collaborative working which had taken place resulting in a strong end of year position.
- Positive alert received on production of the Quality Accounts for 2023/24.
- Good progress continues to be made with delivery of internal audit actions.
- The July committee received the annual report on Counter Fraud, Bribery and Corruption with the majority of work having been delivered and two small areas reaching finalisation. A referral has been made across to People Committee re Counter Fraud to ask that the committee periodically receive the data tracker on delayed disciplinary cases.
- The committee received the Modern Anti-Slavery statement for 2023/24 for agreement to submit for approval at the Board.
- The committee were alerted to proposals to form a new group focussed on information governance and cyber security. The terms of reference for this will be approved via e-governance over the summer period and in advance of receipt of a more detailed assurance report on cyber security at the Audit and Risk Committee in October (which is also an EPRR reporting requirement)
- Positive alerts were received on the post balance sheet changes statement, the internal audit progress report and on work in place to meet the trajectory for achievement of 60-65% compliance on EPRR by September 2024.

It was noted Freedom to Speak Up oversight was delegated by Audit and Risk Committee to People

	and Quality Committee – (HFMA guidance on what is required by way of oversight is to be shared with the chairs of those committees) to support focus and reporting. Similarly with regard to Health and Safety oversight this is currently delegated to both the Quality Assurance Committee and the People Committee. It was noted there is a need to be clear which elements of reporting on these matters the respective committees should be escalating to the Board in their AAA reports. **Action** AW to share the HFMA guidance on FTSU oversight with committee chairs, and AD to pick up with the chairs of the committees to clarify separation of reporting through the AAA's as part of the joint chair of committees meeting to support future planning.
PBoD 24/07/24 Item 09	**Quality Assurance Report & Update on Quality Strategy** The Executive Director of Nursing, Quality and Professions (SMi) drew attention to the following matters from the report: • Key risks to delivery of the Quality Assurance (QA) workplan are related to delays in implementation of the new Electronic Patient Record which impacts on Quality Management System (QMS) roll out and planned quality and patient safety reporting; and general challenges around availability of staff to participate in QA activity. • During Q4 of 2023/24 and Q1 of 2024/25 there were 27 board visits to services, and 7 culture and quality visits. • A quality hotspot approach is being taken and follow up Fundamental Standards of Care visits have been completed to 5 areas identified as requiring a revisit with associated action plans in place and progress reported via governance team meetings. • Due to some vacancies the strength of the thematic review in the report is not as strong as previously, but recruitment has now taken place to the vacant roles, and this is expected to improve in future reporting. • Consideration is taking place on how we present the new CQC regulatory statements into teams and how they might report on their self-effectiveness against these. • The focus on QMS has halted until post implementation of EPR and it is hoped digital support will then be available to support this work. SM noted that the report was helpful and asked that the front sheets include more highlights on the 'so what' to support understanding on key issues to draw these to the attention of the Board. **Action:** SMi to strengthen the front sheet of future reports.
PBoD 24/07/24 Item 10	**Lived Experience Report Q4 23/24 and Q1 24/25** The Lived Experience reports for Q4 23/24 and Q1 24/25 were received and noted. These included updates on progress with delivery of the service user and carer strategies with milestones confirmed as on track; and updates on progress with partnership working. SMi informed the Board work will take place to review the qualitive survey element of the report, with teams being asked to consider mechanisms for improving returns through the Friends and Family Test and other means of collating feedback. It was noted PCREF reporting will be covered in the Lived Experience report going forward rather than as a separate item and the Board were assured this will support ensuring the Trust remains on track for delivering the PCREF plan required from organisations in March 2025. **Action: AW to reflect on board planner** With regard to capturing feedback via lived experience HS noted discussions which had taken place at Quality Assurance Committee around the improvements made in recent years on embedding co-production which has supported the Trust in identifying areas of focus. SMi confirmed further consideration is taking place on how best to reflect feedback more broadly given the range of reports where this may be captured such as via the Restrictive Practice and Transformation reports. SY informed the Board of plans to develop a more strategic approach to involvement and to gathering and responding to insights received potentially through a new insights report. This will be taken forward by the Director of Strategy and the new lead for Corporate Governance. **Note on forward plan planning for receipt of this is to be confirmed.** SMi reminded the Board that the Quality Management System (QMS) was the mechanism intended to bring together broader feedback and this had been held back due to the delay with implementation of EPR.

	BS stressed the benefit of using qualitive feedback to bring the voice of experience into discussions. He noted the 'Safe to Share' document states that feedback will be shared with provider staff and commissioners and asked if the Board would have access to this. SMi confirmed it will be publicly and broadly available and made available to Board colleagues. JD informed the Board about work underway on the development of the new communications strategy with discussions on the strategic approach to engagement and involvement timely for reflecting into that work. OFO drew attention to a statement in the Lived Experience report from an individual stating *'nobody speaks to me about it'* and asked for assurance on how engagement with those placed out of area is managed. SMi provided assurance there is a robust process in place to keep in touch with any service users placed out of area, with any issues raised dealt with promptly and debriefs provided. OMcL suggested feedback suggests a sub optimal solution for out of area and noted references in several places to issues with regard to capacity within the engagement team asking if full resource is now in place and if this is sufficient. SMi confirmed the team is fully resourced. She stressed the need to look at engagement as a day-to-day responsibility within clinical teams to gather feedback, and therefore broader than the remit of the engagement team; with a range of mechanisms required. She confirmed a reminder of this will be covered in the communications cascade. JD noted the need to consider how the Trust might hear from people who may not as yet be accessing services, as well as those we are hearing from either through clinical services or via the engagement team, which he suggested required connections to be built between the engagement team, the communications team and community partners. SM commended the addition of examples of what has changed since last reported to the Board and the increasing use of Alert Advise and Assure updates on the front sheets of board papers.
PBoD 24/07/24 Item 11	**Complaints annual report 2023/24** The annual complaints report was received and noted. The complaints team were commended for improvements made in 2023/24 in provision of timely responses to complaints. This moved from 74% of complaint responses within required timeframes in 2022/23 to 77% in 2023/24. An additional focus has taken place on resolving issues at an early stage before they reach the formal complaints process, liaising with services to ensure points of concern are listened to and resolved. As such the value of reflection of the voice of service users and their families in the report was acknowledged. It was confirmed from April 2024 information about concerns raised have been logged onto a central database to support learning and dissemination. BS suggested, whilst the voice of service users comes through strongly in the report, it would be of benefit to consider putting in time for a more substantive discussion on themes and feedback in a similar way to the approach taken to reflecting on feedback from the staff survey. It was agreed this should take place as part of the preparation for finalisation of the Annual Complaints report for 2024/25. **Action** SMi to advise DL/AW regarding timing for a more detailed Board discussion on the findings in the Annual Complaints report as part of the process prior to receipt and sign off in Q1/Q2 of the next financial year. And to reflect on the themes as a result of the data analysis in the report. **To be reflected on the Board planner.** SM noted a positive recent Board visit she had undertaken to the Complaints team with the Director of Corporate Governance through which the passion of the team in working with service users and their families to respond to their concerns and to support learning was clear. She asked that this focus on learning and a commitment to capturing further information where possible with regard to characteristics will be helpful. It was also noted 407 compliments were formally received during the financial year, an improvement on the previous financial year and SM asked that the team be thanked for their work and the strong improvement in performance. OFO noted formal complaints are highest from under 30s and asked how the Trust benchmarks in this and if this was reflective of the service user profile. SMi confirmed the level of complaints was higher 3 years ago with considerable progress made in reducing this. SM suggested benchmarking in this area may be difficult as it would depend on the services provided by individual trusts and SY provided assurance, as the capturing of data on characteristics matures, this will support further

	analysis and learning, and she expected this to be reflected in the report for 2024/25. The Board of Directors received and **approved** the annual Complaints report for 2023/24.
PBoD 24/07/24 Item 12	**Quality Improvement (QI) bi-annual report** The Head of Continuous Improvement Parya Rostami (PR) joined the meeting and drew attention to the following key points: • The main aim is to ensure QI methodology becomes *'the way we do things around here'* and assured the Board significant progress had been made in this across the Trust and had been reflected. There are 99 QI projects currently with 76 active at the current time. • We are continuing to build capability through training and are participating in the Integrated Care Board systemic approach to building QI capability and knowledge in NHS organisations. • The Trust has been successful in all bids made to participate in national QI programmes including The National Mental Health QI programme and the National Culture of Care QI programme. • The Trust has participated in a number of national and international conferences across the year to share and celebrate progress made. • Three nominations have been shortlisted for the HSJ Patient Safety awards 2024 • Two projects have been successful in securing funding through QExchange. SMi asked the Board to consider the joining together of progress updates on Quality Improvement in the regular Quality Assurance reports given clear evidence of progress and embeddedness of the QI approach. It was agreed, at the suggestion of SY, that discussion on future reporting will take place outside of the meeting to ensure synergy with broader plans around integrated change reporting and the Board asked that a proposal be brought back to the Board following discussion at EMT. **Action** EMT to bring back a proposal to the Board on future report planning. **EMT** Heather Smith (HS) commended the team for progress made in a relatively short period of time in embedding QI into business as usual and driving cultural change. It was noted this had been reflected back through board visits to service areas. [DL left the meeting]
PBoD 24/07/24 Item 13	**Learning and Safety Report (Q4)** The Board received and discussed the Learning and Safety Report for Q4 from the Director of Nursing Quality and Professions, and it was confirmed the Quality Assurance Committee had been assured that learning across patient safety incidents, complaints and safeguarding adults is being identified, triangulated and acted on to improve the quality and experience of patients and staff. The committee recommended a continued focus on reducing self-harm incidents. In relation to a discussion on whether issues such as monitoring of fridge temperatures are picked up on quality visits, and how monitoring takes place, it was confirmed by SMi that fridge temperature deviations are reported through the Medicines Safety report received at QAC. At the meeting in July, there had been robust discussion and continuing challenge in relation to medicines safety and the committee has asked for the report to come back to committee at quarterly intervals with scrutiny and awareness of medication errors being addressed efficiently. **Action: SMi** [post meeting note: monitoring does not take place through the Fundamental Standards of Care quality visits - the Chief Pharmacist has confirmed that fridge temperatures are manually recorded using a pharmaceutical grade fridge thermometer. A back up system is in place for the wards with data-loggers. When deviations are reported with the fridge thermometers, these are checked to corroborate or confute. There is a digital system on Dovedale 1 only (put in as a test bed and maintained). If a deviation is reported, this is checked remotely on-line to corroborate or confute the report]

	In relation to reporting of racial and cultural abuse, BS reflected on a discussion with a member of staff during a Board visit to Dovedale ward and asked for assurance on whether staff are being supported following incidents of abuse from service users. JM advised that debrief support and support to contact the police is offered and reported incidents are categorised as either a potential hate crime or as a hate incident. SY noted that during visits to wards, staff are asked about their experiences, and it has been reported that the level of support has improved significantly, however several of the reports on the agenda for discussion at the board meeting refer to this issue, and this is reflected in the staff survey results which highlights the need for continuing attention to this issue as an executive team. She suggested that there needs to be a visual communications campaign to reassure staff of the Trust position on anti-racism, of what is being done and that they are being listened to. The Board asked that future reports include/clarify assurances against items highlighted. **Action: SMi** [JM left the meeting]
PBoD 24/07/24 Item 14	**Annual Safeguarding Report 2023-24** The Board received and **approved** the Annual Safety Report for 2023/24 for publishing from the Director of Nursing, Quality and Performance subject to two amendments: • referencing the issues relating to Safeguarding Children training in the cover; • clarifying the internal governance processes in the cover report**.** **Action: SMi to take forward with safeguarding lead**
PBoD 24/07/24 Item 15	**Controlled drugs accountable officer annual report (CDAO) 2023/24** Abiola Allinson, Chief Pharmacist (AA) joined the meeting. The Board received and noted the controlled drugs accountable officer annual report for 2023/24 and assurance provided that key risks and concerns relating to management of controlled drugs are understood with plans in place to address issues around incident reporting, second signatures, closer monitoring of supplies on controlled drugs to wards and nursing practice. AD noted the overall increase in medication incidents reported over the last year and queried whether there were any further innovative digital or technological methods for ensuring improvements and safety. AA noted that discussions have been held with other Trusts where they have inputted electronic solutions such as secondary signatories attached to the electronic prescription system but noted that the timing of looking at these new digital solutions needs to be considered in line with the current focus of the organisiation to implement a new electronic patient record. SMi noted the previous point made by MD about being business ready to be able to innovate and noted that this will be discussed further outside of the meeting between executive colleagues. SY added that raising awareness in the context of safety issues is vital and it will be helpful to do this via the leadership cascade for August. A focused approach on the range of safety issues and the development of any IT will be taken forward with the executive management team. **To note and take forward.** The Board congratulated AA for being shortlisted for pharmacist of the year at the Black Healthcare Awards taking place in August. [post meeting note – At the request of the controlled drugs accountable officer the annual report for 2024/25 will be received in September 2025 in order for the CQC annual report (which is received in late July) can be reflected. **Note for forward plan**
PBoD 24/07/24 Item 16	**Transformation Portfolio Report** The Director of Strategy (JD) drew out the following matters post discussion at Finance and Performance Committee who asked: • That further detail be provided in the report in relation to delayed milestones and potential impact

	on the remainder of the portfolio, particularly in relation to the learning disability programme. • That clarification be provided regarding the impact of the Vacancy Control Panel on the pace of making changes across the organisation. The committee was assured by members of the committee that the process had been streamlined and based on feedback received • The relationship between the budget and progress RAG ratings in that a green rated budget may not necessarily indicate strong budget management but rather a lack of progress resulting in budget underspend. HS noted that Finance and Performance committee had asked for more assurance on the portfolio items which are running over such as the Learning Disabilities (LD) programme and aspects of the Electronic Patient Record Programme and requested that updated timeframes and narrative on mitigations within these programmes are included in the report. JD noted that the key milestones and dependencies have been included in Appendix 3 of the report. Discussion took place on the Vacancy Control Panel process and SMi provided assurance to the Board that discussions at VCP are timely and if push back is required this has been appropriate including when budget for roles has not been identified. Discussion took place on delays to implementation of the learning disability programme to January 2025 to allow for recruitment to posts. SY noted that assurance has been received outside of the meeting, from the Interim Medical Director, that learning disability services currently in place are robust and are not affecting service users in terms of quality. A project manager has been appointed to focus on the programme between August and January working closely with teams to operationalise the model and to support staff engagement with a culture and quality visit scheduled to the teams for August. The Board asked that a highlight report on the Learning Disability service, be provided to reflect the latest update and any changes to the programme, at Finance and Performance Committee and in addition to Quality Assurance Committee (at the request of the chair of this committee from a quality assurance perspective) in September for onward reporting to BoD in September**. Action: JD to take forward and to be noted for the FPC and QAC forward plans (AW)**
PBoD 24/07/24 Item 17	**Financial Performance Report (MONTH 2)** The Executive Director of Finance (PE) outlined the financial position for Month 2 (end of May 2024) noting the following: • The year to date deficit position is £1.285, this is an improvement of £0.21m against the plan at this point in the year. • The forecast is expected to achieve the planned deficit of £6.52m • There has been an increase in out of area activity. Year to Date this remains on plan but the forecast is for a £1.419 m overspend as the savings from the reduction in the number of spot bed purchases is not expected to happen as quickly as expected. • Pay cost overspends have been offset by non-pay underspends from a range of areas including premises and an increase in planned income. • Capital expenditure is on plan at Month 2 and forecast to be at year end, however, the uncertainty around the timing of the Fulwood sale continues to be a risk to delivery of the capital programme. • Value Improvement and recovery plans totalling £8.4 m have been developed. Work is ongoing to strengthen and implement the plans and to identify further opportunities to achieve the internal plan target of £9.7 m, this to is enable achievement of the planned savings required of £7.3 m creating headroom of £2.4m in plans in case of slippage and other cost pressures arising in the year. • Cash is lower than expected as income due to be received is high. The finance team will increase focus on debt recovery to address this and to maximise the interest receipts from the cash bank account. However, there are no concerns regarding cash flow or material bad debt risks to highlight at present. SM noted that the level of continued overspend is a concern and requested further assurance on the

	grip and control to ensure delivery of plan, and AD asked what needs to be seen at FPC to demonstrate and to help focus on the factors driving this. PE clarified that clinical management overspend is monitored through service line action plans and hot spots are being managed through recovery plans. NR added that there has been a great improvement in roster management, but more work needs to be done in areas and CP added that roster efficiency meetings are continuing to monitor medical establishment reviews. SY advised the Board that EMT had received a report on medical overspend and a review of what level of medical leadership is required is taking place through the target operating model. OMcL provided assurance that this has been challenged and discussed in Finance and Performance Committee at the previous 2 meetings, and he noted that the overspend is understood. He requested that the accuracy of the figures in the FPC reports is correct. **Action: AW** to check accuracy of the Finance and Performance Committee minutes and the AAA report from the committee to ensure that is states that the Year-to-Date deficit position of £1.285m being £0.21m better than planned. [post – meeting note: this has been reported correctly in the FPC minutes and the AAA report] NR added that good progress has been made regarding agency spend which has been reflected in a significant cost improvement. He advised that there are 3 components which are critical for addressing the overspend together: the Value Improvement Programme, posts over established or unfunded which have recovery plans and ward overspends in relation to 1:1 observation.
PBoD 24/07/24 Item 18	**Integrated Performance and Quality Report (IPQR)** The IPQR was received and updates following discussion at Board Assurance Committees noting: • Finance and Performance Committee challenged that lack of focus on out of area placements within the report and asked that it be given more prominence • The finance dashboard highlights the key financial KPIs for the financial year and consideration is being given as to how this can be presented to avoid duplication with the Finance report. • There is contra variance with regards to bank and agency expenditure reflective of planning profiles which will be reviewed for June reporting. • An action was taken from the previous board meeting regarding clarity on the data relating to the Sheffield Adult Autism and Neurodevelopmental Service (SAANS) service to support understanding of the read across in reporting across the Trust and Place, as noted on the action log. In relation to the update from People Committee, HS requested that the data for compliance with supervision and PDR targets is separated out so as not to conflate the issues relating to the two areas and noted that although mandatory training figures are above the 80% target in all areas, it would be helpful to focus on the number of courses that are not meeting the target. SY confirmed that the IPQR report will undergo further refinement to include analysis and insight of key domains from all the committees, with key highlights noted on the cover report. **PE to note and take forward**. In relation to the 72-hour follow up data only being available for adult acute discharges, not older adults, due to delays in the Rio reporting workstream affecting the reporting for OA Home Treatment Team, SM requested assurance in future reporting that processes are still in place to ensure that this is being addressed, as this is being reported as a gap in the report. She noted that there has been a reported rise in AWOL incidents (absent without leave – detained patients) and noted that this will be reviewed and discussed through the mental health legislation operational group. The Board requested a referral to Mental Health Legislation Committee to review and discuss a rise in detained patients going absent without leave (AWOL). **To be noted on the cross-referral tracker and reflected on the work programme for MHLC. AW to take forward.**
PBoD 24/07/24 Item 19	**Integrated Performance and Quality Report Development Plan 2024/25** The Board received a proposed plan from the Director of Finance for taking forward changes to the Integrated Performance and Quality report (IPQR) and key performance indicators (KPIs) following engagement which has taken place with board members and key leaders within the Trust. This

	engagement process is ongoing and the paper proposed an iterative approach to the development of the IPQR with proposed changes presented through the Board assurance committees and final confirmation agreed at Finance and Performance Committee which has overarching responsibility for the IPQR on behalf of the Board. The approach outlined was accepted.
PBoD 24/07/24 Item 20	**Systems and Partnerships update** The Director of Strategy James Drury (JD) drew attention to the following key items from the report: • Progress made with development of the joint committee arrangements for eating disorders between the partners in the South Yorkshire MHLDA Provider Collaborative. • An update provided on the approach the collaborative is taking in relation to proposed specialist autism services and the proposed specialist community forensic mental health services. • Continued development of partnership working at Place and System levels. • Board was reminded that the Trust is participating in work at Place and across South Yorkshire towards the development of an ICS ten-year infrastructure strategy. SY noted that the collaborative is developing a parity of esteem framework to support demonstrating its impact across the system and to support a broader discussion with acute partners for planning care and community services which will be important when decision are being made about funding transformations. It was noted that feedback and comments on the draft terms of reference are welcomed but they will not be included in the report until an agreed version has been finalised **Action -** remove the draft TORs from the appendix of the paper on the website, until an agreed version has been finalised **AW**
PBoD 24/07/24 Item 21	**Workforce Race Equality Standard (WRES) Report 2024 and Workforce Disability Equality Standard (WDES) Report 2024** Head of Equality and Inclusion Liz Johnson (LJ) joined the meeting to support discussion on the reports. The Executive Director of People (CP) noted the following key items from the report • The percentage of staff experiencing harassment, bullying or abuse from other staff had been • improving year on year however in 2023 this has worsened • There has been a rise in the relative likelihood of ethnically diverse staff entering the formal • disciplinary process • The non-clinical disparity ratio has worsened in the last two quarters of 2023/24 • Clinical disparity ratios remain high despite an increase in ethnically diverse staff in senior roles • The organisation benchmarks poorly on access to reasonable adjustments BS noted that the progress made on the reporting supported by data and reflected that the staff survey results indicated that that disabled staff have a worse experience than able-bodied staff and the percentage of disabled staff who say that the organisation provides equal opportunity is very low. He challenged the wording set out in the report relating to SHSC having a high percentage of disabled staff at all levels with some groups being below the average of 11%, noting that 24% of working age adults in the UK are disabled. He added that there may be many people within the organisation who do not disclose their disabilities and queried whether there were any plans on improving and increasing the number of staff who feel safe enough to disclose their disability, and he recommended raising the visibility of this issue as a health and social care organisation. CP agreed that the right environment is needed to encourage staff to feel safe to share starting at the point of advertising and including ongoing wellbeing discussion during supervision and PDR. She added that the focus on supporting line managers to understand and seek support is crucial and will be included in the new manager development programme. SY noted that supporting staff to stay well and to stay in work goes beyond reasonable adjustments and this links to the employment pathway work that is currently underway in Yorkshire which focuses on preventing people from becoming so unwell that they become a recipient of services. In relation to the WRES, it was noted that a lot of the issues had been discussed in previous items on the agenda. OFO queried the support ongoing to support line managers and it was confirmed that the Manager Development Programme, which is being rolls out from July 2024, will have specific modules on

	dealing with racism and discrimination. There is a continued focus on leadership in addressing discrimination in the Developing as Leaders programme and staff survey results will continue to be reviewed to identify hot spots for further focus. SMi added that an Ethnically Diverse Registered Nurse Network to help support ethnically diverse nurses has been created as part of the commitment in the Nursing Plan and an opening event for the network is being held on Wednesday 28 August. The Board **approved** the reports for publication.
PBoD 24/07/24 Item 22	**Digital Assurance Group Annual Report (Incorporating SIRO and Caldicott Annual Reports) 2023- 2024** The Board received and took assurance from the Digital Assurance Group report incorporating the annual updates from the Senior Information Risk Owner (SIRO), the Director of Finance and the Caldicott Guardian, the Interim Medical Director. The following points were noted: • During the financial year 1 data and information incident warranted reporting to the Information Commissioners Officer (ICO) who determined no further action was necessary. • Data Security and Protection Toolkit (DPST) training compliance was delivered at 95% for the first time. • Elimination in May 2024 of the backlog in relation to Freedom of Information (FOI) & Subject Access Requests (SARs) • Delivery of the data security protection toolkit action plan for areas impacted by the delays to implementing the new Electronic Patient Record (EPR) Following discussion at Audit and Risk Committee and the Board of Directors it was requested additional assurance be provided in respect of cyber security arrangements and this will be reflected in the report for 2024/25. As discussed earlier in the meeting it was re-confirmed a dedicated Information Governance and Cyber Security Group is being established to report into Audit and Risk Committee. The Terms of Reference for this will be approved in the summer and a detailed report received at the committee in October. PE provided assurance around arrangements in place for penetration testing and patching as outlined in the report and reviewed as part of assurance testing annually. **Action -** Assurance on cyber security to be more explicit in the annual report and reflected in AAA reporting from the Audit and Risk Committee throughout the year. **Action: AD/PE to note and take forward.**
PBoD 24/07/24 Item 23	**Annual Health & Safety report 2023-24** [The Director of Corporate Governance, Deborah Lawrenson rejoined the meeting] The Health and Safety Annual Report for 2023/24 was received and the following key observations made by the Director of Strategy James Drury (JD) in introducing the report: • The importance of creating the right environment and setting the right tone to support the Trust to encounter fewer incidents and to support people in having a better experience. • Progress made with regard to slips trips and falls. There is specific focus on this at Birch avenue and Woodlands view given the nature of the services provided at those sites. • In response to the previous 360 internal audit which asked that the Board receive more assurance on fire safety measures it was confirmed in terms of flow through governance Alert Advise and Assure reporting has been provided through Board Assurance Committees overseeing Health and Safety (Quality Assurance Committee and People Committee) with AAA reporting from them to the Board. JD will be discussing future reporting with the chair of Quality Assurance Committee to ensure the correct escalation is taking place through each of these assurance committees via their AAA reports. • With regard to fire safety doors good progress has been made through the capital programme to put in place Kingsway fire doors in our inpatient units with a checking process of these in place by the provider. An independent review of all our fire doors in all units has been commissioned and is expected to conclude in September. In the meantime, reviews of doors are taken into account as they come through from Kingsway and JD provided assurance the picture is improving in terms of oversight. • With regard to physical security and how staff feel about coming and going from work and walking back to their cars, lighting has been improved and the level of brightness of this checked at Michael Carlisle Centre. Work is taking place to look at extending CCTV and

	security at the Longley site. BS reflected following a Board visit the previous day to inpatient facilities, that he had heard from staff that if physical restraint is needed this typically takes place in an area with hard floors and he had been advised there is a new carpet available for such spaces and asked if this could be explored. BS asked if the Trust was planning to use Oxyvision or body worn cameras as a safety measure. SMi confirmed not. She advised these were invasive and controversial interventions. She advised Oxyvision in particular is highly invasive in terms of how it would be monitored outside of the Trust, and having looked at this as an option through a Human Rights lens her view was that its use was potentially a breach of human rights. SY asked if discussion on this had been taken through a formal process and SMi confirmed a paper had been received previously on body worn cameras. It was agreed a paper should be received at Mental Health Legislation Committee in September with a recommendation then made to the Board via the AAA report. **Action SMi to take through MHLC in September.** MD noted there had been an increase in physical assaults in March 2024 moving from a 6 month trend of decreasing numbers and asked if there were any particular reason for this. JD explained it was variable to individual situations. SMi suggested the Integrated Performance and Quality Report would identify location of incidents with associated narrative. It was agreed SMi would review this and provide an update outside of the meeting. **Action –SMi/JD** to review narrative in the IPQR and circulate an update to Board. HS asked if the Executive were confident there was a coherent strategy for reducing violence and aggression. JD confirmed his intention to strengthen the relationship between the Violence and Aggression group and the Health and Safety Committee and it was noted by SY that revised terms of reference for the Violence and Aggression Group are being taken through the Trust's governance. AD asked if, given fire doors are currently one of the highest corporate risks, if there should be a reference to this retrospectively in the Trust Annual Report for 2023/24. JD explained there would be a better understanding of the level of risk when the independent review is received in September and the risk level had been set at a high-level pending receipt of that. DL explained that the Trust Annual Report for 2023/24 has already been submitted and could not be amended, advising reference to this work will be included in the Annual Report for 2024/25 and in the Health and Safety Annual Report for 2024/25. She advised if a change were to be required to the Health and Safety Annual Report for 2023/24 it could be included in the section related to improvements being taken forward in 2024/25. **Action -** reference to the work commissioned in relation to fire door safety to be included in the Health and Safety report 2024/25 and in the Trust Annual Report for 2024/25 **Action JD** OMcL asked if the resources for managing Health and Safety in the Trust were sufficient. JD confirmed the Trust has one Health and Safety advisor supported by staff who work specifically in security services and other associated matters within the team, but he confirmed he would benchmark the provision and there may be opportunities within the wider team to look at resources. **Action – JD** SM commended the ongoing improvements which have been made to the reporting through the year and to the Annual Report for Health and Safety received for 2023/24 which was **approved.**
PBoD 24/07/24 Item 24	**Board Assurance Framework for 2024/25** The Director of Corporate Governance, Deborah Lawrenson (DL) presented the Board Assurance Framework (BAF) for 2024/25 following receipt and discussion at Executive Management Team and the board assurance committees. The BAF for 2024/25 was **approved.** **Action DL** to give consideration as to how discussion might be framed around the gap between a current score and a target score i.e. to support focussing on discussion on those with the highest gap to reaching their target score.
PBoD 24/07/24 Item 25	**Corporate Risk Report** The Head of Corporate Assurance Amber Wild (AW) presented the updated Corporate Risk Report following receipt through Executive Management Team and the Board Assurance Committees.

	It was noted:
	• There are currently 14 risks on the corporate risk register.
	• New risks added were:
	  o Risk 5344 related to Fire Doors
	  o Risk 5321 related to mandatory training compliance
	• Risk 3679 related to ligature anchor point risks is being reviewed in line with the review taking place on the associated BAF risk for the therapeutic environments.
	• 5 of the highest scoring EPR risks have been agreed for escalation onto the Corporate Risk Register following discussion at Finance and Performance Committee and are in the process of being added to Ulysses.
	• Risks related to violence and aggression have been reviewed and it was agreed at People Committee for an overall corporate risk to be developed on relation with staff wellbeing and quality of care in relation to systems not responding adequately to issues around violence, sexual safety and racism for reflection on the Corporate Risk Register. This is expected to be reported to Board in September.
	
	AD noted that the Patient Reported Outcome Measures (PROMs) and impact on statutory reporting due to the delay with EPR, is recorded as a high risk and asked if this was set at the correct level. SY suggested a more detailed review of the corporate risks take place by the Executive Team as she would have expected to see Cyber Security and Out of Area beds as high scoring risks.
	
	In terms of process, it was confirmed by DL that the Corporate Risk Register is received at Risk Oversight Group for confirm and challenge in advance of receipt at Executive Management Team with recommendations then made to Board Assurance Committees. It was agreed a further deep dive should take place by the Executive Team to sense check the risks and scoring on the Corporate Risk Register (alongside the Board Assurance Framework). **Action DL/EMT** to undertake detailed discussion on corporate risks at EMT away time in August. **Action AW** to include a very high-level table on the front cover for future reports with the risks highest to lowest and movement to support focussing the discussion**.**

PBoD 24/07/24 Item 26	**Formal receipt of Auditor reports for the year ending March 2024 (final HOIAO and External Audit Report)** The final Head of Internal Audit Opinion was received and noted with 'significant assurance' having been given. The final External Audit report was received and noted with an 'unqualified' opinion having been given. The Board thanked the auditors for their support through the process and for the finance and corporate governance teams for their work in leading the processes for development of the Annual Report and Accounts and associated activity.
PBoD 24/07/24 Item 27	**Governance report** The Director of Corporate Governance Deborah Lawrenson (DL) presented an update of key governance matters from the report which were noted. The following key matters were highlighted: • The updated Modern Anti-Slavery statement – was **approved** by the Board post receipt through Safeguarding Committee and the People Committee. • The updated Terms of Reference for the Board Assurance Committees were received and **approved** following receipt through Audit and Risk Committee. • Proposed changes to the Constitution were **approved** by the Board post receipt through Council of Governors. DL advised an additional change would be discussed at Council of Governors that month in respect of management of quoracy and percentage of governors required to be present to be quorate. Currently the Constitution required this to be split by constituency which is proposed to be simplified to an overall percentage, The Board were supportive of this additional amendment subject to agreement by the Council of Governors. • The register of interests for Board of Directors was received and it was noted an amendment was required to the declaration of one member of the Board and the document would be updated following the meeting and uploaded to the website. • It was confirmed Fit and Proper Persons declarations for Board members have been completed in line with the new processes and confirmation of such submitted by the Chair by the required

	deadline. • It was confirmed declarations of interest and fit and proper persons test and due diligence required for Governors (including new Governors post elections) is nearing completion. • The election process for the role of Lead Governor will take place in August in readiness for confirming the new appointee at the Annual Members Meeting in September. The current Lead Governor Terry Proudfoot was thanked by the Board for her service in the role. • It was confirmed good progress has been made with receipt of declarations of interest for those required to do so below Board level with only a small number outstanding and being followed up. • It was noted the register of sealings for 2023 -24 had been received with no use of seal in that financial year. • The updated cross committee referral tracker was received and noted.
PBoD 24/07/24 Item 28	**Board work programme 2024/25** The Board noted the updated work programme.
PBoD 24/07/24 Item 29	**Any other business** No additional business was raised at the meeting. The Board congratulated OFO for her award for ambassadorial fundraising work for The Childrens Hospital charity.
PBoD 24/07/24 Item 30	**Reflections on the meeting effectiveness** AD noted: • There were a number of discussions around staff voice, patient voice but had there been sufficient focus on action being taken to address racial abuse. • Continued use of acronyms in reports. She asked that full spellings be used followed by the acronym if required. • Consideration be given to proactive production of an outline or draft AAA reports (in advance of Board Assurance Committee meetings) where possible to support finalising these when the committees fall very close to circulation of Board papers. • There were a number of discussions in which it was acknowledged the Trust could do things differently in future which was encouraging as a learning organisation. OFO commended the quality improvement biannual progress report which supported the Board to consider and reflect the on the quality improvement approach in place at SHSC for the people that we serve. SY reflected back on what had been a positive meeting with improved triangulation between papers which had supported identified key areas to take away for further focus. The Chair thanked those in attendance and closed the meeting.

Date and time of the next Public Board of Directors meeting:
Wednesday 25 September 2024 extraordinary meeting to be held at 9.30am to receive end of year reporting.
Format: to be confirmed
Apologies to: Amber Wild (amber.wild@shsc.nhs.uk)