Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Open

Date:	10 June 2020	Item Ref:	05a

TITLE OF PAPER	Process for Preparation of Action Plans and Delivery of Back to Good within Sheffield Health and Social Care NHS Foundation Trust
TO BE PRESENTED BY	Dr Mike Hunter, Executive Medical Director
ACTION REQUIRED	To note progress made and receive assurance that a robust process is in place in response to the Care Quality Commission (CQC) report and requirements.

OUTCOME	The Board of Directors is asked to: Agree the approach to a "Back to Good Programme" Receive this report for update on progress.
TIMETABLE FOR DECISION	16th June 2020
LINKS TO OTHER KEY REPORTS / DECISIONS	CQC Inspection Reports CQC updates to the Quality Assurance Committee CQC updates to the Trust Board
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Quality & Safety 1.1 Effective governance, and quality assurance and improvement will underpin all we do. A101i Failure to meet regulatory standards (registration and compliance).
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Health and Social Care Act 2008 (Regulated Activities) Care Quality Commissions Fundamental Standards Care Quality Commissions Enforcement Policy Mental Health Act 1983
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Failure to comply with CQC Regulatory Standards could affect the Trusts registration, negatively affect care delivery and require additional funding to address.
CONSIDERATION OF LEGAL ISSUES	Failure to comply with the Health and Social Care Act 2008 (Regulated Activities) and in particular the recent enforcement notice issued could leave the Trust open to further action by the CQC, with a potential financial and reputational impact.

Author of Report	Andrea Wilson
Designation	Director of Quality
Date of Report	18 May 2020

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Summary Report

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
x	x			x		

2. Summary

Background

We were inspected by the CQC between 7 January and 5 February 2020 and their report was published on 30 April 2020. The domains of safety and well-led were rated as 'Inadequate', responsive and effective as 'Requires Improvement' and caring as 'Good'. We were rated as 'Inadequate' overall.

We were found in breach of 47 legal requirements and issued with 1 warning notice and 8 requirement notices across 5 of our services; 3 of which were rated Inadequate and two Requires Improvement. The CQC also recommended that we are placed in Special Measures for quality.

Services inspected and their rating outcomes are listed below:

- Acute wards for adults of working age and psychiatric intensive care units – Inadequate.
- Wards for older people with mental health problems – Inadequate.
- Mental health crisis services and health-based place of safety – Inadequate.
- Forensic inpatient or secure wards – Requires Improvement.
- Community-based mental health services for adults of working age – Requires Improvement.

The CQC have set 65 actions for us to address which comprise:

- 47 Must do actions
- 18 Should do actions

The CQC required a response from the Trust by 30 May 2020 with a plan of how we will address the musts and shoulds in their final Inspection report.

Action Plan development

The Trust has taken steps to ensure that staff have been fully engaged in the process of responding to the CQC findings.

A template (issued by the CQC) was prepared for each must and should containing all relevant actions already underway in relation to the 'you said, we did, we will plan' submitted to the CQC in response to their intial verbal and written feedback at the time of inspection and also actions being taken in response to the Section 29A notice received by the Trust on 17 February 2020. These prepopulated templates were sent out into the relevant service areas for teams and managers to discuss and formulate their approach. Some teams have involved service users in their discussions. East Glade, for example, used its ongoing Microsystems work to develop their action plans and 3 service users were actively involved in this.

These plans were then checked and validated by the Deputy Director for the quadrant as an intial quality assurance check and to ensure that there was 'read across' within the quadrant.

A joint session was held on 13 May 2020 to bring together the Crisis and Emergency Care Network and the Scheduled and Planned Care Network to carry out a further quality assurance and consistency check across the service areas.

Between the 15 and 18 May each plan (clinical operations and corporate services) was discussed with the service by the Interim Chief Operating Officer, Medical Director, Director of Nursing and Professions, and Director of Quality. These sessions were conducted via a combination of Microsoft Teams with people also invited to attend in person, where possible, to ensure that anyone wishing to contribute to the session was enabled to do so. The sessions facilitated direct, two-way feedback between team members and Executive Directors. Discussion took place about the plans, the ambitions of the services in getting back to good and presented an opportunity for the teams to identify any help and support they needed from the organisation or from individuals. There has been positive feedback from staff about this approach and feelings of engagement, ownership and partnership were reported.

An overarching Action Plan has been collated to bring together all Must, Should and ongoing Section 29A actions, plans and outcome measures. This cross references to risk registers and the Board Assurance Framework (BAF) where applicable.

To enable the Trust to focus its resources on areas of highest concern, and to understand what has the potential to cause the greatest harm if not delivered, risk will be further considered and assessed in relation to 3 key impacts. These are:

- Patient safety
- Morale of the workforce
- Reputation of the Trust

Submission to the CQC

Conversations took place with the CQC Lead Inspector to clarify exactly what was required for submission by 30 May 2020. She confirmed that:

1. The Trust was required to complete a high level action plan addressing all the requirements in the final Inspection report.
2. The CQC advised that they would be very supportive of the Section 29A actions being incorporated into the CQC action plan so there is just one Trust plan.It was agreed that an accompanying letter would be be sent from the Trust with the CQC action plan explaining how we have approached the Section 29A notice and what we have achieved since the warning notice was issued.
3. The CQC are not expecting any templates to be returned directly to them, they are for the Trust's internal use only.
4. The CQC plan to write to the Trust detailing how they will inspect against the 29A requirements under the current circumstances. This may be a desk top inspection, potentially in August but this will be explained further in their correspondence.

The high level action plan and accompanying letter were submitted to the CQC on 29th May 2020.

Back to Good – Definition Stage (Stage 1)

In addition to clearly evidencing delivery of the musts and shoulds, a wider programme of change and improvement is required. The Trust is taking a Programme Management approach to this, led and managed by the Trust's PMO. A Back to Good Board, chaired by the Medical Director and Director of Nursing, will oversee the programme of work in its entirety.

The overarching workstreams are:

1) Person Centred Care Records
2) A Theraputic and Great Place to work
3) Everyone Maintains High Professional Standards
4) Rapid Improvement Programme for Acute
5) Rapid Improvement Programme for Recovery
6) Well Led Improvement Programme

The work programme delivery will be underpinned by key enablers:
• Improving Technical Capability
• Organisational Development and Workforce – leadership, engagement, culture, recruitment, retention and staffing

All CQC requirements have been mapped to the workstreams. The existing work in relation to the Section 29A will be transitioned into the relevant workstream to ensure continuity and sustainability of the improvements made. Matrix working will be required as there are areas of overlap between the workstreams and the musts and shoulds allocated to them. Each workstream will be led and directed by clinical leaders from within our services. All work will be clinically led, managerially supported as a key principle. Each programme will have an Executive sponsor.

Workshops with a cross section of staff from clinical and corporate services will be held to define the scope of the work required for each of the workstreams, agree what good looks like and to set outcomes and measurable milestones to ensure progress – this is the Definition Stage (Stage 1) of the process. From this work, Project Teams will be established. Business support is allocated to each project team from the PMO to provide consistency in approach and reporting across the work programme.

We are working with our Service User Engagement and Experience Team to ensure that the Service User and Carer voice is clearly heard within all levels of the Programme and that we utilise a variety of methods of consulting and engaging people to maximise opportunities to contribute to the improvement process. We will also involve key stakeholders and partners and learn from the experience of others.

An initial work plan describing the processes of action plan generation, quality assurance and sign off, project and workstream invitation was developed for the Definition Stage of the process.
Good systems of governance will be required to ensure that all the work programmes deliver the expected outcomes and improvements within the agreed timescales, that issues are flagged up immediately and that assurance can be given about actions being taken to get back on track. We are working on these.

To ensure that momentum is not lost in the interim, weekly monitoring of the work underway to address the Section 29A requirements will continue. The Chief Operating Officer and Director of Quality will meet regularly with Deputy Directors to offer support as they continue to develop and deliver their plans. We will encourage earned autonomy as teams gain confidence and we can see progress.

As the workstreams become more established, these systems will be stood down, and the work migrated into the relevant area. Progress and embeddedness will be monitored via our governance reports and programmes of audit, self-assessment, peer reviews and inspection.
The Back to Good Board will ensure that Trust Board is fully sighted on progress, any significant variation from plan and mitigating actions being taken.

3. Next Steps

Action plan submitted to CQC on 29 May 2020.

Work to continue on development of the project teams and workstreams.

Preparation to continue for the first Back to Good Board.

4. Required Actions

The Board of Directors is requested to:

a) Receive the high level action plan submitted to the CQC
b) Receive assurance that the process undertaken to develop the CQC action plans has been inclusive, and that quality assurance processes have been robust and fit for purpose.
c) Endorse the proposed approach for the Definition Stage (Stage 1) of the Back to Good Programme.
d) Receive assurance that the proposed approach for Stage 1 is robust and fit for purpose.

5. Monitoring Arrangements

The Board of Directors will receive a monthly update on progress

6. Contact Details

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NHS
Sheffield Health and Social Care
NHS Foundation Trust

Back to Good Programme

Programme Overview
10 June 2020

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Programme of work

Sheffield Health and Social Care NHS Foundation Trust

Person Centred Care Records

Collaborative care plans
Risk assessment & management
High quality content

Therapeutic & Great Place to Work

Therapeutic & Healing Dormitories
Seclusion

Everyone maintains high professional standards

Care standards
Consistency
Processes

Rapid Improvement Acute

Environment
High Professional Standards
Staffing
Recruitment & Retention

Rapid Improvement Recovery

Recruitment & Retention
High Professional Standards
Delivery of the Transformation

Well Led Improvement Programme

Improved governance systems
Board Visibility & engagement
High quality data driving CI

Improving Technical Capability
Systems and digital skills

Organisational Development & Workforce
Leadership, engagement, culture, recruitment and staffing

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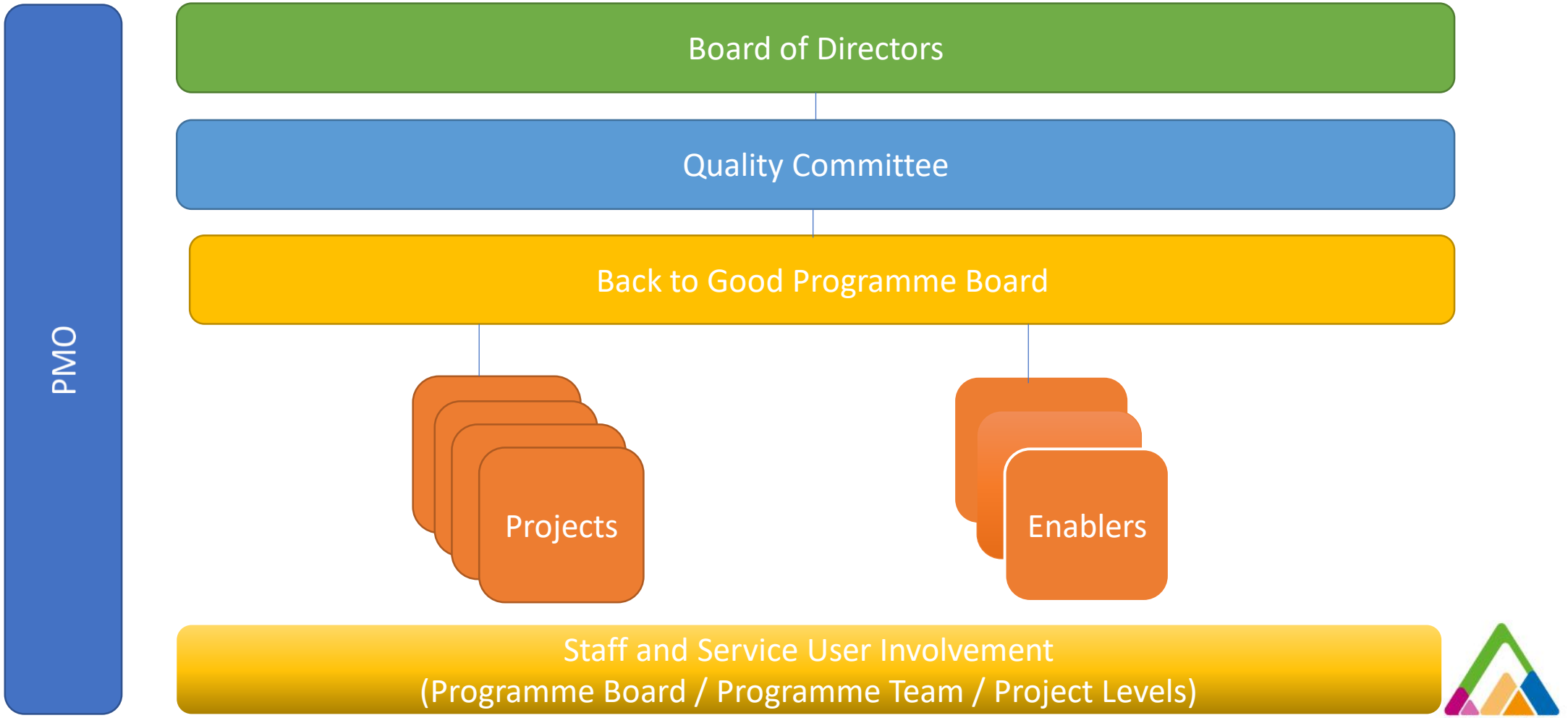
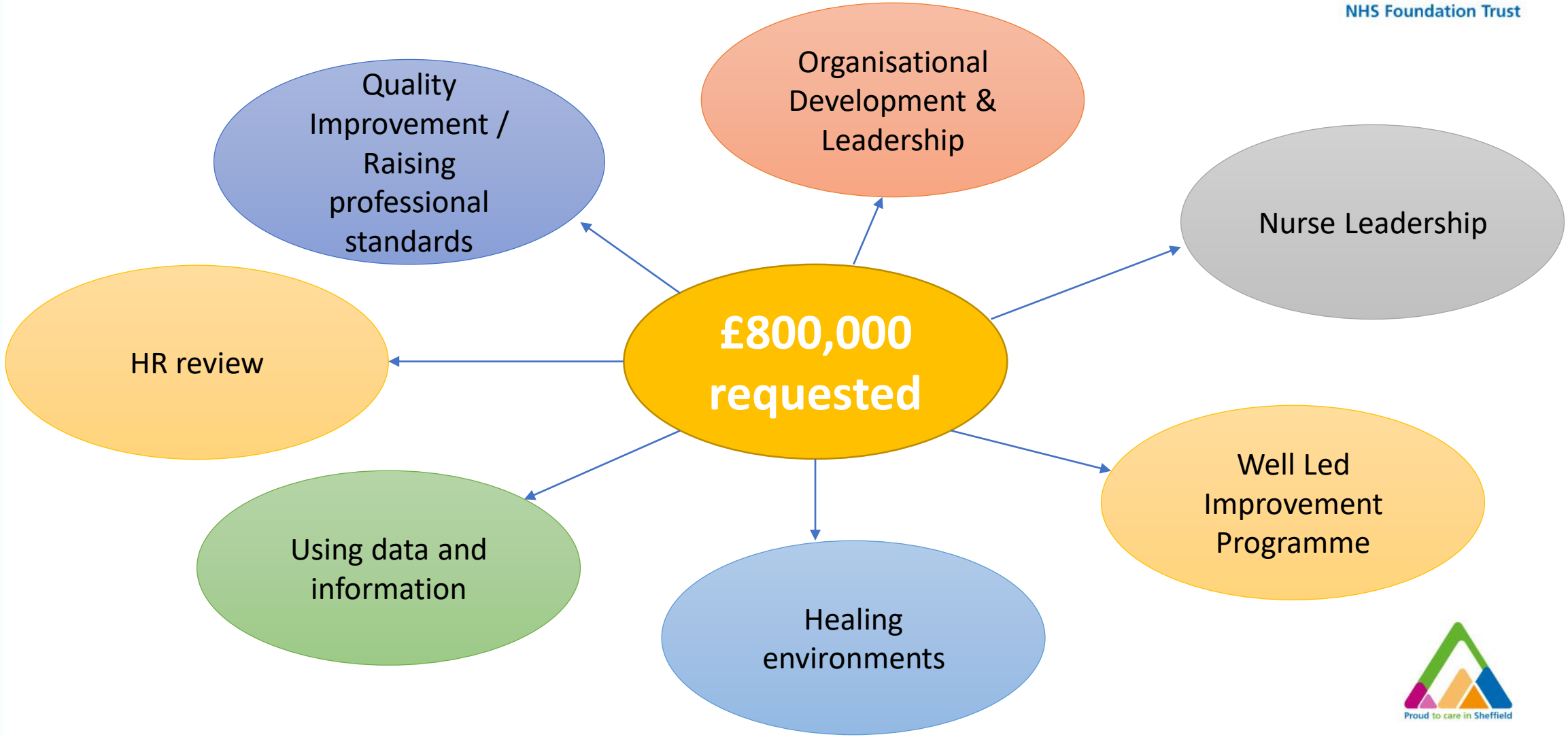
Governance


PMO
Board of Directors
Quality Committee
Back to Good Programme Board
Projects
Enablers
Staff and Service User Involvement
(Programme Board / Programme Team / Project Levels)

Additional Support



CQC Action Plan

Sheffield Health and Social Care NHS Foundation Trust

Risk Impact of noncompletion
High
Medium
Low

Action Progress
Not on track to deliver
On track to deliver
Delivered & embedded

High Level CQC Action Plan	

Back to Good Board Project Stream	Aim of Project Stream	Back to Good Board Project Themes	Risk Impact of noncompletion	Section 29A Warning Notice	Clinical Care Networks	Trust/ Team Level	Back to Good Project Lead	Target Date	Revised Target Date	Date Completed	Action	Progress	CQC Action Description Must & Should Do Numbers	Outcome Measure	Evidence Action Embedded	Monitoring Group / Monitoring Process/Evidence
		Incidents & Investigations		No	All	Trust	tbc	July 2020 - January 2021			Revise the Incident Management Policy to make the process less complex and incorporate the Royal College of Psychiatrists Management of Serious Incidents Investigations Kitemark Standards Develop a SOP as an addendum to the Serious Incident Management Policy outlining the responsibilities of Operational Networrks and Risk/Patient Safety Teams. (June 2020) Develop a SOP for supervision of serious incident investigations by operational networks (June 2020) Review & revise proceses for managing serious incidents/action plan development and governance processes (July 2020) Provide annual training and training updates (August 2020)		**10** The trust must ensure the incident investigation reports highlight all areas of required improvement and appropriate actions are taken. (Regulation 17(	100% of investigations completed within 12 week period or agreed timescale 100% of serious incidents, investigations and action plans considered by Patient Safety & Experience Group 100% of learning from serious incidents shared across the trust 90% compliance with training 100% compliance with Kitemark Standards 100% compliance with annual action plan dip sample audit 100% of action plans presented to the Service		Compliance with Kitemark standards to be audited annually Post training evaluation Quarterly Serious Incident Management Reports Service User Safety Group Patient Experience Sub-group

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