Sheffield Health and Social Care NHS Foundation Trust

# Board of Directors - Open

| Date: | 11th November 2020 | Item Ref: | 11 |
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| **TITLE OF PAPER** | Care Quality Commission Focussed Inspection Reports |
| **TO BE PRESENTED BY** | Beverley Murphy Executive Director of Nursing, Professions and Operations |
| **ACTION REQUIRED** | To receive the report and note the findings of the Care Quality Commission (CQC) focussed inspection following up on the Section 29A Warning Notice August 2020 |

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| **OUTCOME** | Board is informed of the finding and the next steps taken to review and incorporate the findings into the Back to Good Improvement Plan |
| **TIMETABLE FOR DECISION** | November Board meeting |
| **LINKS TO OTHER KEY REPORTS / DECISIONS** | CQC Inspection Reports 30th April 2020 & 22nd October 2020<br><br>CQC updates to the Quality Committee 27th April; 26t May; 22nd June; 27th July; 28th September & 26th October 2020<br><br>CQC updates to the Trust Board 13th May & 26th October 2020<br><br>Back to Good Board updates to the Trust Board 10th June, 12th August & 9th September 2020 |
| **STRATEGIC AIM STRATEGIC OBJECTIVE**<br><br>**BAF RISK NUMBER & DESCRIPTION** | Create a great place to work<br>CQC Getting Back to Good<br><br>BAF.0002<br>There is a risk the Trust does not deliver on its Well-Led Development Plan. This would result in a failure to meet the regulatory framework, get back to good and a failure to remove additional conditions placed on the Trust's Provider Licence.<br><br>BAF.0004<br>There is a risk that the Trust is unable to improve the quality of patient care, resulting in a failure to comply with CQC requirements and achieve necessary improvements. |
| **LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC** | Health and Social Care Act 2008 (Regulated Activities)<br>Care Quality Commissions Fundamental Standards<br>Care Quality Commissions Enforcement Policy<br>Mental Health Act 1983 |

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| **IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT** | Care that does not meet the CQC fundamental standards of care could have an adverse impact on the people we serve. Failure to comply with CQC Regulatory Standards could negatively impact registration of the Trust which would require investment to address. |
| **CONSIDERATION OF LEGAL ISSUES** | Failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, could leave the Trust exposed to regulatory action by the CQC, with a potential financial and reputational impact. |

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| **Author of Report** | Julie Walton |
| **Designation** | Head of Care Standards |
| **Date of Report** | 4th November 2020 |

Sheffield Health and Social Care NHS Foundation Trust

# Summary Report

## 1. Purpose

| For approval | For assurance | For collective decision | To seek input | To report progress | For information | Other (Please state) |
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| | ✓ | | | ✓ | | |
| To update the Board on the findings of the CQC inspection reports published 22nd October 2020 and the next steps in relation to our learning from the reports and the impact on the Improvement Plan. | | | | | | |

## 2. Summary

The CQC issued the Trust with two notices as a result of the CQC inspection in January 2020; a Section 31 notice which was received immediately following the inspection relating to people under the age of 18 years accessing the Psychiatric Decisions Unit (PDU) and a Section 29A warning notice received on 13th February 2020. The warning notice issued related to the following:

- staffing on acute wards, particularly the imbalance of experience;
- compliance with mandatory training and supervision;
- physical health monitoring;
- governance.

Immediate action to address concerns for both notices was taken, which included ceasing access to the PDU for people under the age of 18 years.

The CQC undertook a follow-up inspection of the Acute and Crisis services between 25th and 27th August 2020. The areas visited were the Acute and Psychiatric Intensive Care Unit (PICU), the Wards for Older Adults with mental health problems and Crisis Services, including the Psychiatric Decisions Unit (PDU). The CQC have informed us that they will not be taking any further action in relation to the Section 29A warning notice as they are satisfied that we have made significant improvement in the areas detailed in the warning notice. The warning notice has now lapsed. The CQC also followed up on breaches of regulation from the January 2020 inspection and the Section 31 notice relating to people under 18 years accessing the PDU. The CQC did not inspect against all the Key Line of Enquiries focussing on both notices and breaches of regulation related to areas inspected. The CQC inspected against the following domains:

| **Services/Areas** | Acute adults of working age and PICU | Wards for older people with mental health problems | Mental health crisis services and health based place of safety |
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| **Key Line of Enquiries** | • Safe | • Safe<br>• Effective | • Safe<br>• Effective<br>• Well Led |

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The CQC have told us that they can see significant improvement in the following:


The CQC also identified that we still have some areas where improvement is underway and more time is needed to make consistent and sustained improvements. These areas include mandatory training, physical health monitoring and consistency of staffing.

Three additional breaches of regulation were identified and the CQC issued further 'Must do' and 'Should do' actions as follows:

| Services/Areas | Must do | Should do |
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| **Acute adults of working age and PICU** | The trust must ensure safety of the premises by ensuring staff have access to up to date ligature risk assessments and that environmental risks such as ligature points and blind spots are mitigated. *(Regulation 12 2 d).* | The trust should ensure that all staff complete mandatory training. |
| | | The trust should ensure clinic rooms have the appropriate check. |
| | | The trust should ensure that all clinical equipment is calibrated and safe for use. |

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| | | The trust should ensure that medication is appropriately managed to ensure out of date stock is removed. |
| | The trust must ensure that systems and processes are established and operated effectively. This includes that the sub-contracting of services is managed via robust quality checking processes and senior leadership oversight to ensure the safety of patients. *(Regulation 17 2a)* | |
| | The trust must ensure that risks are assessed, monitored and mitigated by ensuring incidents are reviewed in a timely way and that actions are identified and implemented. (Regulation 17 (2 b) | |
| **Wards for older people with mental health problems** | | The trust should ensure staff are able to accurately record patient observations at the time they occur. |
| | | The trust should ensure that staff complete all face to face training as soon as COVID-19 restrictions allow. |
| **Mental health crisis services and health based place of safety** | | The trust should ensure that staff complete their mandatory training. |

## 3. Next Steps

We are reviewing the 'Back to Good' improvement plan to ensure that additional actions from the recent focused inspection are incorporated. In addition, we are adding the three new 'must do' requirements and will share the revised and updated plan with CQC by the deadline of 1st December 2020.

## 4. Required Actions

Board Members are asked to receive this report for information and note the following:

a) Note that the CQC have informed us that they are satisfied that we have made significant improvement in compliance with the warning notice issued in February, and that they will not be taking any further action in relation to this.
b) Note the positive improvements across the services inspected.
c) Note the three further 'must do' (Requirement) actions following the identification of breaches of regulation.
d) Note the seven 'should do' actions and that plans are in place to address these.

## 5. Monitoring Arrangements

The Quality Committee and Board receive a monthly progress update on the progress of the 'Back to Good Board' and the associated CQC improvement actions.

The Section 29A warning notice action plans are monitored through:

- Weekly CQC S29A action plan oversight calls (led by the Medical Director)
- Quality Committee and Trust Board.

## 6. Contact Details

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