Board of Directors – Public

SUMMARY REPORT	Meeting Date:	28 July 2021
	Agenda Item:	08

Report Title:	**Back to Good Programme Report**	
Author(s):	Zoe Sibeko, Head of Programme Management Office	
Accountable Director:	Dr Mike Hunter, Executive Director Medical	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Quality Assurance Committee
	Date:	14 July 2021
Key Points recommendations to or previously agreed at:	The Committee noted the progress and agreed that there is sufficient assurance that the programme is structured, managing risks and implementing improvements. The Committee noted that evidence for embedding of improvement actions is variable and that this requires attention	

Summary of key points in report

The paper outlines:

The progress of the Back to Good programme as reported to the Quality Assurance Committee on 14 July 2021.

The governance and assurance frameworks that have been established to monitor delivery of the improvement plans developed in response to the outcomes of the recent CQC inspections.

Outcomes and assurance relating to the embeddedness of the improvement actions delivered in Year 1 of the programme.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	✓	**Information**	

Recommendation: The Board is asked to review the programme progress report for May 2021, consider the levels of assurance and assess the risk in achieving SHSC's strategic objective of getting back to good

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Getting through safely	*Yes*		*No*	✓
CQC Getting Back to Good	*Yes*	✓	*No*	

Transformation – Changing things that will make a difference	*Yes*		*No*	✓
Partnerships – working together to make a bigger impact	*Yes*		*No*	✓

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission	*Yes*	✓	*No*		Care Quality Commissions Fundamental Standards Care Quality Commissions Enforcement Policy
IG Governance Toolkit	*Yes*		*No*	✓	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*	✓	*No*		If improvements are not made and regulatory requirements not addressed, we could fail to protect service users from harm.
Financial (revenue &capital)	*Yes*	✓	*No*		Financial investments are not considered at the Back to Good Programme Board, as this falls within the remit of other committees, boards and groups, for example, Capital Programme Group to identify and release funding to address the removal of ligature anchor points within inpatient areas.
OD/Workforce	*Yes*	✓	*No*		We are experiencing difficulty in recruiting and retaining skilled nursing and medical staff, which creates a risk to successfully delivering improvements and providing high quality care
Equality, Diversity & Inclusion	*Yes*	✓	*No*		*Please complete section 4.2 in the content of your report*
Legal	Yes	✓	No		If the programme does not deliver improvements to meet regulatory requirements, then further CQC inspections may find that we are in breach of the Health and Social Care Act.

Title	Back to Good Programme Report

Section 1: Analysis and supporting detail

Background

1.1 This report details progress of the Back to Good programme as reported to the Quality Assurance Committee on 14 July 2021

1.2 During April and May 2021, the CQC undertook the following review and inspections at SHSC:

- The focused review of care at Firshill Rise Assessment and Treatment Service (ATS)
- The core services inspection of the Acute and Older People's inpatient and Crisis pathway
- The Well Led inspection

1.3 The review of Firshill ATS has resulted in SHSC being issued with a Section 26 notice, placing restrictions on the conditions of the unit's registration. A deadline date of 23 July 2021 has been set to respond to the CQC with an improvement plan to meet the regulatory requirements, the majority of which must be initially evidenced by 9 August 2021. The CQC's report on Firshill ATS was published on 15th July 2021, rating the service as "inadequate". The development of a robust improvement plan has been led by the Rehabilitation and Specialist Services triumvirate with involvement from the service and support from corporate services to ensure the requirements are met within the set timescale. A core team meet on a weekly basis to support delivery and monitor progress against plan.

1.4 Following the core services inspection SHSC was issued with a Section 29a warning notice due to some of the findings in our Acute Wards and Psychiatric and Intensive Care Unit. SHSC is required to make significant improvements within these areas by 10 September 2021. Similarly to the approach taken to develop the Firshill ATS improvement plan, the Acute and Community triumvirate have led the work with the involvement of colleagues from across the wards and corporate services. Again, a core group meet on a weekly basis for support delivery and monitor progress.

1.5 Draft reports from the CQC in relation to the Acute and Older People's wards, and Crisis Service elements of the core services inspection and the Well Led inspection are expected to be received in July 2021.

1.6 The findings from the inspections have resulted in changes to the programme scope; it is clear that Year 2 has further complexity than Year 1 in terms of delivery and governance. In response to this revised governance structures have been established to ensure the programme is managed appropriately and brings about the required improvements. For details please see Appendix 1.

In summary the core changes are:

- The number of workstreams has increased to nine with the addition of workstreams specifically focusing on Older People's inpatients, Crisis Services and Firshill ATS.
- A Fundamental Standards of Care meeting has been established replacing the Improvement Group meeting which provided oversight of performance against areas as specified in the Section 29a issued by the CQC in 2020. The Fundamental Standards of Care group continues to provide oversight and monitoring of the Acute Wards

Improvement Plan (Section 29a), the Firshill Improvement Plan (Section 26) and progress against actions taken after CQC Mental Health Act visits.

- The Physical Health Group, which has been established and reports to the Physical Health and Infection Prevention and Control Committee, will act as the Physical Health workstream within the programme and take forward any regulatory requirements from the inspections.

These changes to the delivery and governance structures will ensure that targeted progress is made within set timescales with appropriate control mechanisms and decision-making processes are in place to promote success.

Progress against improvement actions

1.7 74 actions were included in the Year 1 improvement plan. As of 30 June 2021, the status was:

- 54 actions have been completed and the evidence for their completion approved by the Director of Quality, Salli Midgley
- 7 actions are completed and awaiting approval by the Quality Team
- 4 remain open
- 4 have a status of being in exception as final delivery dates await confirmation
- 5 have been reopened by the Director of Quality upon review of the evidence as it was deemed to be insufficient

1.8 The improvement actions with a status of open and on track that have been carried forward from Year 1 of the programme relate to staffing and medicines management. Progress is being made in addressing the required improvements regarding staffing, however the actions remaining open are an indication of the ongoing concern regarding our ability to recruit and retain high quality staff. Medicines management improvement is being led by a Task and Finish Group, led by the Chief Pharmacist and Director of Quality.

1.9 Focus has been placed on assuring actions with a status of complete awaiting approval. This has resulted in the number of completed actions increasing but, conversely, it has also increased the number of reopened items where the evidence has been deemed to be insufficient and further work is required to meet the CQC requirement.

1.10 The Quality Assurance Committee questioned the robustness of the assurance process for confirming that regulatory requirements have been met and that the improvement has been embedded. The Director of Quality is leading a review of the process and necessary amendments will be made as required.

Reopened Improvement actions

1.11 Trust Wide 7 (TW7) '*The Trust must ensure that a physical health strategy is implemented, and that there is monitoring of compliance with this.*'

Acute and Psychiatric Care Unit 26 (A&PICU26) '*The Trust must ensure that staff undertake physical health monitoring with all patients.'*

The evidence provided did not give sufficient assurance that the strategy has been implemented, nor that robust monitoring is in place as highlighted in the Physical Health audit conducted by 360 Assurance, which was presented to Quality Committee in June

2021.

The actions to address the recommendations from the internal audit have been specified and delivery is underway.

1.12 Acute and Psychiatric Intensive Care Unit 69 (A&PICU69) '*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'*

The Director of Quality confirmed that the number of unresolved incidents has significantly reduced, however the 5 day turnaround time for responses is not being routinely achieved.

Concerns surrounding incident reporting are included in the recent Section 29a warning notice, therefore this action has been reopened and will continue to be monitored by the Back to Good Programme Board.

In line with the timescales set in the warning notice, it is intended to have addressed the requirement and transitioned oversight and assurance of this activity to the Clinical Quality and Safety Group by September 2021.

1.13 Acute and Psychiatric Care Unit 70 (A&PICU70) and Trust Wide 71 (TW71) '*Some abusive behaviour remained unchallenged and escalated to assaults on patients and staff. There are concerns around how racist incidents are addressed.'*

It is important to note that these actions do not relate to a breach of regulatory compliance, however the comments were included in the CQC's report from the focused re-inspection of acute, crisis and older adults wards published in October 2020, and therefore included in the improvement actions for Year 1 of the programme.

Both actions have been reopened despite significant work being taken forward by various groups across SHSC, however it is acknowledged that it requires large scale change to take place for these issues to be addressed fully.

The actions will be merged and taken forward at a SHSC-wide level, particularly as they relate to the strategic aim of being inclusive.

Improvement actions in exception

1.14 These relate to the work required on the acute wards to improve the physical environment including the removal of ligature anchor points and the mitigation of environmental and clinical risk that they pose to patients.

Trust-wide 67 (TW67) – '*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.'*

Acute and Psychiatric Care Unit 26 (A&PICU26) – '*The Trust must ensure that patients are cared for in environments which are private and dignified. This includes the removal of dormitory accommodation and ensuring the seclusion suites and CCTV cannot be overlooked and that patients' access to toilet facilities is appropriate.'*

Acute and Psychiatric Care Unit 28 (A&PICU28) – '*The Trust must ensure that the premises used for seclusion are suitable for the purpose of which they are being used, properly maintained and appropriately located for the purpose they were being used. They must be in line with the Mental Health Act Code of Practice.'*

Acute and Psychiatric Care Unit 32 (A&PICU32) – *'The Trust must ensure that it is able to meet the needs of all patients admitted to the ward and ensure that patients with complex*

needs which staff are unable to cater for are not admitted.'

1.15 It should be noted that the above improvement actions relate to areas which have been included in the 2021 Section 29a warning notice, namely, '*The Trust had not done all that was reasonably practicable to mitigate the risks associated with unsafe ward environments in the acute wards for working age adults'*

1.16 A Programme Director has been appointed by the Estates Team, who is leading the development of a programme of works which considers and delivers the various options for completion of the improvements to the physical environments. These include working on live wards, closing wards and / or exploring the use of a module decant facility.

While we are aware that not all works will be completed by 10 September, the above options will foreshorten the dates provided in previous plans on which the CQC commented that patients would continue to be cared for in unsafe environments until Stanage is refurbished in February 2022 and Maple in October 2022.

The revised programme will make clear to clinical leaders the length of time that risks will continue to be posed by environments and therefore how long they have to ensure that appropriate mitigation is in place.

1.17 To strengthen the approach to risk mitigation, a Clinical Nurse Advisor (Clinical Risk and Suicide Prevention) has been appointed and will be in post from August 2021. The Clinical Nurse Advisor will work with ward leaders and teams to develop best practice in clinical risk assessment, including risk related to ligature anchor points.

1.18 A paper will be presented to Quality Assurance Committee in the same month detailing how the role addresses the issues surrounding clinical risk and appropriate mitigation.

1.19 The refreshed estates programme and actions to be taken forward by the Clinical Nurse Advisor have been included in the Acute Wards Improvement Plan, which sets out how we will address the requirements in the Section 29a warning notice issued in June 2021.

Governance and assurance frameworks

1.20 The Programme Board reports to Quality Assurance Committee and also directly to Trust Board.

Section 2: Risks

2.1 BAF 0024

There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care.

This is caused by leadership changes, short staffing, cultural challenges, the lead in time for significant estates and IMST actions and the impact of the global pandemic resulting in risk of harm to people in our care and a breach in the Health and Social Care Act.

The majority of the causes of this risk can be directly linked to an improvement action as described in Section 1 of this report. These will provide mitigation or resolution to the risk. In summary:

- Plans are in place to recruit and retain high quality skilled staff
- A clinical establishment staffing review is being undertaken
- The Estates team and clinical colleagues are working together to remove and / or mitigate the risks associated with unsafe environments
- The Back to Good Programme Board is governing the overall improvement plan, including actions required under Section 29a warning notices as well as requirements that will emerge from the remaining 2021 CQC inspections (focussed Firshill ATS, core services and well led).

2.2 The Quality Assurance Committee questioned the clarity of the risk, in terms of its multiple components, the rating it had been given due to this and whether it had been identified what would be required to change the risk to green. The Director of Quality will review the risk with Neil Robertson, Director of Operations and Transformation and Beverley Murphy, Director of Nursing, Professions and Operations to ensure that it is clearly documented to support appropriate management and monitoring to reduce the impact on the quality of care.

Section 3: Assurance

Benchmarking

3.1 Benchmarking takes place in relation to specific areas of improvement to compare processes, staffing levels and performance metrics with other Trusts. This takes place as necessary throughout the delivery of the programme. Benchmarking information is also captured in the Integrated Performance and Quality Report, which is provided on a monthly basis to Quality Assurance Committee and to Trust Board.

Triangulation

3.2 Evidence of how well improvements have been embedded into every day practice can be triangulated with the Integrated Performance and Quality Report (IPQR) and the Improvement Dashboard. Please see Appendix 2 for details.

3.3 In summary, the information shows:

- Turnover and sickness remain a concern with failure to meet agreed targets
- The number of incidents have increased from April to May 2021
- The use of restrictive practice has remained fairly static between April and May with the number of physical restraint and rapid tranquilisation incidents slightly reducing. However the number of physical restraints, seclusion incidents and use of rapid tranquilisation have marginally increased
- The appraisal and mandatory training targets have been met
- Supervision rates for clinical areas have remained static at 68% compliance with the 80% target, however there has been a slight increase to 49% compliance for

corporate services. Supervision rates remain a concern.

- Physical Health monitoring also remains a concern

The final point triangulates with the outcome of the Physical Health audit which questioned the robustness of the data and the effectiveness of the monitoring process.

It is also important to note that the Director of Operations and Transformation is working with General Managers and Matrons within the Acute and Community Service lines to agree and implement an approach to ensure that supervision targets are met.

3.4 Improvement Case Example:

Relocating Burbage ward to Dovedale 2 ward

Burbage ward moved to the Dovedale 2 ward environment in June 2021. As well as the improved physical environment, the team has developed improved clinical practice. For example, regarding the quality and content of safety huddles, colleagues have devised pro-forma as a guide for discussion points. This has allowed the huddles to become more effective and informative. The points cover; safeguarding, lone working, fire evacuation plan, emergency equipment, planned interventions, discharges/admissions/transfers, and incidents in the last 24 hours

Engagement

3.5 Delivering the improvements within the Back to Good Programme remains a collective effort between clinical and corporate services.

The lessons learned from Year 1 of the programme highlighted the need for early and ongoing engagement with colleagues, this is being used to shape the approach to Year 2.

The learning from the programme has been demonstrated in the collaborative approach taken to develop the improvement plans in response to the inspection outcomes in which the Clinical Directorate's leadership teams have engaged with leaders, their teams and corporate areas.

Section 4: Implications

Strategic Aims and Board Assurance Framework

4.1 Getting Back to Good is a strategic priority for SHSC. Due to the expansive scope of the programme, its successful delivery and embedding of the improvements made will support the achievement of numerous strategic aims.

Equalities, diversity and inclusion

4.2 In response to the feedback from the CQC relating to incidents of racism, the programme team will collaborate with leads of various groups and operational teams to contribute to the organisation wide work on cultural change.

Culture and People

4.3 The lessons learned from Year 1 illustrated how some colleagues perceive improvement to be an add on to their role, and not part of the day job. This is to be addressed within Year 2 of the programme by integrating Quality Improvement approaches into Back to Good workstreams from the outset.

Integration and system thinking

4.4 The Programme Board provides updates to the System Quality Board, led by NHSE/I and also involving the SYB Integrated Care System, CQC, Sheffield CCG and Sheffield City Council.

Financial

4.5 The programme does not have a specific budget. The investment required to deliver improvements are considered within other funding sources.

Compliance - Legal/Regulatory

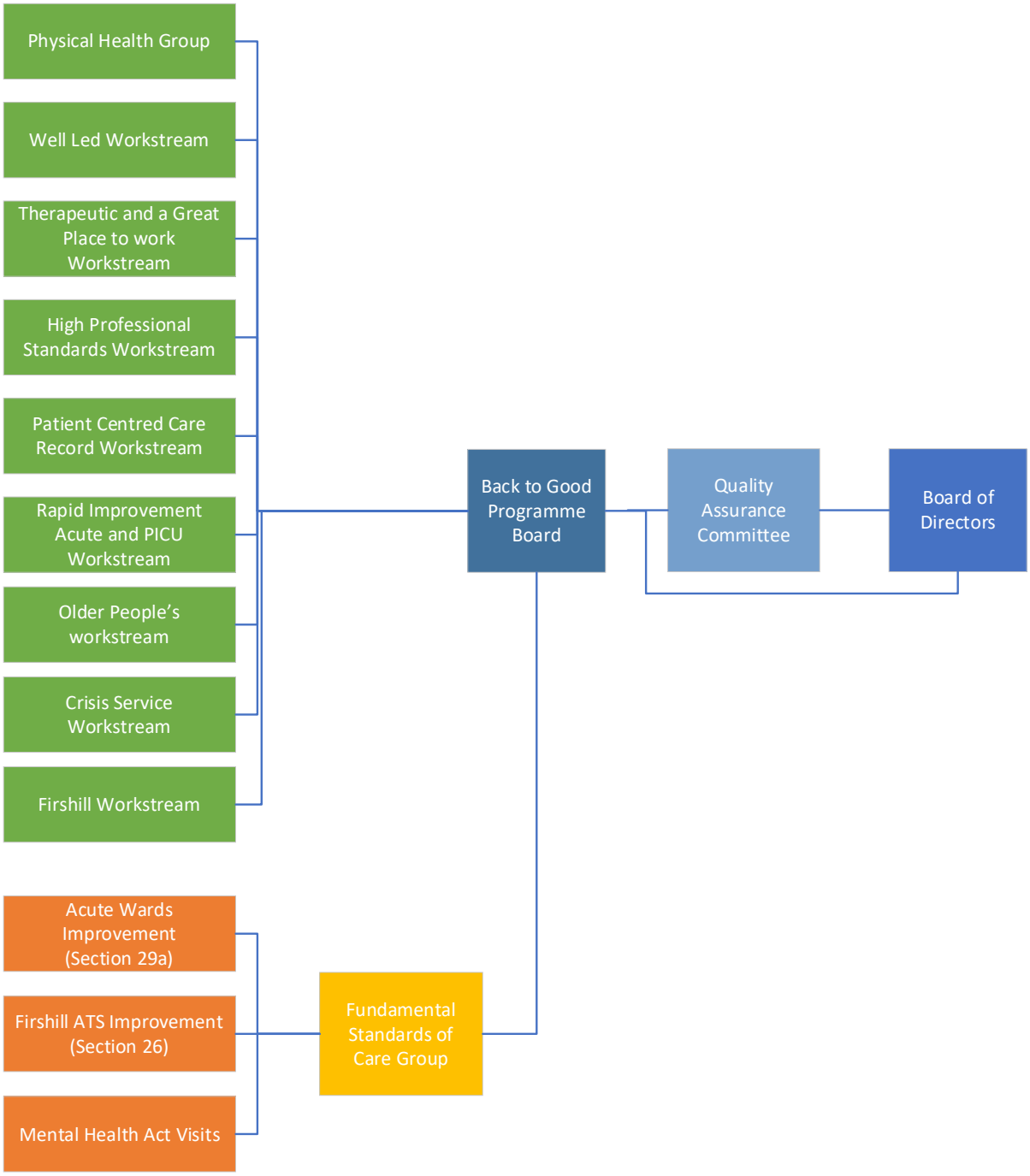
4.6 The programme continues to address regulatory requirements as raised by the CQC.

Section 5: List of Appendices

Appendix 1 Programme Governance

Appendix 2 Data Sources Monitoring and Assurance

Year 2 Programme Governance



Back to Good Programme Improvement Actions and Measures - Information from the IPQR and Improvement Dashboard

SPC Icon Key

Variation		
Icon Pic	Cell Format	Description
	• • •	Common cause
	• L •	Improvement - where low is good
	• H •	Improvement - where high is good
	• L •	Concern - where high is good
	• H •	Concern - where low is good
	• ? •	Special cause - where neither high nor low is good

Target		
Icon Pic	Cell Format	Description
	?	Pass/Fail: the system may achieve or fail the the target subject to random variation
	P	Pass: the system is expected to consistently pass the target
	F	Fail: the system is expected to consistently fail the target
	/	No target identified

Theme	Outcome	Delivered	Data Source	Measure	Performance Indicator (Trustwide)	Month position May 21	IPQR May 2021 (Variation)	Target	IPQR May 2021 (Target)
Staffing	The Trust has the appropriate number of staff to meet the needs of our organisation and provide a safe and high quality service for our users	Increased number of Band 5 and Band 6 nurses.	Band 5 and Band 6 monthly recruitment tracker to People Committee	Actual funded establishment	Headcount	2530	• • •	N/A	/
				Staff in post whole time equivalent Vacancy whole time equivalent Vacancy %	WTE	2207			
				Sickness whole time equivalent Maternity whole time equivalent	Vacancy Rate	11.27%	• H •	N/A	/
				*The Recruitment Team have been tasked with providing similar to the nursing data sets for all roles within the Trust.	Turnover	14%	• H •	10%	F
		4 Medicines Management Technicians in post	Integrated Performance and Quality Report	Workforce information for Clinical Services, Medical, Non Medical Support, GP surgeries on headcount, turnover, sickness and vacancies	Sickness Absence	5.39%	• L •	5.10%	F
		Psychologists, Allied Health Professionals and Occupational Therapist positions filled across Acute and Older Adults wards	Improvement dashboard weekly report	e-roster staffing compliance and actual compliance for acute inpatient wards	e-roster staffing compliance (acute wards)		• • •		?
		The Trust is on track to fill 37 Support Worker positions in March 2021		Details of Take Charge Nurse in Acute in patient wards	actual staffing compliance (acute wards)		• • •		?
				Incidence occurrences during period of staff shortfall					
Incident reporting and investigations	Robust governance processes in place to provide oversight of incident reporting ensuring the Trusts reporting mechanisms enable learning and continuous improvement	Improved incident reporting, processes and oversight	Integrated Performance and Quality Report	All incidents – Trust wide	All incidents – Trust wide	921	• ? •	N/A	/
		Developed incident management policy and relevant Standard Operating Procedures		Medication incidents – Trust wide	Medication incidents – Trust wide	111	• • •	N/A	/
		Provided annual training and guides		Unreviewed incidents at local level – clinical networks	Unreviewed incidents at local level – clinical networks				
		Access to the incident management system is currently being provided to agency staff		Assaults on service users Assaults on staff	Assaults on service users	20	• • •	N/A	/
				Sexual safety incidents – Trust wide	Sexual safety incidents – Trust wide	13	• • •	N/A	/
Restrictive practices	The use of restrictive practice techniques are in line with the Trust policy	Updated Aggression and Violence policy	Integrated Performance and Quality Report	Physical Restraint – Trust wide People physically restrained Rapid Tranquilisation – Trust wide People rapidly tranquilised Seclusion – Trust wide People Secluded	Physical Restraint INCIDENTS	154	• H •	N/A	/
		Blanket restrictions are reviewed annually			Physical Restraint INDIVIDUALS	46	• • •	N/A	/
		Quality Improvement Forum on reducing restrictive practice			Rapid Tranq INCIDENTS	28	• • •	N/A	/
					Rapid Tranq INDIVIDUALS	14	• • •	N/A	/
					Seclusion INCIDENTS Trustwide	51	• H •	N/A	/
					Seclusion INDIVIDUALS Trustwide	25	• • •	N/A	/
Mandatory Training, Supervision and Appraisal	Staff receive training, supervision and appraisals to develop their capability and skills to offer the highest quality care for service users	Achieved Trust targets for appraisal	Integrated Performance and Quality Report	Appraisal compliance rate – Trustwide	Appraisal compliance rate – Trustwide	94.85%	• • •	90%	?
		Revised supervision policy	Directorate / Team level reporting for supervision and training	Supervision policy compliance rate	Supervision policy compliance rate - Clinical Directorates	68%	• • •	80%	F
			Improvement dashboard weekly report		Supervision policy compliance rate - Corporate Directorates	49%	• H •	80%	F
		Achieved Trust target of 80% compliance with training requirements		Mandatory training compliance – Trustwide	Mandatory training compliance – Trustwide	91.04%	• • •	80%	P
		Training courses redesigned and delivered on line		Mandatory training compliance per subject - Trustwide					
Physical Health	Improved Physical Health of service users	Physical Health strategy, policy and SOP approved	Improvement Dashboard Weekly Report	Physical Health Monitoring compliance including:	PH Monitoring Compliance	75.00%	• L •	100%	?
Complaints	Those who complain to the Trust feel listened to and assured that their complaint will be dealt with in a timely manner	Revised complaints management policy and fast track process	Integrated Performance and Quality Report	Family and friends test – Trust wide	Family and friends test – Trust wide	106	• • •	N/A	/
		Complaints Manager in post		Care opinion responses – Trust wide	Care opinion responses – Trust wide	5	• • •	N/A	/
				Number of complaints					