# Board of Directors

| SUMMARY REPORT | Meeting Date: | 22 September 2021 |
|---|---|---|
| | Agenda Item: | 11 |

| | | |
|---|---|---|
| **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:** | 8 September 2021 |
| **Key Points recommendations to or previously agreed at:** | The Committee noted the progress made by the programme however requested that further information is required regarding the level of risk being held due to non-compliance with CQC regulations regarding staffing levels and unsafe environments | |

**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 8 September 2021.
- The approach to delivery and governance structures for Year 2 of the programme as agreed in the Programme Support meeting on the 17 August 2021.

**Progress**

74 actions were included in the Year 1 improvement plan. As of 26 August 2021, the status was:

- 61 actions have been completed, the evidence of which has been approved by the Director of Quality. This is an increase of 6 from July.
- 1 action has been closed as it was agreed by the Programme Board that it didn't relate to a regulatory requirement and therefore should be addressed via other organisational structures. The specific action related to how racist incidents are addressed, work in this area is being taken forward by specific groups with reporting to the People Committee.
- 12 regulatory requirements remain to be met to ensure compliance, these relate to key themes within the programme; staffing, therapeutic environments and physical health.

**Therapeutic Environments**

Unsafe ward environments are the top risk on the Board Assurance Framework:

***Patients could come to harm / quality could be impacted by our unsafe ward environments***

***Risk Score 20***

Work across Burbage, Maple, Stanage and Dovedale 1 wards has been planned as follows:

Burbage has been closed and moved to Dovedale 2, addressing 27% of the Section 29a ligature anchor points.

Phase 1 work on Maple, Stanage and Dovedale 1 was due for completion on 10 September, it included the replacement of bedroom lights, ceiling vents and curtain rails and the installation of blind spot mirrors. This has been achieved with the exception of two items; these will be completed by 17 and 30 September respectively. The Head of Nursing has been informed of the ongoing requirement to mitigate against the risks posed by these ligature anchor points.

Phase 2 work on the same wards which is currently underway and due to complete in February 2022. This work includes replacing windows and doors. This phase also includes the dormitory work on Stanage which was brought forward to commence in August.

Phase 3 work includes replacing radiators, sanitary ware and ceilings in en-suite bathrooms. When planning this work with clinical colleagues it became clear that the level of risk of completing this work, and the improvements required in the common areas on wards, required further consideration. An options appraisal has been undertaken and will be taken to the Therapeutic Environment programme board for approval during September. The recommended approach will be discussed with the CQC for approval and shared with the wider system to gain support.

**Staffing**

Focused activity has been undertaken for a significant period of time to address recruitment and retention issues within SHSC, however staffing remains in the top 3 risks on the Board Assurance Framework:

***Risk of not retaining staff, not workforce planning effectively, failing to provide effective leadership impacting on quality of care***

**Risk Score 16**

Across acute wards work continues to prepare for the Clinical Establishment Reviews which will commence in September, the optimisation of the Health Roster system is taking place due for completion in October and a Recruitment and Retention Group has been established to look at how to improve these areas.

**Physical Health**

The Director of Quality advised that the Physical Health Strategy work is not on track and requires a relaunch. The physical health monitoring is under review currently and will be revised in line with new oversight of fundamental standards. The Programme Board has requested a plan to be presented at the next meeting on the approach to be taken and timescales.

**Firshill Rise Assessment and Treatment Service**

The Firshill Rise ATS Improvement Plan was submitted to the CQC on 09 August 2021. The second submission which sets out how we are meeting the conditions of our registration was issued on the 6 September. The service has been paused allowing work to commence to establish a new clinical model. This will include defining a new operating model, identifying best practice and reviewing the team to establish specialist training, development and leadership.

**Acute Wards, Section 29a**

All actions, with the exception of one, relating to the observation and engagement policy, have been delivered as per the improvement plan. The policy is tabled at Policy Governance Group for approval in September. Completed actions focus on addressing the removal of Ligature Anchor Points and other environmental improvements, ward-based risk assessments, strengthening safeguarding and reducing restrictive practice. Assurance of regulations being met is provided via quality visits which are currently taking place on the wards and desk-based evidence checks, for example, review of documentation

**Year 2 delivery and governance structures**

Leads have been assigned to each of the regulatory requirements, their task is to work with colleagues to identify the actions to be taken to achieve compliance, and then see them through to completion. During consideration of the approaches to the improvement plan it became clear that the continued use of workstreams is not required. Regulation leads will take forward the work with identified colleagues reporting into, and with support of, 'business as usual' groups within SHSC. This ensures that the improvement work remains close to the services and governance groups who will be responsible for ensuring that they are embedded. The improvement plan is to be submitted to the CQC on 19 September.

| **Recommendation for the Board/Committee to consider:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Consider for Action** | | **Approval** | | **Assurance** | ✓ | **Information** | |

Recommendation: The Board is asked to review the programme report for August 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 Recovering Effectively | *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* | | All CQC fundamental standards of care |
| 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. |

# Section 1: Analysis and supporting detail

## Background

1.1 This report details progress of the Back to Good programme as reported to the Programme Board on 26 August 2021 and Quality Assurance Committee on 8 September 2021, and the outcomes of the Programme Support meeting which took place on 17 August in which the governance and delivery structures for Year 2 of the programme were agreed.

## Progress against improvement actions

1.2 74 actions were included in the Year 1 improvement plan. As of 26 August 2021, the status was:

- 61 actions have been completed, the evidence of which has been approved by the Director of Quality. This is an increase of 6 from July.
- 1 action has been closed as it was agreed by the Programme Board that it didn't relate to a regulatory requirement and therefore should be addressed via other organisational structures. The specific action related to how racist incidents are addressed, work in this area is being taken forward by specific groups with reporting to the People Committee.
- 12 regulatory requirements remain to be met to ensure compliance, these relate to key themes within the programme; staffing, therapeutic environments and physical health.

## Therapeutic environments

1.3 Unsafe ward environments are the top risk on the Board Assurance Framework:

***Patients could come to harm / quality could be impacted by our unsafe ward environments***

***Risk Score 20***

1.4 To address this work across Burbage, Maple, Stanage and Dovedale 1 wards has been planned in 3 phases as follows:

Burbage has been closed and moved to Dovedale 2, addressing 27% of the Section 29a ligature anchor points.

Phase 1 work on Maple, Stanage and Dovedale 1 was due for completion on 10 September, it included the replacement of bedroom lights, ceiling vents and curtain rails and the installation of blind spot mirrors. This has been achieved with the exception of two items; these will be completed by 17 and 30 September respectively. The Head of Nursing has been informed of the ongoing requirement to mitigate against the risks posed by these ligature anchor points.

Phase 2 work on the same wards which is currently underway and due to complete in February 2022. This work includes replacing windows and doors. This phase also includes

the dormitory work on Stanage which was brought forward to commence in August.

Phase 3 work includes replacing radiators, sanitary wear and ceilings in en-suite bathrooms. When planning this work with clinical colleagues it became clear that the level of risk of completing this work, and the improvements required in the common areas on wards, required further consideration. An options appraisal has been undertaken and will be taken to the Therapeutic Environment programme board for approval during September. The recommended approach will be discussed with the CQC for approval and shared with the wider system to gain support.

1.5 Revenue support has been requested from the system for the 12 out of area beds to enable the works to take place.

1.6 While this work is being undertaken, the following has been put in place to address the clinical and environmental risks the wards pose. These were part of the improvement plan to respond to the Section 29a.

- A standardised approach to safety huddles has been implemented across Acute wards and the Psychiatric Intensive Care Unit
- Per shift staff have been identified to fulfil the safety lead role
- A policy and standard operating procedure for the removal of ligatures has been approved and rolled out
- Clinical and environmental risk training has been developed and course dates published
- The handover standard operating procedure has been amended to include risks posed by the environment
- The engagement and observation policy is being amended and will be presented to the Policy Governance Group in September for approval. It will be incorporated into the clinical and environmental risk training
- The safety within acute and PICU garden areas is assessed and blanket restrictions on unsupervised garden access are applied if required
- Improved documentation has been provided to ensure staff are aware of ligature anchor points on their wards and how to manage them

1.7 The evidence provided by the wards to provide assurance that the actions have been completed is currently being reviewed by the Head of Clinical Standards.

## Staffing

1.8 Focused activity has been undertaken for a significant period of time to address recruitment and retention issues within SHSC, however staffing remains in the top 3 risks on the Board Assurance Framework:

***Risk of not retaining staff, not workforce planning effectively, failing to provide effective leadership impacting on quality of care***

**Risk Score 16**

The below information relates specifically to the actions which are currently taking place as identified in Year 1 of the improvement plan to address regulation breeches as identified by the CQC in 2020.

1.9 Clinical Establishment Reviews of acute inpatient services will commence on 6 September 2021 using the MHOST tool. The reviews will be set on a minimum of 3 sets of 4 weeks acuity data. NHSEI advise that acuity data period should be over 6 months.

1.10 Optimisation of the Health Roster system to support staff allocation is taking place. The Project Team continue to work with the respective unit managers to review, troubleshoot and embed working practices. Planned completion date is October 2021.

1.11 A Recruitment and Retention Group has been established to focus on targeting recruitment in specific areas and identifying ways of improving recruitment and retention.

1.12 A review of the care provided to Older Adults on G1 and the staffing level required has been planned. G1 and Endcliffe ward are exploring an agreement on a recruitment premium.

1.13 It should be noted that a paper was presented by the Executive Director of Nursing, Professions and Operations to the People Committee in September, which proposed a root and branch approach to understanding staffing issues to enable identification of appropriate and effective approaches to recruitment and retention

1.14 The CQC has raised a regulatory requirement in relation to staffing as a result of the Acute and Older People's inpatient and Crisis pathway inspection. This will be addressed during Year 2 of the Programme.

'The trust must ensure that staffing levels are adequate for the service being provided.'

The regulation lead is the Director of Operations and Transformation, Neil Robertson, who has set up a working group to identify effective and appropriate actions to undertake to achieve compliance. He will also ensure that the outstanding actions relating to the regulatory requirements from Year 1 are delivered in relation to staffing in acute and community services and Rehabilitation and Specialist services.

## Physical Health

1.15 The Director of Quality advised that the Physical Health Strategy work is not on track and requires a relaunch. The physical health monitoring is under review currently and will be revised in line with new oversight of fundamental standards.
The Programme Board requested a plan to be presented at the next meeting on the approach to be taken and timescales.

1.16 The Quality Improvement Team is working with the Head of Nursing for Acute and Community on the review of the current process for recording and monitoring physical health checks, seeking a simplified, improved and more robust method for providing assurance. Subsequently, they will work with the clinical teams to consider existing processes for carrying out the physical health checks, exploring possibilities for further improvements where data may suggest that this is required.

## Firshill Rise Assessment and Treatment Centre

1.17 The Firshill Rise ATS Improvement Plan was submitted to the CQC on 09 August 2021. The second submission which sets out how we are meeting the conditions of our registration was issued on the 6 September.

1.18 The service has been paused allowing work to commence to establish a new clinical model. This will include defining a new operating model, identifying best practice and reviewing the team to establish specialist training, development and leadership. A member of the QI Team is involved in the weekly improvement group meetings and working closely with the service to provide expertise and structure to the improvement process. Within the

training programme that has been developed during the pause period, the QI Team has offered to provide specific QI training, with the intention to use this as an opportunity to identify and embed a forum for continuous improvement in the new operating model, so that continuous improvement becomes 'business as usual'.

### Acute Wards; Section 29a warning notice

1.19 All actions, with the exception of one, relating to the observation and engagement policy, have been delivered as per the improvement plan. The policy is tabled at Policy Governance Group for approval in September. Completed actions focus on addressing the removal of Ligature Anchor Points and other environmental improvements, ward-based risk assessments, strengthening safeguarding and reducing restrictive practice. Assurance of regulations being met is provided via quality visits which are currently taking place on the wards and desk-based evidence checks, for example, review of documentation

### Year 2 governance and delivery structures

1.20 Leads have been assigned to each of the regulatory requirements, they have worked with colleagues to identify the actions required to achieve compliance. An initial draft of the improvement plan is with Executive colleagues for approval. The plan is to be returned to the CQC on 19 September.

1.21 During consideration of the approaches to the improvement plan it became clear that the continued use of workstreams is not required. Regulation leads will take forward the work with identified colleagues reporting into, and with support of, 'business as usual' groups within SHSC or existing project / programme teams and boards. This ensures that the improvement work remains close to the services and governance groups who will be responsible for ensuring that they are embedded.

1.22 To monitor and support delivery outside of the Programme Board meetings, monthly Delivery Group meetings have been established replacing the programme support meeting. These are focused on the 2 key delivery areas; core services and well led. The meetings will be chaired by the Director of Quality.

1.23 The improvement plan will be submitted to the Quality Assurance Committee for clarity of the actions being taken forward, the regulation leads and approaches being taken

## Section 2: Risks

2.1 The risks and mitigation for unsafe wards environments and staffing have been discussed in Section 1

## 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.

In summary:

- Supervision, as at week beginning 30 August, average compliance with the 8 in 12 target is, Trust wide 66.94%, Clinical Services 68.19% and Corporate Services 60.79%
- Physical Health checks compliance, 78.8%
- Training figures for week ending 22 August; Trust wide compliance 91.15%, staff compliance 85.39% of staff are 80% compliant or above.
- The exceptions related to training are; subjects below 80% is Respect level 2. Services below 80% is Grenoside facilities, 76.03%

### Engagement

3.3 Delivering the improvements within the Back to Good Programme remains a collective effort across SHSC. .

## 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 responding to the regulatory requirements identified by the CQC. SHSC's strategic aims and ambition regarding equality, diversity and inclusion are considered when developing and implementing improvement actions.

### Integration and system thinking

4.3 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

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

### Compliance - Legal/Regulatory

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

## Section 5: List of Appendices

## 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 June 21 | IPQR May 2021 (Variation) | Target | IPQR June 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 | Unavailable for June 2021 | | | |
| | | | | Staff in post whole time equivalent Vacancy whole time equivalent Vacancy % | WTE | | | | |
| | | | | Sickness whole time equivalent Maternity whole time equivalent | Vacancy Rate | | | | |
| | | | | *The Recruitment Team have been tasked with providing similar to the nursing data sets for all roles within the Trust. | Turnover | | | | |
| | | 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 | | | | |
| | | 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 | 742 | • • • | N/A | / |
| | | Developed incident management policy and relevant Standard Operating Procedures | | Medication incidents – Trust wide | Medication incidents – Trust wide | 98 | • • • | 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 | 19 | • • • | 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<br>People physically restrained<br>Rapid Tranquilisation – Trust wide<br>People rapidly tranquilised<br>Seclusion – Trust wide<br>People Secluded | Physical Restraint INCIDENTS | 133 | • • • | N/A | / |
| | | Blanket restrictions are reviewed annually | | | Physical Restraint INDIVIDUALS | 33 | • • • | N/A | / |
| | | Quality Improvement Forum on reducing restrictive practice | | | Rapid Tranq INCIDENTS | 30 | • • • | N/A | / |
| | | | | | Rapid Tranq INDIVIDUALS | 6 | • • • | N/A | / |
| | | | | | Seclusion INCIDENTS Trustwide | 23 | • • • | N/A | / |
| | | | | | Seclusion INDIVIDUALS Trustwide | 12 | • • • | 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 | Unavailable for June 2021 | | | |
| | | Revised supervision policy | Directorate / Team level reporting for supervision and training | Supervision policy compliance rate | Supervision policy compliance rate - Clinical Directorates | 67% | • • • | 80% | F |
| | | | Improvement dashboard weekly report | | Supervision policy compliance rate - Corporate Directorates | 53% | • H • | 80% | F |
| | | Achieved Trust target of 80% compliance with training requirements | | Mandatory training compliance – Trustwide | Mandatory training compliance – Trustwide | 90.74% | • • • | 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 | 85.10% | • 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 | 77 | • • • | N/A | / |
| | | Complaints Manager in post | | Care opinion responses – Trust wide | Care opinion responses – Trust wide | 6 | • • • | N/A | / |
| | | | | Number of complaints | | | | | |