Board of Directors

SUMMARY REPORT	Meeting Date:	23 March 2022
	Agenda Item:	8

Report Title:	**Back to Good Board Reporting - Progress and Exceptions**	
Author(s):	Salli Midgley, Director of Quality / Zoe Sibeko, Head of PMO	
Accountable Director:	Dr Mike Hunter, Medical Director	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Quality Assurance Committee
	Date:	09 March 2022
Key Points recommendations to or previously agreed at:	The Quality Assurance Committee approved the Acute and Psychiatric Intensive Care Unit improvement plan, which was created in response to the CQC inspection report published 16 February 2022.	

Summary of key points in report

The Back to Good Programme, as anticipated, was impacted by the Omicron wave during January 2022, resulting in a small number of requirements being reported as in exception or at risk. A number were also completed despite the issues.

The main risks continue to relate to the impact on patient care due to challenges with staffing, training, supervision and the environment. The report details mitigation of these risks and outlines where assurance is necessarily limited.

The report also provides updated narrative on the risks to completion of specific requirements, in addition to a summary overview of completed requirements, and their impact.

The warning notice applied to the Acute and PICU wards has been lifted post-inspection in December 2021. An improvement plan, containing 20 new requirements (9 must and 11 should) was developed in response to the findings from the inspection. This was approved by the Quality Assurance Committee on 09 March 2022 and issued to the CQC on the 11 March 2022.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	X	Information	

To receive the report and consider the assurance provided

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good - Continuous Improvement	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		***The Regulations of the Health and Social Care Act***
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?					

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service user and Carer Safety and Experience	*Yes*	***X***	*No*		***Meeting the requirements of the Back to Good programme supports good patient experience and safety in our care.***
Financial (revenue &capital)	*Yes*		*No*	***X***	***Financial implications of not meeting regulatory requirements are not explicitly examined in this paper.***
Organisational Development/Workforce	*Yes*	***X***	*No*		***The workforce impact on quality of care is highlighted in the paper.***
Equality, Diversity & Inclusion	*Yes*		*No*	***X***	***The explicit EDI impacts are not discussed in this paper.***
Legal	*Yes*	***X***	*No*		***Failure to achieve compliance is a breach of the requirements of the Health and Social Care Act.***

Summary Overview (Reporting Period to January 2022)

Year Two Requirements in progress (from CQC report, August 2021). There are 55 Requirements, of which 25 were due for completion by December 2021. The current position is:

- Completed at due date = 21
- Additional Completed, prior to due date = 6
- Open with an approved extension as of February 2022 = 7
- Open = 21

Acute and PICU, December 2021 Inspection. The inspection report was published 16 February 2022. The report can be viewed here. As a result of the inspection which took place over 7-9 December 2021, the warning notice has been removed. The report indicates 20 new requirements (9 Must and 11 Should). These are separate to the 55 requirements from the August 2021 report (above). The improvement plan was submitted to the CQC within the assigned timescale.

CQC Look Back: 2018 Report. All requirements have been reviewed by the Quality Directorate with PMO support. Evidence has been provided for some of the outstanding requirements. The remainder will be brought into Back to Good Programme governance.

Firshill Requirements 2021. We continue to submit returns to the CQC in relation to the conditions on registration at Firshill Conditions, confirming that the unit remains paused.

Summary of Risk

The risk of the impact of Omicron during January 2022 was highlighted in the previous month's report. Many wards had periods of closure, staffing was significantly impacted and priority given to ensuring patient care was delivered. In addition, during December 2021 the CQC reinspected and further attention was required to the CQC's requests, which had a cumulative impact during January 2022 on capacity and delivery of a small number of requirements. These are detailed below.

Requirements with Extensions Previously Approved

There were 8 requirements which had previously approved extensions.

Supervision compliance Acute and PICU

Progress against revised trajectories is overseen by the Clinical Directorates' monthly performance and quality reviews. Plans were reported last month as in place to monitor to ensure the target is met by February 2022. The Directorate have requested a further extension by one month to meet the targets set due to individual staff missing supervision during January.

Risks
There are concerns about the quality and the methodology to achieve the targets and this has led to further discussion about reviewing the Supervision policy and the manner in which the information is collected. The Back to Good Delivery Group have recommended a new Clinical Supervision Task and Finish group is set up to review the policy, training, recording and quality of clinical supervision to fully assure the quality and requirements on an ongoing basis.

Medicines Competency Framework

Extensions were given until March 2022 to roll out the new framework for annual competencies and to develop a new twice yearly medicines management framework. The annual competency and drugs calculations test is being rolled out and supported by Advanced Clinical Practitioners.

The Medicines Management Framework has been drafted and requires approval through Nursing Council and Medicines Optimisation Committee by March 2022. There are no expected delays to completion. This action is now overseen by the Chief Pharmacist.

All clinicians in patient facing duties will receive Level 3 Adult Safeguarding training.

Training plan has now been received from the external supplier and dates are available for booking up until December 2022. Training trajectories will be monitored via the reporting in Delivery Group.

Matrons will ensure safeguarding supervision is provided, aligned to the safeguarding supervision policy.

Supervision structure and delivery plan has been agreed to deliver the implementation by March 2022.

Wards will achieve 80% compliance in mandatory training across Acute and PICU

Training has been aligned to team availability and without detriment to the safer staffing levels. A new stepped compliance target has been requested which also manages the current capacity booked to maintain compliance for all annual training.

Safeguarding Children to remain March 2022
ILS to move to April 2022
Respect to move to June 2022 (note 4-day consecutive training course)

Mandatory training compliance was raised again in the December 2021 inspection. The actions will be merged so as to keep the dates agreed in Year 2.

Completion of estates work on Dovedale 1.

Work is on track to complete by March 2022.

Audit compliance in relation to the seclusion and rapid tranquilisation policy regarding the offer of food and drink after each seclusion or episode of rapid tranquilisation.

Work is on track with the relaunch of Tendable to support the auditing and evidence of adherence. This will be delivered by March 2022.

Sexual Safety Training.

Remains on track to be delivered by March 2022

Extensions Approved at Programme Board, February 2022

Incidents will be reviewed by the ward / team manager within 5 days of reporting Due December 2021.

This action was previously reported at risk despite significant improvement across SHSC in reducing the number of unreviewed incidents. At the time of reporting there were 292 incidents across SHSC which were unreviewed of which 109 were attributed to one ward who are impacted significantly by the lack of a ward manager. This relates to a Trustwide requirement that will be closed when the back to Good Board receives a report showing that 80% of all incidents reported have been reviewed, which is a significant overall improvement.

Risk and Mitigation: The need to review incidents within 5 days will require ongoing weekly monitoring to ensure that the improvements are maintained. In mitigation, all SHSC incidents are reviewed at Trustwide huddle to ensure that any specific issues are picked up and managed by the teams with corporate support. General Managers have been tasked with reviewing all outstanding incidents from 2021.

Actions at Risk

The following is delayed, which may impact on the future completion of currently open requirements:

Acute and PICU services must meet the supervision compliance level of 80%. Due February 2022

This action will be in exception in February. The risks related to supervision compliance and quality are noted in the requirements with extension.

Completed Requirements: Impact, Assurance and Risks

The following section considers requirements by type and the impact of achieving the requirements, oversight of assurance and embedding and potential risks associated with the completion of the requirements.

Requirement Type	Impact	Assurance and Risks
Supporting staff to deliver high quality and safe care	Staff will have the opportunity to reflect on their practice, identify areas for improvement and put development plans into place. This will positively impact on both staff and service user experiences within the Trust.	A system has been introduced that will monitor and record individual and team level compliance against supervision. A recovery plan is in place for a number of teams within the Acute & Community Directorate,

		and the small minority of services in the Rehab & Specialist Directorate who are not consistently compliant. Weekly reporting is provided to teams to promote improvement and ownership. Whilst a robust system for monitoring and reporting has been developed there remains a number of teams who still fall below the expected compliance rates. Compliance monitoring will occur through directorate level reporting and the IPQR
	Everyone has the right to be protected from harm and abuse and is a core duty of the Trust and the staff working within it. Supporting staff to know when and how to raise a concern will ensure that service users are safe, their wellbeing is promoted and risks to service users and others reduced. Safeguarding approaches should be person led and outcome focused in order to promote choice and control and improved quality of life. A range of safeguarding policies, procedures and reporting have been developed and introduced. Partnership working with Sheffield Local Authority and safeguarding partnerships have been strengthened through the development of joint protocols.	A range of safeguarding policies, procedures and reporting have been developed and introduced. A rapid development plan is in place to improve the performance of the team. Compliance against policies and reporting of Trust wide safeguarding activity will occur through quarterly reporting at the Safeguarding Assurance Committee. Whilst processes have been strengthened there is still further work to do to improve and increase internal reporting. Work is ongoing to raise awareness and understanding of safeguarding responsibilities through a range of additional training opportunities that will be rolled out across services.
Improving the working lives of our staff	Introduction of new roles to support Equality and Inclusion Engagement will improve the experience of people who work in our organisation from Black Asian and Minority Ethnic groups. The role will also support achievement of relevant actions in the national people plan and Covid 19 phase 3 NHSI action required by our organisation. Introduction of new roles to address 'Hate Incidents and Crimes'. The most common experience of Hate Incidents in our services are incidents associated with racism, for this reason the main focus will be on racism experienced by staff. This will promote and ensure that Inclusion and Equality are embedded in all that we do	Although the most common experience of Hate Incidents are associated with racism, incidents related to disability, sexual orientation, transgender identity or religion will also be addressed. Embedding new systems and processes within organisations can take time. Development against organisational strategy will be monitored through the People Committee reporting structures and specifically the inclusion and quality group.

	within our organisation and drive forward the development of an inclusive, fair, and diverse organisation.	
Delivery of SHSC strategic aims	Our digital maturity does not serve our strategic aims effectively. We need to build strong foundations that will deliver short-term, but lasting impact, allowing us to accelerate digital change in the future. A new digital strategy has been developed and approved which through implementation will provide staff with more time to interact directly with service users and deliver a flexible, modern and collaborative working environment.	A delivery plan supports the implementation of the digital strategy and has clearly identified milestones and will be reviewed by the Digital Strategy Group. Any risks will be escalated from the Corporate Risk Register to the Board Assurance Framework