Board of Directors (Public)

SUMMARY REPORT	Meeting Date:	25th May 2022
	Agenda Item:	09

Report Title:	**Back to Good Board Reporting (Period to March 2022)**	
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:	11th May 2022
Key Points recommendations to or previously agreed at:	Further information regarding how completed actions are assured with evidence before moving to business as usual status was requested.	

Summary of key points in report

There are 7 actions in exception with three having previous extensions and forming a theme in relation to achieving policy requirements within clinical services. The impact of covid and staff shortages can account for some of the impact on these actions but there is an overarching issue of broader support to work with clinical teams to meet their needs.

Key risks are:

Achievement of Supervision Target (Acute and PICU)

Achievement of reviewing incidents in a timely manner (Trustwide)

Achievement of Mandatory Training (Acute and PICU)

Use of Tendable to demonstrate assurance with specific aspects of patient care.

The Clinical Directorates are working with teams to support maintaining standards in the context of fluctuating staffing challenges. Staff require high quality supervision and training in order to carry out their duties, they are reporting incidents and these must be reviewed in a timely manner by leaders, and key aspects of care must be audited to demonstrate compliance with standards for patient-care, regulatory, statutory and contractual requirements.

Back to Good Board has challenged and supported the wider team to innovate to ensure standards are maintained.

The use of Tendable (previously known as “Perfect Ward”) to audit key quality and safety issues is currently incomplete. An update on progress against the delivery plan and compliance monitoring is being provided to

Quality Committee through the Learning Lessons report.

Closure of Actions. There is an ongoing theme of incomplete evidence to support audited closure of actions once owners submit their written reports to state completion. It is imperative that actions are audited for good governance and scrutiny. This is a current main focus of Back to Good Board, to garner evidence for completion of audit of action completion.

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	*Yes*	***X***	*No*		***The Regulations of the Health and Social Care Act***
Data Security Protection Toolkit	*Yes*		*No*	***X***	

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 February 2022)

Year 2 requirements now total **75** following addition of **20** further requirements from the December 2021 inspection.

44 were due for completion by March 2022, **32** were actually completed.

This is an increase of **5** completed during March 2022.

4 are in exception as not complete by March 2022 and are detailed below.

8 have been extended and are monitored, and on track

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.

Requirements in Exception

There are four requirements in exception as detailed in the report with the end date noted as overdue in March 2022.

Regulation	Regulation ID	Service	End Date	Exception
The trust must ensure that incidents and safeguarding are reported and investigated in line with the trust's processes and in line with national guidance.	3	Trust-wide	31/03/2022	⚠
The trust must ensure patients have all the information about their care and treatment provided in a way they understand.	30	Crisis and Health Based Place of Safety	31/03/2022	⚠
The trust should ensure that all staff receive supervision in line with the trust target.	42	Acute Wards and Psychiatric Intensive Care Units	28/02/2022	⚠
The trust should ensure that **seclusion is managed** in line with the Mental Health Act Code of Practice in that **medical and nursing reviews** take place on time and it is **ended at the earliest opportunity.**	67	Acute Wards and Psychiatric Intensive Care Units	31/03/2022	⚠

Board will note that requirement 3 and requirement 42 have had previous extensions and should be advised that Back to Good Board agreed to keep these actions in exception, rather than further extend, to maintain focus on the need to address these issues.

Requirement 3
The trust must ensure that incidents and safeguarding are reported and investigated in line with the trust's processes and in line with national guidance.

This requirement was previously extended and should have closed in March 2022. The standard is for managerial review of 80% of incidents within five days of incidents being reported.

Work occurred during March to review monitoring and reporting, however teams were affected by sickness and absence in more senior roles which impacted on the capacity of individuals to review incidents at team level. The numbers of incidents therefore requiring review rose during March and has been sustained into April. Urgent discussions have taken place to identify appropriate incident reviewers outside of the immediate team in order to complete good incident reporting processes. It is notable that all incidents rated as moderate or above have been actively reviewed and often further reporting has taken place but the final housekeeping to close the initiating incident is not always completed.

Requirement 30
Patients have all the information about their care and treatment provided in a way they understand in the Crisis and Health Based Place of Safety.

This action had been completed with respect to the coproduction of a leaflet with service users, however due to a miscommunication the printing deadline had not been met. This will mean the leaflet will now be available by May 31st 2022.

Requirement 42
Trust should ensure all staff receive supervision in line with Trust target in Acute and PICU services

This was the third extended target date and therefore a new date was not accepted but the requirement remains in exception with active monitoring. Rationale was put to the Back to Good Board as to how this requirement was not achieved, which included the impact of sickness, shift patterns and lack of senior staff to provide supervision in particular teams.

Planning is taking place to put in place actions that can support staff to access timely professional supervision from staff external to their service. The impact of evening group supervision is being scoped to support staff on night shifts as well as payment of overtime to bring them in earlier if they wish to do so.

Requirement 67
The Trust should ensure that seclusion is managed in line with the Mental Health Act Code of Practice in that medical and nursing reviews take place on time and it is ended at the earliest opportunity.

This requirement was not met due to the action relating to the demonstration of best practice through the use of Tendable. Although verbal reassurance had been given in teams on the oversight of seclusion as a live event, SHSC has agreed Tendable as the concrete assurance mechanism on conclusion of every seclusion episode. We are broadening the pool of staff who can support audit when absence/sickness or acuity means that the regular team have difficulties completing the audit.

Summary of Risk

There are consistent themes in the requirements that are not being met on time, despite the requirements being agreed through a coproduced approach when responding to the CQC report. The highlighted exceptions relating to supervision and management of incidents particularly illustrate these concerns.

In addition, the action related to training across acute and PICU services, previously reported as having been achieved at 80%, has been found to be less robust under closer scrutiny. Training figures were consolidated and did not note the wide variation in attainment between wards leading to figures from 52% to 100% across the 4 wards (80% should be regarded as the required rate for each ward individually).

Staff are not always prioritising supervision due to clinical demand and not always able to access this in a timely and protected way. Some staff are not always able to book onto and protect their mandated training needs. Managers and their deputies do not always protect time to manage incidents on a daily basis as a good housekeeping exercise.

These observations suggest incomplete planning for fluctuating circumstances and that there is insufficient wrap around support to pick up these duties/responsibilities to give protected time to staff.

Completed Requirements: Impact, Assurance and Risks

There is frequently a delay in receiving the evidence required to complete the audit and final closure element of the process where action owners have marked their requirements as 'complete awaiting approval'. There is a risk to the programme delivery in that whilst requirements are noted as complete, we have not received the appropriate assurance to evidence the actions taken have been embedded and are sustainable. The following actions have been agreed to ensure more timely submission of evidence and final approval for outstanding requirements:

- Regular reporting of 2nd requests for evidence to the Back to Good delivery group for discussion, action and escalation where required.
- The Head of Clinical Quality Standards and the PMO to work through the outstanding evidence that will support the audit and closure of requirements within the Back to Good Improvement Plan. Meetings with action owners to examine evidence began week commencing 16th May 2022.

For most requirements, there are ongoing reporting and monitoring arrangements through established governance arrangements at either local or corporate level. Where this is not the case, a separate review of embeddedness will occur 6 months post closure. Detailed in Table 1 below is an overview of the ongoing monitoring arrangements for actions that are now closed but where there is a need to ensure that standards / arrangements are sustained.

Table 2 provides an overview of actions that are closed, where a separate 6-month review for embeddedness is required.

Requirements that have been closed that do not require significant ongoing monitoring and assurance are detailed in Table 3.

Table 1 - Overview of the ongoing monitoring arrangements for actions that are now closed but monitoring for sustainability required

Committee / Group	Service	Action
Safeguarding Assurance Group	Trustwide	Data on delegated function is shared with the Local Authority on a quarterly basis to evidence management of safeguarding concerns as approved by the Executive Director of Nursing, Professions and Operations
		All section 42 enquiries against the Trust will be copied to the Local Authority for oversight by the Trust Safeguarding practitioners. Two points of contact will occur 1. Terms of Reference prior to investigation 2. Completed S42 enquiry forms.
		Participation in Sheffield Adult Safeguarding Partnership and Sheffield Children's Safeguarding Partnership statutory audit.
		All safeguarding activity will be reported quarterly within the Safeguarding report, through safeguarding assurance committee and into Quality Assurance committee
Safeguarding Assurance Committee / Clinical and Quality Safety Group	Trustwide	Incident reporting levels will be mapped to the National Reporting and Learning System (NRLS) to ensure compliance with national guidance
		Ulysses incident reporting system to mandate the safeguarding field as a requirement before an incident is submitted to support review of all internal incidents aligned to safeguarding policy
		All incidents will be reviewed daily (working day) at the Trust wide incident huddle with the presence of a Safeguarding practitioner/lead to ensure all actions have been taken to safeguard patients. Criteria for investigation aligned to the national 3 stage test (Section 42)
Clinical Quality and Safety Group	Trustwide	Review of complaints monitoring and reporting and revisions made to ensure effective weekly reporting to clinical triumvirates and a good learning feedback loop.
		Weekly Serious Incident Panel to manage timeliness of reports chaired by Director of Quality/ Executive Director of Nursing, Professions and Operations
		The Serious Incident Tracker will be reviewed on a weekly basis to ensure that timescales are met for * allocation of investigators * development of Terms of Reference * attendance at Serious Incident Panel

		at week 4 and 8
Electronic Patient Record Programme Board	Trustwide	Awarding of the Electronic Patient Records contract for the new system
Health and Safety Committee	Acute Wards and Psychiatric Intensive Care Units	Review the Building Fire Risk assessment process and documentation to ensure reviews are accurately reflected and any risk gaps are identified and actioned appropriately.
Mental Health Legislation Ops Group	Mental Health Wards for Older People	An 'Aide memoire' to be developed and placed in nursing hub and on the seclusion observation room wall to prompt and enhance correct documentation for seclusion.
People Committee / Inclusion and Equality Group	Acute Wards and Psychiatric Intensive Care Units	Implementation of the action plan to tackle racist incidents experienced by staff from service users. A Band 6 Lead will be appointed to support delivery and embedding of this action.
Quarterly Performance Review	Trustwide	Implement a system to monitor and manage compliance against the delivery of supervisions in line with Trust policy and lead improvements to services who do not meet the minimum standard.
	Trustwide	Monitor compliance against the delivery of mandatory training to all staff members within the Clinical Directorate.
	Crisis and Health Based Place of Safety	Monitor through the Quarterly Performance Review compliance against the delivery of mandatory training to all staff members within the Crisis services.
Reducing Restrictive Practice Group	Acute Wards and Psychiatric Intensive Care Units	Every patient has an appropriate mattress as defined by risk assessment

Table 2 – Overview of actions that will require separate 6 monthly review for embeddedness

Committee / Group	Service	Action
Inpatient Managers Meeting	Mental Health Wards for Older People	Ward managers to ensure block booked agency staff access online JAC Pharmacy System training as part of ward induction prior to start date.

Table 3 - Actions that have been closed that do not require ongoing monitoring and assurance

Service	Action
Trustwide	Complete a pilot transition of Complaints service to Quality Directorate to improve liaison with related services, following move of line management from 13 September 2021.
Trustwide	Awarding of the Electronic Patient Records contract for the new system
Trustwide	Approve a new digital strategy
Trustwide	New posts (Workforce Race Equality Standard Engagement, health Inequalities and support for staff Network Groups) appointed to support deliver the aims of the Equality, Diversity and Inclusion Assurance group to allow for two way communication of issues raised.
Trustwide	Review of Trust Grievance Procedure and Policy.
Acute Wards and Psychiatric Intensive Care Units	Make clear the minimum number of staff required on duty to safely support full restraint and include in the Use of Force Policy.
Trustwide	Equality, Diversity and Inclusion Assurance group established within the People Directorate governance structure to promote and ensure that inclusion and equality are embedded in all that we do within our organisation.
Acute Wards and Psychiatric Intensive Care	Implementation of the action plan to tackle racist incidents experienced by staff from service users. A Band 6 Lead will be appointed to support delivery and embedding of this action.

Units	
Acute Wards and Psychiatric Intensive Care Units	Update the Duty of Candour and Being Open policy ensuring it is available electronically for all staff Trust wide.
Trustwide	Policies will be developed, approved and implemented to ensure robust governance for the management of staff allegations, safeguarding supervision and PREVENT
Mental Health Wards for Older People	Art Therapists to work in partnership with clinical operations and estates to ensure colours and design are incorporated into the refreshed therapeutic environment, and provide co-production with the ward team.