Board of Directors

SUMMARY REPORT	Meeting Date:	23rd November 2022
	Agenda Item:	09

Report Title:	**Back To Good Board Progress and Exceptions Risk Report**	
Author(s):	Zoe Sibeko, Head of PMO Sue Barnitt, Head of Clinical Quality Standards	
Accountable Director:	Mike Hunter, Medical Director	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	9th November 2022
Key points/ recommendations from those meetings	Committee noted that little progress has been made with regards to completing the Quality Assurance review for actions marked as 'complete awaiting approval'. It was highlighted that the reduced capacity currently available in the Care Standards team had negatively impacted on progress however interim agency resource had been acquired to support this activity. It is expected that for all actions noted as 'complete awaiting approval' that supporting evidence will have been reviewed by end of November 2022 and confirmation provided within the next report to Quality Assurance Committee. Committee members also requested that a review of the incomplete actions be undertaken and an overview provided with regards to their impact on the delivery of care standards for the next Quality Assurance Committee.	

Summary of key points in report

In addition to reporting progress in the Back to Good Programme, this report also contains a summary of SHSC's response related to the broadcast of a television programme in September 2022, showing the mistreatment, in another organisation, of people with mental health problems.

In relation to the main Back to Good Programme, the report covers the areas of risk reported in September 2022. Quality Assurance Committee had requested to be sighted on the following: the management of the clinical risk associated with the shortfalls in mandatory training for key areas including Immediate Life Support, Fire and Respect training.

A key risk continues to relate to incomplete evidence provided to allow for assurance activities to be completed.

Nine requirements were reported in September 2022 as being in exception, however one is now marked as complete awaiting approval and two should be completed within the month:

1. Ensure that effective, embedded, and sustainable governance is in place across SHSC. Out of 22 Tier II groups in place, 19 annual reviews of effectiveness have been completed. This was reported to Audit and Risk Committee in October 2022, and this requirement is subsequently due to close.
2. Ensure engagement with patients and carers, and involvement in their care, is strengthened.

3. Ensure patients' advocates, relatives, friends or carers are involved in their care.
4. Achieve training targets per subject course - as reported to Quality Assurance Committee in September 2022, there is a targeted focus on the achievement of compliance for Fire Safety and Immediate Life Support (ILS).
5. Achieve training targets per acute ward.
6. Achieve supervision target - wards are at risk of a worsening position due to the limited number of supervisions currently planned ahead.
7. Deliver medicines management competencies for nurses – amendments made to 3 yearly training package due for sign off from Medicines Optimisation Committee and Nursing Council.
8. Use, and document the use of, de-escalation prior to physical restraint.

Complete awaiting Approval

9. Ensure that staff do not inadvertently use the green room on Endcliffe ward to seclude patients – this SOP has been developed and approved therefore action complete.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

The Board of Directors are asked to receive this report and consider the assurance contained within.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	*Yes*		*No*	***X***
CQC Getting Back to Good	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*		*No*	***X***
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*		Actions within the Back to Good programme directly relate to CQC standards
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?				***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*		Several actions relate to the completion of training and supervision which has a workforce impact in terms of provision and monitoring.
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		Equity and equality are key drivers of regulatory compliance.
Legal	*Yes*	***X***	*No*		Failure to achieve compliance is a breach of the requirements of the Health and Social Care Act.
Environmental Sustainability	*Yes*	***X***	*No*		Within the requirements identified in the Back to Good programme are several actions that support the principles of environmental sustainability and the effective use of resources.

SHSC Response Following the Television Broadcast in September 2022 of Mistreatment of Service Users in the Edenfield Unit

Immediate steps were taken in SHSC in response to the programme broadcast on 28th September 2022. A statement from the Chair and Chief Executive expressed shock at the unacceptable treatment and also spoke directly to SHSC's values, speaking up, and individual and collective responsibilities in preventing anything similar happening in SHSC. A group of senior leaders met to reflect on the impact of the programme and to consider the questions raised for SHSC. Leaders subsequently took the same approach in their service lines and teams. The annual cycle of internal SHSC quality, culture and fundamental standards reviews of services was brought forward and has now recommenced.

A paper and discussion at Quality Assurance Committee on 12th October 2022 was followed by a further discussion at the Board of Directors Workshop on 26th October 2022. The Board received the joint response from Providers in the South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative to the Integrated Care Board, outlining each provider organisation's response and the shared themes across providers. For SHSC, these next steps connect directly with our work to improve learning from complaints, increase feedback from services users, carers and families; extend the role of advocacy, maintain progress in recruitment and increase the visibility of senior leadership, including out-of-hours.

In South Yorkshire, the Adult Secure Care Provider Collaborative, with South West Yorkshire Partnership NHSFT as the lead provider, is responsible for the commissioning and quality governance of placements in low- and medium-secure services for people from South Yorkshire. The line of sight for quality runs from individual service users and their clinical placements in services via case managers to the Adult Secure Care Provider Collaborative. SHSC is a member of the South Yorkshire Adult Secure Care Provider Collaborative and, as such, is linked with the quality oversight process.

A number of measures are in place in SHSC to give increased visibility to standards of care. These include promoting speaking up via training and the work of the Freedom to Speak Up Guardian, who presented their annual report at Public Board in September 2022. The internal SHSC quality, culture and fundamental standards reviews report via Quality Assurance Committee. Board continues to triangulate information and risks in reports through Board visits across services. The annual Use of Force Act report was presented at Public Board in September 2022, detailing SHSC's compliance with the requirements of the Act and reduction in seclusion in SHSC over the last year. In SHSC, restrictive practices are overseen by the Least Restrictive Practice Oversight Group, which reports to Mental Health Legislation Committee and on to Public Board. Triangulating information is within the monthly Integrated Performance and Quality Report.

The CQC noted more robust safeguarding arrangements were in place in SHSC in their report published in February 2022. Implementation of the CQC's regulatory requirements continues to be overseen by the Back to Good programme, which reports to Quality Assurance Committee and Board of Directors.

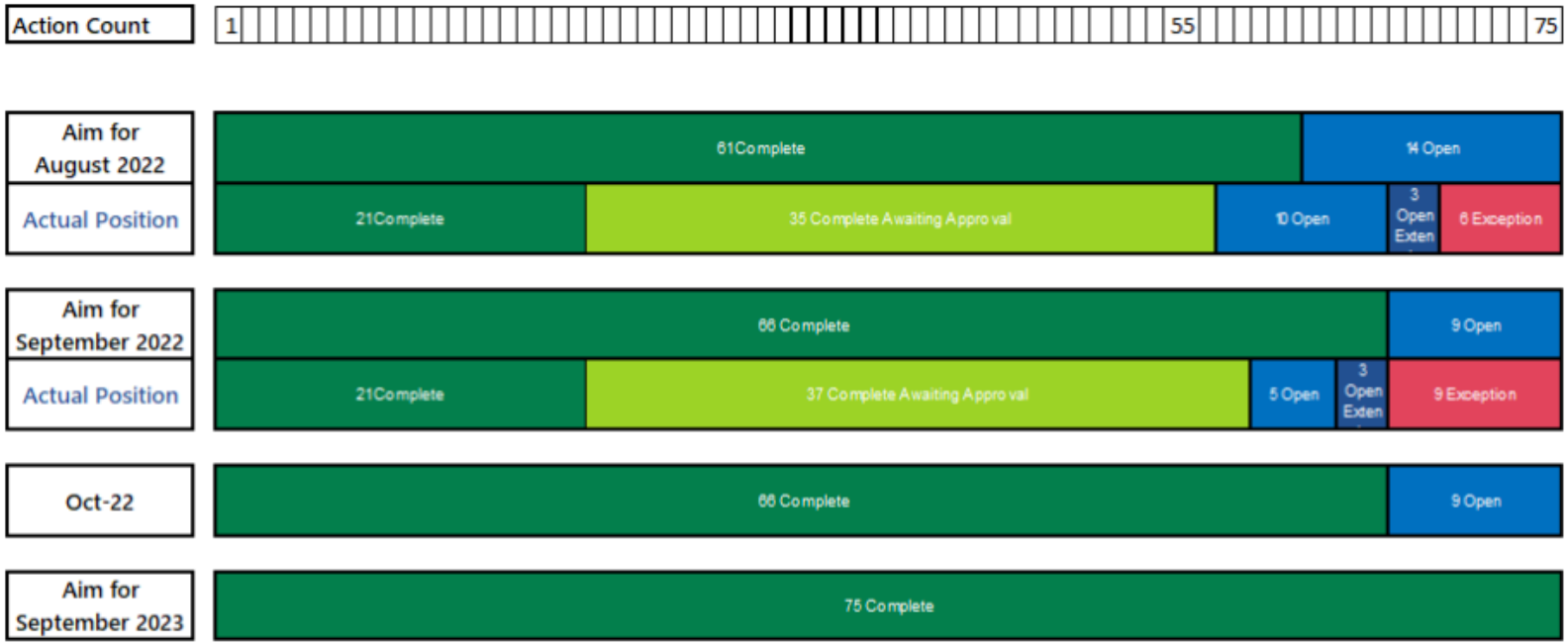
SHSC continues to respond to all concerns raised – via a range of routes including incidents, complaints and safeguarding – through the established systems and processes that are established in SHSC's governance arrangements.

Improvement Requirements Summary September 2022

Table 1: Status of requirements

Status	
Open	Work has commenced and remains ongoing against agreed completion date
Complete	Evidence has been assured by the Head of Clinical Quality Standards
Complete awaiting approval	The requirement has been met in line with local assurance processes. Awaiting assurance from Head of Clinical Quality Standards
Exception	The requirement will not be delivered within agreed timescales. Or more than one extension has been requested
At risk	The due date may not be met
Open extension approved	The Programme Board has approved an extension to the due date

Overall Improvement Regulations Progress – September 2022



21 complete requirements (remains the same as August)

37 requirements are complete awaiting approval (increase of 2 since August)

9 requirements are in exception (increase of 3 since August)

8 requirements are open, or open with an approved extension (decrease of 5 as 3 are in exception and 2 are now complete awaiting approval)

Requirements in exception in September 2022

Regulation	Regulation ID	Service	End Date	Exception
The trust must ensure that effective, embedded and sustainable governance and risk management processes are in place to assess, monitor and improve the quality of services.	1	Trust-wide	31/08/2022	
The trust must ensure that engagement with patients and carers and involvement in their care is strengthened.	9	Trust-wide	31/12/2022	
The trust must ensure that patient's advocates, relatives and friends or carers are involved in their care.	21	Acute Wards and Psychiatric Intensive Care Units	30/08/2022	
The trust must ensure that compliance with training achieves the trust target in all mandatory training courses including intermediate life support and restraint interventions.	23	Acute Wards and Psychiatric Intensive Care Units	30/06/2022	
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	
Recommendation to introduce Medicine Management competencies for nurses	55	Trust-wide	29/07/2022	
The trust should ensure all staff are up to date with **mandatory training**	68	Acute Wards and Psychiatric Intensive Care Units	30/06/2022	
The trust should ensure staff use and clearly **document the use of de-escalation** prior to physical restraint	69	Acute Wards and Psychiatric Intensive Care Units	30/09/2022	
The trust should ensure that staff do not use the **green room on Endcliffe ward** to inadvertently seclude patients	75	Acute Wards and Psychiatric Intensive Care Units	31/08/2022	

Back to Good Risk Report (September 2022)

1. Introduction

1.1 The report covers the areas of risk as reported to the Back to Good Programme Board in September 2022. Quality Assurance Committee specifically asked in the October 2022 meeting to be sighted on the management of the clinical risk associated with the shortfalls in mandatory training for key areas including Immediate Life Support, Fire and Respect training.

1.2 A key risk continues to relate to incomplete evidence provided to allow for assurance activities to be completed.

1.3 Nine requirements were reported as being in exception.

Overview of Requirements in Exception:

2. Governance Requirement

2.1 The requirement is in exception because of a previous gap in providing effectiveness reports from Tier 2 groups to Board sub-committees. A process is now in place, and reports have been provided from the majority of Tier 2 groups to their respective sub-committees. Audit and Risk Committee received the overarching report in October 2022, and it is anticipated that this requirement will subsequently complete.

3. Service User Engagement Requirements

3.1 The requirements pertaining to service user and families engagement and involvement are in exception, in one instance as the evidence has not been provided to allow for assurance activities to be completed. The remaining area of risk relates to being able to provide service information in an accessible format. To address this the Communications Team and the Head of Equality and Diversity are working together to mitigate this risk by linking with services to review the existing online information, to amend as appropriate, and ensure accessibility. It is anticipated that this requirement will close in December 2022.

4. Training Requirements

4.1 On average the 80% standard is being achieved across Acute and PICU wards, however there are important areas where training is consistently below the standard. As reported to Quality Assurance Committee in September 2022, there is a targeted focus on the achievement of compliance for Fire Safety and Immediate Life Support (ILS). The risk rating remains to have a moderate score of 12 based on the future projections for training for staff. Failure of staff to attend planned training sessions will impact on delivery of the overall requirement.

Date>	28-Aug	21-Sep
Area	Compliance	Compliance
Burbage	88.8%	87.9%
Endcliffe	91.1%	89.6%
Maple	91.4%	91.8%
Stanage	89.2%	89.6%

Overall (Acute & PICU) Subjects below 80% as of 21 Sept	28 Aug Compliance	21 Sept Compliance
Information Governance (95% target)	84.2%	85.6%
Resuscitation (BLS) (80% target)	63.9%	67.5%
Mental Health Act (80% target)	80.0%	78.9%
Safeguarding Children L3 (80% target)	73.3%	65.5%
Mental Capacity Act L1 (80% target)	80.6%	75.4%
DoLS L2 (80% target)	83.3%	77.8%

4.2 The following table outlines how the risk is being managed and actions being taken to promote improvements in compliance.

Clinical Risk/Issue	Risk Mitigation	Agreed Actions
Staff not always compliant with mandatory training therefore, risk of unsafe practice introduced/increases	• Ensure every shift has Qualified Nurse on duty (and not Preceptor only) • Ensure every shift has at least 1 ILS trained staff member on duty • Ensure every shift has at least 3 RESPECT trained staff on duty • Incident report and escalation when in exception • Ensure all staff have received full ward induction • Ensure Evacuation protocol and PEEP scores known by staff on duty • Ensure adequate handover of clinical information including risk and care plans • Ensure availability of alarms, keys, access cards	• Continue to follow escalation process to ensure staff staffing levels maintained • Exception reporting and monitoring of minimum safe staffing standards by shift • Allocated time for mandatory training evidenced on rota (planning) • Focus on critical courses for those who are not compliant with many including: Fire, Information Governance, ILS, Respect Level 3

5. Supervision Requirement

5.1 Supervision compliance rates across remain a concern and the risk rating has a high score of 16.

5.2 The table below summarises the information and highlights that 3 out of the 4 wards are at risk of a worsening position if the planned number of future supervisions is not increased.

Ward	Supervision compliance	Supervision compliance based on known bookings
Burbage/Dovedale 2	46.2%	23.1%
Endcliffe	97.4%	Maintained
Maple	63.3%	53.3%
Stanage	75.9%	44.8%

5.3 The following table demonstrates how the risk is being managed and actions being taken to promote improvements in compliance

Clinical Risk/Issue	Risk Mitigation	Agreed Actions
Staff not being regularly supervised due to shortage of staff on duty and availability of assigned supervisor Staff not feeling supported during course of their work Increase in staff absences (work-related stress)	• Focus on those who have gone longest without recorded supervision – priority of offer if capacity is limited. Monitor. • Allocated time for supervision evidenced on rota (planning). Aim for 8 clinical staff supervisions to take place a week . Monitor. • Release time for staff – via mutual support from adjacent wards/staff for short periods of time • Attempt for regular group debriefs and supportive sessions – for staff to practically receive support and have reflective space • Additional Learning Environment Manager support and check in for students and preceptors on the ward • Ward Manager allocating additional protected time during working week for supervisions to take place • Supervisor capacity increased via other people: matron, AHPs, Psychology	• Allocated time for supervision evidenced on rota (planning). • Ward Manager allocating additional protected time during working week for supervisions to take place • Increase in Supervisor capacity from other staff groups

6. Medicines Management Competencies Requirement

6.1 Final approval of the training material is scheduled for Medicines Optimisation Committee and Nursing Council. It is expected that relevant resources will be agreed within the month and can then marked as completed. The overall risk is low.

7. De-escalation Prior to Physical Restraint Requirement

7.1 The requirement is in exception due to 2 actions:

7.1.1 Three wards have de-escalation spaces which need to be improved. Work has commenced on two, the outstanding ward is Endcliffe. A plan has been agreed for this work and it is due to complete in November 2022. Programme Board agreed to highlight this as an exception until the work in Endcliffe is complete in November 2022. Oversight of the full programme of work remains within the remit of the Therapeutic Environment Programme Board.

7.1.2 A pilot of post incident reviews has been completed, though full implementation will not be achieved until March 2023. Back to Good Programme Board agreed an extension until March 2023 to allow for full implementation and embedding.

8. Avoiding Seclusion in Green Room on Endcliffe Ward Requirement

8.1 Progress is being made in relation to ensuring that staff do not use the Green Room on Endcliffe Ward to inadvertently seclude patients. A Standard Operating Procedure has been developed and was approved at the end of October 2022; therefore this action is now complete.

9. Embeddedness checks for completed actions

9.1 The Quality Assurance Committee had previously requested a forward planner of when spot checks will be completed for requirements which have been met but do not naturally report to an established group or committee to ensure embeddedness. The following checks are due for completion within quarter 3, with outcomes included in the next report.

Action ID	Description
A7.1	Monitor that agency are fully inducted into the ward area as per the induction check-list and take appropriate steps where there are gaps.
A7.2	Revision of the nursing agency agreements to ensure that training and skills required such as Respect level 3 are clearly articulated and monitored.
A9.5	Undertake a scoping exercise to prioritise the development of accessible information where reasonable adjustments are identified.
A15.2	Prior to mattress being provided, risk assess patient and seclusion suite risks to determine appropriate mattress depth
A30.1	Single Point of Access (SPA) will develop and implement a standardised care plan for all new assessments that will include patients' views, strengths and goals. This will be co-produced with service users. This care plan will be inclusive and available in other formats when required.
A30.2	Single Point of Access (SPA) will offer all service users a copy of their care plan and document whether or not a copy has been given. Staff will ensure service users understand their care plan and document this discussion in their notes.
A46.2	Provide online training for all staff, with an initial focus on acute inpatient areas and the Psychiatric Intensive Care Unit as priority areas.
A73.2	Daily safety huddles to identify patients who have a PEEP score of A (score of A refers to patients who require support to mobilise and safely evacuate in an emergency). The huddle to be used to communicate care needs