Board of Directors - Public

SUMMARY REPORT	Meeting Date:	22nd March 2023
	Agenda Item:	9

Report Title:	**Back to Good Board Reporting**	
Author(s):	Sue Barnitt, Head of Clinical Quality Standards Zoe Sibeko, Head of PMO	
Accountable Director:	Dr 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:	8th March 2023
Key points/ recommendations from those meetings	The Committee had asked for a focused risk report regarding the remaining open Back to Good requirements. The committee had also asked to receive evidence for assurance of progress against the supervision recovery plan. In addition, the committee were provided with an overview of activity that supports staff to identify and address any practice issues which may arise due to a lack of supervision. No additional requests for information were made by Quality Assurance Committee.	

Summary of key points in report

The report covers progress of delivery within the Back to Good Programme up to January 2023 as reported to the Programme Board.

Six requirements have actions that require quality assurance checks to enable closure, however these have not been progressed due to the lack of supporting evidence. Escalation via the Programme Board has occurred to prompt timely submission of evidence and it is anticipated that these requirements will be closed shortly. The total number of requirements that are now complete is 58 out of 75.

Ten requirements were reported as being in exception, these are:

- Ensure that statutory and delegated safeguarding functions are carried out effectively
- Ensure that care is provided in estates which are suitable, safe, clean, private and dignified
- Ensure engagement with patients and carers and involvement in their care is strengthened
- Achievement of training targets per course
- Achievement of training targets per acute ward
- Achievement of supervision target
- Ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intramuscular medication
- Ensure that staff carry out and document capacity assessments and subsequent best interest's decisions in line with the principles of the Mental Health Act

- Management of Section17 leave to maintain safety of patients and staff
- Use, and document the use of, de-escalation prior to physical restraint

This report describes the actions needed to complete requirements and the associated risks and their mitigation.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	
The Board of Directors is asked to receive the report and consider the assurance in its content.							

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good – Continuing to improve	*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?				***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*	***X***	*No*		***Reducing inequalities is a fundamental principle of the improvements needed to get back to good.***
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.***

Back to Good Programme Report

Summary Overview (Q3)

Year 2 requirements now total **75** with the December 2021 inspection included

As reported to Programme Board on 23 January 2023, the current status is:

- 58 requirements are complete
- 6 requirements are complete awaiting approval
- 10 requirements are in exception
- 1 is open with an existing extension to a revised due date being approved

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 ten requirements in exception

Regulation	Regulation ID	Service	End Date	Exception
The trust must ensure that the statutory and delegated safeguarding functions are carried out effectively and robust reporting, governance processes and oversight is in place.	2	Trust-wide	31/12/2022	
The trust must ensure that care is provided in estates and accommodation which are suitable, safe, clean, private and dignified.	5	Trust-wide	31/12/2022	
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 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	
The trust must ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intra-muscular medication	56	Acute Wards and Psychiatric Intensive Care Units	31/12/2022	
The trust must ensure that staff carry out and document **capacity assessments** and subsequent **best interests decisions** in line with the principles of the Mental Capacity Act 2005	57	Acute Wards and Psychiatric Intensive Care Units	31/03/2023	
The trust must ensure that staff **manage section 17 leave** appropriately to maintain the safety of patients and staff	58	Acute Wards and Psychiatric Intensive Care Units	31/12/2022	
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	30/03/2023	

Prior to providing a comprehensive overview of each of the requirements, the Board of Directors is asked to note:

- Requirements 23, 68 and 42 have had previous extensions and should be advised that Back to Good Programme Board agreed to keep these requirements in exception to maintain focus on the need to address these issues.
- Requirement 57 despite having a due date of March 2023 was reported as in exception to bring it to the Programme Board's attention as there has been slippage in delivery of some of the actions.

- Requirement 69 has a due date of March 2023; however, it was reported to Programme Board that the completion of the works will be delayed until April 2023.

Requirement 2

The Trust must ensure that the statutory and delegated safeguarding functions are carried out effectively and robust reporting, governance and oversight is in place

All actions to meet this requirement have been completed with the exception of achieving the 90% compliance target for Adult Level 3 Safeguarding training. The current training compliance level is 76%. There has been a delay in achieving the required compliance rate due to the availability of training courses that staff can access. Training has now been brought in house as planned to follow the completion of sessions by the external trainer. Further analysis is required to understand the anticipated completion date.

Risk: Given the extended period of non-compliance the residual risk is moderate

Requirement 5

The trust must ensure that care is provided in estates and accommodation which are suitable, safe, clean, private and dignified

All actions to meet this requirement have been completed with the exception of implementing the entire ligature anchor point (LAP) eradication programme on the inpatient wards. Phase 1 and 2 LAP works are complete.

A business case for the Phase 3 works on Stanage ward has been approved by Finance and Performance Committee and work has commenced; the planned estimated completion date is August 2023. Estates works to replace doors on Maple ward is delayed due to the need to decant service users to an alternative space to enable works to be completed. The plan is for the newly refurbished Stanage Ward to be utilised once complete.

The oversight and delivery of this work is within the remit of the Therapeutic Environment Programme Board.

Risk: The risk to patient safety posed by the remaining ligature anchor points is being managed via operational controls. There are established ligature review processes in place, supported and kept current via daily activities for example safety huddles. The efficacy of these measures is audited in order to provide assurance. The residual risk is moderate.

Requirement 9

The trust must ensure that engagement with patient and carers and involvement in their care is strengthened

The outstanding action relates to being able to provide service information in an accessible format. All existing online information has been reviewed and amended accordingly which is to be used as the basis for the easy read information, however there has been issues with the completion of this task due to supplier issues.

Options are being considered which include:

1. In house completion
2. Procurement of new supplier or use of voluntary/third sector organisations
3. Linking with other Trusts

Risk: Progress is currently delayed whilst a new approach is being agreed. The residual risk is moderate.

Requirement 23
The Trust must ensure that compliance with training achieves the Trust target in all mandatory training courses including intermediate life support and restraint interventions.

and

Requirement 68
The trust should ensure all staff are up to date with mandatory training

As of 16th February 2023, overall compliance is 86.71%. However, at the individual team and subject level there remain gaps in compliance, particularly in respect to Safeguarding Children Level 3, Medicines Management Awareness and Mental Health Act. Compliance is affected by some staff being on long-term sick and housekeeping and nursing staff not being compliant with some core subjects.

Within previous reports allocation of e-learning days as part of the recovery plan for Acute Wards and PICU has been highlighted. Following discussion with the Operational Support Manager for these areas it has been confirmed that protected time is being used within clinical settings to improve mandatory training compliance. Two types of protected time are being recorded on e-roster: e-learning days and 'workday's'. Workdays include activities such as attending an MDT meeting and shadowing other roles, as well as training.

	E-Learning days	**Workdays**
January 2023	**17**	**101**
February 2023	**14**	**87**

E learning days are either completed on site or at home and checks regarding completion are undertaken.

In addition to this there are other types of protected time which have been allocated over the same periods

- Academic days - 122 days (E.G. ACP, TNA, formal study courses)
- Face to Face Training for Basic Life Support, Immediate Life Support, RESPECT Moving & Handling and Suicide Prevention, Care Certificate etc - 76 days
- Preceptorship - 25 days

This overview provides assurance to the committee that despite there being consistent staffing challenges, ward leadership teams are working proactively to release staff and promote protected learning time. However, it must be noted that for some colleagues, due to the length of time it takes to complete the e-learning modules additional time may need to be allocated.

As noted within the Back To Good Programme Board in February, compliance can fluctuate across subjects based on where focus from clinical teams currently lies however there are clear standards regarding requirements for each shift to ensure patient safety and quality of care.

Risk: Staff not always compliant with mandatory training introduces the risk of deficits in practice. As described a plan is being actioned to operationally manage the clinical risk. Until the plan has been effectively delivered the residual risk remains high.

Requirement 42

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

Supervision compliance as of 12th February 2023 is 70% (no change on previous month).

A review of the SHSC Clinical Supervision policy was undertaken in 2022 and at that point the policy content was considered to be appropriate and fit for purpose. However, across a range of our services there is poor uptake of clinical supervision likely due to time pressures, lack of opportunity, suitable expertise of supervisors and individual perspectives regarding the value of the experience.

Detailed information by staffing group has been established which highlights the need for other disciplines to focus on improving their supervision rates to support improved ward based compliance.

Clinical supervision is one of a numbers of activities taking place within the Trust which supports the promotion of good practice, reflection and clinical decision making. For example:

- Ward Psychology Open Sessions
- Professional Nurse Advocate
- Post Incident Support
- Preceptorship Support
- Huddling Up for Safer Healthcare (HUSH)

Risk: Based on the known supervision bookings, a decrease in compliance is expected on the wards. Plans are in place to mitigate the risk by adopting more flexible approaches to supervision such as inter-professional and inter-team supervision. Focus is being placed on booking supervisions and providing the conditions to ensure that it takes place. The residual risk remains high pending completion of the recovery plans.

Requirement 56

The Trust must ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intramuscular medication

As requested by Back to Good programme Board, a conversation at Physical Health Management Group took place mid-February to determine the criteria for closure of this action. It was agreed that submission of required audits for a consecutive 3 months with a compliance rate of 80% would be sufficient to enable closure. The Clinical Lead will also guide a coaching conversation with members of the Multi-Disciplinary Team regarding shared ownership of completion.

Risk: Without completion of physical health observations it is difficult to understand a service users baseline and therefore it is harder to identify deteriorations in physical health conditions. Recent utilisation statistics demonstrate an improving position therefore the residual risk is low.

Requirement 57

The Trust must ensure that staff carry out and document capacity assessments and subsequent best interests in line with the principles of the Mental Health Act

The training to support staff knowledge and competence has been developed, aligned to staff roles and is awaiting publication on the Electronic Staff Record (ESR) and E Learning. A training implementation plan has been devised based on priority of need and agreed by Mental Health Legislation Operational Group.

The audit tool has been approved at Mental Health Legislation Operational Group. It will be trialled within the Learning Disability Service. Implementation of the audit maybe affected by capacity. This is deemed to be the most important action to be completed to meet the requirement, and options of support need to be explored.

Risk: Delays in implementation of these actions may result in missed opportunities to improve care in relation to mental capacity and best interests. The residual risk is high and a recovery plan is being developed.

Requirement 58

The trust must ensure effective management of Section 17 leave to maintain the safety of patients and staff.

This requirement is a new exception as of January 2023 due to exceeding completion date set. Following review of the policy, the outstanding actions within this requirement include:

- Provision of training to all registered nurses, psychologists and AHPs working in inpatient settings
- 'Dip sample' audits in relation to s17 leave practice

The training has been developed and is currently awaiting publication on Jarvis. A new audit tool has been developed and a plan is in place for its implementation. Discussions are taking place to move the audits on to Tendable.

Risk: The residual risk is moderate due to the lack of assurance regarding application of S17 leave policy.

Requirement 69

The trust should ensure staff use and clearly document the use of de-escalation prior to physical restraint

Three wards have de-escalation spaces which need to be improved:

- Work has been completed on Stanage and G1
- The work on Endcliffe has been delayed with completion planned for August 2023.

Oversight of the programme of work remains within the remit of the Therapeutic Environment Programme.

Risk: The residual risk is moderate and this is mitigated by the use of a Standard Operating Procedure to cover interim de-escalation arrangements on Endcliffe Ward.

Summary of Risk

The requirements that remain open are representative of the areas of concern identified by the CQC from 2020 onwards, demonstrating these are our most challenging issues.

The following table highlights changes in risk rating for the remaining open requirements.

Requirement	Risk Rating	Risk Trend
Ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intramuscular medication	Low	
Ensure engagement with patients and carers and involvement in their care is strengthened	Low	
Ensure that statutory and delegated safeguarding functions are carried out effectively	Moderate	
Ensure that care is provided in estates which are suitable, safe, clean, private and dignified	Moderate	
Management of Section17 leave to maintain safety of patients and staff	Moderate	N/A as new exception
Use, and document the use of, de-escalation prior to physical restraint	Moderate	
Achievement of training targets per course	High	
Achievement of training targets per acute ward	High	
Achievement of supervision target	High	
Ensure that staff carry out and document capacity assessments and subsequent best interest's decisions in line with the principles of the Mental Health Act	High