Board of Directors

SUMMARY REPORT	Meeting Date:	24th May 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:	10 May 2023
Key points/ recommendations from those meetings	The Committee discussed the oversight arrangements for completed requirements and those that remain in exception. The Committee asked that consideration be given to how all oversight could be captured through SHSC's business as usual processes, including the governance structure of sub-committees and groups.	

Summary of key points in report

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

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 per acute ward and PICU
- Achievement of training targets per acute ward and PICU
- Achievement of supervision target per acute ward and PICU
- 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 mitigation.

In April's Quality Assurance Committee a request was made to receive wider information regarding supervision compliance for services in addition to Acute and PICU. It has been agreed that supervision compliance monitoring will be included in the business as usual activity of the People Committee. Specifically in relation to clinical services; Older Adults, Acute, Community and Crisis are underperforming against the target therefore four recovery plans will be submitted to the People Committee in July.

In regards to completed requirements:

- Work is scheduled to take place in Q1 to provide ongoing assurance as to the embeddedness of the requirements via the completion of checks and through engagement with governance groups linked to the requirement.
- A series of embeddedness quality checks regarding the concerns raised within the CQC 29a warning notices issued in 2020 and 2021 have commenced, with the detail reporting at Quality Assurance Committee. The approach taken includes a desktop review of task related requirements to ensure these are in place and a set of quality check visits to the bed-based areas within the Trust to test out application in practice and staff understanding.

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

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	*Yes*	***X***	*No*	
Continuous quality 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?				***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, Engagement 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.***

Summary Overview

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

As reported to Programme Board on 24th April 2023, the current status is:

- 60 requirements are complete
- 4 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 have continued to submit returns to the CQC in relation to the conditions on registration at Firshill Conditions, confirming that the unit remains paused. An application to vary conditions at Firshill has been approved and conditions 2-7 removed resulting in the issuing of a new registration certificate. Condition 1 remains in place, which outlines the need for CQC authorisation should a request to admit a service user to the service be required. The net effect of these changes is that the site is registered without restriction as a community base but with a condition limiting potential inpatient admission.

Requirements in Exception

There are ten requirements in exception

Regulation	Ref	End Date	Revised End Date	Status
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	31/12/2022	31/07/2023	Exception
The trust must ensure that care is provided in estates and accommodation which are suitable, safe, clean, private and dignified.	5	31/12/2022	31/08/2023	Exception
The trust must ensure that engagement with patients and carers and involvement in their care is strengthened.	9	31/12/2022	30/06/2023	Exception
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	30/06/2022	TBC	Exception
The trust should ensure that all staff receive supervision in line with the trust target.	42	28/02/2022	30/09/2023	Exception
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	31/12/2022	30/06/2023	Exception
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	31/03/2023	TBC	Exception
The trust must ensure that staff **manage section 17 leave** appropriately to maintain the safety of patients and staff	58	31/12/2022	TBC	Exception
The trust should ensure all staff are up to date with **mandatory training**	68	30/06/2022	TBC	Exception
The trust should ensure staff use and clearly **document the use of de-escalation** prior to physical restraint	69	30/03/2023	30/06/2023	Exception

The Board of Directors is asked to note that the requirements which were in exception in March remain the same in April. This demonstrates how these are the key challenges within the programme to address.

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 77% (1% increase). There has been a delay in achieving the required compliance rate due to access by staff to training courses available. Following review of planned activity against number of staff requiring training it is clear that compliance will not be achieved by the end of May 2023 as anticipated, the revised date for completion is by 31st July. The Safeguarding team are exploring options to increase training availability.

Risk: The residual risk remains moderate with a risk score of 12 however given we will now be experiencing an extension to the period of non-compliance, the risk will remain for longer.

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 remains moderate with a risk score of 12.

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 have been difficulties with the completion of this task due to supplier issues. A decision to procure Sheffield Voices as the preferred provider to develop the easy read information has been made. This requirement will close once we begin to see the publication of documents on the website and we have sufficient assurance regarding the robustness of the process, therefore the completion date of 30th June has been set.

Risk: The residual risk remains moderate, with a score of 9 as although progress has been made in preparing the materials, they have not yet been made available on the website for public access.

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 14th April 2023, overall compliance for SHSC Acute and PICU wards is:

- Maple Ward - 90.6%
- Dovedale 2 - 87.44%
- Burbage – 89.89%
- Endcliffe – 88.59%

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.

Notable progress related to the mandatory training recovery plan:

- **Level 2 Basic Life Support –** attendance at face-to-face group sessions is being monitored and has been good with minimal cancellations. Although some additional staff have become non-compliant, additional sessions are planned.
- **Moving and Handling People** – group sessions arranged locally, 8 sessions at MCC and 10 at Longley Centre for April and May 2023.
- **E-Learning Training Days –** 51 staff have dedicated days booked in April and May 2023

However, from the 28th March 2023, training compliance in most areas remains static. Several training courses have seen a reduction in compliance due to staff falling out of compliance; monitoring of which is ongoing, and additional courses are planned accordingly.

It is anticipated that addition of new courses over the coming weeks will result in a fall in compliance (because of a change in the denominator) and a review of mandatory training requirements due to commence in May 2023 may also impact on compliance figures. A recovery plan is in place as per the SHSC Performance Framework, which is reporting to Quality Assurance Committee.

Risk: Staff not always being compliant with mandatory training introduces the risk of deficits in practice. On a shift-to-shift basis, the risk is operationally managed by optimising the mix of staff with different training. Until the overall recovery plan has been effectively delivered the residual risk remains high with a risk score of 16.

Requirement 42

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

Supervision compliance as of 4th April 2023 is 72% an increase of 2% in February and March

Across a range of our services there is limited 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 all professional disciplines to focus on improving their supervision rates to support improved ward-based compliance. Trajectories for expected supervision compliance have been mapped and further work is being completed to provide assurance that planned sessions are being delivered and provide confidence regarding the plan in place. A recovery plan is in place as per the SHSC Performance Framework, which is reporting to Quality Assurance Committee.

Risk: Based on the current known supervision bookings, a decrease in compliance is predicted 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, with a score of 16, pending completion of the recovery plans.

In April's Quality Assurance Committee a request was made to receive wider information regarding supervision compliance for services in addition to Acute and PICU. It has been agreed that supervision compliance monitoring will be included in the business as usual of the People Committee. Specifically in relation to clinical services Older Adults, Acute, Community and Crisis are underperforming against the target therefore 4 recovery plans will be submitted to the People Committee in July.

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

Completion of care delivery physical health audits across the acute wards continues to improve with all areas submitting the required audits in March 2023 and all areas showing improvements in compliance scores for the standards set. The Back to Good delivery group will continue to monitor compliance for months of April and May and then make an informed decision regarding closure of the action based on improvements in compliance scores.

Reporting to Physical Health Management Group of service level data regarding key standards has commenced and will inform quarterly exception reporting to Physical Health Committee.

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, with a score of 6.

In month completion of Rapid Tranquilisation (RT) audits continues to be a challenge. Internal governance checks highlight that not all RT are being completed following an incident, particularly a challenge where RT incidents are high. A group has been convened in May 2023, which includes the Directorate Leadership Team, to agree an improvement plan.

Risk: Without the completion of the rapid tranquilisation audits it is difficult to understand the quality of this practice. The residual risk is moderate with a score of 12.

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 has now been published on the Electronic Staff Record (ESR) and E Learning module. 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 are being 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, with a score of 16, and a recovery plan is being incorporated within the broader training recovery plan that reports to Quality Assurance Committee.

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, with a score of 12, due to incomplete 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, with a score of 12, 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	Likelihood	Severity	Risk Score	Risk Trend	Risk Trajectory
Ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intramuscular medication	2	3	6		
Ensure engagement with patients and carers and involvement in their care is strengthened	3	3	9		
Ensure that statutory and delegated safeguarding functions are carried out effectively	3	4	12		
Ensure that care is provided in estates which are suitable, safe, clean, private and dignified	3	4	12		
Management of Section17 leave to maintain safety of patients and staff	4	3	12		TBC (new exception)
Without the completion of the rapid tranquilisation audits it is difficult to understand the quality of this practice.	4	3	12	TBC (New risk)	TBC (New risk)
Use, and document the use of, de-escalation prior to physical restraint	4	3	12		
Achievement of training targets per course	4	4	16		
Achievement of training targets per acute ward	4	4	16		
Achievement of supervision target per acute ward	4	4	16		
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	4	4	16		

Completed Requirements: Impact, Assurance and Risks

There is a requirement to monitor for embeddedness the completed requirements. This is mapped under 3 headings and will be undertaken as follows:

1. Business as usual governance groups

   Groups identified within the programme as having ongoing monitoring accountability will receive a list of completed requirements and an overview of the assurance required. The group will be asked to submit a statement of assurance to confirm they have ongoing oversight or plan of action to address shortfalls.

2. Requires focused embeddedness checks

   Some requirements do not naturally align to an existing business as usual governance group. Where this is the case an embeddedness check will be conducted and where possible included within existing arrangements such as Section 29a quality check visits.

3. No follow up required

   The actions supporting the completion of these requirements are task based and once complete do not require any further oversight.

This work is scheduled to take place in Q1.

A series of embeddedness quality checks regarding the concerns raised within the CQC 29a warning notices issued in 2020 and 2021 have commenced. The approach taken includes a desktop review of task related requirements to ensure these are in place and a set of quality check visits to the bed-based areas within the Trust to test out application in practice and staff understanding.

The first set of visits are scheduled to take place on 3rd May 2023 and will include visits to the 4 Acute and PICU wards. The decision to widen the quality checks to other ward settings including forensic and older adults to obtain assurance regarding these standards was agreed at a clinical leadership engagement meeting held on 18th April 2023.

Findings related to the visits will be reported in detail at Quality Assurance Committee and in overview form at Board of Directors.