Board of Directors

SUMMARY REPORT	Meeting Date:	26 July 2023
	Agenda Item:	10

Report Title:	**Q1 2023/24 Quality Assurance Report (Inc Back to Good)**	
Author(s):	Sue Barnitt, Head of Clinical Quality Standards Zoe Sibeko, Head of PMO	
Accountable Director:	Salli Midgley, Director of Nursing, Professions & Quality	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	12/07/2023
Key points/ recommendations from those meetings	N/A	

Summary of key points in report

The Board are asked to receive and **take assurance from** this new Quality Assurance Report and approve a request to stand down reporting from Back to Good. Replacement papers are noted below **for approval**. The report provided is for Q1 however it is proposed that reporting take place bi-annually.

As we approach the closure of the final actions held within the Back to Good Improvement plan, conversations at Trust Board have begun to consider how we provide triangulated information regarding the range of strategic quality assurance programmes that take place across the Trust.

This ambition aligns with the developing of our Quality Management System #Quality@SHSC which is a strategic objective in our Quality Strategy. The milestones below indicate the phases of development which will bring together the range of quality assurance information currently collated and the ambition of Quality@SHSC

- Phase 1 (June 2023 to December 2023) – review of the information we capture and presenting this into a format that supports triangulation. This is dependent on capacity due to delayed RIO implementation. The quality dashboards will be piloted x 3 by December 2023.
- Phase 2 (January 24 onwards) – commence reporting regarding key areas of quality and patient safety concerns and improvements within SHSC based on Quality@SHSC roll out plan (subject to capacity and roll out of RIO).

In the interim, whilst we work towards phase 2 reporting, the outstanding actions from the Back to Good programme are now routed through business-as-usual reporting and into Committees of the Board. To avoid repetition, it is proposed to close the Back to Good Board and reporting into Quality Assurance Committee and the Board.

In replacement the Board will receive:

- A Bi-annual Quality Assurance Report which will include updates on any completed visits through the Fundamental Standards, Culture & Quality Visit programme and Board visits as well as any other key

improvement plan updates associated with quality assurance (e.g. Sexual Safety).
- Service User and Carer Engagement biannual report via Lived Experience and Coproduction Assurance Group/ Quality Assurance Committee; this will include updates on Engagement Strategy, Carers Strategy and Patient and Carer Race Equality Framework.

Recommendation for the Board/Committee to consider:

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

The Board is asked to receive the report and consider the assurance in it's content, and approve next steps outlined in terms of future reporting.

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?	*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, 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.*

Section 1: Analysis and supporting detail

Introduction

1.1 As we approach the closure of the final actions held within the Back to Good Improvement plan, conversations at Trust Board have begun to consider how we provide triangulated information regarding the range of strategic Quality Assurance (QA) arrangements that take place across the Trust. Our core quality assurance processes are:

- Service user and carer feedback
- Fundamental Standards of Care Visits (Bed Based services) which incorporated previous CQC requirements under Section 29A
- Culture and Quality Visits (Community and Corporate services)
- Board Visits (Executive and Non- Executive Director visits to services)
- Development of Quality Management System
- Audit, Accreditation and Compliance with NICE Guidance

1.2 Further work is required to ensure that the information we capture is fit for purpose and supports our understanding about whether we are providing the quality of care we aspire to identify gaps and work towards addressing these. The development of our Quality Management System (Quality@SHSC) over the next 2 years will be instrumental in helping both services and the wider organisation to recognise what they are doing well and where there are re areas for improvement. Quality@SHSC will also be supported by the development of a set of Key Quality Indicators (KQI) and Patient Reported Experience Measures (PREM).

1.3 Aligning the range of QA information, we hold and gather will take time therefore the following phases are proposed:

- Phase 1 (June 2023 to December 2023) – review of the information we capture the information and getting this into a format that supports triangulation. This is dependent on capacity due to delayed RIO implementation. The quality dashboards will be piloted x 3 by December 2023.
- Phase 2 (June 23 onwards) – commence reporting regarding key areas of quality and patient safety concerns and improvements within SHSC based on Quality@SHSC roll out plan (subject to capacity and roll out of RIO).

1.4 In replacement of the Back to Good report, the Board will receive:

- A bi-annual Quality Assurance Report which will include updates on any completed visits through the Fundamental Standards, Culture & Quality Visit programme and Board visits as well as any other key improvement plan updates associated with quality assurance (e.g. Sexual Safety).
- Service User and Carer Engagement bi-annual report via Lived Experience and Coproduction Assurance Group/ Quality Assurance Committee; this will include updates on Engagement Strategy, Carers Strategy and Patient and Carer Race Equality Framework.

Section 2: Quality Assurance Workstreams

Board Visits

2.1 In June 2023, Quality assurance Committee received a detailed report regarding the findings from Q1 visits and proposed changes to the Board Visit process. In summary, during Q1 of 2023/24 there were ten Board Visits scheduled, all of which were completed. The plan for Q2 onwards is to have four Board Visits per month to ensure that all services are visited within a 12-month period. Work is underway to

scope out visiting arrangements for corporate services; these will be introduced during Q2 2023/24.

2.2 The Board visit process continues to be an iterative process and in response to feedback from those conducting and receiving the visits changes have been made. These include:

- Improved process of booking schedule to reduce cancellations.
- Wider availability of visiting slots to enable staff team to participate and more meaningful experience of service user interaction for all concerned.
- Specific service users/carers engagement opportunities to engage directly with Board on each visit.
- Visit Briefing Paper better tailored to service considering 'things to be curious about'.
- Revised Feedback Templates includes sections for Service User/carer comments and staff comments.

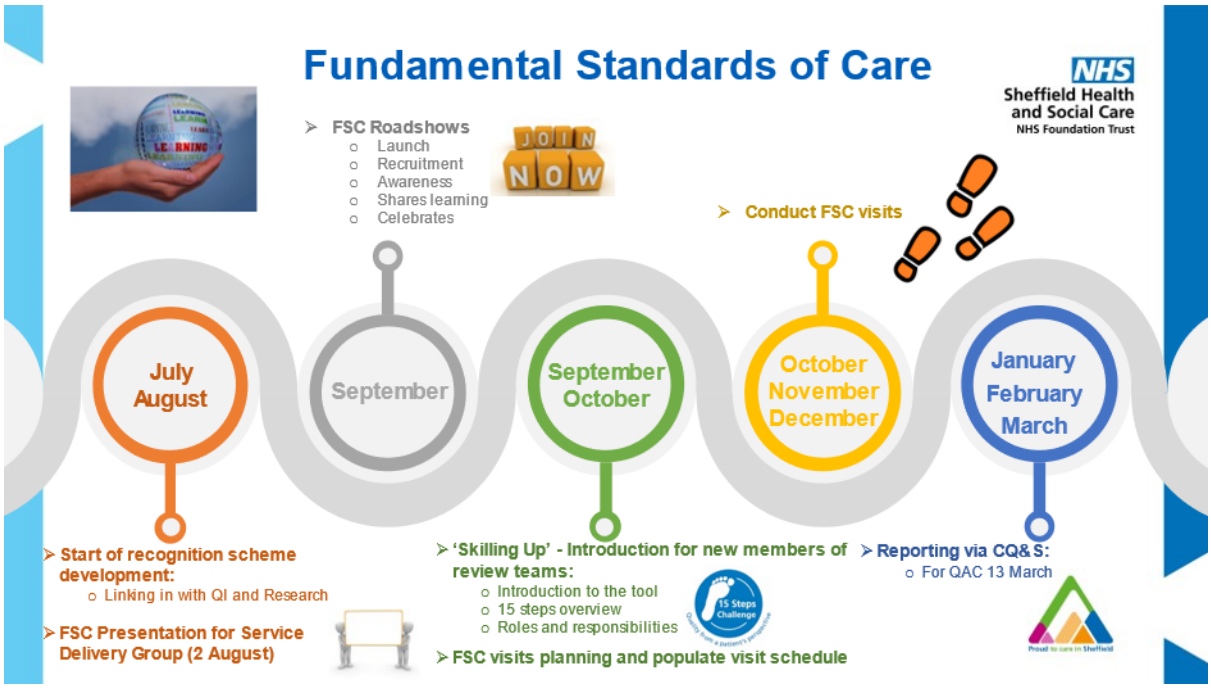
2.3 A review of the Board Visit Standing Operating Procedure (SOP) is being undertaken which will incorporate the recent changes to include the engagement opportunities and feedback from Service Users/Carers and from staff visited. The updated SOP will be included within the next bi-annual report.

Fundamental Standards of Care (FSC)

2.4 Key findings from the 2022 round of FSC visits were presented to Clinical Quality and Safety group in March 2023. A recap of the overall findings can be found in appendix One ; main points for action were:

- Increase provision of meaningful activities on wards
- Increase access to advocacy
- Insufficient staff numbers on shift
- Staff understanding of Ligature Anchor Point (LAP) assessment and management
- Better signage required for blanket restrictions
- Quality of seclusion environments
- IPC and sharps practice
- Suitability of clinic spaces

2.5 Planning for the 2023 programme of FSC visits has commenced; the timeline below indicates the key activities scheduled.



As part of the FSC approach we are looking to develop an organisational recognition scheme. Conversations with QI colleagues have commenced along with reaching out to other Trusts to encourage the sharing of learning from the recognition programmes they have introduced though it is likely that the SHSC scheme will not be introduced before the 2024 schedule of visits. Additional time has been factored in this year to provide increased opportunities for 'skilling up' new members of reviewing teams following feedback from the 2022/23 set of visits and review of the tool to ensure appropriate to service area (e.g. Older Adults version).

Focussed Quality Reviews : CQC Section 29a Checks

2.6 In June 2023, Quality Assurance Committee received the 2nd of two reports following the completion of the CQC Section 29a quality check visits to acute and PICU wards. These were initiated followed the improvement notices in 2021 and this is the second year of embeddedness checks to ensure that the issues are resolved and that learning and improvements are embedded in practice. There were some issues found during these checks which has resulted in local action plans being developed which will be signed off through Clinical Quality and Safety Group with progress reporting to Quality Assurance Committee in September 2023. Four Trust wide recommendations were proposed:

1. Better signage to identify whether a door should be locked or unlocked to aid checks.
2. Review of training we have available to support wards with the management of dual diagnosis.
3. Review of Trustwide ligature cutter replacement process as delays in receiving new cutters when used.
4. Awareness raising regarding safeguarding as 'everyone's businesses.

2.7 Section 29a quality checks completed in May and June 2023 delivered assurance against the following key areas:

- Improved understanding of ligature anchor point procedures and application
- Adherence to locked door requirements
- Reporting of repairs
- Application of the Observation and Engagement policy
- Suitability and cleanliness of clinic spaces

2.8 Work is now underway to ensure that the areas reviewed as part of the 29a quality checks is included with the 2023 programme of Fundamental Standards of Care visits. This will close down the Section 29A Focussed visit programme for the acute and PICU wards in recognition of the improvements with annual reviews through fundamental standards.

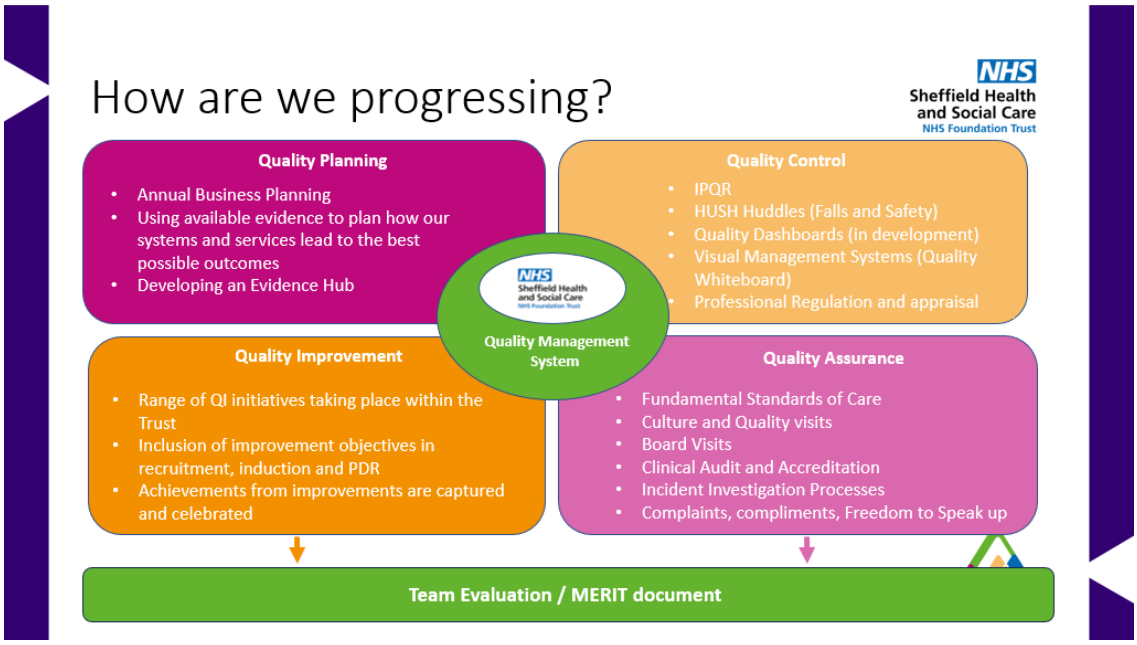
Culture and Quality Visits

2.9 Long Term absence of staff members within the Care Standards team impacted significantly on scheduling and facilitation of Culture and Quality Visits during Q3 and Q4 of 2022/23 and Q1 2023/24. A visit to Specialist Eating Disorder Service (SEDS) is currently in planning and is due to take place in July 2023. The team are working with SHSC Project Management Office (PMO) team to create the 2023/24 visiting schedule which will be presented in the next quarterly report. A review of the visit process is also being completed to ensure efficiency; the current approach to identify Key Lines of Enquiry (KLOE) is bespoke to each service which takes up a significant amount of time for both the Care Standards team and those conducting the visit. During Q3, Culture and Quality visits will be stepped down to facilitate the completion of FSC visits to bed-based services as it is often the same pool of people that support both visiting programmes.

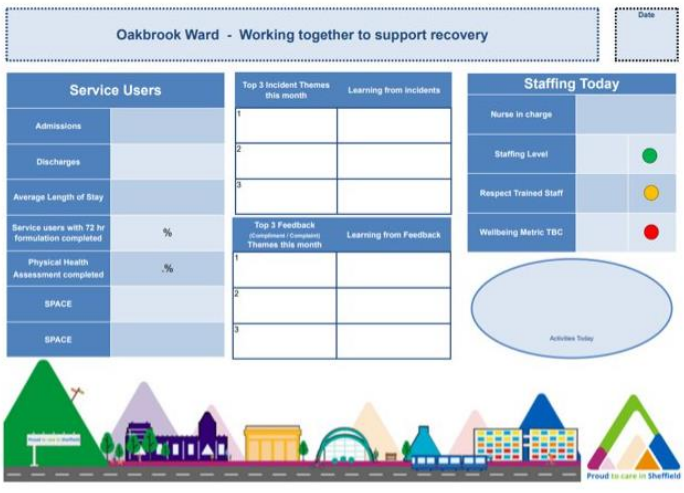
Quality Management System #Quality@SHSC

2.10 Work continues to develop the SHSC Quality Management System. A working group has been established comprising of colleagues from Care Standards, Quality Improvement, SHSC Digital, Workforce, Business Planning, Business Performance and our nominated expert by Experience. Scoping has commenced to identify the currently known activities we complete that sits within each of the 4 domains of a Quality Management System and an event scheduled for 02.08.23 to further map SHSC business as usual processes and agree a launch communication plan.

2.11 It is anticipated that findings from the range of core quality assurance activities completed will inform a Team Evaluation document which is held locally by each team.



2.12 Delays in the implementation of the RIO Electronic Patient Record system has stalled the development of the quality dashboards for teams identified within the pilot (G1, Dovedale, CERT and Oakbrook) however we are progressing the development and trial of the Quality Boards in these areas. The 'Visual Management system' (Quality Boards) have been developed with staff and service users with input from the Expert by Experience supporting this piece of work.



2.13 Finally, to note SHSC have been invited to present at the Royal College of Psychiatrists Quality Improvement Conference in November 2023 following the submission of an abstract compiled by out Expert by Experience, Katy Stepanian and titled 'Co-producing Quality Management Systems in a Mental health Setting using Quality Improvement'.

Back to Good Programme

2.14 Plans are being developed to close the programme. Its performance will be reviewed and a closure report completed. The report will also define the circumstances which have to arise to stand up a programme of this size and complexity again. A survey will be issued to requirement leads and stakeholders to gain feedback and lessons learned to inform future work.

7 requirements remain in exception.

2.15 **Achievement of supervision target per acute ward and PICU**

Supervision compliance per ward as of 11th June.

Burbage Ward:	
Compliance Rate	73.9% (reduction from 78.3%)
Nursing Compliance Trajectory	Achieved compliance in June
Non-Nursing Compliance Trajectory	August 2023
Dovedale 2 Ward:	
Compliance Rate	60% (no change)
Nursing Compliance Trajectory	Achieved compliance in June
Non-Nursing Compliance Trajectory	September 2023
Maple Ward:	
Compliance Rate	57.6% (change from 62.5%)
Nursing Compliance Trajectory	January 2024
Non-Nursing Compliance Trajectory	December 2023
Endcliffe Ward:	
Compliance Rate	61.1% (change from 93.9%)
Nursing Compliance Trajectory	February 2024
Non-Nursing Compliance Trajectory	December 2023

2.16 The plan to achieve the supervision target was based on the delivery of supervision every 4 weeks. To reduce any associated pressures of achieving this, the frequency was changed to every 6 weeks with the understanding the targets would still be achievable, however this target has not been maintained, therefore indicating that staff are not receiving regular supervision. To address this, the involvement and commitment of the Directorate Leadership Team is required and an approach is to be defined to assign responsibilities based on roles.

2.17 The Quality Assurance Committee agreed that ongoing monitoring is to be provided by the **People Committee** from July 2023, therefore this requirement is closed from the perspective of being within the remit of the Back to Good Programme, however it is clear that further work is required to ensure that regular supervision occurs. Recovery plans are to be developed for all service lines within the Acute and Community Directorate.

Risk: The compliance rates for all wards have dropped. The risk trajectory is worsening.

2.18 **Achievement of training targets per course per acute ward and PICU**

As of 23rd May 2023, overall compliance for Acute and PICU wards is:

- Dovedale 2 Ward – 86.68%
- Endcliffe Ward – 88.81%
- Maple Ward– 90.30%
- Burbage Ward – 90.61%

2.19 During May there has been a reduction in compliance against some essential mandatory training courses. A focused review of courses and wards is to take place to understand the associated clinical risks and to identify appropriate support to be provided to mitigate this.

2.20 Notable gaps in compliance for specific subjects are:

- Dovedale 2: Medicines Management at 25%, Mental Health Act at 50% and Mental Capacity Act Level 1 is 53.8%
- Endcliffe: Resuscitation L2 (BLS) at 53.3% and safeguarding children level 3 at 56.3%
- Maple Ward: Mental Health Act at 46.2% and Resuscitation Level 2 (BLS) at 65.7%
- Burbage: Mental Health Act 46.2%, Clinical Risk Assessment and Safeguarding Children Level 3 both at 50%

2.21 It should be noted that although some wards have low compliance rates for Resuscitation Level 2, the associated risk is reduced as compliance targets for ILS have been achieved. Additional Resuscitation Level 2 courses are being run in June for staff on Maple and Endcliffe Wards.

2.22 There is a low compliance rate on Dovedale 2 for the Medicines Management training, however some mitigation and assurance is provided as instances of the use of rapid tranquilisation is low and staff do complete the required rapid tranquilisation audits with an average quality score of 90% in February and March. However, this fell to 62% in April.

2.23 To address this the following supportive measures, risk mitigation and oversight is being provided:

- Safe staffing achieved on every shift and is based on the clinical skills required. Each shift has at least 1 ILS trained nurse on duty, a nurse with current rapid tranquilisation training and a minimum of 3 RESPECT level 3 trained staff.
- Group e-learning training sessions have been organised for administrative and housekeeping staff.
- Clinical Leads for each staffing group have an awareness of team and individual compliance rates, they are also accountable for ensuring this is followed up to ensure completion.
- All block booked agency staff and Bank staff are fully inducted and receive training.
- Essential training courses associated with high clinical risk to be identified and staff members who are not compliant will be prioritised to attend. Any cancellation of attendance of at these courses will require Ward Manager and Matron authorisation and a record of cancellations is to be maintained.

2.24 The Programme Board noted the current tension between reducing temporary staffing as per the Agency Reduction Project and achieving training and supervision targets. However, progress is being made, which will prove to be supportive, in the Agency Reduction project to provide tools, techniques and training to managers to undertake effective roster, leave and absence management.

2.25 In preparation for closure of the programme, training compliance for the organisation will be monitored at the **People Committee**. Compliance with courses identified as essential to manage clinical risk, for example, ILS, will be monitored by the Clinical Quality and Safety Group with monthly updates provided to the 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, however as we are not seeing improvements as expected the risk trend is worsening.

2.26 **Ensure that statutory and delegated safeguarding functions are carried out effectively**

As of 30th June, compliance for Safeguarding Adults Level 3 is 78.9%**.** Training is now being delivered by the Safeguarding team and dates are available for booking. Targeted communications are now being developed for the specific individuals who need to attend training to achieve the final 10%. Reporting is through Safeguarding Assurance Committee and onwards to Quality Committee every quarter.

Risk: The residual risk remains moderate, with a score of 9, however the risk trajectory is improving, with an expected completion date for the requirement in July 2023.

2.27 **Ensure that care is provided in estates which are suitable, safe, clean, private and dignified**

Phase 3 of the LAP work has commenced on Stanage Ward; the planned estimated completion date is October 2023. From this point staff and service users from Maple Ward can decant to Stanage and the programme of works on Maple to commence to complete the LAP removal programme. This work will not be completed prior to the closure of the Back to Good Programme however 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.

2.28 **Use, and document the use of, de-escalation prior to physical restraint**

Requirement has been met since the report was written when the de-escalation space on Endcliffe Ward was completed in June.

2.29 **Staff carry out and document capacity assessments and subsequent best interest's decisions in line with the principles of the Mental Health Act**

The pilot of the audit is ongoing, with a completion timescale of mid-July. From this feedback will be gathered and a recommendation made as to whether the requirement has been met.

Risk: Delays in implementation of the audit 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 mental health legislation committee.

2.30 **Management of Section 17 leave to maintain safety of patients and staff**

As above, the pilot of the audit is ongoing, with a completion timescale of mid-July and a recommendation will be made.

Risk: The residual risk is moderate, with a score of 12, due to incomplete assurance regarding application of S17 leave policy. Monitored at Mental Health legislation committee.

The following requirements were completed during June 2023.

2.31 **Ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intramuscular medication**

Assurance has been provided by the Physical Health Management group that audits are taken place at the required frequency and to the agreed standard. Robust systems are in place for oversight and monitoring of audits and compliance. In addition the Least Restrictive Practice Operations Group provided similar assurance that rapid tranquilisations are being effectively audited.

The Programme Board agreed to close the requirement.

2.32 **The trust must ensure that digital and information technology systems are fit for purpose**

The Wi-Fi roll out is complete as planned, with the exception of areas which are having improvements to their estate, therefore it is not possible to complete the work until an appropriate time.

Summary of Risk

2.33 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 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		
Without the completion of the rapid tranquilisation audits it is difficult to understand the quality of this practice.	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		

Section 3: Assurance

Triangulation

3.1 Section 29a quality checks completed in May and June 2023 delivered assurance against the following key areas which were highlighted as areas for improvement within the 2022 FSC visits:

- Improved understanding of Ligature Anchor Point (LAP) procedures and application
- Adherence to locked door requirements
- Reporting of repairs
- Application of the Observation and Engagement policy
- Suitability and cleanliness of clinic spaces

Section 4: List of Appendices

None