Board of Directors – Public

SUMMARY REPORT	Meeting Date:	22 November 2023
	Agenda Item:	11

Report Title:	**Back to Good Programme, Year 2 Closure Report**	
Author(s):	Sue Barnitt, Head of Clinical Quality Standards Zoe Sibeko, Head of PMO	
Accountable Director:	Dr. Mike Hunter, Executive 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 November 2023
Key points/ recommendations from those meetings	Due to the origin of the programme being focused on compliance, the leadership approach taken at the outset was significantly directive and the majority of the tasks undertaken were transactional in nature. Quality Assurance Committee recognised this and requested consideration given as to when it would be appropriate to move away from this approach when delivering change. They asked whether the programme stayed in a directive state for too long at the risk of disempowering people and how this learning could be applied to other programmes. Acknowledgement was given to the CQC ratings, that SHSC are classified as 'requires improvement' across all domains with the exception of caring, which is classified as 'good', and that we should be proud of being rated as a caring organisation.	

Summary of key points in report

The Back to Good Programme, Year 2 closure report has been submitted for approval to close the programme based on the progress made, assurance provided, and the lessons learned. Year 2 ran from October 2021 – August 2023.

Programme Performance:

- Section 29a warning notice issued as a result of the CQC Well Led, Crisis, Acute, PICU and Older Adults pathway was lifted in February 2022
- CQC rated SHSC as Requires Improvement in February 2022
- It has been agreed in principle that the oversight and monitoring will be devolved from the system level Quality Improvement Board to place in Sheffield. With a view to this taking place in March 2024
- NHS England have requested our support in sharing our knowledge, skills, experience and programme controls with other Trusts with a rating of 'inadequate'.

- Scope:
  - 71 out of 75 requirements (musts and shoulds) have been met. The outcomes are linked to quality and equality measures for example, patient safety, patient and carer experience,

clinical effectiveness and operational effectiveness
    - Scope: The unmet requirements pertain to mandatory training and supervision compliance and ward improvements. Monitoring and oversight is being provided by the People Committee and Tier II groups and the Therapeutic Environment Programme Board through to Finance and Performance Committee

- Time: The programme was extended by 5 months to allow for key requirements to be met. This was controlled and monitored by the Programme board via effective reporting and comprehensive risk management.

- Quality:
    - Evidence of completed requirements have been checked and approved by the Head of Clinical Quality Standards
    - All requirements were linked to a BAU governance group to support delivery and oversight outside of the Back to Good Programme Board. This arrangement will continue post programme closure.
    - A series of embeddedness quality checks regarding the concerns raised within the CQC Section 29a warning notices issued in 2020 and 2021 occurred in Q1 2023/24 with detailed reporting at Quality Assurance Committee.

- Lessons Learned:
    - We must continue to build on the approach of working together as a team with a shared sense of purpose, bringing together expertise to work in an inclusive manner. We need to involve people more effectively from the outset to shape direction and manage resources to ensure that support is provided within priority areas.
    - Ensure that there is a clear understanding of what improvement is required, the baseline which improvement will be measures against, what outcomes are expected, evidence provided and what benefits will be achieved within a clear realisation plan.
    - We must consider the leadership approach and level of governance required based on the type of programme are undertaking, be it specification led, transformation, or driven by political and societal change. In acknowledging the focus of the change and assessing the predictability of the outcome we thereby apply the required level of leadership and governance and through regular review ensure that it remains appropriate and effective.

Recommendation for the Board/Committee to consider:

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

The Board of Directors is asked to receive the report, approve closure of the programme based on the progress, assurance and lessons learned considered within 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?	*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.*

Sheffield Health and Social Care NHS Foundation Trust

Back to Good Programme

Year 2 Closure Report

Senior Responsible Owner	Mike Hunter, Executive Director, Medical
Author	Zoe Sibeko, Head of Programme Management Office Sue Barnitt, Head of Clinical Quality Standards
Contributors	Back to Good Programme Board
Version	0.1
Date	24 October 2023

Decision for Closure

Approval Board/Committee	Quality Assurance Committee
Date	8 November 2023
Decision	
Details of monitoring group / committee	Various depending on nature of the original CQC requirement. Oversight and monitoring has been transitioned to the most relevant and appropriate committee or group Quality Committee and Board of Directors will receive biannually a Quality Assurance report and a Service User and Carer engagement report

Version Control

Version	Date	Author	Comments

1. Regulatory context

To place Year 2 within the regulatory context of the CQC inspections and our improvement journey, the following chronology has been provided for the entire Back to Good Programme.

Regulatory event	Date of Visit	Report receipt and outcome	Status of delivery
CQC Well Led inspection 2020	7 January 2020 – 5 February 2020	Report: 30 April 2020 Rating: Inadequate Outcome: Section 29A warning notice	Complete Delivered via Year 1 and 2 of the programme.
Regulatory Section 29A notice 2020	7 January 2020 – 5 February 2020	4 work groups set up to respond	Complete Warning notice lifted October 2020.
Firshill Rise inspection	28 April 2021 – 10 May 2021	Report: 15 July 2021 Rating: Inadequate Outcome: Section 26 warning notice	In progress Service paused. Learning Disability Programme responsible for delivery.
CQC Inspection 2021. Well Led, Crisis, Acute and Older Adult pathway	5 May 2021 – 28 May 2021	Report: 19 August 2021 Rating: requires improvement Outcome: Section 29A warning notice	Complete Year 2 of Back to Good Programme.
Regulatory Section 29A notice	5 May 2021 – 28 May 2021	Task and Finish group set up to develop improvement plan. Monitoring and oversight via Back to Good Programme	Complete
Follow up CQC Inspection 2021. Well Led, Crisis, Acute and Older Adult pathway	7 December 2021 – 9 December 2021	Report: 16 February 2022 Rating: requires improvement Outcome: Section 29A lifted	Complete Warning notice lifted February 2022.

1a CQC Rating

The outcome from the last inspection in December 2021:

Overall	Requires improvement
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

SHSC has not been inspected since December 2021, and therefore retains an overall rating of Requires Improvement, not Good, as the programme name suggests. However, this is a positive in that the CQC have changed their regulation approach and now undertake inspections within organisations they deem to be at risk. It should also be noted that we have a rating of good, for caring and how this is a real positive to be rated as a caring organisation.

As part of the response to being rated as inadequate by the CQC, SHSC was placed into special measures which provides a framework within which the CQC and NHS England work together to ensure a timely and coordinated response to improve the quality of care. This includes being assigned an NHS England Improvement Director and support and monitoring via a regional Quality Improvement Board.

The Quality Improvement Board (QIB) met on 24 October 2023 and agreed in principle that oversight would be devolved from QIB, which operates at a system level, to place in Sheffield. The transition will be developed in January with a view to moving to place-based oversight from March 2024.

A further endorsement of the progress made as an organisation and the success of the programme is that NHS England have asked for our support in sharing our knowledge, skills, experience, and programme controls with other Trusts with a rating of inadequate

As agreed with the CQC, SHSC do not provide returns in relation to the conditions on registration at Firshill. The unit remains paused. The Learning Disabilities Programme is developing and implementing a service which provides person centred, strengths based high quality care based on a robust community offer.

2. Summary of Programme Performance

The evidence and information provided for this report has been sourced from:

- Monthly reports to the Quality Assurance Committee and Board of Directors
- Reports and briefings to the Quality Improvement Board, Council of Governors and the Health Oversight and Scrutiny Committee
- Monthly progress reports from requirement leads
- A survey issued to the Back to Good Programme Board, requirement leads, and action owners involved in the delivery and assurance of the programme. However, this is limited as only 7 out of 22 people invited to complete the survey responded.
- Back to Good Programme Year 1 Closure Report

The following table provides a summary of performance against agreed scope and time cost and quality standards:

Item	Detail	Status
Scope	75 requirements (musts and shoulds) were identified during the CQC Inspection in May and December 2021	71 of 75 requirements were met and ongoing monitoring and oversight transitioned to BAU committees and groups The scope included requirements which remained unmet from Year 1. These were met by April 2022.
Time	Start date: October 2021 Expected programme completion date March 2023	Started as planned. Actual completion August 2023 (delay of 5 months)
Cost	A budget was not allocated to the programme. Costs were absorbed by existing budgets or as approved by Business Planning Group and / or Finance and Performance Committee for specific projects for example Therapeutic Environments Programme	N/A
Quality	The improvement plan specified the evidence that would be provided and instruction on how we would know if the requirement had been achieved.	All 71 completed requirements have had the evidence checked and approved by the Head of Clinical Quality Standards. All requirements were linked to a BAU governance group to support in delivery and ongoing oversight outside of the Back to Good Programme Board. Ongoing assurance as to the embeddedness of the requirements takes place via the completion of checks and through engagement with governance groups

Item	Detail	Status
		A series of embeddedness quality checks regarding the concerns raised within the CQC Section 29a warning notices issued in 2020 and 2021 occurred in Q1 2023/24 with detailed reporting at Quality Assurance Committee.

3. Performance against the Improvement Plan

a. Scope

71 of 75 requirements (musts and shoulds) were met during the programme lifecycle.

Regarding the 71 requirements which have been met, the areas of improvement relate to:

Service	Improvement
Trust wide	• Trust wide governance and risk management processes • Safeguarding training, processes and oversight • Incident management and reporting • Complaint management and reporting • Grievance process improvements • Application of duty of candour • Increased engagement and involvement of patient, carer, significant others and advocates in their care • Board of Directors decision making focuses on patient and carer experience when decisions are being made • Improved estates and environments • Assessment of and mitigation against the risk of closed cultures • Oversight of training and management of agency staff • Governance and oversight of practice in relation to the Mental Health Act and Mental Capacity Act • Digital; for example, access to information, improved Wi-Fi • Equality and Diversity strategy • Medicines management and reconciliation • Staff training and supervision
Core services; Crisis, Acute, PICU and Older Adults	• Mitigation, training and audit to protect patients from the potential harm caused by ligature anchor points

Service	Improvement
	• Reporting of safeguarding incidents • The use of blanket restrictions that are not individually risk assessed • Agency staff training • Staffing levels • Access to information needed to complete role effectively • Patients' involvement in treatment and care planning • Physical health monitoring • Application of the Section 17 leave policy via robust training • Leaders acting upon risks, issues and performance within services • The use of least restrictive practices • Personal emergency evacuation plans • Ward improvements

It is clear from the improvements delivered that we can lead and deliver complex programmes of change well and at pace. However, some requirements remained unmet; these are key areas of challenge for the organisation and are redolent of some of the areas of risk raised in the 2020 Section 29a, namely, training, supervision and estates.

Unmet Requirements	Ongoing delivery and governance arrangements
Ensure that care is provided in estates which are suitable, safe, clean, private, and dignified	Delivery within the Therapeutic Environment Programme. Responsibility for oversight and monitoring is within the remit of the Therapeutic Environment Programme Board, Transformation Board, Finance and Performance Committee and Quality Assurance Committee
Achievement of training targets per course **And** **Achievement of supervision target per acute ward**	Achievement of mandatory training targets are to be managed per service across SHSC extending the focus from the Back to Good Programme scope Responsibility for oversight of mandatory training has been transferred to the People Committee. To support this, the Clinical Quality and Safety Group receive reports pertaining to mandatory training compliance to ensure the impact of non-compliance on clinical quality and safety is understood and that supportive remedial actions are identified
Achievement of supervision target per acute ward	Achievement of supervision targets are to be managed per service across SHSC extending the focus from the Back to Good Programme scope.

Unmet Requirements	Ongoing delivery and governance arrangements
	Responsibility for oversight of supervision has been transferred to the People Committee

The level of risk associated with each of the outstanding requirements are understood and have been communicated to the Quality Assurance Committee and Board of Directors.

b. Outcomes

The outcomes delivered through meeting the requirements have brought about improvements in quality and equality.

SHSC's quality measures, as stated within the Quality and Equality Impact Assessment, relate to patient safety, patient and carer experience, operational effectiveness, clinical effectiveness, workforce, reputation, delivery of strategic objectives and sustainability.

Equality measures link to not discriminating against people with protected characteristics and increasing opportunities for improved relations with people within the same group or others

It is difficult to map programme outcomes to individual quality and equality measures, as they are multifaceted, for example staff training improves patient safety, workforce, clinical effectiveness, patient and carer experience and other quality measures.

However, it is clear that by delivering outcomes related to improved ward environments, improved governance and reporting, appropriate staffing levels, increased physical health monitoring, increased use of least restrictive practices and increased involvement of patients, carers and significant others has made a positive difference to the quality of care provided and received.

c. Time (Plan)

The extension to the programme timescale, which was brought about by delays to the planned achievement of requirements, was managed through a robust reporting and governance process managed by the Back to Good Programme Board. Extensions to timescales were agreed after a clear understanding of the delays, revised timescales and risks quality measures were understood and accepted.

In accordance with the principles of the programme, requirements which were reporting as being delayed remained in exception, which meant that the Delivery Group and Programme Board retained close oversight via monthly reports and offered support and guidance to the requirement lead.

The programme continued to run until it was endorsed to close by the programme board once it was clear that requirements could be overseen by existing governance groups, and the overhead of running a programme was no longer required.

d. Quality

Lessons were learned from Year 1 of the programme in which it was felt that it was task orientated, as opposed to being focused on quality, sustainability, behavioural and culture change. From commencing the development of the Year 2 improvement plan the focus was on quality and being clear what evidence would be provided to show improvements had been made.

Feedback from the programme closure survey indicates that a robust process was undertaken to develop the improvement plan. However, it was clear that the background to the requirement and baseline data was not available and so there was initial uncertainty as to whether the requirement would be met.

Submission of evidence to support the closure of requirements was problematic. In line with the principles of the programme, if a lead reported to Programme Board that a requirement had been met in line with local assurance processes, evidence was to be submitted to the Head of Clinical Quality Standards. In most instances this did not happen. This posed a significant risk to the programme as the programme board could not take assurance that the requirement had been met or that the operational level of risk posed was acceptable. In addition, it could hinder the programme's progress if completed actions were to be reopened. To mitigate this, the Quality Assurance Committee agreed a process in July 2022 which came into effect that September in which non-submission of evidence was escalated to the Director of Nursing, Operations and Professions.

To ensure quality standards continue to be met, there was need to monitor the completed requirements for embeddedness. This activity was mapped under 3 headings and 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 did not naturally align to an existing business as usual governance group. Where this is the case an embeddedness check was conducted

3. No follow up required

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

A series of embeddedness quality checks regarding the concerns raised within the CQC 29a warning notices issued in 2020 and 2021 took place. The approach taken included a desktop review of task related requirements to ensure these were 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 visits included the four Acute and PICU wards and other ward settings including forensic and Older Adults.

The findings related to the visits have previously been reported in detail Quality Assurance Committee and in overview form at Board of Directors.

e. Risk and Issue Management

Risks and issues pertaining to programme delivery were raised and generally managed by requirement leads via monthly highlight reports to the Delivery Group and Programme Board. However, these were often not updated in a timely manner and contained ageing risks unless they were escalated to the Programme Board due to the risk score

The Programme Board had good oversight of the key risks. The programme report to the Quality Assurance Committee and Board of Directors provided a comprehensive understanding of the risks and mitigating actions to be taken while a requirement remained unmet.

f. Programme Board and Team

Based on experience of and feedback received in Year 1, the delivery structure of the programme was amended. Workstreams were disbanded and Requirement Leads were identified to lead the changes.

In addition, the support team was changed to two Delivery Teams who met to provide help and guidance and check and challenge to Requirement Leads to promote delivery and to ensure that the Programme Board could retain a focus on providing direction, leadership and decision making.

Programme Board members were the requirement leads or supported delivery of the programme.

Feedback received in the survey indicates that:

- Leads felt fully supported by the Delivery Groups and the Programme Board to deliver their requirements
- Leads felt that they received some support or were fully supported by operational areas (colleagues, peers, leadership teams)
- The membership of the Programme Board was appropriate to achieve the programme goals, however it was queried whether the Director of People should have been a member
- Programme Board members felt they had the appropriate information to complete their role effectively
- Leads and Board members felt that the highlight reports completed by the leads were useful to monitor progress and to help them complete their role well

g. Co-Production

Co-production took place during programme delivery via a range of methods depending on the requirement to be met. In Year 1, representatives from Sheffield Flourish, and Sheffield Carers and Young Carers were members of the Programme Board. Based on their recommendation, it was agreed that this would not continue into Year 2 as it wasn't particularly effective due to operational nature of some requirements.

4. Ongoing evaluation and assurance

With the closure of the programme, ongoing assurance will be provided by the following methods as agreed by the Quality Assurance Committee and Board of Directors.

- A Biannual Quality Assurance Report will be provided to give triangulated information regarding the range of strategic quality assurance programmes that take place across SHSC. It 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).
- A 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.

5. Follow on actions

Recommendation to be provided to the Quality Assurance Committee as to when an improvement programme of a similar size, complexity and level of risk would be required (similar to Back to Good Programme) as opposed to managing the outcome of an inspection via Business-as-Usual governance and oversight arrangements.

Action Owner: Head of Clinical Quality Standards. Due Date: January 2024

6. Lessons Learned

The following lessons can be applied to any programme

Title	**Better Engagement**
Description	We must continue to build on the approach of working together as a team with a shared sense of purpose, bringing together expertise to work in an inclusive manner. We need to involve people more effectively from the outset to shape direction and manage resources to ensure that support is provided within priority areas.
Derivation	Feedback from requirement leads regarding engagement from the start of Year 2, the level of involvement, information provided, ability to shape the actions to meet requirements
Actions	Ensure colleagues are involved from the start of a programme, understand the context of the work they are to undertake and provide support and a sense of community to delivery. Support prioritisation of work so people can complete programme and project responsibilities well. Ensure involvement and cohesion with corporate services so appropriate support is provided

	Owners**:** PMO, Programme Senior Responsible Owners and Project Leads, Operational leaders

Title	**Data, baseline measures, evidence, and outcomes**
Description	Ensure that there is a clear understanding of what improvement is required, the baseline which improvement will be measures against, what outcomes are expected, evidence provided and what benefits will be achieved within a clear realisation plan
Derivation	The lack of evidence provided in a timely manner and the risk posed to the programme.
Actions	Digital and Business Performance colleagues to understand what data is available to provide baseline information and to measure the impact of the change PMO to support development benefits and realisation plan Quality Improvement Team, Clinical Effectiveness and Quality Standards to support delivery of the improvement, specify outcomes and evidence and support the delivery of sustainable change

Title	**Type of programme and the application of an appropriate leadership approach and level of governance**
Description	We must consider the leadership approach and level of governance required based on the type of programme are undertaking, be it specification led, transformation, or driven by political and societal change. In acknowledging the focus of the change and assessing the predictability of the outcome we thereby apply the required level of leadership and governance and through regular review ensure that it remains appropriate and effective.
Derivation	Due to the origin of the programme being focused on compliance, the leadership approach taken at the beginning was significantly directive and the majority of the tasks undertaken were transactional in nature. Quality Assurance Committee recognised this and requested consideration of when it is appropriate to move away from this approach within a programme, did it stay a directive state for too long at the risk of disempowering people and how can this learning be applied to other programmes.
Actions	Implementation of the Change Framework to support decision making regarding appropriate leadership and level of governance and oversight required Programme Boards review every quarter whether the leadership approach and level of governance is appropriate and proportionate based on the

	current state of the programme, its area of focus and the predictability of the outcome