Public Board of Directors
Item number: 10
30 July 2025

Confidential/public paper:	Public
Report Title:	**Quality Assurance Report:** Q4 2024/25 and Q1 2025/26
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Accountable Director:	Dr Caroline Johnson, executive director of nursing, professions and quality
Presented by:	Caroline Johnson - executive director of nursing, professions and quality
Vision and values:	Striving to continuously improve clinical quality is central to our strategic ambition of delivering outstanding care. This commitment is underpinned by our Trust values, which guide how we work with service users, carers, staff, and partners: • **We are respectful and kind** • **We are inclusive** • **We work together** • **We keep improving**
Purpose:	This report provides a comprehensive summary of the clinical quality assurance activities undertaken during Q4 2024/25 and Q1 2025/26, demonstrating our ongoing commitment to maintaining and enhancing clinical standards
Executive summary:	This report provides a comprehensive overview of clinical quality assurance activity across the Trust during Q4 2024/25 and Q1 2025/26. It highlights sustained improvements in care quality, informed by triangulated evidence from Fundamental Standards of Care (FSoC) visits, Board engagement, service user feedback, and regulatory input from the Care Quality Commission (CQC). **Key achievements include**: • Positive feedback from patients and carers across multiple services • Strong performance in the 15 Steps Challenge, indicating safe, welcoming, and well-organised environments • Implementation of the Enhanced Support framework, with demonstrable improvements in previously challenged services • Progress in embedding the Quality Management System (QMS) and transitioning to the Ulysses audit platform • Continued delivery of the Physical Health Strategy, including targeted training and clinical support **Areas requiring ongoing focus include:** • Improving care planning and risk assessment documentation • Enhancing mandatory training compliance • Addressing environmental improvements in specific services The report provides assurance that these areas are being actively managed through structured improvement plans and governance oversight. The Quality Assurance Committee is asked to receive the report and take assurance from the progress outlined.

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	**X**	*No*		All of our work should support the principles of environmental sustainability and the effective use of resources.
Deliver Outstanding Care	*Yes*	**X**	*No*		In order to deliver outstanding care all of our services and all of our work with the people of Sheffield needs to be of the highest quality
Great Place to Work	*Yes*	**X**	*No*		Quality of care and quality of services ensures that those working for the Trust feel valued.
Reduce inequalities	*Yes*	**X**	*No*		Without inclusivity the highest possible level of quality is unachievable.

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
Quality Standards relate to CQC regulations under Health and Social Care Act, Equalities Act, Use of Force Act, Human Rights Act, the Health and Safety at Work Act and all other clinical standards such as NICE.	
Board assurance framework (BAF) and corporate risk(s):	**QAC BAF Risks –** **BAF 0024** Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience, staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action. **BAF 0025b** There is a risk of failure to deliver the therapeutics environment programme at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skills staff to deliver works to timeframe required resulting in unacceptable service user safety, more restrictive care and a poor staff and service user experience. **BAF 0029** There is a risk of a delay in people accessing core mental health services through the requirements of 'The Right Care Right Place' caused by issues with models of care, access to beds, flow, crisis care management and contractual issues resulting in poor experience of care and potential harm to service users. **BAF 0031** There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services, caused by failure to adopt an inequalities based approach to care resulting in poorer access, later presentations and risk of poorer outcomes
Any background papers/items previously considered:	This paper is received on a 6-monthly basis. The previous paper was received in January 2025. This report was presented to the Quality Assurance Committee on 9 July, and the following comments were noted: • The bullet points in the summary highlighting areas for improvement are helpful for focusing on the areas in the report. • The process for feedback from Board visits was discussed and it was confirmed PowerPoint slides were fed directly back to the teams after the initial feedback report including actions which have taken place is response to the visit. It was suggested a review of this process to ensure triangulation with the non-executive directors.

	• Concern remains around the standards of clinical documentation, risk assessment, and care planning, however work is ongoing to address these issues. • Clarity on how audits on the Fundamental Standards of Care (FSoC) are prepared and a need for a cutting-edge dynamic process is required. It was confirmed a system refresh of both FSoC and culture of care visits is planned to align with the Care Quality Commission (CQC) with further focus on engagement. • The committee noted the Physical Health Strategy came over on a more positive note than previously. • The committee asked for future reporting to be incorporated into an Alert Advise Assure format to evaluate judgements and show conclusions and challenged the updates of audits. The next report will focus on the culture and quality visits with updates on the FSoC review.

Recommendation:	The Board of Directors is asked to:
	• **Note** this report as evidence of the Trust's commitment to clinical quality and regulatory compliance.
	• Take **assurance** from progress in:
	  o Embedding Enhanced Support with measurable service improvements
	  o Advancing the QMS and transitioning to Ulysses
	  o Delivering the Physical Health Strategy
	  o Responding to CQC feedback and maintaining positive engagement
	• **Support** ongoing actions in:
	  o Improving care planning and risk documentation
	  o Increasing compliance with mandatory training (BLS/ILS)
	  o Completing environmental upgrades
	  o Strengthening service user and carer involvement
	• **Note** the Quality Strategy (2022–2025) is being refreshed, with a new strategy due in Q4 2025/26.
	• **Note** the GGI review of quality governance will conclude in August 2025, with findings to be presented in October 2025

Board of Directors

30 July 2025

Quality Assurance Report

Q4 2024/25 and Q1 2025/26

1. Introduction

This Quality Assurance Report is presented to the Board as part of the Trust's commitment to transparency, accountability, and continuous improvement in the delivery of care. It provides assurance that the Trust is actively monitoring, evaluating, and enhancing the quality of its services across all care settings.

The report serves three core purposes:

- **Demonstrating the quality of care**: It outlines how services are performing against national and local standards, including those set by the Care Quality Commission (CQC), with a focus on patient safety, clinical effectiveness, and patient experience. This includes findings from the Fundamental Standards of Care (FSoC) visits to all bed-based services, Board visits, and community engagement activities.
- **Highlighting priorities for improvement**: It identifies key areas for development, such as improving the quality of documentation, care planning, and risk assessment; enhancing physical healthcare delivery; and responding to feedback from service users and carers.
- **Providing assurance to stakeholders**: The report is intended to assure the Board, patients, carers, commissioners, and regulators that the Trust is committed to delivering high-quality mental and physical healthcare and is taking proactive steps to address areas for improvement

2. Demonstrating the Quality of Care

2.1 Fundamental Standards of Care visits

All bed-based services were reviewed during Q4 2024/25 and Q1 2025/26 using the Trust's Fundamental Standards of Care (FSoC) methodology. This structured programme is aligned with CQC standards, national guidance, and local quality frameworks, and focuses on three core domains: patient safety, clinical effectiveness, and patient experience.

Each visit followed a standardised approach:

- Full inspection of the clinical environment and documentation
- Engagement with staff, patients, and carers
- Observation of multidisciplinary team (MDT) meetings, handovers, and daily safety huddles
- Use of a comprehensive 194-question assessment tool, incorporating the 15 Steps Challenge to assess first impressions and environmental quality

Findings were recorded in real time, and each service developed a local improvement plan. Learning and recommendations were shared with relevant oversight committees to support Trust-wide quality improvement.

Key Highlights

All services scored above average (Confident or Very Confident) on the 15 Steps Challenge, reflecting welcoming, safe, and well-organised environments with clear safety information.

	Welcoming	Safe	Caring and Involving	Well Organised and Calm	Overall rating
Beech	Very Confident	Very Confident	Very Confident	Very Confident	Highly Commended
Birch	Confident	Confident	Confident	Confident	Commended
Burbage	Very Confident	Confident	Confident	Confident	Commended
Dovedale	Very Confident	Confident	Confident	Confident	Commended
Dovedale 2	Very Confident	Confident	Confident	Very Confident	Commended
Endcliffe	Confident	Confident	Very Confident	Confident	Commended
Forest Close	Very Confident	Confident	Very Confident	Confident	Commended
Forest Lodge	Confident	Confident	Confident	Confident	Commended
G1	Confident	Confident	Confident	Confident	Commended
Stanage	Very Confident	Confident	Very Confident	Confident	Commended
Woodland View	Very Confident	Confident	Confident	Confident	Commended

Daily Safety Huddles were embedded across all areas, with multidisciplinary participation from clinical and non-clinical staff.

Positive feedback from patients and residents highlighted that their concerns were listened to and their needs met. Notably, Beech Step-Down Unit, Stanage Ward, and Forest Close received particularly high praise.

Relatives and carers commended the care provided at Woodland View, Birch Avenue, Stanage Ward, G1, and Dovedale Ward.

Patient and Carer Voice

Feedback gathered during the visits provided valuable insight into the lived experience of care:

- **Environment**:
  "Very calm, enough privacy, I sleep very well",
  "I like that I have my own room with a wrist fob"
- **Food**:
  "The food is mostly nice but some cooks are better than others",
  "I take part in cooking group… I cater for myself which I like"
- **Activities**:
  "Yes, clay modelling, writing, painting, art therapy",
  "It can get boring. But a lot of people come and sing to us"
- **Safety**:
  "I feel safe here and staff are always nearby",
  "Very confident she is safe (mum) and staff always ring if there are any issues"
- **Staff Recognition**:
  "All very good, similar faces, welcoming, very friendly",
  "They are all approachable and have name tags"
- **Care Planning**:
  "They give me a copy after the MDT",
  "The staff shared my dad's care plan with me"

- **Complaints and Advocacy**:
  "I spoke to my advocate about a complaint and they helped me",
  "There is a family support group so I can always raise issues"

Areas for Improvement

i) **Documentation and Risk Assessment**

While documentation was generally acceptable, there was limited assurance in the quality and consistency of risk assessments and care planning. Best practice was observed at Forest Close and Stanage Ward.

Improvement actions underway in response to the findings include:

- Full implementation of goal-based care plans via the Rio EPR system
- Launch of the Personalised Assessment of Risk (PAR) project in October 2025, aligned with new national guidance
- Development of local audit tools as part of the Ulysses audit platform this will be launched in August 2025
- Risk Champion training to ensure quality assurance focuses on formulation and planning

ii) **Mandatory Training Compliance**

Most services did not meet compliance targets for face-to-face mandatory training, particularly Basic Life Support (BLS Level 2).

Compliance is monitored monthly via the Integrated Performance and Quality Report (IPQR) and overseen by the People Committee.

iii) **Environmental Standards**

Refurbishment needs were identified in:

- Dovedale Ward
- Woodland View Nursing Home (work underway)
- Forest Close

These issues did not impact compliance with care standards. Other areas had refurbishment plans in progress at the time of the visits.

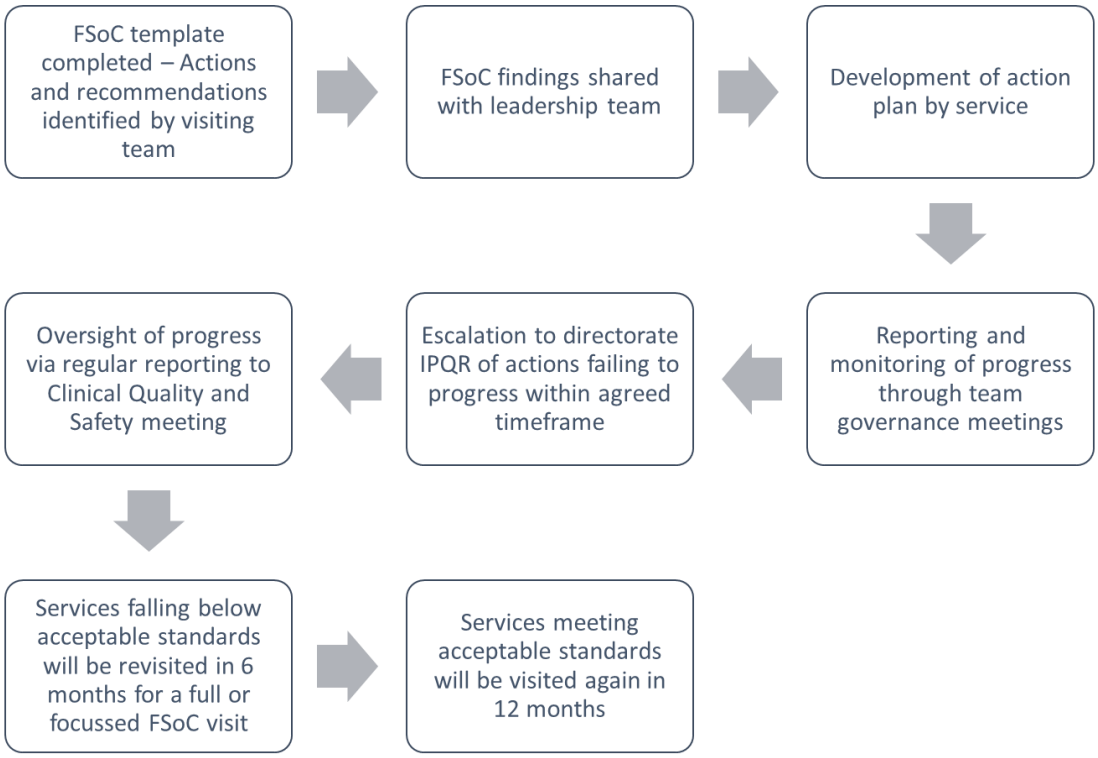
iv) **Meaningful Activity Provision**

- Dovedale 2 Ward and Birch Avenue were identified as needing to enhance therapeutic and recreational activity provision.
- Locally owned improvement plans are in place and being monitored.

Governance and oversight

Improvement action plans developed following FSoC visits are:

- Owned and implemented by local teams
- Monitored through directorate governance structures
- Subject to oversight by the Clinical Quality and Safety Group (CQ&SG)



2.2 Board Visits

During Q4 2024/25 and Q1 2025/26, 12 services were visited by Non-Executive and Executive Directors as part of SHSC's commitment to staff engagement and visibility of leadership. These visits are guided by three key principles:

- Listen – to staff views and experiences directly
- Ask – to learn about good practice and areas of concern
- Assure – to support assurance at both Board and service levels

Staff Feedback Highlights

- Pride in winning the *Shine Award for Excellence in Coproduction and Involvement*
- Strong commitment to anti-racism and inclusive service delivery
- Positive progress as an early adopter of the *Patient and Carer Race Equality Framework (PCREF)*, with meaningful community engagement
- Creation of safe spaces and open-door culture, with lived experience embedded in service design
- Implementation of the *Triangle of Care* standards
- Efforts to improve *Family and Friends Test* response rates through more accessible feedback options
- Improvements in culturally appropriate meal options, including halal choices

Patient and Carer Feedback

- Positive stories of long-term, holistic support from staff, including housing, healthcare, and education
- Appreciation from asylum seekers for compassionate and practical support during resettlement

Board Member Actions (We Said, We Did)

- Escalated feedback to national staff survey team regarding advocacy questions
- Raised concerns about rough sleeper support and loss of HAST Mental Health input
- Liaised with Communications, Strategy, and People Directorates on:
    - Training facilities and estates strategy
    - Physical health and wellbeing resources for staff
    - Celebrating team successes and volunteer contributions
- Promoted SAANs online training and shared good news stories via internal communication

2.3 Quality Management System

The implementation of the RiO electronic patient record system in March 2025 necessitated a revision to the original timeline for establishing SHSC's Quality Management System (QMS) framework. Despite this adjustment, the Trust has made meaningful progress in aligning its approach with the four pillars of a holistic QMS, as defined by NHS England: Quality Planning, Quality Control, Quality Assurance, and Quality Improvement.

The four aspects of a quality management system: planning, control, assurance, and improvement.
from 'How to move beyond quality improvement projects' : BMJ 2020;370:m2319

SHSC already has a number of well-embedded processes that support the Quality Control and Quality Assurance elements of the QMS. These include:

- **Daily Safety Huddles** – enabling real-time risk identification and response
- **Escalation Processes** – ensuring timely communication of concerns to senior leadership
- **Fundamental Standards of Care (FSoC) Inspections** – providing structured assessments of care quality
- **Culture of Care Inspections** – focusing on staff experience and service culture
- **Board Visits** – offering direct engagement between frontline teams and senior leaders

These mechanisms provide a strong foundation for monitoring, maintaining, and improving the quality of care across the organisation.

To further strengthen the QMS the following enhancements are underway:

- Clinical Quality Audits will be introduced across bed-based services in July 2025 and Community Services in August 2025. These audits will provide structured, consistent data to support service-level improvement and assurance.
- Following the launch of Rio in March 2025, work has commenced to extract and utilise data on key service measures. This data will underpin the Trust's efforts in quality assurance, control, improvement, and planning, enabling more informed decision-making and targeted interventions.

These developments will support the development of a robust, data-driven QMS that supports continuous improvement and accountability across SHSC.

Next Steps:

- A formalised QMS framework will be presented to the Clinical Quality and Safety Group (CQ&SG) in August 2025. This will map existing processes, identify gaps, and clarify leadership responsibilities.
- Work is ongoing to embed service user and carer feedback into the QMS, ensuring their voices are integral to quality governance. This will be supported by the LECAG group reporting into the Clinical Quality and safety Group to enable a triangulated view of quality.

2.4 Enhanced Support Criteria and Governance

In May 2025, the Executive Management Team (EMT) approved the introduction of a formal Enhanced Support process, replacing the previous 'hotspot' approach. This new framework provides a standardised method for identifying, monitoring, and supporting services with emerging or sustained quality concerns. It also introduces clear entry and exit criteria, ensuring consistency, transparency, and accountability in how support is deployed and withdrawn.

A service may be considered for Enhanced Support if it presents with more than four of the following concerns:

- Poor quality outcomes from internal or external reviews
- Significant increase in the number of incidents within a calendar month
- Rise in complaints or negative service user feedback within a quarter
- Non-compliance with risk management or other key policies
- Escalation of more than two concerns from service users, relatives, or staff
- Identified health and safety issues
- Incidents involving serious harm to service users
- Safeguarding concerns raised or reported
- Freedom to Speak Up or whistleblowing concerns
- Emerging themes related to patient safety

During the reporting period 3 services have been supported through the hotspot/enhanced support process- Burbidge ward, Woodlands View and Forest Lodge. This approach has seen all three areas improve with Burbidge ward and Woodlands expected to exit enhanced support in Q2 2025-26. Quality Assurance Committee receives bi-monthly reports in relation to service receiving Enhanced support.

2.5 Ulysses Audit transition and Implementation

Over the past three years, the Trust utilised the Tendable audit platform to support clinical audit activity. However, a review found that the platform was not meeting the organisation's needs due to several key limitations:

- Low staff engagement with the system
- Limited usability of data for analysis and comparison
- High operational costs, with restricted flexibility to expand audit content without incurring additional charges

In response, the Trust is transitioning to the Ulysses audit module, which offers a more integrated, cost-effective, and user-friendly solution. As Ulysses is already in use for incident management, staff are familiar with the platform, and early feedback has been positive.

Implementation Timeline

- Training: Delivered throughout June and July 2025
- **Go Live:**
    - Bed-Based Services: 1 August 2025
    - Community Services: 1 September 2025

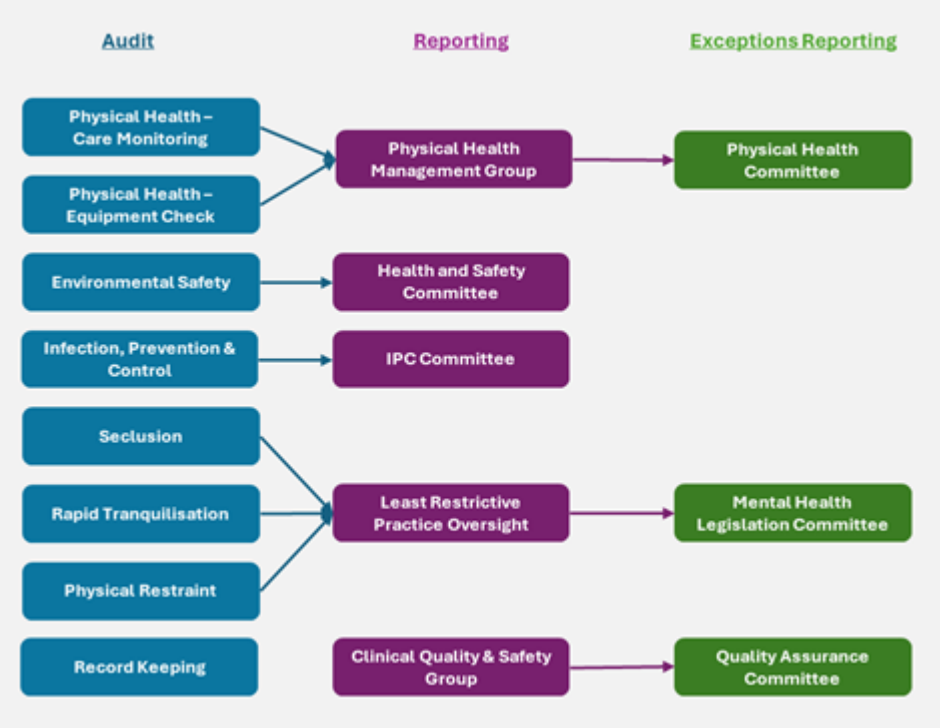
Audit Development and Alignment

All existing audits from the Tendable platform have been reviewed by the Physical Health Management Group (PHMG) and the Physical Health Committee (PHC) to ensure they remain aligned with current policy, clinical standards, and best practice.

The following audits will be launched within the Ulysses platform:

- Seclusion Audit
- Physical Restraint Audit
- Rapid Tranquilisation Audit
- Physical Health Care Delivery
- Physical Health Equipment
- Environmental Safety
- Infection, Prevention, and Control

In addition, Record Keeping and Section 17 Leave audits have been completed and are currently being formalised into written reports.



The Ulysses platform will become a vital tool for quality assurance and early warning system for areas of concern, once it has been fully implemented.

2.6 Quality Strategy

The current Quality Strategy, developed in 2022 during a period when the Trust was in special measures, has now reached the end of its intended lifespan. In recognition of the Trust's progress and evolving priorities, the strategy is currently undergoing a full refresh. A closure report, summarising achievements and lessons learned, along with a refreshed Quality Strategy, will be presented to the Quality Assurance Committee in Q4 2025/26. This will ensure continued alignment with national standards, regulatory expectations, and the Trust's commitment to continuous improvement

2.7 Physical Health Strategy

The Trust's Physical Health Strategy is now approaching its second year of implementation and continues to make strong progress across its five key workstreams:

1. Deteriorating Patient
2. Living Well
3. Planned Care
4. Unplanned Care
5. Digital Health

Each workstream is designed to improve the physical health outcomes of service users, particularly those with serious mental illness, by embedding best practice, improving early intervention, and enhancing access to care.

To support the delivery of the strategy, a Physical Health Strategy Lead has been appointed (2 days per week). This role is pivotal in coordinating activity across all five workstreams, ensuring alignment, and maintaining momentum in delivering the strategy's objectives.

Implementation and Forward Planning

- A working implementation plan has been developed to prioritise urgent and high-impact areas of work, while also setting out a phased approach for longer-term developments.
- Over the next 6–12 months, the team will focus on delivering key actions aligned to the strategy, with an emphasis on improving care quality, staff capability, and service user outcomes.
- Progress is monitored through the Physical Health Committee and reported directly to the Quality Assurance Committee (QAC), ensuring strong governance and oversight.

This structured and collaborative approach ensures that the strategy remains dynamic, responsive to emerging needs, and embedded across the organisation.

Physical Health Team Training

Ensuring compliance with Basic Life Support Level 2 (BLS 2) and Immediate Life Support (ILS) training remains a key priority for the Trust. Performance is being closely monitored by both the Physical Health Management Group (PHMG) and the Physical Health Committee (PHC), with continuous improvement efforts underway at both Trust-wide and local team levels.

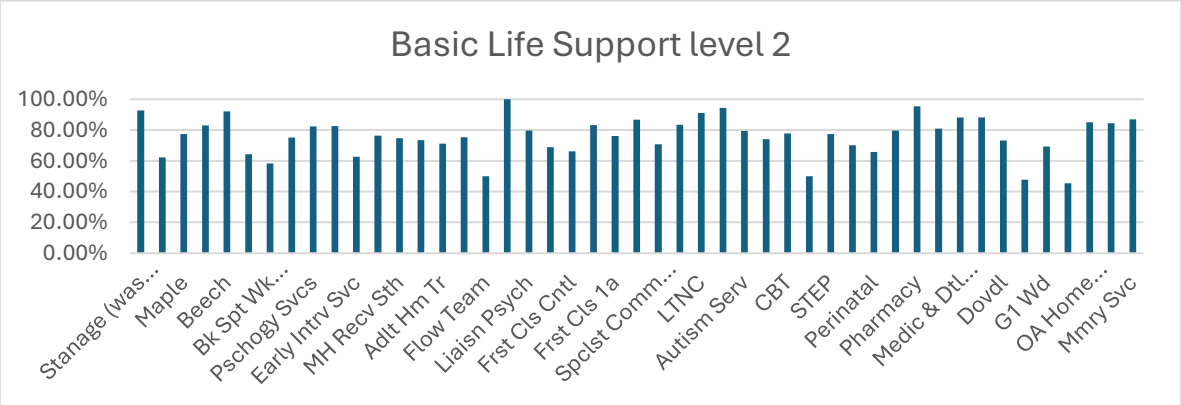
Target: Achieve and sustain 80%+ compliance across all teams within the next three months.

Support Measures:

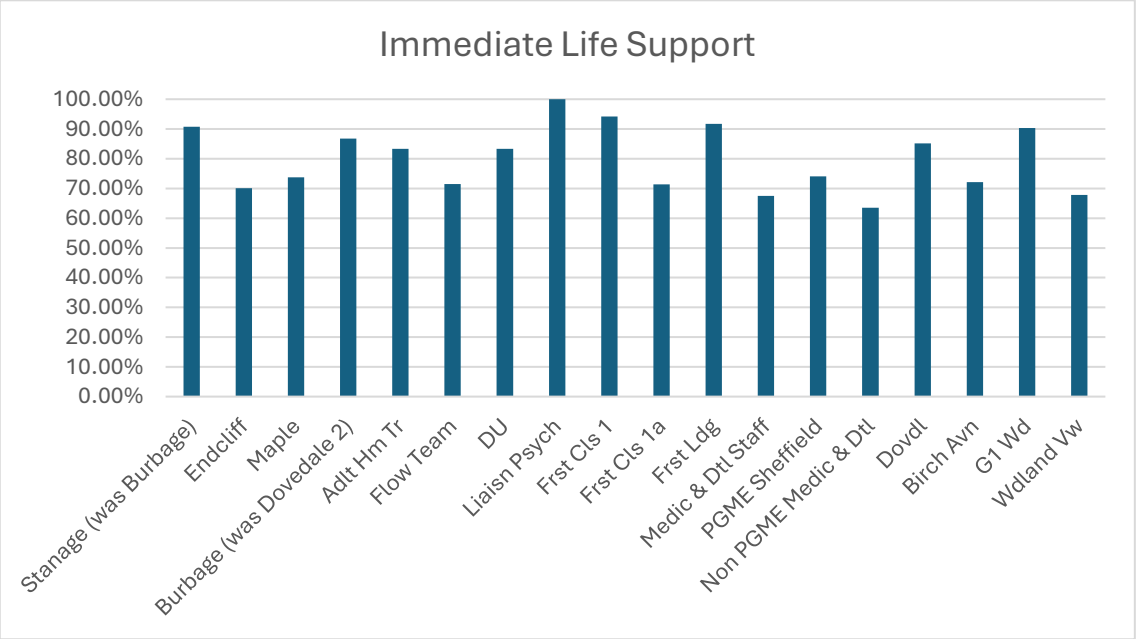
- Collaborative working across teams to share best practice and cascade training.
- **Clinical Educators** are providing targeted support to underperforming teams.
- The **Resuscitation Officer**, in collaboration with the Training Department, is actively identifying and addressing barriers to training attendance and access.

These efforts are part of a broader strategy to ensure all staff are equipped with the necessary life-saving skills and to embed a culture of continuous learning and safety across the organisation.

Basic Life Support Training Compliance



Immediate Life Support Training Compliance



To improve training compliance and enhance staff capability in managing physical health needs, several key initiatives are underway:

Training Capacity and Infrastructure

Currently, only half of the available training room capacity at Chestnut Cottage is being utilised, therefore offering an opportunity to expand the training offer.
The Physical Health Management Team is exploring options to expand the training offer to provide simultaneous sessions therefore increasing staff throughput and improving overall mandatory training compliance.

A formal proposal will be presented to the Clinical Quality and Safety Group (CQ&SG) in August 2025.

New Training Programme – Pilot

A new training programme focused on responding to deteriorating patients and promoting physical wellbeing is being piloted at:

- Forest Lodge
- Forest Close
- Birch Avenue
- Woodland View

Topics include:

- Tissue Viability and Wound Care
- Early Signs of a Deteriorating Patient
- Diabetes Awareness and Skills

- The pilot will be evaluated in August 2025, with findings reported to PHMG and CQ&SG for potential wider rollout.

Cascade Training Model

A bite-sized training programme is in development, led by Physician Associates and local staff. This initiative, aligned with Health Education

England content, will be coordinated centrally and presented to PHMG in August 2025.

Clinical Guidance Action Cards

A set of 15 clinical guidance action cards has been developed to support staff in managing physical health conditions related to serious mental illness and general deterioration. Cards use a traffic light system:

- **Red** – Emergency
- **Amber** – Urgent
- **Green** – Everyday Management

Cards will be distributed to all relevant clinical services in **July 2025** and made available electronically via **Jarvis**. A Qualtrics survey will be conducted in January 2026 to assess their effectiveness.

Physical Health Incidents

As part of a process change in reviewing incidents, the whole Infection Prevention Control and Physical Health (IPCPH) team consistently attend the Daily Incident Safety Huddle (DISH), review and incident manage from a physical health perspective. This ensures a variety of clinical skill and experience is represented. From reviewing incidents, we have been able to develop bespoke support tools for front facing staff. A reflection of the Support

Clinical Support

The Physical Health Team plays a critical role in providing rapid, specialist support to clinical teams in response to complex physical health presentations. This support is often initiated through incident reviews discussed in the Daily Incident Safety Huddle, direct requests from ward-based clinical teams, or referrals from the Executive Director of Nursing. Each team member brings a unique skill set, enabling tailored, expert input that enhances the quality of care. Their visible presence on wards fosters strong, supportive relationships with staff, promoting confidence, capability, and professional development. This proactive and collaborative approach now constitutes a significant proportion of the team's activity and reflects a positive cultural shift—staff are increasingly seeking out the team's expertise, which is a testament to the trust and value placed in their contribution.

3. Care Quality Commission (CQC) regulatory compliance

The Care Standards Team continues to maintain a robust and responsive relationship with the Care Quality Commission (CQC). Throughout Q4 2024/25 and Q1 2025/26, all CQC enquiries relating to the standard of care provided have been responded to promptly and comprehensively. At the time of reporting, there are three outstanding enquiries from the start of the reporting period. These remain unresolved due to factors outside the control of the Care Standards Team, and this has been clearly communicated to the CQC. The team continues to monitor these cases closely and will provide updates as further information becomes available.

CQC Enquires Q4 2024/25 and Q1 2015/26

Between Q1 2024/25 and early Q2, the Care Quality Commission (CQC) received seven anonymous whistleblowing concerns relating to care at Woodland View Nursing Home, from the same person. All concerns were fully investigated by the Trust, with findings shared with the CQC. The majority of the concerns were found to have limited or no substantiating evidence, and the CQC has since closed its

enquiries, having received assurance from the organisation. A summary of the key findings is provided below:

- Resident Safety: No evidence was found to support allegations of residents being dropped. One incident involved a resident lowering herself to the floor due to illness, which was appropriately managed by staff.
- End-of-Life Care: Residents receiving end-of-life care are only moved to communal areas when it is in their best interest and following consultation with family members.
- Incident Reporting: All incidents are recorded and reviewed through the Trust's Ulysses system and daily safety huddles. A total of 114 incidents were reported over the past six months, reflecting a culture of active and transparent reporting.
- Staff Conduct: No recent evidence was found to support claims of staff sleeping during shifts. Unannounced night visits by senior leaders confirmed staff were engaged in appropriate duties.
- Staffing Levels: Minimum night staffing levels have been consistently maintained. Any unfilled shifts are escalated and covered through bank or agency staffing.
- Meal Provision: A four-week rotating menu is in place. While occasional substitutions may occur due to supply issues, there is no evidence of repetitive or inadequate meal offerings.
- Resident Assessment: All new residents are assessed on admission, with timely and appropriate care planning documented.
- Nutrition Monitoring: Residents are regularly assessed for malnutrition using the MUST tool, with referrals to dietitians made where clinically indicated.
- Water Safety: Elevated legionella levels were identified in August 2023. Immediate action was taken, including tap isolation and provision of bottled water. No residents were affected, and monthly water quality checks are ongoing.
- Incontinence Supplies: Additional incontinence aids are purchased monthly to supplement NHS provision, ensuring resident dignity and comfort.
- Environmental Safety: No exposed sockets or pipes were identified. All maintenance issues are logged and addressed promptly.
- Staff Concerns: Staff-related issues are managed in line with Trust policy, with oversight from the People Directorate and senior leadership.
- Medical Oversight: All incidents involving residents are assessed by qualified staff, with medical attention sought as appropriate.

The Trust remains committed to maintaining high standards of care and transparency and continues to work closely with the CQC to ensure ongoing assurance and improvement**.**

Recent CQC activity

In May 2025 the CQC completed unannounced visits to the Trusts Adult Inpatient Services at the Michael Carlisle Centre (MCC). A full overview of the visits and the CQC formal response and any subsequent improvement action plan will be provided in the next report, however, informal feedback so far has been largely positive, and this included positive comments made by patients and their family. There were some immediate concerns that were fed back and these included:

- **Risk Assessments**: DRAM risk assessment (while remaining robust) is not integrated with new national guidelines. This work is currently underway as part of the Culture of Care Programme. A personalised Approach to Risk template is currently being built into RiO and the training is being rolled out across the Trust.
- **Sink taps**: not anti-ligature in the patient beverage bays. Estates action taken immediately.
- **Patient Fridge**: was able to be pulled out from under counter (Stanage Ward). Estates action taken immediately.
- **Care Plans:** During recent reviews, it was noted that rapid tranquilisation guidance was not consistently included in all care plans. However, it is important to clarify that the Trust does not routinely expect this information to be present unless a patient has been assessed as potentially requiring rapid tranquilisation. Additionally, care plans were found to be inconsistently personalised and not always contemporaneous. In response, the Trust has undertaken a programme of work to improve the quality and consistency of care planning, as outlined in this report. This includes the rollout of goal-based care plans, enhanced training for staff, and the development of local audit tools to support continuous improvement in care planning practice.
- **Bedrooms:** Not every bedroom had blind spot mirrors. Estates action taken immediately.
- **Training:** questions were raised regarding compliance with mandatory training and the availability of formal training in care planning and risk assessment. In response, the Trust has confirmed that both formal care planning training and structured risk assessment training are currently being rolled out across relevant services. These programmes are designed to strengthen clinical competency, ensure consistency in practice, and support the delivery of safe, person-centred care. Progress is being monitored through local governance structures and reported via the Integrated Performance and Quality Report.
- **Psychological support:** It was identified that psychological support services were operating below establishment due to vacancies in key practitioner roles. These posts have now been successfully recruited to, strengthening the service's capacity to provide timely and effective psychological input. This development supports improved access to psychological care for service users and enhances the multidisciplinary team's ability to deliver holistic, person-centred care
- **Audit:** Standards and audit tools not consistently agreed or applied. Several tools in use across the inpatient areas and no SHSC wide audit currently. As outlined in this report the Ulysses audit platform is being implements to provide a standard clinical audit process.

During a post-visit relationship meeting with the lead CQC inspector, the Trust received positive verbal feedback regarding the overall quality of care. The inspector noted a significant improvement in service quality, with particular recognition given to Burbage Ward, where previous concerns had been raised. This feedback reflects the impact of sustained improvement efforts and the effectiveness of the Enhanced Support process in driving meaningful change.

4. Quality Governance Review

To ensure the Board remains fully sighted on quality issues and that concerns are identified and addressed in a timely and effective manner, it is essential that the

Trust maintains robust and transparent quality governance processes. In support of this, the Executive Director of Nursing, Professions and Quality has commissioned the Good Governance Institute (GGI) to undertake a comprehensive, independent review of quality governance arrangements across all levels of the organisation.

This review will assess the effectiveness of current structures, reporting lines, and assurance mechanisms, and will identify opportunities to strengthen governance and accountability. The review is scheduled to conclude in August 2025, with findings and proposed governance structures to be presented to the Quality Assurance Committee in October 2025.

5. Summary and triangulation

This Q4 2024/25 and Q1 2025/26 report highlights a range of planned and implemented improvements in clinical quality standards, reflecting the sustained efforts of both clinical quality teams and frontline staff. These improvements are informed by multiple sources of intelligence, including:

- Fundamental Standards of Care (FSoC) visits
- Board visits
- Engagement team activities
- CQC feedback

Together, these sources provide growing narrative and observational evidence of service user and carer satisfaction, as well as assurance that our clinical environments are improving—becoming cleaner, safer, and more welcoming.

In parallel, the development of enhanced clinical systems is underway. These systems will provide data-driven assurance and support continuous improvement by offering services access to meaningful, actionable data.

While progress is evident, the report also acknowledges ongoing areas of concern and risk, particularly around:

- Standards of clinical documentation
- Environmental improvements in specific services

Work to address these areas is already in progress, and this report provides assurance that these challenges are being actively managed through structured improvement plans and governance oversight.

6. Recommendations

The Board of Directors is asked to:

- **Note** this report as evidence of the Trust's commitment to clinical quality and regulatory compliance.
- Take **assurance** from progress in:
  - Embedding Enhanced Support with measurable service improvements
  - Advancing the QMS and transitioning to Ulysses
  - Delivering the Physical Health Strategy
  - Responding to CQC feedback and maintaining positive engagement
- **Support** ongoing actions in:
  - Improving care planning and risk documentation
  - Increasing compliance with mandatory training (BLS/ILS)
  - Completing environmental upgrades
  - Strengthening service user and carer involvement
- **Note** the Quality Strategy (2022–2025) is being refreshed, with a new strategy due in Q4 2025/26.

- **Note** the GGI review of quality governance will conclude in August 2025, with findings to be presented in October 2025