Sheffield Health and Social Care NHS Foundation Trust

Board of Directors

Date:	13th January 2021	Item Ref:	08

TITLE OF PAPER	**Back to Good Board Progress Report**
TO BE PRESENTED BY	Dr Mike Hunter, Executive Medical Director
ACTION REQUIRED	To update on progress with the 'Back to Good Board' and Improvement Plan. To receive assurance that a robust process is in place in response to the Care Quality Commission (CQC) report and requirements.

OUTCOME	Members are assured of the progress with 'Back to Good Programme'.
TIMETABLE FOR DECISION	N/A
LINKS TO OTHER KEY REPORTS / DECISIONS	CQC Inspection Reports 30th April 2020 and 22nd October 2020 CQC updates to the Quality Committee 23rd November 2020 CQC updates to the Trust Board 2nd December 2020
STRATEGIC AIM STRATEGIC OBJECTIVE **BAF RISK NUMBER & DESCRIPTION**	Deliver outstanding care; Create a great place to work CQC Getting Back to Good A101i Failure to meet regulatory standards (registration and compliance).
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Health and Social Care Act 2008 (Regulated Activities) Care Quality Commissions Fundamental Standards Care Quality Commissions Enforcement Policy Mental Health Act 1983
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Failure to comply with CQC Regulatory Standards could affect the Trusts registration, negatively affect care delivery and require additional funding to address.
CONSIDERATION OF LEGAL ISSUES	Failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, could leave the Trust exposed to regulatory action by the CQC, with a potential financial and reputational impact.

Author of Report	Julie Walton
Designation	Head of Care Standards
Date of Report	29th December 2020

Proud to care in Sheffield

Sheffield Health and Social Care NHS Foundation Trust

Summary Report

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
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To update the Board on progress with the Back to Good Board Programme and the latest meeting of the 'Back to Good Board' held on 16th December 2020.						

2. Summary

a) Risk to Delivery of the Back to Good Programme

As reported in December 2020, the main overall risk to delivery of the programme continues to be the risk to quality and safety in inpatient environments connected with complexities and subsequently extended timelines for the completion of estates work.

In addition, there is a reliance on IT changes to our electronic patient record system Insight, with limited capability in terms of systems developments and IT resource, including accessibility to mobile devices and Wi-Fi stability. This particularly impacts two worksteams, Physical Health and Rapid Improvement Acute in relation to contemporaneous records, restrictive practice and physical health observations.

b) Progress

In addition to receiving updates on progress with improvement actions, the BTGB received a progress report on the Patient Centred Care Records (PCCR) project. The Patient Centred Care Record workstream is tasked with improving the quality and standard of all care records, across all services and systems. The BTGB heard how work was progressing with clinical information on a range of systems including Insight (the primary electronic patient record), SystemOne, IAPTUS and in some cases paper-based records.

Every year the Trust's clinicians create 1.17 million records for service users within our inhouse Insight system. It is recognised that care planning and risk assessments are critical tools that clinicians use to document the needs and wishes of our service users. We are preparing to deploy a new electronic records system. Therefore, work on these two modules has been a primary focus for system changes so far. The main challenge is that any technological changes are constrained by the limitations of our existing system (Insight).

Development has been undertaken with the support of our service user engagement group and includes a wider plan of work, which is being scoped to improve assessments and all external facing correspondence. The next phase of the project will also incorporate the spread of local improvements across all other service areas.

A continued focus at the December BTGB was progress with the development of workstream outcomes and measures for every improvement action. These have been reviewed by members of the Clinical Governance and Business Performance team.

Out of the 66 improvement actions:

- 25 have measures applied and are currently being reported on
- 11 have the relevant data available but are not currently reported on
- 30 require further definition of the outcomes and measures to enable meaningful reporting

Of the outcomes realised through completion of the improvement actions many relate to safety, physical health and good governance. They include:

Trust Wide:

- Supervision, appraisal and mandatory training targets have been achieved providing staff with knowledge, development and support to fulfil their roles effectively.
- Accurate and contemporaneous records are kept in line with the fit and proper persons regulation, thereby the Trust conforms with statutory requirements in terms of the suitability of its Board membership.
- The Trust has a designated nurse for safeguarding children

Forensic / Low secure areas:

- Fridge and freezer temperatures meet safe requirements as determined
- Ligature risk assessments are completed for new room changes or if the use of a room has changed
- Patients receive medicines that have been stored safely in line with good practice guidance
- Consistent approach implemented to document care and treatment records so staff can readily find information to support the care of patients
- Staffing levels assessed on the night shift ensuring staff and patient safety in the event of an emergency. Exceptions are reported as serious incidents

Community teams:

- Eastglade fire risk assessments are completed to keep staff and service users safe
- Premises and equipment used are clean, calibrated and properly maintained
- Risk assessments completed to confirm defibrillators and adrenaline is available at community bases ensuring cardiac arrest and / or anaphylaxis is recognised and appropriate treatment administered
- Ligature risk assessments are undertaken, reviewed and actions are taken to control any potential ligature points
- Dignity curtains in place across the sites

Decisions Unit

- The Trust does not admit under 18's into the Decisions Unit
- The layout and operations of the unit offers sufficient privacy, dignity and comfort to those using it
- Patients receive medications in a timely manner

Older Adults Ward

- Blind spots on Dovedale ward have been identified and safety risks mitigated

<u>Achievements</u>

Early improvements relating to electronic record development have been achieved in the initiation phase of the PCCR workstream to ensure that the service users' voice is heard, and service users are involved in the co-production of their care plan/risk assessment records. Early improvements include:

- The ability to record that a copy of the care plan has been offered to a patient. Further developments will include conditional formatting to ensure a copy is always offered and the response recorded. Also, the provision of local reports to allow local managers to track progress.

- Service user personal statement functionality added to the client home page for the Recovery Teams. Service users have been involved throughout the creation and have helped to agree the content.

- To aid in the provision of live actionable information available at the point of care a quick launch button has been added for care plans and risk assessments to the menu bar which will provide information on last read, edited, by who and a RAG rating showing compliance against agreed standards.

Mental Capacity Act 2005

There has been a review across the systems and processes relating to the assessment of a service user's capacity, from governance oversight to training. Achievements have included:

- The review and revision of standards across practice expectations including what must be recorded, with guidance and electronic prompts created.
- Embedding of monitoring and oversight of The Mental Capacity Act within the Mental Health Legislation Committee.
- A survey of staff training requirements has been completed to enable targeted team level training.

These improvements have been fundamental to ensure that a service user's rights are protected and promoted. The next steps are the delivery of training and auditing across the Trust to monitor how well the changes have been embedded and sustained.

Progress on Improvement Actions

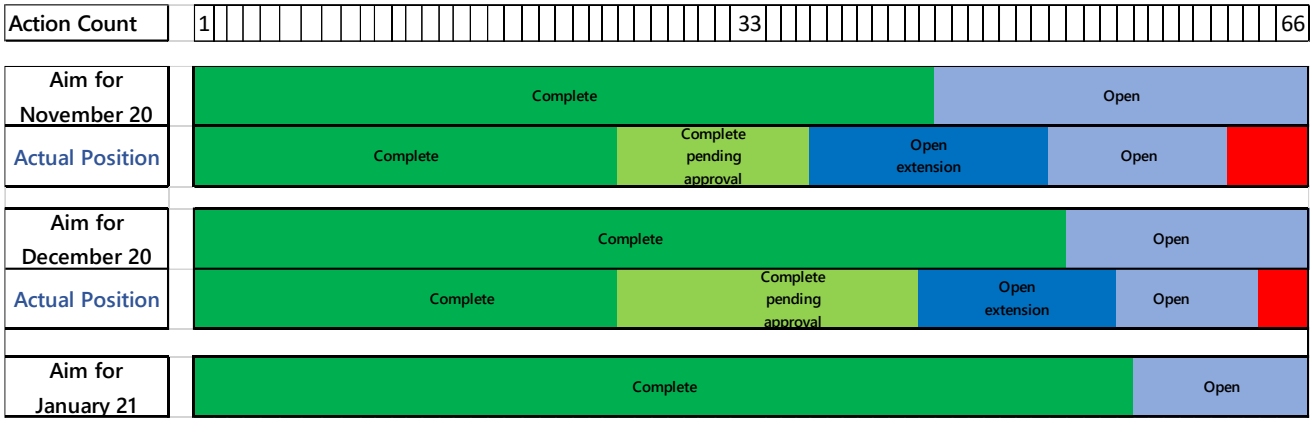
As of the Back to Good Board December 2020

Out of 66 actions:

- 38% Complete
- 27% Complete awaiting approval
- 14% Open
- 18% Open – Extension Approved
- 3% Exception

Improvement action progress December 2020/January 2021

The aim by December 2020 was to have completed 52 actions; 25 have been completed with 18 completed in accordance with local assurance processes, and await final assurance checks by Care Standards.



Since the BTGB in December progress with the 18 Improvement Actions awaiting Care Standards assurance checks are as follows:

- 18 have had assessment
- 3 have been recommended for consideration as complete
- 15 are subject to further evidence requests

Requests for Exceptions in December 2020

Improvement Actions	Number/type of Requests	Outcome
TW3 The Trust must ensure that there are robust arrangements in place for monitoring and auditing compliance with the Mental Capacity Act	Extension to timescale (Dec 2020) Sub action: Building on awareness of staff survey we will develop innovative methods of staff training. Plan to be completed by the end of December	Change to complete awaiting approval
A&PICU 31 The Trust must ensure that staff do not use non approved restraint techniques including the use of mechanical restraint	Extension to timescale (Dec 2020) Sub actions pertaining to approval of the Aggression and Violence policy by Policy Governance Group and the completion of a Quality Improvement Forum event focusing on reducing restrictive practice took place immediately prior to the Programme Board meeting	Change to complete awaiting approval
A&PICU 30 The Trust must ensure that staff maintain an accurate and contemporaneous record of patient care including seclusion records in line with the Mental Health Code of Practice	Extension to timescale (Feb 2021) Sub action: Extension to deploy and mobilise Insight activity codes associated with restrictive practice. Pilot planned to take place on Maple Ward. Extension allows for completion of pilot and roll out across inpatient areas The Programme Board requested that deployment plans are considered at the same time as the IT development is specified	Extension agreed
MHWOP 38 The Trust must ensure that care and treatment is provided in a safe way for service users. The Trust must assess the risks to Health and Safety of service users. This includes completing risks assessments, the management of falls risks and required observations are undertaken	Extension to timescale (Jan 2021) Sub action: New falls policy to be completed. This is to be submitted to the Policy Governance Group in January 2021	Extension agreed

MHWOP 63 The Trust should ensure that blanket restrictions are regularly reviewed on G1 ward	Change of sub-action wording Sub action: Trust wide Access and Egress policy to be reviewed and updated. The wording is to be changed to the Blanket Restriction Policy.	Agreed
C&HBPOS 46 The Trust must ensure that effective governance systems are put in place to oversee, monitor and support the operations of the crisis service	Request to complete sub action: Further develop dashboards to support operational status at a glance and monitoring against plan Action no longer relevant. It has been superseded by operational practice	Agreed
CMWA 59 The Trust must ensure they monitor and have oversight of the staff buddy system	Request to remove sub action: Clinical supervision will support staff to consider lone working with the development of risk management plans. It was deemed that as this relates to good practice and guidance it was not required as a sub action	Agreed

The majority of the actions in exception requiring extension relate to the Well Led, Patient Centred Care Records and Rapid Improvement Acute Work Streams.

There are three main themes associated with requests for an exception:

1. Dependency on IT updates following the system upgrade.
2. Changes to estates work scheduling has had an impact on the commencement and completion of work relating to seclusion and dormitory elimination.
3. Audit completion

<u>Revised Back to Good Improvement Plan</u>

The Improvement plan has been reviewed to ensure that additional actions from the latest CQC published focussed inspection are incorporated.

The number of improvement actions has increased from the original 66 to 73 in total.

The plan was updated with additional actions both ‘must do’ and ‘should do’, but also included actions we identified from the body of the inspection reports on addressing behaviour that challenges, and in particular that associated with racial abuse and agency staffing . Although these were not direct actions required by the CQC it was felt important that we should include them in the Improvement Plan to ensure that focussed attention is given to these areas. The plan was submitted to CQC on 3rd December 2020.

3 Next Steps

To review the Improvement Action plan with a view of the next phase of checking that changes to practices have become embedded and are sustained going forward. This will be supported by development of further reporting to monitor impact.

4 Required Actions

Board Members are asked to receive this report for information and assurance. Please note the following.

a) There are 25 improvement actions completed with a further 3 recommended as complete.
b) Note the positive achievements in improving support to staff and the quality of care to our service users.
c) Note that there were 4 actions in December requesting an extension to timescale, 1 requesting sub-action word change and 2 relating to the request to move sub actions.
d) Note the 3 themes that are impacting on the target dates for sub-actions, IT, estates and audit.
e) Note that the BTGB continues to oversee and coordinate progress to maintain momentum with completion of actions.
f) Note the concerns over the delays in improvement work related to estates issues namely the elimination of dormitories and improvements to seclusion facilities continues to pose as a risk to the programme along with IT development.

5 Monitoring Arrangements

Monthly progress reports to Quality Assurance Committee and Trust Board.

6 Contact Details

Dr Mike Hunter, Executive Medical Director
Email: mike.hunter@shsc.nhs.uk
Marthie Farmer (PA)
Email: Marthie.farmer@shsc.nhs.uk
Telephone: 0114 226 4496

Julie Walton, Head of Care Standards
Telephone: 0114 271 8378
Email: Julie.walton@shsc.nhs.uk
Sue Dale (PA)
Direct line: 0114 2718642

Zoe Sibeko, Head of Programme Management Office
Email: zoe.sibeko@shsc.nhs.uk
Telephone: 01142250710