Board of Directors - Public

SUMMARY REPORT	Meeting Date:	24 July 2024
	Agenda Item:	09

Report Title:	**Quality Assurance Report**	
Author(s):	Sue Barnitt, Head of Clinical Quality Standards Salli Midgley, Director of Nursing, Professions and Quality	
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:	10.7.24
Key points/ recommendations from those meetings	• Noted the impact of vacancies on the ability to collate and theme findings from visits • Request for a review of the Board Visit approach to consider further strengthening the approach to enable staff and service user voice to be heard • Noted the ongoing delay with quality management system approach due to RIO implementation. • Overall a request to improve the report with robust assurance once the team is in place.	

Summary of key points in report

The report aims to provide an overview of the work completed relating to our quality assurance activity during Q4 2023/24 and Q1 2024/25 and update on actions previously identified.

Key risks to the Quality Assurance Workplan are:

- Delays in RIO implementation impacting on:
  - QMS roll out and planned quality and patient safety reporting.
- General challenges in availability of staff to participate in Quality Assurance activity.

Quality Assurance activity occurring since last report:

- During Q4 2023/24 and Q1 of 2024/25 twenty-seven Board visits took place
- 7 Culture and Quality visits have taken place
- Follow up Fundamental Standards of Care Visits have been completed to the 5 areas identified as requiring a revisit. Action plans have been developed with regular reporting on progress via governance team meetings. Q1 overview reporting is due to be presented at Clinical Quality and Safety Group late July.
- Quality Hotspot approach
- Care Quality Commission (CQC) embeddedness review

Quality Strategy Progress

- The milestones for 2024 are in delivery currently and should be completed by December 2024.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	X	Information	
The Board is asked to receive the report and consider the assurance in its content.							

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	*Yes*	**X**	*No*	
Deliver Outstanding Care	*Yes*	**X**	*No*	
Great Place to Work	*Yes*	**X**	*No*	
Ensuring our services are inclusive	*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 Quality Assurance Visiting Programmes 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 paper several actions support the principles of environmental sustainability and the effective use of resources.

Section 1: Analysis and supporting detail

Summary

1.1 The report aims to provide an overview of the work completed relating to our quality assurance activity during Q4 2023/24 and Q1 2024/25 and update on actions previously identified. As a reminder, our core quality assurance activity detailed within the report is aligned to our Quality Strategy and forms the basis of the milestones set within it.

- Developing and Embedding a Quality Management System
- Ensuring we have robust a Quality Assurance Framework in place.
  - Fundamental Standards of Care (FSoC) visits to bedded services.
  - Board Visits (Executive and Non- Executive Director visits to services)
  - Culture and Quality visits (Community, Rehabilitation and Specialist services)
  - Audit, Accreditation and Compliance with NICE Guidance
  - Service user and carer feedback.

1.2 Plans to align the range of QA information we hold and gather into the Quality Management System (QMS) have been delayed because of changes in Tranche 2 RIO implementation dates therefore new key dates will need to be agreed.

1.3 A range of quality assurance visits have taken place during Q4 2023 and Q1 2024/25 and whilst there have been some amendments, due to absence and outbreaks, these have in the main been in line with the planned schedules. 27 Board Visits, 7 Culture and Quality visits and 5 focused FSoC visits have been completed.

1.4 Updates against actions identified in the last report are detailed in the table below.

Quality Assurance Activity	Action required	Update
CQC Quality Statements and readiness	Develop key questions to support SHSC to self-assess our position, starting with the 'Safe' domain.	Delayed due to team capacity. A plan is in place to take this forward in Q2 with staff in post. Meetings have taken place in July and work commences in August
CQC Alert - Communal use of Wheelchairs (Care Homes Setting)	Repeat spot check audit 6 weeks post Blue Light Audit to review practice.	Completed March 2024 and findings detailed in report

Section 2: Quality Assurance Workstreams

Quality Assurance Visits

2.1 During Q4 2023/24 and Q1 of 2024/25 twenty-seven **Board Visits** took place, these were to both clinical and corporate teams within the Trust. 4 visits were a 'rescheduled' visit due to IPC outbreaks or Executive team availability. Details of the visits completed can be found in appendix 1.

Themes

1. A number of specialist services reported to be concerned about financial stability and investment into their service area. Local finance meetings are taking place and discussions with commissioners where appropriate.
2. Estates: areas needing investment and repair working with estates to establish priorities of these services. Broader discussions on the capital plan are taking place and will be communicated with teams.
3. Communications: Specialist services requesting a bigger profile and integration into SHSC through communication team. Services were requesting to 'showcase' their achievements and raise the profile of their teams. Service managers advised to work with Comms to showcase via Jarvis.
4. Review of pathways such as attention deficit hyperactivity disorder (ADHD) to reduce waiting times. This work is underway and regularly reported to Quality Assurance Committee (QAC)
5. Challenges of Rio. This is regularly monitored and reported through to Executive Clinical Design Group and Board via the Digital team and key clinical leadership roles.

Board visits were able to feedback and note actions taken in written feedback to the services.

2.2 Since last reporting to QAC in January 2024, 7 **Culture and Quality Visits** have taken place – 3 in Q4 2023/24 and 4 in Q1 2024/25. There has been a number of visits where visit reports have not been submitted and due to changes in the team these have not been followed up. Once the new Head of Clinical Quality is appointed, reports will be chased up or visits will be repeated to ensure learning is extracted and areas for improvement highlighted.

2.3 Full **Fundamental Standards of Care** visits were completed during Q3 2023/24, and summary of findings were presented in the report to Quality Assurance Committee in January 2024. The main areas for improvement were:

- Compliance with IPC requirements – specifically bare below the elbow
- Suitability of clinic spaces and monitoring of clinic and drug fridge temperatures
- Staff access to electronic patient record system (impacted by RIO implementation)
- Medicines management – administration and storage
- Availability of service user and carer information / leaflets
- Basic Life Support training below compliance target for all areas
- Access to team development time.

All services were requested to return their final action plans and to monitor progress via team governance meetings. This has not occurred consistently, and the new Head of Clinical Quality will be requested to review this governance and ensure improvement plans are delivered. Five services were identified as requiring a follow-up assurance visit prior to their annual review as they are noted to have 10 or more standards not met within the 'safe' domain. These visits have now been completed and FSoC tools have been updated and amendments to action plans have been made. A summary of areas of improvement noted during these focused visits are available in appendix 3.

2.4 The key findings from the range of quality assurance visits completed have been collated and are themed below and demonstrate both improvements achieved and those that are still required across our services.

Team Culture and Staff Wellbeing

The majority of feedback from visits demonstrated an overwhelming picture of strong team spirit and a strong emphasis on staff wellbeing and mutual support. Positive feedback regarding the 'Shine' awards was provided and recognition of the positive impact of awards on team morale. Some teams are already thinking about future nominations. Many teams spoke about the positive leadership approaches they experience within their teams that foster a supportive environment. It was noted on one of the visits that preceptees were feeling more supported on the ward. In other areas, staff reported having a positive induction experience.

Person-Centered Care and Service User Experience

Conversations highlighted that there is a dedication to delivering person-centered care across SHSC teams. Several examples of effective co-design and co-production practices which have or are taking place were presented which demonstrates delivery of compassionate care and advocacy for service users. Volunteering within SHSC, whether paid or unpaid, continues to be strengthened and there is increased interest in getting involved. It was felt that supporting people to move from a volunteer position into employment with SHSC should be the next step in the volunteer pathway.

There were various examples of positive service and carer feedback shared during the visits which highlighted how teams were providing person centered and trauma informed care, though it was highlighted that teams would welcome more support from the Experience and Engagement team to improve feedback mechanisms. Visits also demonstrated evidence of coproduction and involvement in quality improvement initiatives such as the carer stress risk assessment and risk management approach developed by the Recovery North Team.

Two community teams have service user involvement groups and welcomed being linked with the Experience and Engagement Team to be supported to help carers further. The service user group created actions however these need to be integrated into governance process to ensure their completion and monitoring. They were held regularly and were well attended. The Long-Term Neurological Team also has a group co-facilitated by someone with lived experience providing authenticity to their service user engagement.

At some visits it was not appropriate to engage with service users at the juncture, this would be due to their presentation or their choice to decline to speak.

Several visits involved the review of clinical records. The standard of documentation across services is variable and whilst there were examples of clear, contemporaneous and good quality record keeping, there were also issues identified with the timely writing of records following visits and updating of care plans and risk assessments which links to other findings in relation to quality of record keeping.

Opportunities for Improvement:

- Culture and Quality Visits to strengthen how to gather and produce service user feedback. The service user is the centre of the care, and we need to improve the route we obtain service user feedback during the quality visits.
- The broader record keeping improvement plan will support addressing the issues identified in these visits.

Operational Challenges

Delays in relocations and facility/environmental improvements were noted to cause

frustration within some teams and staff although there were several examples where significant upgrades to team environments had positively improved the experience of service users and their families and the staff working within them. Clinic room spaces in several areas were highlighted as not fit for purpose and temperature was control difficult to maintain; these have been highlighted though staff were unclear whether any works were planned.

Opportunities for Improvement:

- Review of community clinic spaces with areas requiring improvements added to estates plan. This has been shared with the therapeutic environment board.

Quality Hot Spots

In addition to the planned visits, ongoing intelligence is utilized to monitor services for "quality hot spots" through incident huddles, safeguarding concerns, complaints and freedom to speak up. Where potential hot spots are identified discussions take place with the Director of Nursing, Quality and Professions, Directorate Leadership Team and appropriate others; it is usual to ask the Head of Nursing to then lead the discussions to develop an improvement plan for the service. Over Quarter 4 and Quarter 1 the following services have been requested to develop Improvement Plans:

Maple Ward (Now closed)
Woodland View Nursing Home (Now Closed)
Birch Avenue Nursing Home (ongoing – in monitoring and assurance)
Dovedale 2/Burbage (ongoing – new plan June 2024)

Governance for these plans is outlined in a Standard Operating Procedure and reported through Clinical Quality and Safety Group, with updates to the Executive Management Team.

2.5 **CQC Patient Safety Alert - Communal use of Wheelchairs (Care Homes Setting)**

Following the issue of the above patient safety alert, SHSC have taken action to review and improve the level of knowledge and understanding staff, based on the older adult's wards, have regarding the use of communal wheelchairs with their service users. An audit has been completed by the Moving and Handling Lead and a paper presented to the Physical Health Committee in May 2024 which outlined the key findings as:

- Almost 1/5 of the wheelchairs found in our care homes settings were unusable.
- Only Birch Avenue were able to guarantee that all wheelchairs in use had been recently service and were safe to use.
- While nearly 50% of staff spoken too felt physically able to assist a wheelchair user, 46% of the staff had never had any training on how to do so.
- Only 9% of the staff had knowledge of how to assist a service user into or out of a wheelchair safely.

Actions have been agreed to improve this position and will be monitored through quarterly reporting to the Physical Health Committee. With immediate effect, SHSC progressed contracting of routine servicing and maintenance checks through Sheffield Teaching Hospitals (STH). A range of guidance documents and risk assessments have been developed and implemented to support staff and maintain patient safety.

2.6 **Quality Management System**

Work continues to develop the SHSC Quality Management System (QMS) though progress remains limited due to organisational capacity of stakeholders across SHSC.

Delays in the implementation of the RIO Electronic Patient Record system have continued to have an impact. It is likely that plans to introduce service level quality data dashboards will not occur until summer 2025. In the interim, we continue to support the implementation of the Visual Management System (aka Quality Whiteboards) within areas that wish to introduce them. A recent Culture and Quality Visit conducted highlighted the benefit of having a standardised approach / best practice on their use. The Care standards team will work with Quality Improvement colleagues to progress this.

The working group have commenced work to map dependencies to identify where bottlenecks and risks to progressing implementation may occur. A SHSC QMS stakeholder workshop is scheduled for 20.06.24 to continue the detailed mapping of activity already taking place.

2.7 **CQC Quality Statements and Staff Readiness**

Plans to align the range of QA information we hold and gather into the Quality Management System (QMS) have been delayed because of changes in Tranche 2 RIO implementation dates therefore new key dates will need to be agreed.

Progress against actions identified within the CQC Staff Readiness Implementation plan which was shared with Quality Assurance Committee in January 2024 have also been delayed due to team capacity however we have begun to consider the process we need to have in place to support the sharing of pro-active evidence about services to support improvements in our CQC rating through the online CQC portal.

The Director of Nursing, Quality and Professions has undertaken a rapid review of the 2020/21 CQC requirements and reviewed the current position for embeddedness. These was shared with the Executive Management Team in June 2024.

key areas for investigation included the following requirements:

- Statutory and mandatory training across the organization
- Environmental improvements for Dovedale ward
- Waiting times for the Health Based Place of Safety
- Service users understanding their rights under the Mental Health Act

It was agreed that a broader assurance review will take place to establish the position and to include earlier CQC reports for Community Mental Health Team (CMHTs), Forest Lodge and Forest Close. This will be undertaken by the interim Quality Lead. An update will be given to QAC in the next Quality Assurance Report.

2.8 Quality Strategy Update

Overall, steady progress is being made against Quality Strategy objectives. As detailed above, implementation of the Quality Management System is at a slower pace than we would like and is affected by delays in the RIO EPR implementation. Where possible we have progressed, other elements related to the QMS though there is overall slippage on the timescales set for this priority.

Updates regarding the objectives linked to Coproduction and Lived Experience are provided within the strategy update presented to Quality Assurance Committee therefore not repeated within this report. Continuous Improvement and Sustainability are also

reported through separate mechanisms.

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Quality Strategy 2022 - 2026

Our Vision: **to improve the mental, physical & social wellbeing of the people in our communities**

Strategic Aims: **Deliver outstanding care** **Create a great place to work** **Make effective use of resources** **Ensure our services are inclusive**

Key Priorities:

Develop a culture of continuous Improvement	Embed coproduction and lived experience methodology	Implement an evidence-based Quality Management System	Deliver a Quality Assurance Framework	Ensure sustainable high-quality outcomes
as an integral part of all that we do, ensuring a learning and just culture	in service developments and redesigns to provide responsive, accessible services	to coordinate and embed quality improvement, quality control, quality planning and quality assurance	to assure and control evidence-based care, benchmarking nationally as good quality	for the service users of today without compromising those of tomorrow

Milestones

2022	Robust QI skills training programme in place offering a suite of options to ensure accessibility and suitability for all	Benchmarking data for Inpatient areas against the fundamental standards of care will be available
2023	Continuous improvement embedded in all recruitment, induction, and PDR processes	Implementation of the SHSC Quality Management System (QMS) Approach
2024	All SHSC staff will have an enhanced understanding of Patient Safety having completed an agreed syllabus and implemented the Patient Safety Incident Response Framework (PSIRF)	Completion of Culture and Quality visiting programme across the organisation

1. Patient Safety Training: Roll out of level 1 training

   All SHSC staff will have an enhanced understanding of Patient Safety having completed an agreed syllabus and implemented the Patient Safety Incident Response Framework (PSIRF) – **Currently Level 1 has been rolled out as a mandated subject and SHSC compliance is 94.9%**

2. Completion of Culture and Quality visiting program across the organisation

   Since Q1 2023/24 twelve Culture and Quality visits have been completed which include all of the services categorised in the high priority services. As detailed in the last report to Quality Assurance Committee, completion of Culture and Quality visits were significantly delayed due to team capacity in 2023. There are a further seventeen visits planned to the end of the financial year at which point all services will have received a quality assurance visit. Some services will have received two visits in the timeframe where a request has been made for a return visit. All medium priority services will have received a visit by October 2024 and all of these have a lead identified.

Section 3: Summary of Key Risks and Assurances

3.1 The following risks / areas for improvement are key themes identified through the range of quality assurance activity completed and described within this report and required responses will be considered primarily through Clinical Quality and Safety meetings and relevant findings fed into other committees as appropriate.

- Staffing levels impacting on the quality of care
- Standards of documentation and timely updating of risk assessments and care planning

3.2 Areas of assurance obtained across recent visits include:

- Medications fridge management – temperature recording
- Improved application of BBTE standards
- Appropriate use of communal wheelchairs within Birch Avenue
- Improvements in compliance with Mandatory Training subjects in a range of services

Section 4: List of Appendices

Appendix 1 – Board Visit Schedule

Appendix 2 – Culture and Quality Visit Schedule

Appendix 1 – Schedule of board visits Q4 2023/24 and Q1 2024/25

Board Visits during Q4

NHS Sheffield Health and Social Care NHS Foundation Trust

Service	Date	Executive Member	Non-Executive Member
*Perinatal Mental Health Service	10/01/2024	Deborah Lawrenson	Anne Dray
*Forest Lodge	18/01/2024	Caroline Parry	Mark Dundon
Older Adult Community Mental Health Team (OA CMHT)	25/01/2024	Salma Yasmeen	Anne Dray
Quality Improvement	29/01/2024	Neil Robertson	Heather Smith
SAANS (return visit 4 months)	30/01/2024	Salli Midgley	Sharon Mays
Homeless Assessment & Support Team (HAST)	02/02/2024	Neil Robertson	Anne Dray
Early Intervention Service (EIS)	07/02/2024	Mike Hunter	Yinka Fadahunsi-Oluwole
Beech fka Wainwright Crescent	13/02/2024	Salli Midgley	Heather Smith
Dovedale Ward	21/02/2024	Phillip Easthope	Yinka Fadahunsi-Oluwole
Engagement & Experience	04/03/2024	Salma Yasmeen	Anne Dray
*Maple	08/03/2024	Neil Robertson	Owen McLellan
Community Mental Health Team - South base (fka Recovery Service South)	11/03/2024	James Drury	Anne Dray
*Chaplaincy	13/03/2024	Phillip Easthope	Sharon Mays
*Complaints Team	26/03/2024	Deborah Lawrenson	Sharon Mays

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2 visits were cancelled during Q4 – G1 (weather warning, resched to Q1) and Birch Avenue (outbreak, resched to Q1)

*Feedback forms not yet received from Board members at time of finalising report

Board Visits during Q1

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Service	Date	Executive Member	Non-Executive Member
G1	10/04/2024	James Drury	Owen McLellan
Flow Co-Ordinators	16/04/2024	Deborah Lawrenson	Anne Dray
QUIT	22/04/2024	James Drury	Heather Smith
Dovedale 2 Ward (Burbage Ward)	01/05/2024	Deborah Lawrenson	Yinka Fadahunsi-Oluwole
Birch Avenue	03/05/2024	Salli Midgley	Anne Dray
Community Mental Health Team - North base (fka Recovery Service North)	15/05/2024	Phillip Easthope	Yinka Fadahunsi-Oluwole
Crisis Resolution Home Treatment Team (CRHTT)	16/05/2024	Salli Midgley	Anne Dray
*Workforce Development and Training	31/05/2024	Neil Robertson	Heather Smith
*Community Intensive Support Service (CISS)	03/06/2024	Phillip Easthope	Heather Smith
*Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) Service	11/06/2024	Caroline Parry	Brendan Stone
*Building Successful Families	14/06/2024	Neil Robertson	Anne Dray
Burbage Ward	20/06/2024	Salli Midgley	Brendan Stone
Community Learning Disabilities Team (CLDT) and Case Register	24/06/2024	Caroline Parry	Heather Smith

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1 visits was cancelled during Q1 – CRHTT in April and resched to May (Exec unwell)

*Feedback forms not yet received from Board members at time of finalising report

Appendix 2 – Schedule of Culture and Quality Visit Q4 2023/24 and Q1 2024/25

C&Q Visits during Q4 and Q1

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Service	Date	Lead
Long Term Neurological Conditions	January 2024	Linda Wilkinson
Decisions Unit & 136 Place of Safety	February 2024	Vin Lewin
Community Enhancing Recovery Team	March 2024	Mo Mackenzie
Liaison Psychiatry	April 2024	Hester Litten
Older Adult Community Mental Health Team	May 2024	Sue Barnitt
Assertive Outreach Team	June 2024	Linda Wilkinson
Gender Identity Clinic	June 2024	Salli Midgley