SCAS Tripartite Provider Assurance Meeting

Title of paper	SCAS Section 29a quality assurance visit December '22		
Agenda item (Number)		**Date of meeting**	Click or tap to enter a date.
Executive lead	Sara Courtney	**Sponsor (GP Board member or Executive Director)**	Nicky Lucey
Author	Simon Freathy, Quality Improvement Programme Manager, HIOW ICB		

Purpose	For decision	☒
	To ratify	☐
	To discuss	☒
	To note	☐

Link to strategic objective	Refer to Appendix A

Executive Summary

Following the CQC Section 29a notice issued to SCAS in May 2022, the Organisation entered an enhanced Oversight process for the monitoring of the delivery and outcomes of their improvement programme. The Tri-partite Provider Assurance Meeting was increased from quarterly to monthly and two additional oversight meetings were established to specifically oversee the delivery of the Safeguarding Improvement Programme and the delivery of the Section 29a improvements.

A quality assurance visit to Otterbourne House and supplemental quality assurance interviews via TEAMS were undertaken during a week in December 2022. Representatives of Hampshire and Isle of Wight ICB, Buckinghamshire, Oxfordshire and Berkshire West ICB and Frimley Health and Care ICS. The focus of the visits and interviews was to test the assurance presented at the oversight meetings - in person, within the Organisation - on the improvement foundations delivered within SCAS since their CQC inspection report publication: The five domains tested were:-

- Safeguarding
- Patient Safety
- Governance – medical devices
- Culture – Freedom to Speak Up (FTSU)

The workstream leads for these areas gave a short update and then answered questions. Separately the Non-Executive Director with a responsibility for quality, the safeguarding adult lead, clinical governance leads, patient safety managers and the patient safety specialist were interviewed to ascertain their understanding and embeddedness of the recent changes and ongoing improvement plans.

- Infection Prevention and Control

A focussed visit was undertaken at North Harbour make-ready station to review ongoing management of the pigeon infestation and infection control and health and safety practices.

Assurance was gained that SCAS have made good progress within these foundation actions, improvements and workstreams, including some innovative approaches with FTSU and triangulation of feedback.

Are there any potential conflicts of interest that the committee needs to be aware of?

None

Recommendations	Consider stepping down current level of enhanced monitoring of SCAS 29a improvement plan.

	Consider reducing the frequency of the Safeguarding Oversight arrangements from fortnightly to monthly.
Publication	**Include on public website** ☐

CONTENT

1. **Summary**

1.1 This paper will outline the findings of quality assurance visits and interviews that took place in December 2022. A quality assurance visit to Otterbourne House and supplemental quality assurance discussions via TEAMS/phone were undertaken by representatives of Hampshire and Isle of Wight ICB, Buckinghamshire, Oxfordshire and Berkshire West ICB and Frimley Health and Care ICS.

1.2 The focus of the visit and discussions was to gain assurance on the 'well-led' aspects of the Section 29a notice and how this was reflected in the delivered foundation improvement actions for:

- Governance – medical devices
- Safeguarding
- Patient Safety
- Culture – Freedom to Speak Up

1.3 The workstream leads for these areas gave a short update and then answered questions. Separately the Non-Executive Director (NED) with a responsibility for quality, safeguarding adult lead, clinical governance leads, patient safety managers and the patient safety specialist were interviewed to ascertain their understanding of the recent changes and ongoing improvement plans.

1.4 Infection Prevention and Control (IPC) - A focussed visit was also undertaken at North Harbour make-ready station by HIOW ICB IPC staff to review ongoing management of the pigeon infestation identified in the CQC report.

2. Context

2.1 Following the CQC Inspection 6/7 April 2022 and 10/11 May 2022, the Trust were issued with a Section 29a Warning notice on the 24th of May. An Executive level working group including representatives from SCAS, the ICBs and regional team was immediately established to oversee the response to this warning notice. The subsequent inspection report published in August 2022 has assessed the Trust overall as inadequate.

2.2 The SCAS oversight framework segmentation rating has been reviewed in discussion with the NHSE regional team, with the rating moving from 2 to 4, which means the Trust entered the Recovery Support Programme (old Special Measures). This recommendation was finalised through NHSE governance and communicated to the Trust 5th October 22.

3. Areas of quality focus

3.1 Governance – Medical Devices

To enhance and test the evidence of improvement assurance gained through the oversight meetings, the Medical Device lead and colleague were interviewed. They gave an outline of the revised processes for logging and monitoring medical devices using a cloud-based system to track maintenance schedules and equipment locations. This system was demonstrated in real-time to highlight that devices were flagged as requiring maintenance 'soon' so they could be safely removed from service in a controlled manner. All key assets were logged ahead of schedule. There is a current business case for RFID monitoring of all medical devices which will significantly enhance this process.

They highlighted that they are still developing business as usual processes and are sighted on the ongoing challenges they are facing (culture/staff behaviours regarding medical devices). They described the revised governance processes with a dedicated medical device meeting and an identified lead for medical device education. They are looking are developing their team with asset management qualifications. They are actively monitoring SLAs with equipment providers which was not occurring before. They noted an increase in reporting regarding devices which was seen as a positive sign of increased awareness.

3.2 Safeguarding

To enhance and test the evidence of improvement assurance gained through the oversight meetings, the recently appointed associate director (AD) for safeguarding was interviewed. She described how they were currently building the team and only 2 administration staff and 1 business manager remained from previous set up. Staff were being given portfolios to manage. The safeguarding adults lead has been in post for 2 weeks with a safeguarding adults practitioner due to start in February. The safeguarding childrens lead had been appointed and was due to start in the new year with the safeguarding childrens practitioner post was currently out to advert. There were proposals to recruit to the posts of liberty protection standards lead and a learning disabilities lead. There are good working relationships with the ICB safeguarding teams.

They described the 3 levels of priority for actions they have identified and gave their rationale for these.

Priority 1:

- Safeguarding referral system – referral issues remain, the SOP needs input and this is viewed as the main priority. They described the 'traffic light system' that is now in place to aid prioritisation and to mitigate previous risks. They are receiving approximately 150 referrals a day, a 30% increase from 12 months ago. IT outages remain an ongoing risk/challenge.
- Safeguarding training for all levels. This will progress at a greater pace when new staff are onboard. They are working with SCAS communication team to raise awareness of the team and training offer. Level 3 training has a clear trajectory and delivery plan which is on track.
- Child Protection - Information Sharing service (CP-IS).

Priority 2:

- Fire risk referrals
- Capturing and embedding learning from Serious Case Review (SCR)/ Safeguarding Adults Reviews (SARs)
- Audit plan for 23/24
- Strengthening relationships with Independent Safeguarding Boards – currently working with 24 boards across multiple counties. Prioritising key ones.

Priority 3:

- Safeguarding Supervision
- Peer review

The AD Safeguarding has taken on the role of allegation management lead. Allegation management was previously poorly understood. Training has been provided to HR and the Freedom to Speak Up Guardian. Twelve cases were referred in November.

Non-Executive Director (NED) support – the safeguarding AD had identified that the NEDs needed safeguarding support and training. Training using a scenario-based approach was being provided to the board later that week. Chief Nurse in addition has asked the newly appointed AD for SG to come back to Board with additional SG training as recommended by our external SG Strategic Review.

3.3 Patient Safety and incident management.

To enhance and test the evidence of improvement assurance gained through the oversight meetings, the Patient Safety Lead and AD were interviewed. They outlined the revised processes that have been implemented including the disbanding of the Patient Safety Incident Group and the setting up of the new and current Incident Review Process (IRP). It was acknowledged that the IRP process continues to be refined with the sign off of completed investigations potentially being moved to a stand-alone meeting to keep the correct level of focus. A review of Serious Incident (SI) and 'detailed clinical investigation reports' (formerly referred to as 'major investigations') has been completed with ICB input. There has also been a review of policies including the SI and adverse events policies. Another area of focus has been on ensuring the duty of candour is meeting the statutory requirements.

They highlighted that they have increased operational line involvement with SI reports with draft reports going to service level Clinical Governance Meetings to enable better ownership and involvement in action plans. This was noted to be quite a culture shift and would take time to fully embed.

The commitment to a just and learning culture was emphasised with a focus on compassionate leadership. This was being reflected in the training offer to line managers across the organisation. In order to measure the effectiveness of this approach a safety

culture survey is planned in the spring to get a baseline, with a follow up survey to be planned later in the year.

3.4 Culture - Freedom to Speak Up

To enhance and test the evidence of improvement assurance gained through the oversight meetings, the FTSU Guardian and senior member of the Organisational Development (OD) were interviewed. The team recognised that the CQC report was incredibly difficult for the organisation but provided an opportunity to improve. The planned recruitment of further FTSU guardians meant that there would be more planning around the role. A FTSU champion role was being implemented and the Health Education England FTSU e-learning package was being utilised.

There was felt to be a good/open relationship with the Executive/Senior Leadership Team with discussions about 'listening up'. There are regular calls with the Chief Executive and the Chair of the Board.

SCAS has moved the 'hosting' of the FTSU role to within the Organisational Development function. This is a novel approach that we have not seen elsewhere and feels like a progressive approach.

The FTSU guardian is keen to forge a closer working relationship with the patient safety team on, particularly on strategy work around safety culture. He described a building connection that was not in place previously.

They described how the FTSU feedback was included in the People Voice Portfolio. There is triangulation of information from diverse sources including:

- Human Resources – including exit interviews
- Student feedback
- Complaints/plaudits
- Patient Safety events
- Other incidents
- Friends and Family responses

They were innovating by utilising Natural Language Processing through one of their Business Intelligence team. This approach will ensure all themes including qualitative are being captured.

The Guardian outlined the approach taken during the recent national FTSU month. Given the large geographical spread, and the mobile nature of the workforce, additional sessions were undertaken with a dedicated vehicle visiting crews in-situ, mainly outside Emergency Departments at the acute providers. This 'roadshow' approach included a range of accessible resources for staff and importantly also provided a private confidential space if needed. This flexible approach is very welcome as it would have reached staff who would not have been reached if static resource were used at stations.

3.5 NED discussion

The NED had been in post for approximately 12 months and had been involved in the task and finish group set up in response to the last CQC safeguarding inspection to look at the resource and skills to manage the safeguarding agenda within SCAS. She tries as able to attend all safeguarding meetings and associated calls. She reflected that there had been a real investment in safeguarding and can definitely see the steps taken so far to improve the organisation and culture.

They were aware that the safeguarding lead had reviewed and updated all relevant policies but was not aware of the process of external validation involving the regular meetings with the ICBs.

The need for specific board training was noted with the acknowledgement that there was some focused safeguarding training happening later that week. It was felt that there should be dedicated training for board members in areas such as patient safety culture which there needed to be board oversight on.

The NED also talked about whether NEDs should be involved in incident review panels. They explained the Board often gets numbers of incidents but nothing about learning outcomes or how this is embedded in the organisation. They expressed a need to change the board report on patient safety so that it is more meaningful, providing a greater level of assurance.

3.6 Director of Patient Care/Chief Nurse

The Director of Patient Care had a detailed understanding of the focus of the improvement programmes and where each one was against its delivery plan. She reflected that there still needed to be better triangulation of information. The Board had recognised that it needed to move from reassurance to assurance. This echoed the view of the NED that the format of Patient Safety and Quality reports to the board needed to be refined. The Director of Patient Care felt that the Board now had a better understanding of the challenges across all the CQC Improvement portfolios, not just their specific portfolios.

3.7 Individual discussions with Patient Safety Specialist, Patient Safety Managers and Divisional Clinical Governance Managers.

All staff were able to give a clear account of what changes have been made and the rationale for these changes, even if they were not involved in the decisions at the time.

It was recognised by the majority of staff spoken to that whilst the CQC inspection, and it's findings, were an incredibly difficult period of time to work through, it had provided an opportunity to drive improvement and had resulted in increased investment and resources.

Staff reflected on the scale and pace of changes that had been made. Some felt that they were not allowed 'to be involved'; their knowledge and experience was not taken into account, and they were not involved and that decisions that were made at a higher level during the initial response to the CQC report. For some staff this was a very difficult process although the majority reflected that changes needed to be made to enable SCAS to become a learning organisation. All felt that they were now able to influence the changes that needed to be made.

All staff reflected the impact of the current operational and staffing challenges and the effect this had on their workloads through increased incidents.

All staff spoken to felt well supported by their line managers, had regular touch-ins and were able to approach them with concerns.

Staff had noticed a positive change in approach with the sharing of information and staff engagement with OD with listening events and the use of webinars for topics like patient safety.

Staff reflected that there remains a divide between corporate areas such as governance and operational Divisions and teams. There has been a shift in culture but there is still work needed, particularly in some localities, but this was a known issue. It was felt this could impact the implementation and sustainability of action plans following patient safety incidents.

3.8 IPC focussed visit to North Harbour Ambulance Station – pigeon infestation

The ICB IPC lead and a colleague visited North Harbour Ambulance station and spoke with the Director of Operations, Estates and IPC team members. Findings are below:

- The pigeon problem is now fully resolved with no pigeons in the vicinity and no evidence of droppings.
- The trust were aware of the impact the pigeon infestation had on staff and had been taking action to resolve the issue.
- Since the CQC report the trust has taken a more permanent solution for all effected stations by removing the resident pigeons in May/June 2022 rather than relying on deterrents.
- Feedback during our visit suggests that the staff seen wearing PPE and respirators while pressure washing an item by CQC were not the Make Ready Team, but in fact the HART staff who were cleaning some equipment prior to removing it from the station.
- The wearing of respirators while pressure washing could be appropriate following a risk assessment of the individual circumstances.
- There was no evidence that staff members were routinely wearing respirators where inappropriate to do so.
- All staff report incidents via Datix and directly via phone/email to relevant teams (including IPC and estates). There is also a manager on site 24/7 who can respond to any incidents/issues identified.
- Feedback/risks/concerns are communicated to teams through a variety of methods (team meetings, newsletters, Intranet, Yamma, Pod casts, Terrafix, Hot News)
- Cleaning processes were in place and are as per the Cleaning Standards 2021.
- Audits are undertaken by the contractor who provide the make ready service and the staff side cleaning.
- Currently there is no process for assurance audit, however this is being reviewed.
- The cleaning staff have an induction and there are policies in place with regards to cleaning processes.
- Regular updates for staff are being reviewed.

4. Conclusion

The visit to Otterbourne House, North Harbour Ambulance Station and the individual discussions with the NED, Patient Safety and Clinical Governance Managers has provided additional assurance to that already presented in formal meetings that SCAS have delivered in full the foundation improvements in the quality areas identified within the Section 29a notice.

These improvements, and the rationale for them were understood by staff involved in implementing them within the organisation.

These improvements will take time to fully embed within the organisation and staff spoken to were aware of the challenges in implementing these and now felt able to own the majority of changes needed.

Ongoing assurance for these improvements can be best monitored through routine quality assurance by the System Quality Group.

5. Recommendations

As a result of the significant amount of evidence presented at the two Oversight Groups and the testing of this evidence during the quality visit in December 2022, that the current arrangements are reviewed and reduced.

It is recommended that the Safeguarding Oversight Group reduces its frequency from fortnightly to monthly. There is still a significant work programme to deliver in 2023, active recruitment still underway and multi-agencies to assure on progress.

It is recommended that the S29A Oversight Group is stood down from January 2023 as all the foundation actions in the improvement plan have been delivered, evidence and tested.

It is recommended that HIOW System Quality Group review and reduce SCAS Oversight arrangements and for monthly TPAM to become the single oversight arrangement.

It is recommended that operational pressures and performance are monitored separately from CQC Improvement progress.

The ICB recommends that SCAS consider the following:

- Review training given to Board members on key areas such as safeguarding and patient safety culture.
- Review the format of patient safety and quality reporting to Board and sub-Board committees. Consider best practice approaches taken in other providers.
- Improve Board reporting granularity using best practice examples from other Providers
- Consider focussing IRP on new incidents only and hold separate investigation report sign-off meeting.

- Continue to strengthen the relationship between the FTSU Guardian and the Patient Safety Team – moving from a 'push' to 'pull' approach around ''including the voice of people' in every patient safety conversation.
- Continue to embed ownership of incident management and action plans with operational teams in partnership with corporate teams.
- Consider the strengthening of patient safety function with regards to organisational learning and continue to develop the safety culture approach to improvement/action plans.
- Establish formal links with regular meetings between leads for safeguarding, patient safety, medical devices and FTSU.
- Consider approaches to facilitate easier timely reporting of incidents by front-line crews.
- Consider the development of IPC assurance audits and programme.

6. Decision required

The TPAM members are asked to:

- Endorse the change in oversight arrangements for Safeguarding and S29A

Simon Freathy, Quality Improvement Programme Manager, HIOW ICB, 5th January 2023.