# NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
# TRUST BOARD MEETING HELD IN PUBLIC

**THURSDAY 8TH SEPTEMBER 2022, 10.00AM, Via MS Teams**

| ITEM | TIMING | REF | TITLE | LEAD | ACTION | ENC |
|---|---|---|---|---|---|---|
| 1 | 1000 | P336/22 | Welcome and Apologies for Absence | David Rogers | **Note** | |
| 2 | 1002 | P337/22 | Declarations of Interests – and changes to be notified | David Rogers | **Note** | |
| 3 | 1003 | P338/22 | Minutes of the Previous Meeting held on 14th July 2022 | David Rogers | **Approval** | **Enc. 1** |
| 4 | 1005 | P339/22 | • Action Monitoring Schedule<br>• Matters arising not covered by the rest of the Agenda | David Rogers | **Note** | **Enc. 2** |
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| 5 | 1010 | P340/22 | Patient Story - TCP | Kenny Laing | **Note** | **Video** |
| 6 | 1025 | P341/22 | REACH Recognition Team Award – **Dawn Brown - Stoke-on-Trent Community Directorate** | Dr Adeyemo | **Note** | **Verbal** |
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| 7 | 1035 | P342/22 | Chief Executives Report | Dr Adeyemo | **Note** | **Enc. 3** |
| 8 | 1045 | P343/22 | Chairs Report | David Rogers | **Note** | **Verbal** |
| 9 | 1050 | P344/22 | Questions from Members of the Public | David Rogers | **Note** | **Verbal** |
| | | | ***10 minute break*** | | | |
| | | | **QUALITY** | | | |
| 10 | 1100 | P345/22 | Safer Staffing Monthly Report July 2022 | Kenny Laing | **Assurance** | **Enc. 4** |
| 11 | 1110 | P346/22 | Safe Staffing Annual Report 2021/22 | Kenny Laing | **Assurance** | **Enc. 5** |
| 12 | 1115 | P347/22 | Serious Incident Report Quarter 1 2022/23 | Dr Dennis Okolo | **Assurance** | **Enc. 6** |
| 13 | 1120 | P348/22 | Mortality Surveillance Quarter 1 Report 2022/23 | Dr Dennis Okolo | **Assurance** | **Enc. 7** |
| 14 | 1125 | P349/22 | Quality Committee Assurance Report from the meeting held on 4th August 2022 and 1st September 2022 | Patrick Sullivan | **Assurance** | **Enc. 8** |

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| 15 | 1130 | P350/22 | Improving Quality and Performance Report (IQPR) Month 4 | Eric Gardiner | **Assurance** | **Enc. 9** |
| 16 | 1135 | P351/22 | Service User Carer Council Update July / August 2022 | Sue Tams | **Assurance** | **Enc. 10** |
| **PEOPLE** | | | | | | |
| 17 | 1145 | P352/22 | Freedom to Speak Up Report 2021/22 | Marie Barley | **Assurance** | **Enc. 11** |
| **PARTNERSHIPS** | | | | | | |
| | | | No items | | | |
| **SUSTAINABILITY** | | | | | | |
| 18 | 1200 | P353/22 | Finance Report Month 4 | Eric Gardiner | **Assurance** | **Enc. 12** |
| 19 | 1210 | P354/22 | Finance and Resources Committee Assurance Report from the meeting held on 1st September 2022 | Russell Andrews | **Assurance** | **Enc. 13** |
| 20 | 1220 | P355/22 | Board Assurance Framework Quarter 1 2022/23 | Laurie Wrench | **Assurance** | **Enc. 14** |
| **CONSENT ITEMS** | | | | | | |
| 21 | 1230 | P356/22 | Any Other Business | David Rogers | **Note** | **Verbal** |

**Date and Time of Next Public Board Meeting**
**Thursday 13th October 2022 at 10.00am Via TBC**

**TRUST BOARD**

**Minutes of the Public Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 14th July 2022 At 10:00am via MS Teams**

**Present:**

**Chair:**

David Rogers
Chair

**Directors:**

Patrick Sullivan
Non-Executive Director / SID

Janet Dawson
Non-Executive Director / Vice Chair

Dr Buki Adeyemo
Interim Chief Executive

Tony Gadsby
Associate Non-Executive Director

Phil Jones
Non-Executive Director

Laurie Wrench
Associate Director of Governance

Joan Walley
Non-Executive Director

Dr Dennis Okolo
Interim Medical Director

Dr Keith Tattum
GP Associate Director

Shajeda Ahmed
Director of People, Organisational Development & Inclusion

Eric Gardiner
Executive Director of Finance, Performance and Estates

Pauline Walsh
Associate Non-Executive Director

Ben Richards
Director of Operations

**In attendance:**

Lisa Wilkinson
Corporate Governance Manager

Joe McCrea
Associate Director of Communications

Patient Story
Ade (Adebayo Olajide) – Clinical Psychological Services
Jane Parker - Senior Clinical Psychologist
Laura Jones – Service Manager
Conor Coman - Trainee Clinical Psychologist
Veronica Emlyn - Patient Experience Lead

REACH Team Award
Facilities Team
Anne Melville – Head of Facilities
Sue Petrozzi – Support Services Assistant

Members of the Public
No members present

The meeting commenced at 10:00am

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| **309/2022** | **APOLOGIES FOR ABSENCE**<br>Sue Tams, Chair, Service User and Carer Council, Jenny Harvey Unison Representative, Russell Andrews Non-Executive Director, Chris Bird Director of Partnerships, Strategy and Digital, Kenny Laing Executive Director of Nursing and Quality | **Action** |
| **310/2022** | **DECLARATION OF INTEREST RELATING TO AGENDA ITEMS**<br>There were no declarations made.<br><br>***Noted*** | |
| **311/2022** | **MINUTES OF THE OPEN AGENDA – 9TH JUNE 2022**<br>The minutes of the open session of the meeting held on 9th June 2022 were approved.<br><br>***Received*** | |
| **312/2022** | **ACTION MONITORING SCHEDULE AND MATTERS ARISING FROM THE MINUTES**<br>The Board reviewed the action monitoring schedule and agreed the following:-<br><br>***300/22 Quality Committee Assurance Report - R&D Report***<br>***Tony Gadsby requested the link for the report. Lisa Wilkinson to action.*** *14.07.22 – Link circulated following the meeting.*<br><br>***306/22 Board Assurance Framework Quarter 4***<br>***Discussion to be had at a future Board Development Session around the ongoing development of a new prototype for the BAF in conjunction with CACI*** *14.07.22 - Complete. Laurie Wrench advised the new prototype would be developed over the next 4-6 weeks which would be shared with Executives and Non-Executives for comments.*<br><br>***Received*** | |
| **313/2022** | **PATIENT STORY - Ade (Adebayo Olajide) – Clinical Psychological Services**<br>Alastair Forrester introduced Adebayo Olajide. Veronica Emlyn, Patient Experience Lead, Jane Parker Senior Clinical Psychologist and Laura Jones Ward Manager, Ward 5 supported Ade. Ade talked about his personal difficulties and shared his experience of using the Trust's psychological services. A video was shared with the Board and will be made available on the Trusts public website.<br><br>Jane Parker explained when Ade came to the Clinical Health Psychology Team he saw one of the new trainees, Conor Coman and the two worked really well together. Jane Parker explained the team was very small and unfortunately did have quite a long waiting list and there had been staffing difficulties but the team had worked really hard to look at risk across the duration of people's waits. Risk assessments are carried out at the start of the process and safety nets are created.<br><br>Conor Coman took the opportunity to thank Ade for his bravery and making the video adding it had been a privilege and an honour to work with him.<br><br>Joan Walley suggested the Board needed to think about how we could build on this experience and talked about the link between physical and mental health and how we do the preventative work, the therapy and signpost people on. | |

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| | Patrick Sullivan felt the video highlighted the importance of psychological therapy and support for so many people in dealing with a wide range of challenges and felt this was a real reminder when we see figures about waiting lists that every individual on that waiting list is quite desperate to get to that support and is having to wait too long.<br><br>David Rogers acknowledged the recent focus on safe staffing of wards for Inpatient care but that there had been less of a focus on the adequacy of staffing for working in the community and therefore waiting lists had grown. The situation was a lot better than it had been but we are still not there yet in making the system aware of where the pressures are. Ben Richards also acknowledged the challenges around waiting lists but highlighted that there were processes in place to ensure people are safe whilst they are waiting. The challenge remains in terms of getting staff in posts but we are making positive steps.<br><br>Jane Parker highlighted the importance of voluntary sector services to help build safety nets and integration between CMHT and clinical health psychology. Jane Parker suggested the Trust consider looking at a meta clinic for patients who are going to fall through the gaps and these are our patients with complex physical health and complex mental health.<br><br>Joe McCrea advised a new member of his team Molly Mansfield, would be building up our stakeholder contacts with a particular brief to go beyond healthcare into public health, local government and the voluntary sector.<br><br>Dr Buki Adeyemo thanked Ade for emphasizing the importance of the psychological treatment he had received adding what was important to the Trust was that there was no separation i.e. we do not see physical or mental health separate therefore the Trust was really pleased to have the Mental Health Liaison Team. Dr Buki Adeyemo welcomed Jane Parkers idea of a multidisciplinary team approach and felt this was the way to work around challenges, specifically workforce which has been a complex situation and requires us to think differently. Dr Buki Adeyemo gave assurance, these were the things being worked through as a senior leadership team.<br><br>***Noted*** | |
| **314/2022** | **REACH RECOGNITION TEAM AWARD**<br>The REACH Recognition Team Award for July 2022 was presented to the Facilities Team.<br><br>Dr Buki Adeyemo introduced the team who were supported by Anne Melville, Head of Facilities.<br><br>The Facilities Team and Community Support Staff continue to provide a first class service to the Trust every year. The facilities team provide an excellent standard of work and unrivalled level of flexibility, whether it's cleaning, transport, the management of cleaning, coordination of staff, responding to COVID outbreaks, liaising with SERCO or overseeing the quality of patient meals.<br><br>The patient led assessments of the care environment we know will be re-established in the Autumn. In previous years, the Trust has performed strongly in all areas and remains in the top quartile for performance. In addition the Facilities Team continue to support the Observe and Act program of internal lead patient reviews linking with our Estates Team to ensure that all environments remain of the highest quality. | |

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| | The team fully embrace and deliver on all of the Trust values. Put simply, they are a can do and will do service. The pride that they take in their work is clear for all to see. The team make a hugely valuable contribution to our Trust services and have been a key part of our ability to manage the challenges of the COVID pandemic.<br><br>Anne Melville thanked the Board for the honour of receiving the REACH Award adding it was definitely teamwork and took the opportunity to say how proud she was of the team.<br><br>The REACH Award presentation was recorded and will be available on the public website.<br><br>Board members congratulated the team on their award.<br><br>***Received*** | |
| **315/2022** | **CHIEF EXECUTIVES REPORT**<br>Dr Buki Adeyemo updated the Board on activities undertaken since the last meeting and drew the Board's attention to other issues of significance or interest.<br><br>**Mental Health Representative – Integrated Care Board (ICB)**<br>Dr Buki Adeyemo confirmed that she had been appointed as the mental health representative to the Integrated Care Board (ICB) on behalf of the Trust.<br><br>**Dragons' Den has returned**<br>After a short break, Dragons' Den returned as one of our innovation platforms aimed to support staff in developing new ways of working and delivering services. Our Dragons' Den panel, made up of our executives, a non-executive, and a representative from our Service User and Carer Council, heard six fantastic pitches looking to gain support or resources for their ideas.<br><br>This year applicants brought a variety of fantastic ideas and innovations to the Den, ranging from developing our digital world to exploring how we use our outdoor space to thinking outside of the box on how we deliver care.<br><br>All six pitches will now be supported to take their project forward, working closely with the Research and Development and Finance teams.<br><br>**Administration Conference**<br>80 colleagues recently participated in Combined Healthcare's Administration Conference. It was a chance to thank our administration staff for all of the support and hard work they have provided over the past two challenging years, and continue to provide. The day provided time for staff to reflect on how they work and what development opportunities they want in the future, listen to the journeys of colleagues and their career progression and participate in Q&As. The guest was Pete Cohen, a motivational speaker who inspires audiences to think outside the box.<br><br>Patrick Sullivan referred to the West Midlands Provider Collaborative within the report and asked who lead the collaborative. Dr Buk Adeyemo confirmed the Chair was Rosheen Williams, who was the Chief Executive at Birmingham and Solihull, Mental Health Trust.<br><br>Tony Gadsby referred to the draft of the Mental Health Act and asked if there was anything in the bill that gave us cause for concern or would change the way we have to do things? Dr Buki Adeyemo confirmed the Board would need to work through the implications of the bill, but the immediate thing to note was the change around | |

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| | learning disability and autism that was highly likely to have an impact on how we manage patients with a diagnosis of learning disabilities and autism, we will need to establish whether there is an underlying mental health reason why they will be detained. Dr Dennis Okolo highlighted one of the changes was around the duration of the Section 3, with the workforce issues and having to have that additional demand might be a challenge.<br><br>Philip Jones stated that the Integrated Care Board (ICB) and the Integrated Care System (ICS) had not been as visible as it maybe could have been and suggested it would be worthwhile if we heard more about the programs of work, priorities and how it will engage going forward. Dr Buki Adeyemo confirmed updates would be provided as and when available. David Rogers suggested the ICS vision be a regular feature of all Board meetings and that there's an element in there which reflects what's moving forward.<br><br>***Received*** | |
| **316/2022** | **CHAIRS REPORT**<br>David Rogers provided a verbal update.<br><br>David Rogers advised Matthew Taylor, Leader of NHS Confederation had been raising the profile of the Confederation and had signed up all the ICS's to be part of the Confederation and was integrally involved in ICS development.<br><br>David Rogers talked about there being a need for each ICS to have a shared vision and purpose. What are we there to do? What are we going to achieve? Where are we going to make an impact? How are we going to do it? We also need data. The evidence base for things that are not good and what we are going to do about it. We need to be able to talk to each other about finance, about risk sharing and develop a way of dealing with that and finally, we need to get the relationships right across Staffordshire.<br><br>We need to be able to manage two things at the same time, deal with immediate crisis problems that need resolving but remain focussed on the longer term changes and plans and not lose sight of that point on the horizon that we are heading for. There is a mixture of frustration at the moment and a determination not to lose the benefits of collaboration that we identified during COVID.<br><br>***Noted*** | |
| **317/2022** | **QUESTIONS FROM MEMBERS OF THE PUBLIC**<br>The Trust continued to encourage the use of Ask the Board Online as part of its ongoing commitment to openness, transparency and innovation.<br><br>**Ask the Board question:**<br>What are your hopes for the Wellbeing College?<br>**From Adam Towlson**<br><br>**Response**:<br>Alastair Forrester provided a response. The Wellbeing College is co-produced and co-facilitated with service user and carers. It provides a wide range of courses, workshops and activities to support people, to help people to discover interests, and to develop their skills. It has a focus around mental wellbeing and recovery and is available to everyone in North Staffordshire who is over 18 years. Importantly the Wellbeing College is open for everyone and not just for people who have used mental health services in the past. | |

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| | We are currently developing a prospectus of courses. We are doing this by reaching out to our local communities to ask the questions about what kinds of courses people would like to access – essentially asking what it is that people need and find most valuable to maintain their mental wellbeing and recovery.<br><br>The college delivers courses at various venues throughout North Staffordshire; the college Summer School has been launched this week which includes sessions on:<br>• Physical Health – held at Port Vale<br>• Co-production<br>• Healthy Eating and Drinking<br>• Tackling Anxiety<br><br>We are currently developing a full year's prospectus; our vision being that the college will go from strength to strength and that co-production will remain at the heart of everything that the college provides.<br><br>It was agreed that Pauline Walsh and Alastair Forrester to discuss outside of the meeting potential links between the Wellbeing College and Keele.<br><br>Tony Gadsby asked as a Board how we would measure the success of the College. Alastair Forrester explained there would be an evaluation of each of the programs and gathering feedback from people that use the college, looking at the numbers and understanding what the benefits have been to individuals. Tony Gadsby suggested an annual report might be appropriate.<br><br>**Ask the Board question:**<br>As a patient who suffers with CPTSD, that more allowances and considerations are made for those of us who suffer with CPTSD and mental health issues in general.<br>It's really hard when you are arguing with medical professionals because you're too anxious (extreme fear) of doing a procedure etc. due to CPTSD or some other mental health issues. In most cases it's the consultants who ignore or show no or to little understanding, compassion or general empathy to a person's personal situation<br>**From Wendy Burr**<br><br>**Response**:<br>Dr Dennis Okolo provided a response. Complex PTSD is difficult and more severe if occurring in early life as well as where other factors are involved in its onset. The main stay of treatment is a combination of medication and psychological therapy.<br><br>Considering these patients' presentations, they ought to be treated sensitively and compassionately. Even more so as it may take years for the symptoms of complex PTSD to be recognised, in which case the developmental history is pivotal in unearthing some of the symptoms, including the associated behaviours which get altered as patients get older.<br><br>The Trust will offer support where needed and highlight the points made to consultants about continuous need for compassion in sensitively obtaining information and discussing treatment options in general and particularly in patients with CPTSD. Ben Richards advised work had taken place around the Armed Forces Covenant and Veterans Aware where there had been some really good examples where people had dealt with CPTSD.<br><br>***Noted*** | **AF** |
| **318/2022** | **NURSE STAFFING MONTHLY REPORT (April 2022)** | |

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| | Alastair Forrester, Deputy Director of Nursing and Quality presented the report.<br><br>During May the overall fill rate was 91.6%. This decreased slightly from 93.7% recorded in April. The fill rate for registered nurse shifts was 80% a very small decrease from 80.5% the previous month. We continue to encourage staff to highlight incidents relating to staffing levels and in May there were 12 incidents that were reported. These were all within our adult acute wards and the Darwin Centre and they were due to short notice sickness and increased acuity within the patient group. None of these incidents resulted in patient harm.<br><br>We continue to use bank and agency staff to support shortfalls and we continue to perform well around care hours per patient day and we do remain in the upper quartile nationally for the high number of care output per patient day. Registered nursing vacancies did increase in May by 4.8WTE. In comparison, our healthcare support work positions continue to be over established which helps with our overall vacancy position and provides a level of consistency and also reduced reliance on temporary staffing. We continue to have a number of recruitment pathways and have 35 graduate nurses who will be commencing in October with the Trust which will have a big impact on our current vacancy level.<br><br>Patrick Sullivan noted the CQC recently visited Cumbria, Northumberland, Tyne and Wear (CNTW), which is an outstanding organisation and highlighted at one point the service did not have enough nursing and support staff to keep people safe and were using high levels of agency. It quotes levels of vacancies and some of those vacancy rates would be very similar to ours Patrick Sullivan felt the CQC were starting to criticise organisations around inadequate staffing levels and they had effectively put some private sector companies out of business.<br><br>Phil Jones referred to Registered Nurse vacancies noting the increase at Psychiatric Intensive Care Unit (PICU) in particular which had 9.4WTE. Phil Jones asked how we were coping on that particular unit and what had led us to that position. Alastair Forrester provided some assurance around PICU advising regular updates took place with Ward Managers to review particularly vacancies, turn over and sickness rates. PICU does use agency staff but they use a very regular group of agency staff to ensure consistency within the staff team. There has been no significant increase in incidents, but we are mindful it is the highest area of vacancy that we have at the moment.<br><br>Phil Jones acknowledged that Eric Gardiner was undertaking a piece of work to convert some of the long term agency staff into permanent employees. Phil Jones asked if we were able to do this with any of the agency staff on PICU. Alastair Forrester confirmed conversations with taking place with agency bank staff and bank staff to see if we can recruit them substantively and there is a huge degree of flexibility that is afforded to people who work on an agency and we are trying very hard to meet people's requests around flexible working.<br><br>Janet Dawson asked if we had enough staff to keep all wards open and if the Board had done enough in terms of governance in the event of an incident and could this be evidenced. Janet Dawson acknowledged previous discussions about measuring community safer staffing and Derbyshire's Community Board has a piece of software that does that and suggested it might be worth looking to see whether somebody else had the answer to something we are trying to build. Dr Buki Adeyemo provided assurance that the Trust had staff to staff the wards and a way of prioritising services and would take decisions to close services where it was deemed unsafe to manage them. | |

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| | Shajeda Ahmed highlighted the need, in terms of CQC, to be realistic in the fact that the health and care sector use temporary workforce supply and that was perfectly fine to do as long as we had assurance levels in place. We need to be looking more around what our flexible working proposition is and the system as a whole is looking at this in terms of how we make our recruitment proposition, our contracts of employment, more flexible to try and draw in more people who are currently occupying the temporary labour market workforce supply. We also have the vacancy management plan and great inroads have been made in terms of really enhancing our recruitment and retention proposition.<br><br>Laurie Wrench provided assurance that the Trust had a thorough induction process for agency and bank staff and the Trust was very much cited on the Greater Manchester and CNTW report and were looking at where lessons can be learnt and ensure that we are prepared for a CQC visit.<br><br>Joan Walley highlighted the increasing role of anchor institutions in the NHS and some really good work that has been taking place in the region and asked for the Deputy Director of Public Health to be invited to speak at a future Board Development Meeting re: Anchor Institutions.<br><br>***Received*** | **LW** |
| **319/2022** | **Infection, Prevention and Control Annual Report (DIPC) 2021/22**<br>Alastair Forrester, Deputy Executive Director of Nursing and Quality presented the report.<br><br>Last year was a very difficult year in terms of managing COVID-19 and the report shows the spread of COVID-19 outbreaks throughout the year. There were 23 outbreaks in total. These were ward based or based within community teams and sometimes staff only outbreaks.<br><br>There were a certain number of peaks in the early part of this year due to the Omicron variant and we had a number of outbreaks, sometimes up to six outbreaks at any one time within certain areas.<br><br>We delivered a very successful COVID vaccination program. 95% of our workforce including our partners, CDAS and SERCO were fully vaccinated, there were 97% of staff partially vaccinated and 83% of staff who received vaccines one and two and also the booster dose. There was a slightly lower flu vaccination program uptake last year 60.2% but that was reflective of the national update rate.<br><br>IPC training continues to be delivered through e-learning and we achieved 89% last year as a Trust.<br><br>The IPC team continues to support the Water Safety Group. There was one case of C-Difficile, which was determined to be a community acquired infection. There were 57 cases of E-Coli.<br><br>Tony Gadsby noted in terms of the flu vaccination 60% intake was quite a reduction from previous years and given the indications of a high incidence of flu coming out of Australia asked if we were making any plans to improve this? Alastair Forrester confirmed the Trust had already commenced planning and we will be linking in with University Hospital of North Midlands (UHNM) again this year. This winter we may also have the COVID booster as well to provide to our staff. We have a 90% CQUIN target around this so we are very focused on ensuring that we can achieve that. We have 40 trained vaccinators within the Trust and we plan to deliver some clinics on | |

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| | site at the Harplands along with a number of mobile clinics and roving vaccinators to capture as many staff as we can and to encourage uptake.<br><br>***Received*** | |
| **320/2022** | **Okenden Report**<br>Alastair Forrester, Deputy Director of Nursing and Quality presented the report.<br><br>The report was a review of maternity services at Shrewsbury and Telford hospitals. The review commenced in 2017 and was a significant wide-ranging review of the maternity service and also family experiences. There were some principal findings that the Trust were asked to consider around the quality of care in the investigation processes and the ability of services to learn lessons from those investigations and the report itself highlighted that care had fallen below best practice. There was only one external review that had been undertaken that did not acknowledge any system wide failings. There was failure to follow national clinical guidelines or lack of action from senior clinicians following escalations and the report talks about this culture of between some professional groups as well.<br><br>The report focusses also on the lack of psychological safety and due to that there was then an inability to make some of the positive changes that the Trust would need due to the constant change in the leadership team that also impacted on the delivery of service improvements. The report talks about the reviews often being cursory, not being multidisciplinary, not identifying the underlying systemic failings and some significant cases of concern were not investigated at all. It was noted there were things within the report that we need to consider and reflect on and ensure that we have that assurance.<br><br>Janet Dawson talked about the culture, highlighting the importance of freedom to speak up and people not being brave enough or scared of retribution. The good news for our Trust when we look at our staff survey and the results is that the culture within our own organisation is for people to feel comfortable to speak up.<br><br>***Received*** | |
| **321/2022** | **Mortality Surveillance Annual Report 2021/22**<br>Dr Dennis Okolo, Interim Executive Medical Director presented the report.<br><br>The report covers patients who have died naturally between 1st of April 2021 to March 2022.<br><br>The reviews tend to centre on the quality of care provided to the patients from the Trust preceding their death and sets out the context of the investigations or reviews, but also why this is important and defines premature mortality.<br><br>The reviews are primarily geared towards continuous improvement of care, irrespective of whether the quality of care they received was a contributor to their death or not. It also follows on with the methodology adopted from the Royal College of Physicians. The data shows that of the 62 reviews all were good, adequate and excellent, but for two that that were rated as poor, further details of which are included within the report.<br><br>***Received*** | |
| **322/2022** | **QUALITY COMMITTEE ASSURANCE REPORT** | |

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| | Patrick Sullivan, Non-Executive Director / Chair presented the assurance report from the committee held on the 7th July 2022. Patrick highlighted the following:<br><br>It was not possible to hold the Quality Committee meeting due to quoracy. Papers were therefore circulated virtually to Quality Committee members for comment and approval, particularly those papers that were presented at Board.<br><br>The Board were asked to ratify the policies that were approved virtually by the Committee.<br><br>***Received / Ratified*** | |
| **323/2022** | **IMPROVING QUALITY PERFORMANCE REPORT (IQPR) – Month 2**<br>Eric Gardiner, Executive Director of Finance, Performance and Estates presented the report:<br><br>The IQPR used a balanced scorecard approach which remains a work in progress and will have some refinements over the next few months.<br><br>Our performance does remain very positive. There were 17 measures that met the standards and the 13 that had not, there were 3 special cause variations compared to 6 last month. These related to referral to treatment with 18 weeks, recovery and agency spend. There remained 2 performance improvement plans in place.<br><br>Patrick Sullivan noted the decline in the number of targets being met since January 2022 and asked if we anticipated it would get harder to meet these targets as time goes on given the context that people are having to work in. Eric Gardiner confirmed this was the case which came back to discussions that we have around our staffing and doing as much as we can to be innovative to recruit people. We know the demand for mental health services is growing. Challenges remain from coming out of COVID which have not gone away, whilst we cannot give assurance that we are going to hit all the targets this year, we will do our best to look after our service users through the next 12 months.<br><br>***Received*** | |
| **324/2022** | **SERVICE USER AND CARER COUNCIL REPORT**<br>Alastair Forrester, Deputy Director of Nursing and Quality presented the report.<br><br>The Council are currently reviewing the service user and carers strategy and identifying priorities of how we can take that strategy forward.<br><br>There was a general discussion around discharge and patients receiving a lack of clarity in some discharge letters. There is a piece of work that is going on it has been raised through transformation discussions and it will look at a review of some of the Lorenzo documentation to try and ensure letters are more meaningful for people.<br><br>The peer support worker network meetings are continuing to provide training, supervision and support to peer support workers. We recently successfully recruited a Band 5 Senior Peer Support Worker and we are currently reviewing the Volunteer policy which will be linking into the requirements of the NHS Patient safety framework to recruit some volunteer patient safety partners who will support our patient safety agenda.<br><br>We recently submitted our application for triangle of care and the patient experience team are working through requirements of that. | |

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| | Joan Walley asked if there was any way of ensuring that all our different departments or services were covered by the umbrella of what the Council actually offers and if there were any kind of weaker areas where we might need to provide support for greater involvement from those weaker areas. Alastair Forrester advised we work with a very diverse range of service users and the service user council can only accommodate a certain number of people and naturally we know that we try to support everybody that attends the Council and people will have their own concerns that they want to bring to the Council to discuss. We are mindful of refreshing and renewing the membership of the Council.<br><br>***Received*** | |
| **325/2022** | **ASSURANCE REPORT FROM THE PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE**<br>Janet Dawson, Non-Executive Director / Chair presented the summary from the meeting held on the 4th July 2022 and highlighted the following:<br><br>Janet Dawson advised there was a podcast available of the very positive staff story received by the Committee from a staff member who was part of developing the Aspirant Leaders Program.<br><br>The Committee received the Freedom to Speak Up Annual Report and it was great to see such a focus on this and we have now appointed three days a week to a substantive role.<br><br>The Committee received a full report on the Staff Support and Counselling Service over the last 12 months. This dealt with the second year of COVID and provided a really fantastic program that is available to people, both in terms of face to face support and in terms of learning and various courses they can attend.<br><br>There were no policies for approval<br><br>Phil Jones asked in terms of the Freedom to Speak Up Annual Report of the 46 issues which were raised, most of them appeared to be around line management issues yet the staff survey indicated this was a fairly positive area for us, is this something we should be concerned about. Janet Dawson advised when these are investigated, the role of line management is sometimes to encourage people to do something and maybe about change management. What we do not want to see is bullying and unfairness, but managers do have the right to manage and to move things on if necessary ensuing this is done in the right way therefore we did not feel that there were undue concerns around that.<br><br>Laurie Wrench advised the Freedom to Speak Up report would come to September Board as it has to be the Guardian who presents the report as a national requirement. We are trying to encourage people to have the conversation with line managers in the first instance and come to the Freedom to Speak Up Guardian if they feel that they have not received an adequate response and one of the things we are promoting with line managers is to communicate and feedback to people who are raising the concerns. Therefore people perhaps do not feel it has been closed off or dealt with and managed and get that element of closure. This is something we are working on.<br><br>Shajeda Ahmed advised we are encouraging people to use whatever mechanism they wish to raise their concerns. We are undertaking an educational piece around that as sometimes people get can get confused as to what approach to use. All of | |

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| | our managers are going through coaching developmental learning in terms of that approach, also as an organisation that very much adheres to the principles of restorative just culture, as part of our e-learning, we have the Freedom to Speak Up Training for all of our workforce.<br><br>***Received / Ratified*** | |
| **326/2022** | **EQUALITY AND DIVERSITY ANNUAL REPORT (EDI)**<br>Shajeda Ahmed, Director of People, Organisational Development and Inclusion delivered the report.<br><br>The report supports the delivery of our duty in terms of the Equality Act 2010 as we are required to report and publish how we as an organisation are mainstreaming the equality duty and articulating the work that we're doing as a Trust and publishing progress made. The report seeks approval to be published.<br><br>In terms of some of the highlights for 21/22, we have been absolutely firm and steadfast in terms of delivering on this agenda. We are very proud to have been recognised for the excellence with some of the national awards including the HPMA Award for leading on EDI for 2021, the HSJ Staff Engagement Award for 2021 and the HSJ Workforce Race Equality Award for 2020 and as an organisation, we have been key in terms of our impact, not just within the Trust, but also across the wider the system in that education and developing the wider inclusion agenda.<br><br>The report includes a long list of achievements and captures some of the developmental work that has taken place within clinical services to try and embed inclusion and address health inequalities including new roles and services, in particular in relation to learning disabilities and the work of our Inclusion Council and Staff Network, for which we have received regional and national accolade in terms of the robust infrastructure that we have.<br><br>Phil Jones noted the lack of statistics around comparisons of where we are in terms of ethnicity, disability, female and male staff etc. compared to norms and elsewhere. Shajeda Ahmed advised this information would be supported with the publication of our diversity and inclusion data book our WRES and WDES reports our EDS and Gender Pay Gap report for the period up until March 2021. Year on year improvements around our WRES and our WDES data, has been highly pleasing. Shajeda Ahmed provided assurance there were no concerns.<br><br>Joan Walley refereed to the traveler's community and the legislation on the statute book which potentially is going to undermine this ethnic minority group, they are under quite a lot of stress in one way or another and when you look at different aspects of physical health and mental health, there are real concerns about mental health now. Joan Walley asked if there was scope as we go forward to have a spotlight on how effective we are enriching our understanding of what the mental health needs are for traveler communities. Shajeda Ahmed advised we had the EDS 3 which the Trust was piloting and she would ensure this was incorporated into that in terms of our reach out and focus.<br><br>***Received / Approved*** | **SA** |

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| **327/2022** | **MONTH 2 FINANCE REPORT (2022/2023)**<br>Eric Gardiner, Executive Director of Finance, Performance and Estates presented the report.<br><br>The Trust now has a break even planned which will be illustrated in next month's report that does not change the deficit position which we are reporting as at the end of Month 2 which is £832K. In Month 3 that trend does continue. We are accepting we are in a deficit position now and that will continue for a few months as we go forwards. That deficit is driven by three main things which is predominantly around the deficit with Transforming Care Programme (TCP) and the debt with the Council. We do have a plan around this and are expecting that debt will grow for the next few months, but then should reduce quite significantly in the last six or seven months of the year.<br><br>The second part of the deficit is driven by some non-recurrent items that unfortunately did not meet the 31st of March 2022 cutoff date. A small part of the overspend relates to CIP, which is currently behind plan.<br><br>In terms of agency spend this has reduced in month but it is in line with expectations. Agency caps are going to be reintroduced but they are going to be updated on a slightly different basis.<br><br>Patrick Sullivan questioned what needed to happen to break even. Eric Gardiner advised we do need to deliver our CIP and we need to deliver more than what we had in our plan. If that is resolved this will enable us to release a number of provisions which are in the balance sheet from the end of last year. In terms of what the ask will be of this year we are starting to see cost pressures which we have been told not to plan for. The first being COVID which is having a real impact particularly on the Acute Wards, inflation, and how the system deals with the system challenges.<br><br>Tony Gadsby asked in terms of the discussions with the local authorities, relative to TCP, are we going to put some sort of mechanism in place for subsequent years to ensure we do not have to have these discussions again. Eric Gardiner explained one of the key things which is a problem is the Councils do not have somebody to review the cases as quickly as we would like, therefore it may be possible for us to fund that post initially if that makes an impact and reduces costs.<br><br>***Received*** | |
| **328/2022** | **ASSURANCE REPORT FROM THE FINANCE AND RESOURCES COMMITTEE**<br>Phil Jones, Non-Executive Director presented the assurance report from the Committee held on the 7th July 2022 in Russell Andrews absence, highlighting the following:<br><br>The month 2 position shows a deficit mainly due to CIP delivery, non-recurrent expenditure and bad debt provision. Agency costs remain high at current run rate levels in month 2. Capital spend was slightly ahead of plan. The cash balance was behind plan mainly due to the late payments from the CCG's which have been settled during June. The Committee noted that the Better Payment Practice Code was not achieved in month. The Committee expressed their concern at the current in year position and remained supportive of any actions required to mitigate this. It was requested that a best, worst and most likely case is presented going forwards for the forecast financial position. | |

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| | The Director of Operations presented a paper to update on the latest position regarding the Trust CIP plan for 2022/23. It was noted that at month 2 just over half of the required CIP plans had been identified and achieving full CIP delivery remained a concern. The paper included a number of suggested areas in which exploratory work was taking place which would result in more transformational CIP. Assurance was given regarding cash releasing schemes which although did not contribute to the CIP target were being actioned to directly impact run rate costs. The committee were concerned regarding the current CIP position and noted the challenges facing colleagues.<br><br>The Deputy Director of Finance presented a paper on the latest annual forecast for TCP & P86 which includes price inflation and activity growth and has been built in conjunction with operational colleagues. It was noted that the inflationary price increase for providers had been agreed and would be fully covered by commissioners. The forecast is refreshed monthly and can at times be volatile given the low volume high cost nature of service placements. Committee will be presented with an update on a quarterly basis.<br><br>The Committee received a verbal update on the progress regarding two business opportunities. The Trust has worked in partnership with colleagues to develop a bid for Integrated Offender Health Services. This is an integrated service which includes some elements of existing provision delivered through the Trust for people in contact with the criminal justice service as well as new elements focussed on support for people leaving custodial sentences to integrate back into their communities. The process of developing the joint bid has been very positive and we now look towards September 2022 for the announcement of the preferred bidder.<br><br>There was a brief update on the progress to vertically integrate with another GP Practice following on from the detailed review at last committee. There remain no material issues of concern and the Trust is continuing to work with relevant partners to progress to business case stage.<br><br>Janet Dawson asked if details of bids come to the Board? Phil Jones advised bids are reported via the summary of the Committee. Larger business opportunities are brought in full papers to the Board. Philip Jones felt if the summary provided Inadequate detail, then a more detailed report may be required. Dr Buki Adeyemo highlighted the Trust's Standing Financial Instructions provided this detail. Laurie Wrench confirmed what came to Board was based on level of authority to approve as per the Standing Financial Instructions and Standing Orders.<br><br>Patrick Sullivan highlighted the importance around Non-Executives being aware of business opportunities being proposed due to potential conflicts of interest. This was acknowledged.<br><br>***Received*** | |
| **329/2022** | **AUDIT COMMITTEE SUMMARY**<br>Phil Jones, Non-Executive / Chair presented the Audit Committee Summary from the meeting held on 17th June 2022.<br><br>The committee received the Annual Accounts 2021/22 and noted that the Trust delivered its adjusted financial performance surplus, the cash requirement, the capital resourcing limit and the external financing limit. There were no changes to financial statements from the draft position on 25 April 2022. The surplus for the year for continuing operations was £1,461,000, total comprehensive income was | |

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| | £2,076,000. The Audit Committee received assurance through audit that the accounts had been put together in a sound and appropriate basis.<br><br>KPMG presented a report confirming that the Head of Internal Audit Opinion was one of: 'Significant assurance with minor improvements required'. The work confirmed that the Trust has a generally sound system of internal control in place which is designed to meet the Trust's objectives and that controls in place are being consistently applied in all key areas and reviewed. The report included the three final reviews which were the DSP Tool kit, Digital Transformation and Data Quality reviews with a total of 33 recommendations. Thanks were made to KPMG and the Finance Team and it was recognised that the Finance team had recently won the West Midlands HFMA Finance Team of the Year<br><br>The committee received the internal audit recommendations report which provided progress of internal audit recommendations with:<br>• 13 actions implemented<br>• 7 actions not yet due<br>• 3 actions overdue<br><br>Three extensions were requested and granted as follows:<br><br>• E-rostering<br>• TCP and Project 86<br>• Controlled drugs.<br><br>The Committee Effectiveness report was positive and will pick up any development points from that feedback.<br><br>Patrick Sullivan referred to the head of internal audit opinion providing significant assurance with minor improvements required and asked if the minor improvements were to do with technicalities and technical issues that that just need to be dealt with. Phil Jones advised they have their own kind of archive judgments within the internal audit control system and minor improvements is generally changes to controls or changes to processes or ways that we do things which are not fundamental to the operations of those systems.<br><br>Patrick Sullivan referred to the external audit report and financial statements and the significant risk around the management override of controls. Phil Jones advised the management overrides systems was something that every auditor had to look at as an inherent risk. It does not mean that we have that risk. It's an inherent risk because you can have all of the systems operating perfectly within an organization but if senior managers are in a position to override those controls then they have no effect.<br><br>Register of Declared Interests were received. Chairs action was requested to approve minor amendments to the Board member declarations paper which was agreed by the Chair of the Committee.<br><br>***Received*** | |
| **330/2022** | **CHARITABLE FUNDS COMMITTEE**<br>Joan Walley. Non-Executive / Chair presented the summary report for the Charitable Funds Committee meeting held on 27th May 2022 and verbal update from the meeting held on 8th July 2022. | |

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| | The Committee report to the Corporate Trustees therefore the report was brought to Board for information to advise of the progress being made to date.<br><br>There are now engagements across different departments and the Just Giving Page has now been established.<br><br>The Committee are also looking to proceed with membership of the NHS Charities Trust.<br><br>***Received*** | |
| **331/2022** | **BOARD MEMBERS DECLARATIONS OF INTEREST REGISTER**<br>Laurie Wrench, Associate Director of Governance presented the register.<br><br>The Board were asked to approve prior to publication to the Trust Public Website.<br><br>***Received / Approved*** | |
| **332/2022** | **QUARTER 1 STRATEGY UPDATE**<br>Dave Hewitt, Chief Information Officer presented the report.<br><br>The report highlighted progress made. There was one item currently highlighted RAG rated red which related to recruitment and retention.<br><br>The report included a dashboard broken down into strategic themes areas and during quarter 3 of this year we will be looking to undertake a review and update of the Trust Strategy which will be led by the Director of Partnerships, Strategy and Digital linking in across the organisation.<br><br>***Received*** | |
| **333/2022** | **BOARD ASSURANCE FRAMEWORK (BAF) OPENING DRAFT 2022/23**<br>Laurie Wrench, Associate Director of Governance presented the report**.**<br><br>Laurie Wrench presented the opening draft of the 2022/23 Board Assurance Framework. The report had been cited at Committees for comment.<br><br>There were a number of carryover options brought forward and a number of new objectives.<br><br>The team are in the process of developing a more visual document, which will be shared at a future Board.<br><br>***Received*** | |
| **334/2022** | **ANY OTHER BUSINESS**<br><br>There were no items of other business discussed.<br><br>***Noted*** | |
| | **DATE AND TIME OF NEXT MEETING**<br><br>The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 8th September 2022 at 10.00am Via MS Teams. | |

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| | **MOTION TO EXCLUDE THE PUBLIC**<br><br>The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted. | |

The meeting closed at 12:55pm

Signed: _____ Date_____
Chairman

# Board Action Monitoring Schedule (Open Section)

| | Trust Board - Action monitoring schedule (Open) | | | | | |
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| **Action** | **Meeting Date** | **Minute No** | **Action Description** | **Responsible Officer** | **Target Date** | **Progress / Comment** |
| 1 | 14th July 2022 | 317/22 | **Questions from Members of the Public**<br>Pauline Walsh and Alastair Forrester to discuss outside of the meeting potential links between the Wellbeing College and Keele. | Alastair Forrester | 8th September 2022 | **The Trust has been working with Keele and linking in with Christine Armstrong to explore how students could co-produce programmes for the wellbeing college.** |
| 2 | 14th July 2022 | 318/22 | **Nurse Staffing Monthly Report April 2022**<br>Joan Walley asked for the Deputy Director of Public Health to be invited to speak at a future Board Development Meeting re: Anchor Institutions | Laurie Wrench | 8th September 2022 | **Will be considered within the Board Development programme going forward.** |
| 3 | 14th July 2022 | 326/22 | **Equality and Diversity Annual Report**<br>Joan Walley asked if there was scope as we go forward to have a spotlight on how effective we are enriching our understanding of what the mental health needs are for traveller communities. Shajeda Ahmed advised we had the EDS 3 which the Trust was piloting and she would ensure this was incorporated into that in terms of our reach out and focus. | Shajeda Ahmed | 8th September 2022 | **To be included in the Board Development Session on Health and Inequalities.** |

# REPORT TO PUBLIC TRUST BOARD

Enclosure No: 3

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| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | CEO Board Report | | |
| Presented by: | Dr Buki Adeyemo, Interim Chief Executive | | |
| Author: | Dr Buki Adeyemo, Interim Chief Executive | | |
| Executive Lead Name: | Dr Buki Adeyemo, Interim Chief Executive | **Approved by Exec** | ☒ |

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| Executive Summary: | | **Purpose of report** | |
| This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest. | | **Approval** | ☐ |
| | | **Information** | ☒ |
| | | **Discussion** | ☐ |
| | | **Assurance** | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Resource Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☐<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☒<br>2. We will actively promote partnership and integrated models of working ☒<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | N/A | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | | |
| Shadow ICS Alignment / Implications: | N/A | | |
| Recommendations: | To receive for information and assurance | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1.0 | | 23/08/2022 |

# Interim Chief Executive's Report to the Trust Board
# 8 September 2022

## 1.0 PURPOSE OF THE REPORT

This report updates the Board on strategic activity undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.

## 2.0 STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE SYSTEM

The Integrated Care Board (ICB) has now appointed to the Executive Team with Chris Bird being the final member joining on the 1st August 2022 as Interim Chief Transformation Officer.

## 3.0 OUR TRUST

The summer has been busy despite many staff taking leave. There have been changes in the Executive Team and we have continued to build relationships across the ICB with Ben Richards taking on the system lead role for Mental Health and Learning Disability. Service improvement and transformation has continued, utilising clinical and corporate staff through the Community Mental Health Transformation and the service reviews that are taking place across the organisation. We have continued to deliver outstanding quality services despite the pressure of COVID-19 and IPC measures, workforce challenges and working with health and social care partners to meet population health demand.

Please see below examples of some highlights from the past 2 months.

## 3.1 QUALITY STRATEGIC THEME

### Annual General Meeting (AGM)

The AGM for Combined Healthcare will take place online as a virtual event on Friday 23rd September at 2pm. As well as the Trust's latest Annual Report, Financial Accounts and Quality Accounts being publicly launched, we will reflect on the achievements and key areas of work for Trust over the past year.

### Awards news

The Trust has recently been shortlisted for both 'Trust of the Year' and 'Mental Health Innovation of the Year' at this year's HSJ Awards ahead of the official awards ceremony to be held later this year on 17th November.

Ward 2 team at Harplands Hospital has been shortlisted for a Nursing Times award in the 'Enhancing Patient Dignity' category due to the development of the Recovery Book.

The Learning Disability (LD) team is also celebrating three shortlisted nominations for this year's Nursing Times Awards 2022 in the 'LD Nursing' category, for the PBS Project, Health Passports and digital implementation of the LD Nursing Model.

Finally, the Older Adults Community Mental Health Team have been nominated for the Your Heroes award.

**New 'Our Services' section on Trust intranet**

As part of the further improvements to the Trust's intranet site CAT, we have launched a new 'Our Services' section after a significant effort from across our frontline teams to update information.

**Learning Disability Nursing Conference**

I am pleased to see colleagues meeting face to face and being able to connect following a successful and well attended conference for front line staff with various guest speakers in attendance.

**3.2 PEOPLE STRATEGIC THEME**

**Senior staff changes**

Liz Mellor, formally Deputy Director of Operations has been appointed as the Interim Director of Strategy and Partnerships for 12 months and Rachael Birks has been appointed the Interim Deputy Director of Operations. A great example of promoting talent from within the organisation and succession planning. Interim arrangements are also now in place to cover Acute Services and Urgent Care.

**REACH Awards 2022**

I am pleased to be able to confirm REACH awards will be held face to face this year on 10th November, there will also be watch live online option. The planning and nominations process is well underway with over 100 nominations so far.

**3.3 SUSTAINABILITY STRATEGIC THEME**

Liz Mellor will now lead the ICS Green Plan and this will include a collaborative approach to the bid submission for Delivering a Net Zero NHS: Clinical Innovation Competition by October 2024.

**3.4 PARTNERSHIPS STRATEGIC THEME**

**North Staffs Wellbeing College launches with Summer School**

North Staffs Wellbeing College, an initiative from the Trust, recently launched with a successful week-long Summer School programme. The vision for the College is to offer, together with partner organisations, a wide range of courses, workshops and activities to support our community with discovering interests and developing their skills on their wellbeing journey.

**SMI annual Physical Health Checks promotion with Rethink Mental Illness**

As part of the Community Mental Health Transformation Programme, the SMI (severe mental illness) Physical Health team has been developing ways to make the annual physical health

check more accessible for service users and this includes building relationships with the mental health charity Rethink Mental Illness.

**First Primary Care newsletter for Community Mental Health Transformation Programme**

As part of the Community Mental Health Transformation Programme, the first newsletter targeted at colleagues in Primary Care across Stoke-on-Trent and Staffordshire was recently issued.

**PEGiS AGM**

Colleagues from the Trust including Ben Richards and Liz Mellor and a number of clinicians recently attend the AGM for PEGiS, a parent engagement group in Stoke-on-Trent, demonstrating the strong working relationships the Trust has with PEGiS.

**4.0 Conclusion**

As we prepare for Autumn and some of the challenges ahead, we know it will be a busy period for the Trust. Planning for winter and the continuing demand across the system, responding to the workforce pressures or the unknown of Covid now forms part of our day-to-day business. Collectively, with partners we will respond to the impact of the cost of living increase on our communities' whist continuing to deliver outstanding care to those who need our services.

# REPORT TO PUBLIC TRUST BOARD

Enclosure 4

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| Date of Meeting: | 8th September 2022 | | |
| Title of Report: | July 2022 Monthly Safer Staffing Report | | |
| Presented by: | Kenny Laing, Executive Director of Nursing & Quality | | |
| Author: | Alastair Forrester, Deputy Director of Nursing & Quality | | |
| Executive Lead Name: | Kenny Laing, Executive Director of Nursing & Quality | **Approved by Exec** | ☒ |

| Executive Summary: | **Purpose of report** | |
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| Purpose:<br>This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during July 2022 in line with the National Quality Board requirements.<br><br>Key Findings:<br>• During July 2022, an overall fill rate of 94.4% was achieved; this has increased from 93.5% in June 2022.<br>• The fill rate for RN shifts was 74.0% in July 2022, a decrease from 79.3% in June 2022.<br>• Ward occupancy levels increased in 2 areas and decreased in 11 areas during July 2022.<br>• RN vacancies increased by 1.20 WTE in July 2002 to 47.53 WTE<br>• HCSW vacancies remain over established by +5.51 WTE<br>• Recruitment to vacancies continues to be challenging with graduate nurses continuing to fill a majority of RN vacancies.<br><br>Recommendations:<br>The Quality Committee and Trust Board are asked to receive the report, to note the challenges in filling shifts and with recruitment to nurse vacancies, and to acknowledge and support the mitigations that are currently in place. The Board should be assured that the Trust are continuing to maintain safe staffing levels within our ward inpatient areas. | **Approval** | ☐ |
| | **Information** | ☒ |
| | **Discussion** | ☐ |
| | **Assurance** | ☒ |

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| Seen at: | SLT ☐ Execs ☒<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Resource Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☐<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☒<br>2. We will actively promote partnership and integrated models of working ☐<br>3. We will provide the highest quality, safe and effective services ☒ | | |

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| | 4. We will increase our efficiency and effectiveness through sustainable development ☐ | |
| Risk / legal implications:<br>Risk Register Reference | Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards. | |
| Resource Implications:<br><br>Funding Source: | Temporary staffing costs.<br><br>Budgeted establishment and temporary staffing spend | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | |
| Shadow ICS Alignment / Implications: | Nil | |
| Recommendations: | To receive the report for assurance and information | |
| Version | Name/group | Date issued |
| 1 | SLT | Virtual |
| 2 | Quality Committee | 01.09.22 |

## 1.0 Introduction

This report details the ward daily staffing levels during the month of July 2022 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to NHS Digital. Additionally from June 2018 Care Hours per Patient Day (CHPPD) have also been required to be reported to NHS Digital. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours (appendix 1).

## 2.0 Background

The monthly reporting of safer staffing levels is a requirement of NHS England and the National Quality Board in order to inform the Board and the public of staffing levels within in-patient units.

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a six monthly basis and report the outcome of the review to the Trust Board of Directors. A comprehensive annual report for 2020/21 was presented to the October 2021 Trust Board and the recommendations relating to safer staffing reviews are progressed and monitored through the Safer Staffing Group.

## 3.0 Trust Performance

During July 2022, the Trust achieved a staffing fill rate of 74.9% for Registered Nurses and 106.0% for care staff on day shifts and 72.0% and 112.3% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 94.4% was achieved; this has increased from 93.5% in June 2022.

Details of the actions taken to maintain safe staffing levels are provided below. Staffing data, including established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1.

The impact of unfilled shifts alongside the additional contributory factors are also provided below and are summarised in Appendix 2.

The Safer Staffing Group continues to oversee the safer staffing work plan and Safer Staffing Action Plan.

## 4.0 Care Hours per Patient Day (CHPPD)

The Trust is required to report CHPPD on a monthly basis. The CHPPD calculation is based on the cumulative total number of patients daily over the

month divided by the total number of care hours. The CHPPD metric has been developed by NHSI to provide a consistent way of recording and reporting deployment of staff providing care in inpatient units. The aim being to eliminate unwarranted variation in nursing and care staff distribution across and within the NHS provider sector by providing a single means of consistently recording, reporting and monitoring staff deployment. The CHPPD are therefore, the average number of actual nursing care hours spent with each patient per day.

Benchmarking for CHPPD is available through the Model Hospital for Mental Health Trusts. NSCHT performs in the upper quartile and, when compared to similar organisations, is well above the national median for the number of CHPPD. The latest reported position (Q4 2021/22) demonstrated that the Trust provides patients with an average of 14.5 CHPPD. In comparison the national median was 11.3 hours and the peer median which was also 11.3 hours.

## 5.0 Impact

WMs report the impact of unfilled shifts on a shift-by-shift basis.

### 5.1 Incidents reported relating to staffing levels

Staffing levels remained challenging during July 2022. There was one incident reported of staffing challenges within inpatient areas. This incident occurred at Ward 4 when a bank nurse attending for a night shift and not realising that the ward had a COVID outbreak and felt unable to work on the ward. The Site Manager was able to reallocate staff from elsewhere to cover this shortfall.

No patient harm occurred as a result of this incident.

### 5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. There were eleven occasions when patient activities were cancelled. There was also one occasion when patient activities were shortened due to shortfalls in staffing levels. This equated to 10 hours and 1 hour respectively. A majority of these cancellations occurred at Ward 1. On one occasion activities were able to be rescheduled.

### 5.3 Impact on Staff Experience

In order to maintain safe staffing levels the following actions were taken by Ward Managers during July 2022:

- 123 staff breaks were cancelled (equivalent to approximately 1.9% of total breaks). This figure has decreased from June 2022. Ward 4 reported the highest number of missed breaks, 29 in total. Any time

accrued due to missed breaks is taken back with agreement of the Ward Manager.

- During July 2022, 17 mandatory training sessions had to be cancelled, a majority of these (14) occurred at Ward 4 and were cancelled as a result of a COVID-19 outbreak and not due to staffing shortfalls.

- There were 8 reports of staff appraisals being cancelled, these all occurred at Ward 4.

**5.4 Mitigating Actions**

There were three COVID-19 outbreaks declared in July 2022, these occurred at Ward 4, Ward 5 and Edward Myers Unit (EMU). All wards have now re-opened with Ward 4 being the last to stepdown their outbreak measures on the 4th August 2022.

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. 498 RN shifts were covered by HCSW's where RN temporary staffing was unavailable. RN staff covered 153 HCSW shifts where HCSW temporary staffing was unavailable. Additionally, as outlined in section 5.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross-covered to support safe staffing levels.

There were 30 occasions in July 2022 (64 hours total) when members of the multi-disciplinary team provided additional support to maintain safe staffing levels. These occasions occurred most frequently at Ward 4. This mitigation continues to demonstrate the high level of flexibility provided by staff when responding to shortfalls.

There were at least 31 occasions (35 hours total) reported when staff worked additional unplanned hours to support ward staffing levels. These occasions occurred most often at Ward 3, Ward 4 and the Darwin Centre.

Daily Safer Staffing Huddles continued during July 2022, providing an efficient and effective response to identifying and mitigating potential staffing shortfalls. The commitment and dedication of all Trust staff in supporting and responding to staffing requests continues to be recognised.

**5.5 Bank and Agency Usage**

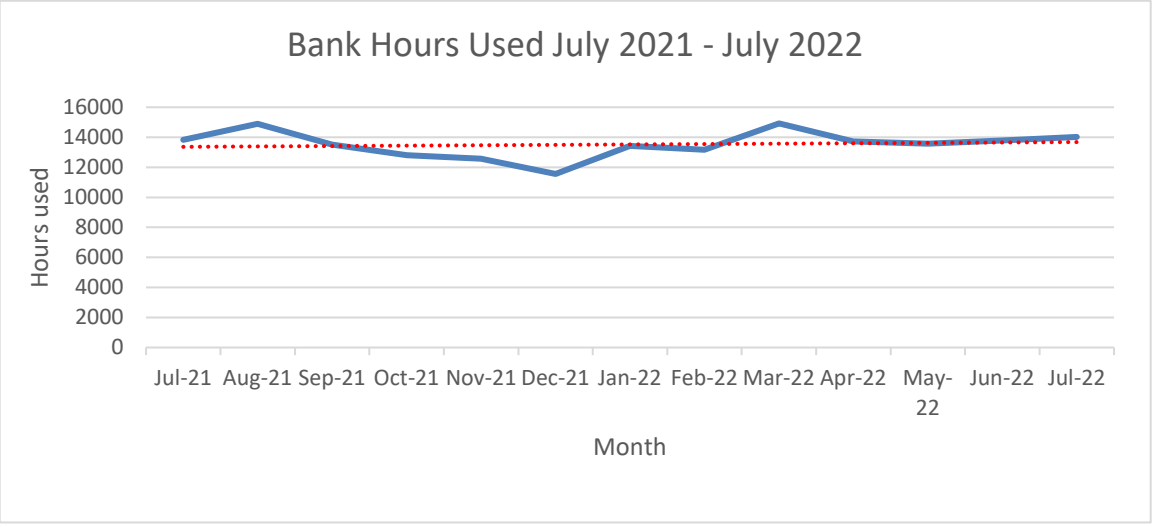
The Temporary Staffing Team have continued to engage bank and agency staff to cover staffing shortfalls until at least September 2022. This is in addition to the twelve shifts for agency 'pool' staff that have been approved each day to support ward inpatient areas. The Temporary Staffing Team have been able to provide a

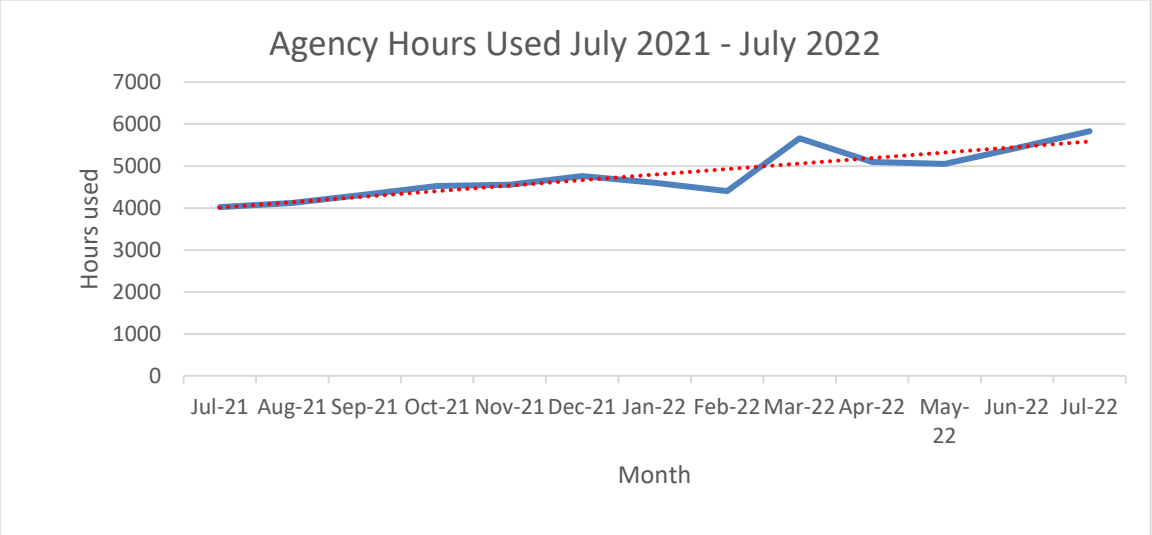
number of agencies with direct access to the Healthroster, enabling them to view shortfalls and allocate staff accordingly.

Bank and agency usage continues to be essential for the maintenance of safe staffing levels. This is demonstrated in the two graphs below. The requirement for nursing bank hours has remained constant during the past 12 months – averaging 13,500 hours each month.

Agency nurse usage has significantly increased over the same period, increasing from 4,020 hours in July 2021 to 5,820 hours in July 2022, this is demonstrated by the trend line. Total agency nurse usage within ward areas has averaged 4,800 hours per month during the past 12 months. We do not expect to see any significant reduction in overall agency usage until at least September/October 2022 when our next cohort of nurse graduates will commence with the Trust.

**Bank and Agency Usage within inpatient areas July 2021 – July 2022**



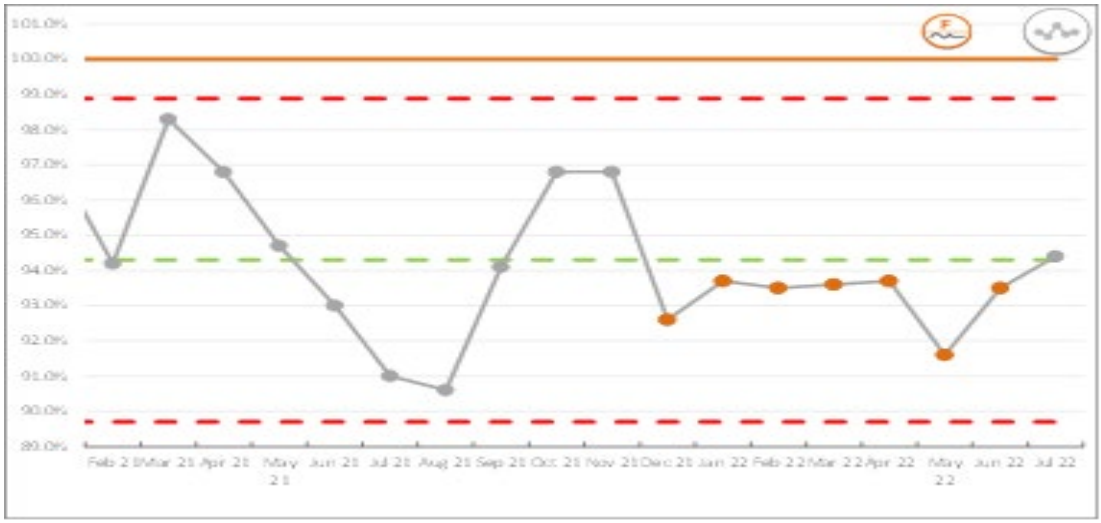
### 5.6 Overall Fill Rate

The overall staffing fill rate during July 2022 was 94.4%. This has increased from 93.5% in June 2022 and is outlined in the SPC chart below. The chart provides an overview of the total fill rate for the past 18 months. During this period staffing fill rates have remained within the area of common cause variation.

A decline in the overall fill rate can be seen between March and September 2021. This has been more noticeable than in previous years due to the ending of the March student nurse intakes and the resulting absence of spring graduates. As expected fill rates began to improve from September 2021 when a number of graduate RN's commenced with the Trust. Fill rates dipped again in December 2021, this was primarily due to increased levels of COVID-19 infections and a reduced availability of bank and agency staff. From January - July 2022 an average fill rate of 93.4% has been achieved.

The Trust continues to take the required actions to mitigate any shortfalls in fill rate and this position is summarised above in section 5.4.

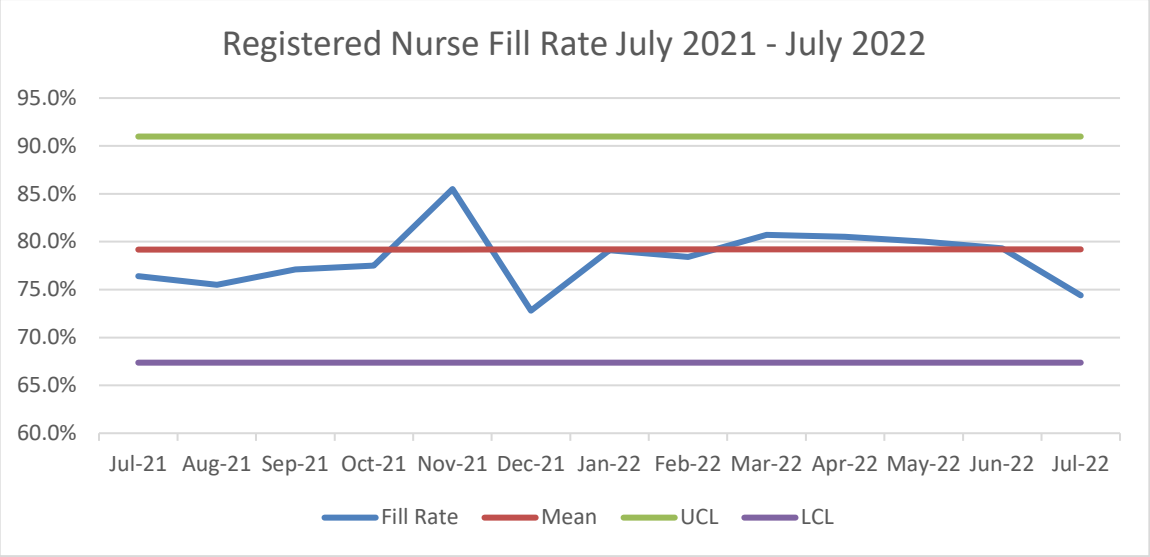
**Overall Fill-Rate December 2020 – July 2022**




### 5.7 Total Registered Nurse Fill-Rate

The total Registered Nurse fill rate during July 2022 was 74.4%. This has decreased slightly from the 79.3% fill rate reported in June 2022.

The trend over the past 18 months is presented in the chart below. We can see that the RN fill rate has consistently remained within the area of common cause variation though remains a challenge due to the reasons outlined above.




### 5.8 Recruitment

In line with the national picture, recruitment to all nursing posts continues to be difficult. A Task and Finish Group has been working to deliver 33 recruitment and retention schemes.

The Trust continues to employ a majority of our RN's from the newly graduating student nurse cohorts. During October 2021, 27 nursing graduates commenced with the Trust and it is predicted that at least a further 41 graduate nurses will commence in October 2022. Relationships with both local HEI's, as well as those further afield remain strong and have helped to improve recruitment and attract the best graduates to join our workforce.

A cohort of 7 BSc Nursing Apprentices commencing in April 2022 and we are currently planning for the commencement of 6 MSc Nursing Apprentices in September 2022.

Furthermore, the Trust Board have recently approved funding to support the recruitment of a cohort of 20 Trainee Nursing Associates who will commence training in September 2022 with Keele University.

We continue to deliver a robust programme of preceptorship to our newly qualified nurses. We also support a number of academic programmes, which run alongside significant work based and placement learning.

In addition, we are currently expanding our support for nurses who trained overseas to enable their registration to be recognised in the UK. We are continuing to contribute to the regional NHSE international nurse recruitment programme for mental health and learning disability nurses and we have secured funding to support a collaborative bid to recruit 10 MH Nurses from overseas.

### 5.9 Registered Nurse and HCSW Retention

During July 2022, three Registered Nurses (3.00 WTE) left the Trust; two Community Nurses and one from the Acute and Urgent Care Directorate (Ward 3). The reasons provided for leaving were relocation and for an improved work life balance.

Three HCSW's (2.80 WTE) left the Trust during July 2022. All were from the Specialist Directorate. Two worked within inpatient areas and one within the community. Reasons provided for leaving were the same as for our RN leavers, relocation and for an improved work life balance.

### 5.10 Staff support and well-being

The Nursing Directorate continue to offer support and advice on staffing issues and they receive daily staffing updates from Ward Managers, Quality Improvement Nurses (Matrons) and the E-Rostering and Temporary Staffing Team as appropriate.

The E-rostering team have continued to maintain the co-ordination and allocation of the bank staff and the agency pool. The operational directorates have welcomed this support and intervention.

To further support the nursing teams a number of Registered Nurses are undertaking the Professional Nurse Advocate (PNA) Training Programme. This is a Level 7 Accredited PNA Training Programme accessible to Bands 5 and above. It will support the facilitation of restorative clinical supervision in practise, and lead and deliver quality improvement initiatives in response to the service demands and the ongoing changing patient requirements.

The Trust preceptorship programme has been enhanced, providing additional support and supervision for our newly registered staff. The initial induction programme has been updated to ensure that staff receive a thorough briefing regarding COVID-19 and the required Infection Prevention and Control (IPC) standards and expectations.

The Ward Managers Forum takes place each month. This meeting has recently undergone a significant review of the meeting structure and format. Dedicated time is provided for reflection, group supervision, and wellbeing discussions. Additionally, the senior nursing team continue to maintain visibility within ward inpatient areas.

The Staff Psychological Wellbeing Hub are now providing regular in reach sessions within ward areas. Recognising that staff may benefit from some additional support and time to discuss and reflect upon the challenges of work.

## 6.0 Summary

Ward staffing continues to be challenging during July 2022, with patient acuity continuing to be high within a number of wards.

Ward Managers, Service Managers and Quality Improvement Nurses (Matrons) continue to review staffing levels on a daily basis to ensure that patient safety remains paramount. Any significant staffing concerns are escalated through the operational directorates and via the Senior Operational Team.

RN vacancies within ward inpatient areas increased by 1.20 WTE to 47.53 WTE. Although this is the third consecutive monthly increase in RN vacancies, the overall staffing fill rate and RN fill rates remain high.

HCSW positions continued to be over established by +5.51 WTE during July 2022.

The national shortage of Registered Nurses and a reduction in university graduates continues to impact RN vacancies. The Nursing, Operational and Workforce Directorates are continuing to employ a number of strategies to attract both RNs and HCSW's during this time.

## 7.0 Recommendations

The Trust Board is asked to:

- Receive the report
- Note the challenges with recruitment and the mitigations that are currently in place
- Note the challenge in filling shifts in July
- Be assured that safe staffing levels have been maintained.

# Appendix 1 July 2022 Safer Staffing

| | Registered Nurses | | | | | | Care Staff | | | | | | Registered Nurse | | Care Staff | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward | Day Establishment Hours | Day Clinically Required | Day Actual | Night Establishment | Night Clinically Required | Night Actual | Day Establishment Hours | Day Clinically Required | Day Actual | Night Establishment | Night Clinically Required | Night Actual | Day Fill Rate (%) | Night Fill Rate (%) | Day Fill Rate (%) | Night Fill Rate (%) |
| Assessment & Treatment | 918.00 | 918.00 | 938.75 | 688.20 | 688.20 | 368.20 | 1162.50 | 2212.50 | 1556.00 | 688.20 | 1509.60 | 1556.70 | 102.3% | 53.5% | 70.3% | 103.1% |
| Darwin Centre | 1320.00 | 1320.00 | 637.50 | 688.20 | 688.20 | 355.20 | 1162.50 | 1207.50 | 1763.50 | 688.20 | 721.50 | 1033.30 | 48.3% | 51.6% | 146.0% | 143.2% |
| Edward Myers Unit | 918.00 | 918.00 | 841.00 | 341.00 | 341.00 | 344.10 | 1162.50 | 1162.50 | 709.00 | 688.20 | 688.20 | 588.30 | 91.6% | 100.9% | 61.0% | 85.5% |
| Summers View | 930.00 | 930.00 | 564.25 | 332.32 | 332.32 | 353.65 | 930.00 | 930.00 | 776.25 | 664.64 | 664.64 | 633.03 | 60.7% | 106.4% | 83.5% | 95.2% |
| PICU | 1413.00 | 1413.00 | 998.00 | 688.20 | 688.20 | 591.00 | 1674.00 | 2034.00 | 2136.00 | 1376.40 | 1642.80 | 1699.60 | 70.6% | 85.9% | 105.0% | 103.5% |
| Ward 1 | 1320.00 | 1320.00 | 916.00 | 344.10 | 344.10 | 388.50 | 1162.50 | 1582.50 | 1428.00 | 688.20 | 1032.30 | 931.05 | 69.4% | 112.9% | 90.2% | 90.2% |
| Ward 2 | 1320.00 | 1320.00 | 957.75 | 688.20 | 688.20 | 412.50 | 1162.50 | 1267.50 | 1554.00 | 688.20 | 743.70 | 1276.50 | 72.6% | 59.9% | 122.6% | 171.6% |
| Ward 3 | 1320.00 | 1320.00 | 1172.92 | 688.20 | 688.20 | 468.90 | 1162.50 | 1365.00 | 1461.08 | 688.20 | 843.60 | 1194.70 | 88.9% | 68.1% | 107.0% | 141.6% |
| Ward 4 | 1467.00 | 1467.00 | 947.58 | 344.10 | 344.10 | 348.70 | 1162.50 | 1732.50 | 2095.08 | 1032.30 | 1454.10 | 1403.30 | 64.6% | 101.3% | 120.9% | 96.5% |
| Ward 5 | 1320.00 | 1320.00 | 1040.57 | 688.20 | 688.20 | 367.20 | 1162.50 | 1312.50 | 1638.58 | 688.20 | 1376.40 | 1626.70 | 78.8% | 53.4% | 124.8% | 118.2% |
| Ward 6 | 1178.25 | 1178.25 | 994.05 | 688.20 | 688.20 | 356.43 | 1162.50 | 1387.50 | 1957.30 | 1032.30 | 1276.50 | 1623.60 | 84.4% | 51.8% | 141.1% | 127.2% |
| Ward 7 | 1320.00 | 1320.00 | 1036.00 | 344.10 | 344.10 | 344.10 | 1162.50 | 1162.50 | 1318.00 | 1032.30 | 1032.30 | 1021.20 | 78.5% | 100.0% | 113.4% | 98.9% |
| Totals | 14744.25 | 14744.25 | 11044.37 | 6523.02 | 6523.02 | 4698.48 | 14229.00 | 17356.50 | 18392.80 | 9955.34 | 12985.64 | 14587.98 | 74.9% | 72.0% | 106.0% | 112.3% |
| | | | | | | | | | | | | | | | | |
| Dragon Square | 1087.50 | 1087.50 | 959.75 | 310.00 | 310.00 | 308.75 | 1162.50 | 1162.50 | 979.00 | 620.00 | 680.00 | 360.00 | 88.3% | 99.6% | 84.2% | 52.9% |

| | Total Nursing Staffing | | | Total Hours Per Day | Patients | CHPPD | Safe staffing was maintained by | RN Vacancies | HCSW Vacancies | Bed Occupancy July 2022 | Movement |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward | Overall RN % | Overall Care Staff % | Overall Staffing | | | | | | | | |
| Assessment & Treatment | 81.4% | 83.6% | 82.9% | 4557.65 | 93.00 | 49.01 | Nurses working additional unplanned hours and altering the skill mix | 2.76 | -0.45 | 50% | ↓ |
| Darwin Centre | 49.4% | 145.0% | 96.2% | 4206.00 | 277.00 | 15.18 | Nurses working additional unplanned hours and altering the skill mix | 6.56 | -5.19 | 64% | ↑ |
| Edward Myers Unit | 94.1% | 70.1% | 79.8% | 2609.90 | 174.00 | 15.00 | Nurses working additional unplanned hours and altering the skill mix | 0.88 | 0.40 | 47% | ↓ |
| Summers View | 72.7% | 88.4% | 81.5% | 2537.18 | 303.00 | 8.37 | Nurses working additional unplanned hours and altering the skill mix | 2.60 | 0.00 | 92% | ↓ |
| PICU | 75.6% | 104.3% | 93.9% | 5548.60 | 182.00 | 30.49 | Nurses working additional unplanned hours and altering the skill mix and support from the MDT. | 9.40 | -0.48 | 97% | ↑ |
| Ward 1 | 78.4% | 90.2% | 85.6% | 3739.30 | 326.00 | 11.47 | Nurses working additional unplanned hours and altering the skill mix and support from the MDT. | 2.72 | 0.87 | 79% | ↓ |
| Ward 2 | 68.2% | 140.7% | 104.5% | 4651.25 | 475.00 | 9.79 | Nurses working additional unplanned hours and altering the skill mix | 5.94 | 0.82 | 70% | ↓ |
| Ward 3 | 81.8% | 120.2% | 101.9% | 5017.60 | 512.00 | 9.80 | Nurses working additional unplanned hours and altering the skill mix and support from the MDT. | 5.02 | -1.63 | 81% | ↓ |
| Ward 4 | 71.6% | 109.8% | 95.9% | 5276.17 | 441.00 | 11.96 | Nurses working additional unplanned hours and altering the skill mix and support from the MDT. | 3.52 | 0.68 | 94% | ↓ |
| Ward 5 | 70.1% | 121.4% | 99.5% | 4951.55 | 196.00 | 25.26 | Nurses working additional unplanned hours and altering the skill mix | 3.93 | -1.32 | 66% | ↓ |
| Ward 6 | 72.4% | 134.4% | 108.8% | 5524.38 | 354.00 | 15.61 | Nurses working additional unplanned hours and altering the skill mix | 3.79 | 1.31 | 76% | ↓ |
| Ward 7 | 82.9% | 106.6% | 96.4% | 4372.80 | 424.00 | 10.31 | Nurses working additional unplanned hours and altering the skill mix | 0.41 | -0.52 | 67% | ↓ |
| Totals | 74.0% | 108.7% | 94.4% | 52992.38 | 3757.00 | 14.10 | | 47.53 | -5.51 | | |
| | | | | | | | | | | | |
| Dragon Square | 90.8% | 72.7% | 80.5% | 2607.50 | 133.00 | 19.61 | Nurses working additional unplanned hours and altering the skill mix | 0.58 | 0.87 | 72% | ↓ |

## Appendix 2 Staffing Issues

- An overall fill rate of 94.4% was achieved during July 2022; this has increased from 93.5% in June 2022. Fill rates have remained consistent since January 2022.
- The RN fill rate decreased from 79.3% in June 2022 to 74.0% in July 2022.
- RN vacancies within ward inpatient areas increased by 1.20 WTE to 47.53 WTE.
- HCSW positions remained over established by +5.51 WTE in July 2022.
- RN night shift cover continues to remain challenging particularly in those areas with this highest RN vacancies and where more than one RN is required for the night-time shift.
- Three Registered Nurses and three HCSW's left the Trust during July 2022.
- Ward occupancy levels increased in 2 areas and decreased in 11 areas during July 2022.
- Patient acuity continued to remain high within the adult acute wards.
- There were 3 ward based COVID-19 outbreaks during July 2022.
- Ward teams are supported by Quality Improvement Lead Nurses (Matrons), Nurse Practitioners and a Site Manager who in turn, is also supported by an On-Call Manager out of hours.
- Safer Staffing Huddles continued during July 2022, providing an efficient and effective response to identifying and mitigating potential staffing shortfalls.
- Staffing levels continue to remain under constant review, ensuring that the Trust is as alert as possible to changes, which could affect safe staffing levels within our ward inpatient areas, these being our most critical services.

# REPORT TO PUBLIC TRUST BOARD

Enclosure 5

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Annual Safer Staffing Report 2021/22 | | |
| Presented by: | Kenny Laing, Executive Director of Nursing, AHP & Quality | | |
| Author: | Alastair Forrester, Deputy Director of Nursing & Quality | | |
| Executive Lead Name: | Kenny Laing, Executive Director of Nursing, AHP & Quality | **Approved by Exec** | ☒ |

| Executive Summary: | **Purpose of report** | |
|---|---|---|
| Summary:<br>An annual review of the nursing establishments is presented to the Trust Board in line with national best practice. The purpose of this paper is to provide assurance of safe nurse staffing levels. Ward staffing numbers have been determined using nationally validated tools. All ward staffing plans have been subject to professional review by Ward and Service Managers, QILN's (Matrons) and the Deputy Director of Nursing before final approval by the Director of Nursing.<br><br>Safe staffing levels have been maintained 2021/22 with newly graduating nurses making up a large majority of our Registered Nurse recruitment.<br><br>Daily safe staffing review meetings take place to evaluate real-time patient acuity and dependency, professional judgement, operational activity and information aligned to staff availability utilising the Trust's electronic rostering system.<br><br>Mid and full year staffing review meeting took place with all Ward Managers and Matrons during 2021/22. Formal reviews of staff levels using the MHOST tool took place in three acute ward areas where acuity was particularly high.<br><br>The Safecare tool was reintroduced in 2021/22 and is being used consistent across all ward areas. Going forward, this will support decision making around staffing reviews and establishment and skill mix reviews.<br><br>There continues to be a well-recognised national shortage of Registered Nurses. Reducing these vacancies remains one of the main priorities for the Trust. Several innovative methods of recruitment and retention have been explored during 2021/22.<br><br>Other developments and achievements that have supported safe staffing levels in 2021/22 are:<br><br>➢ The appointment of 87 Registered Nurses, 65 Healthcare Support Workers and 13 Allied Health Professionals (AHP's) during 2021/22<br>➢ The recruitment of a cohort of 7 BSc Nursing Apprentices commencing in March 2022<br>➢ Securing funding (circa £100,000) from Health Education England (HEE) to support up to 6 existing staff – Nursing Associates/Assistant Practitioners to undertake a two year nursing top up degree<br>➢ Expanding our support for nurses who trained overseas to enable their registration to be recognised in the UK.<br>➢ Supporting the regional international nurse recruitment programme<br>➢ Commencing the Professional Nurse Advocate (PNA) Training Programme<br>➢ The delivery of an enhanced preceptorship programme<br>➢ Development of a Trust Task and Finish Group to support recruitment and retention<br>➢ Building the clinical practice placement capacity for all learners<br>➢ Working in partnership with local Universities to deliver our Mental Health Apprentice Nurse programme.<br>➢ Recruitment within the Practice Education Facilitation Team to support members of specific ethnic groups | **Approval** | ☐ |
| | **Information** | ☒ |
| | **Discussion** | ☒ |
| | **Assurance** | ☒ |

| | | | |
|---|---|---|---|
| ➢ Commissioning of Safecare training for all Ward Managers, Deputy Ward Managers and Quality Improvement Nurses (Matrons)<br><br>Recommendations:<br>The Quality Committee and Trust Board are asked to note the challenges in filling shifts, the challenges with recruitment to nurse vacancies and to acknowledge and support the mitigations that are currently in place. The Trust Board should be assured that we are continuing to maintain safe staffing levels within our ward inpatient areas. | | | |
| Seen at: | SLT ☒ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ✓<br>• Finance & Resource Committee<br>• Audit Committee<br>• People, Culture & Development Committee<br>• Charitable Funds Committee | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ✓<br>2. We will actively promote partnership and integrated models of working ✓<br>3. We will provide the highest quality, safe and effective services ✓<br>4. We will increase our efficiency and effectiveness through sustainable development ✓ | | |
| Risk / legal implications:<br>Risk Register Reference | None identified | | |
| Resource Implications:<br><br>Funding Source: | NA | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | | |
| Shadow ICS Alignment / Implications: | Nil | | |
| Recommendations: | To receive the report for assurance and information | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | SLT | |
| 2 | Quality Committee | 01.09.22 |

## 1. Introduction

Since 2014 all Trust's in England have been required to monitor nurse staffing within in-patient wards to ensure that safe staffing levels are maintained. This monitoring comprises of monthly reporting to the Board and NHS England and an annual strategic staffing review; followed 6 months later by a comprehensive review focused on safer staffing workforce plans.

National Quality Board (NQB, July 2016) published *"supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: safe, sustainable and productive staffing".* This document provided an updated set of expectations for nurse staffing levels, to help NHS provider boards make local decisions that will support the delivery of high quality care for patients within the available staffing resource.

In addition NHS Improvement, (October 2018) published "*Developing workforce safeguards - Supporting providers to deliver high quality - care through safe and effective staffing".* This document strengthens requirements relating to governance and accountability in relation to Safer Staffing. Both this NHSI report and the NQB mental health resource (2018) inform Trust safer staffing practice and reviews moving forward. This document offered organisations best practice advice in effective staff deployment and workforce planning, relating to redesigning roles and responding to unplanned changes in workforce as well as helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually.

In line with the NQB requirements, a 12 monthly safe staffing review of staffing levels in inpatient areas has been completed with the results reported in this paper.

To enable the Board to meet this requirement this review has:

- Identified the progress made since the previous safer staffing review in 2020/21
- Examined current staffing levels
- Reviewed the MDT and skill mix; exploring new roles and training requirements
- Benchmarked with other MH trusts using Care Hours per Patient Day (CHPPD) data
- Highlighted areas of best practice and quality improvement undertaken by wards to ensure efficient and effective use of resources
- Provided recommendations that include practice, workforce and establishments

### 1.1 Background to safer staffing

In line with the NQB requirements the Director of Nursing & Quality has provided the Board with assurance in relation to safer staffing over the past 12 months. This has

been via monthly reports setting out the monthly fill-rates, the impact of fill-rates on service user and staff experience and the mitigations that are in place to maintain safer staffing within the in-patient wards.

The annual safer staffing review discussions for the 2021/22 review were held during April and May 2022. Involved in these discussion were Ward Managers and Quality Improvement Lead Nurses (Matrons) and the Deputy Director of Nursing, AHP & Quality.

### 1.2 National Context to Safer Staffing Levels

The National Quality Board (2013) published guidance sets out the expectations for all Trust Boards to *"take full responsibility for the quality of care provided to patients and as a key to quality take a full and collaborative responsibility for nursing and care staffing, care and capabilities".* The NQB requirements arose from the considerable discussion that has taken place regarding the impact that nurse staffing levels have on the quality of patient care. Francis (2013), Berwick (2013) and Keogh (2013) highlight the negative impact on patient outcomes where staffing levels are not sufficient. This has been highlighted in a number of high profile patient safety inquiries including the Mid-Staffordshire NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust. Furthermore in 2005 Lankshear published a systematic review of international research that looked at the relationship between nurse staffing and patient outcomes and found that *'higher nurse staffing and richer skill mix (especially of Registered Nurses) are associated with improved patient outcomes'*. The House of Commons Health Committee Report (2018) on the Nursing Workforce heard evidence that *'nursing shortages are now having a negative impact on the quality and safety of patient care'* and a number of recommendations are made by the committee in relation to working conditions, pay, continued professional development, flexible career pathways, routes into nursing and flexible working.

Further guidance, specific to Mental Health and Learning Disability Trusts, was published by the NQB in January 2018 and NHSI published 'Developing workforce safeguards' in October 2018. Additionally Mental Health Trusts have been required to report Care Hours per Patient Day (CHPPD) since July 2018.

## 2. Progress since previous annual review

A comprehensive annual report for 2020/21 was presented to the October 2021 Trust Board and the recommendations relating to safer staffing reviews are progressed and monitored through the Safer Staffing Group. Some of the staffing challenges experienced during 2020/21 have continued into 2021/22. As expected we have continued to experience staffing challenges relating to the COVID-19 pandemic. Increased community transmission rates often resulted in increased COVID related sickness absence amongst our nursing workforce.

We continued to experience a national shortage of Registered Nurses (RNs) and we continued to explore new pathways into nursing, innovative recruitment campaigns and retention initiatives supported by ward and corporate teams. The Trust aim continues to be not only to attract nurses to the Trust but to also ensure the retention and loyalty of those staff for the longer term. Despite these challenges, safe staffing levels have been maintained with the overall priority being the delivery of excellent patient care.

Progress achieved includes:

- The appointment of 87 Registered Nurses, 65 Healthcare Support Workers and 13 Allied Health Professionals (AHP's) during 2021/22
- The recruitment of a cohort of 7 BSc Nursing Apprentices commencing in March 2022
- Securing funding (circa £100,000) from Health Education England (HEE) to support up to 6 existing staff – Nursing Associates/Assistant Practitioners to undertake a two year nursing top up degree with Staffordshire University
- Supporting HCSW apprenticeships within our Acute and Urgent Care Wards; this includes our own apprentices and those who rotate through our ward areas as part of a Staffordshire wide programme
- Expanding our support for nurses who trained overseas to enable their registration to be recognised in the UK.
- We are continuing to contribute to the regional NHSE/I international nurse recruitment programme for mental health and learning disability nurses and we have secured funding to support a collaborative bid to recruit 10 MH Nurses from overseas
- A number of Registered Nurses who have commenced the Professional Nurse Advocate (PNA) Training Programme
- The delivery of an enhanced preceptorship programme, providing additional support and supervision for our newly registered staff
- The review and update of the Trust induction programme to ensure that staff receive a thorough briefing regarding COVID-19 and the required Infection Prevention and Control (IPC) standards and expectations
- Development of a Trust Task and Finish Group to support recruitment and retention
- Continuing to build the clinical practice placement capacity for all learners
- Continuing to work in partnership with local Universities to deliver our Mental Health Apprentice Nurse programme.
- Additional recruitment within the Practice Education Facilitation Team to support members of specific ethnic groups
- The commissioning of Safecare training for all Ward Managers, Deputy Ward Managers and Quality Improvement Nurses (Matrons)

The above areas are explored further within the report.

## 2.2 Nurse staffing levels performance April 2021 – March 2022

The two charts below provide details of the overall percentage of nurse staffing fill rate.

Chart 1 demonstrates that overall nurse staffing levels remained within the area of common cause variation throughout 2021/22. This represents that overall safe staffing levels have been maintained. We can see a predicable increase in fill rate during times of increased recruitment activity, for example between September and November 2021 when graduate nurses complete their training and begin employment.

We also experienced for the first time in 2022; a year without a March graduate nursing cohort to recruit from. We can therefore see a consistent downward trend from April to August, these being the months when Registered Nurse recruitment is most challenging.

During 2020/21 we experienced a significant rise in fill rates during the summer months when clinical practice placement were suspended in response to the COVID-19 pandemic and as a result the Trust were able to temporarily recruit a number of Associate Nurses. During 2021/22 as the pandemic improved all learner placements were able to continue uninterrupted with no release of learners to support clinical areas.

From December 2021 onward we can see that the overall staffing fill rate has remained relatively constant, averaging 93% in the months December to March. This is encouraging and indicates that there is stability being maintained within the workforce, possible reduction in turnover and a reduction in sickness absence.

**Chart 1**: Overall nurse staffing fill-rate (RN and HCSW) April 2020 – March 2022

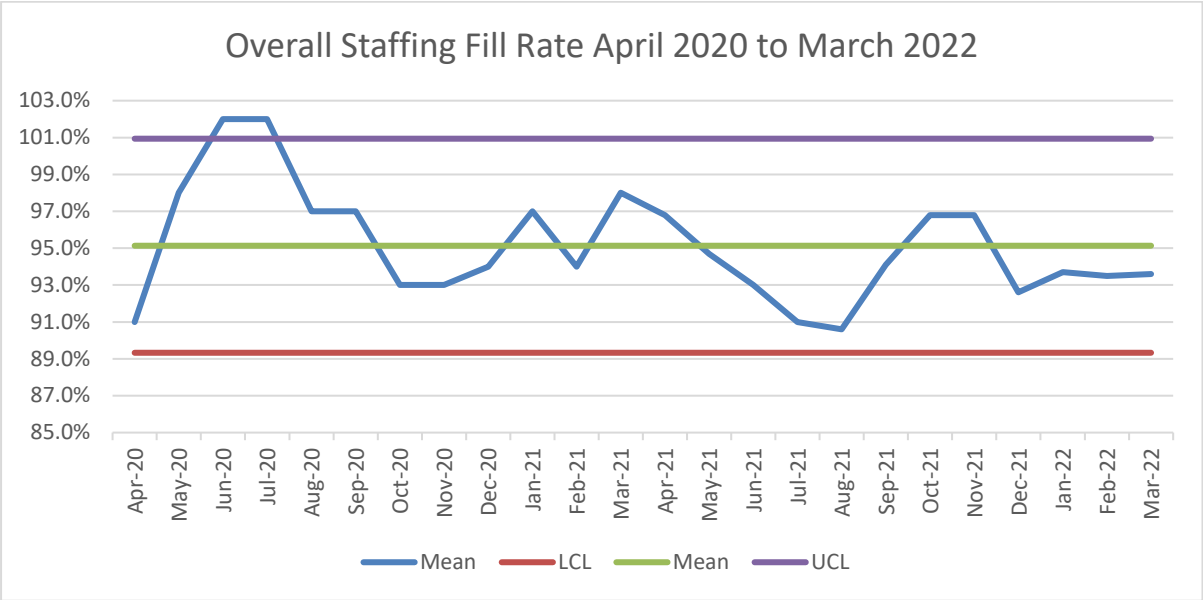
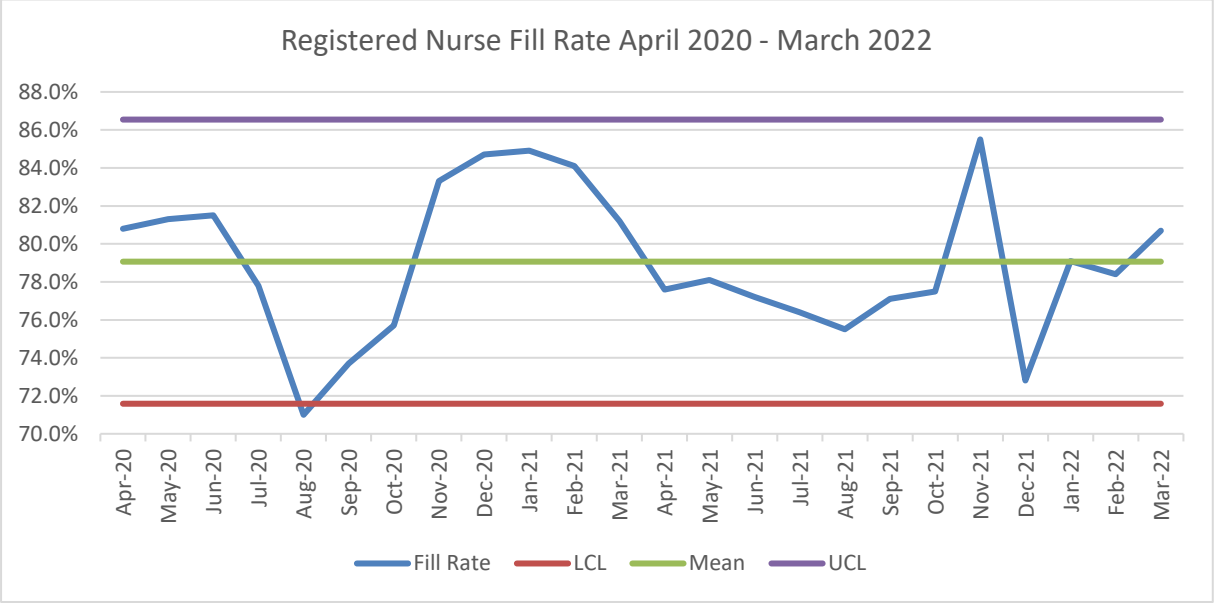


Chart 2 (below), provides an overview of Registered Nurse (RN) fill rates from April 2020 to March 2022. A sharp increase in RN staffing levels can be seen in autumn each year, followed by a decline or tapering off of fill rates in November. This clearly demonstrates the impact that graduate nurses have on the Trust RN staffing levels. Although, there is no clear reason for the sharp decrease in November 2021, we did not experience an increase in leavers during this month and it may therefore be purely due to internal staff movements. Reassuringly we see that RN fill rates begin to stabilise and increase from January 2022; maintaining a three month average of 80%.

**Chart 2**: RN fill-rate April 2020 – March 2022

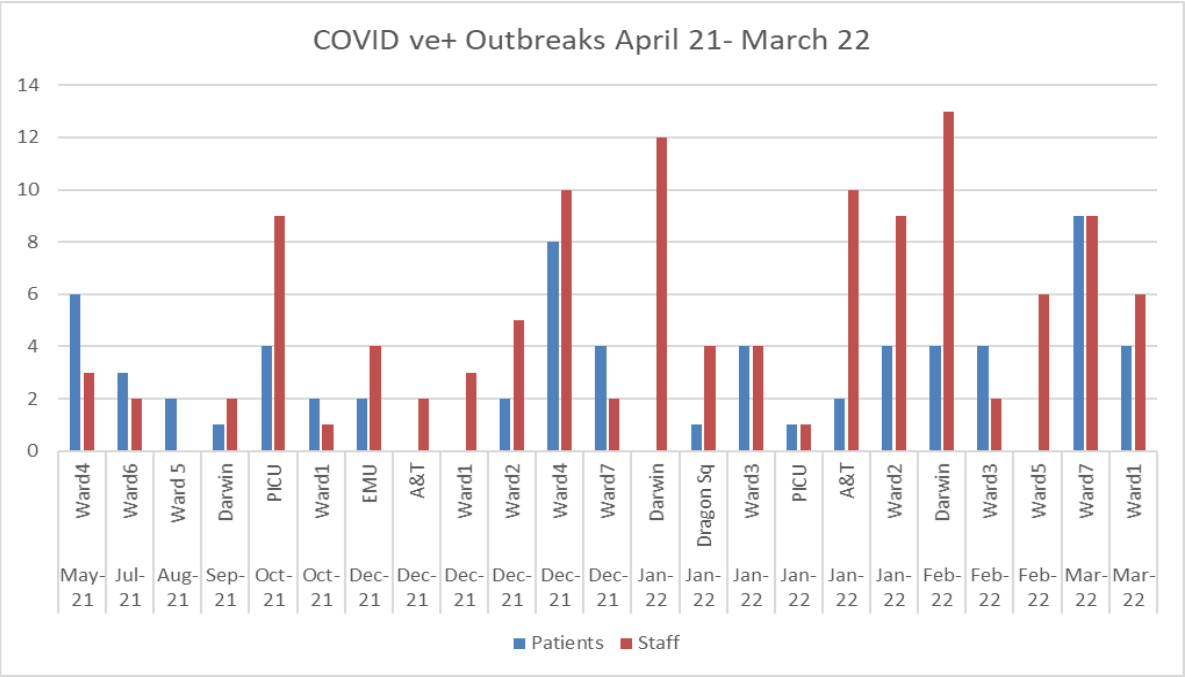



## 3.0 Impact of COVID-19

COVID-19 outbreaks continued effect staffing levels during 2021/22. New variants impacted on workforce, patients and visitors. National guidelines were updated frequently and these were monitored and reviewed by the Infection Prevention and Control Team and submitted to the Incident Management Group (IMG) and the Clinical and Professional Advisory Group (CPAG).

The frequency and location of COVID-19 outbreaks during 2021/22 is provided in Chart 3 below. In total there were 23 outbreaks during 2021/22; 4 of these were staff only outbreaks, reflecting the increased transmissibility of the Omicron variant within the wider community. During the 23 outbreaks, a total of 67 patients and 119 staff were identified as being COVID positive.

**Chart 3:** COVID-19 related Outbreaks April 2021 to March 2022




### 3.2 Face to Face Training

The importance of face to face staff training should not be underestimated. As part of the COVID-19 response plan the Trust took the decision to stand down all face-to-face training from March 2020. Training recommenced later in 2020 but had to be stood-down again in October 2020 when the second wave of COVID began. This remained the situation until May 2021 when face to face training was once again reinstated. It was particularly important to ensure that staff continued to receive training in the use of 'hands on' physical interventions such as the Management of Actual and Physical Aggression (MAPA) and Cardiopulmonary Resuscitation (CPR).

Face to face training has only been interrupted once since May 2021; this was for four weeks in January 2022 and was due to staffing pressures created by increased absences as a result of the highly transmissible Omicron variant of COVID-19.

Other areas of the Trust mandatory training programme continued to be delivered in a more streamlined form to ensure that training could continue via online platforms.

The relatively good position that the Trust had maintained over recent years in relation to mandatory training compliance, helped to mitigate some of the initial risks of ceasing face-to-face training.

A more detailed overview of staff training during 2021/22 is provided in section 6 of this report.

## 4.0 Progress of Recommendations from the 2019 Annual Safer Staffing Review

The overall progress towards the recommendations from the 2020/21 safer staffing review is summarised at the end of this report in appendix 1. Of the 22

Recommendations, 16 have been completed. The areas where further work is needed are outlined in the table below:

| 2020/21 SS Review Recommendation | Progress |
|---|---|
| The E-rostering Team will continue to provide training and support confirm and challenge sessions with Ward Managers around roster completion. Updates will be provided to the Trust Safe Staffing Group. | A review of all rosters has been undertaken by the E-rostering Manager and shared with Ward Managers. All wards have had an initial review and the E-rostering Manager is currently working with Ward Manager's address any areas for improvement. |
| Building upon the success of recruiting a number of apprentice nurses the Head of Nursing will explore the development of a longer term recruitment strategy for nursing apprentices. | Achieved and successfully delivered in 21/22 this action is ongoing and will transfer to the 22/23 Action Plan to provide continued oversight. |
| The Acute and Urgent Care Directorate should continue to review the specialist dietetic support requirements for each patient as appropriate. Risks should be escalated through the Directorate structure. The Head of AHP will continue to review any shortfalls in support and will work alongside the Quality Improvement Lead (Matron) to recruit the required level of dietetic support. | Recruitment to this position remains ongoing and is being led by the Head of AHP in conjunction with the Acute and Urgent Care Directorate. Therefore, this will be carried over onto the Safer Staffing Action Plan 2022-2023. |
| Assessment and Treatment Ward Manager and Quality Improvement Lead (Matron) to work with the recruitment team to explore the opportunities to provide a nuanced recruitment programme for learning disability nurses and HCSW's. | Consultant Nurse for Learning Disabilities is currently reviewing the delivery of a bespoke recruitment programme for the learning disability nursing vacancies. This will therefore be transferred over to the 2022-2023 Safer Staffing Action plan and remains ongoing. |
| Ward 4 Manager and Quality Improvement Lead (Matron) to work with the HIS to improve reliability of Wi-Fi connections. | Improvements are being made in combination with the inpatient environmental improvement works (Project Chrysalis). Designs have been completed and the priorities of work will be driven by the project requirement and known issues. This action remains ongoing. |

| | |
|---|---|
| The Ward 2 Manager to explore the potential of developing a Peer Mentor or Peer Volunteer role within the team, initially to support patient activities. | Ward 2 Manager to link with the Trust Patient Experience and Recovery Lead to discuss options for recruitment. |

## 5. Safe Staffing Review Meetings

### 5.1 Evidence-based workforce planning and professional judgement

The NQB and NHSE/I expect Trusts to use evidence based tools and also professional judgement to review and determine staffing levels. During 2021/22 training was provided to Ward and Senior Managers to support the implementation of the e-rostering module SafeCare across all in-patient areas. This module incorporates the Hurst Tool and comprises of a census 3 times per day in relation to patient dependency and acuity. Results are provided in a calculation identifying the staffing levels required to support patients on a shift by shift basis.

Towards the end of 2021/22 we began to see greater consistency in the completion of SafeCare. Once this is fully embedded, it will provide robust and reliable evidence which can then be used to inform the Safer Staffing reviews. This will support the Director of Nursing in their role by providing assurance to the Board in relation to safer staffing by informing the Annual Safer Staffing Review.

The Royal College of Nursing (RCN, 2010) recommends a registered to non-registered nurse ratio of 60:40, alternatively the Safe Staffing Alliance (2013), a group of senior nurses, believes Registered Nurse-to-patient levels should never fall below 1:8 during the day. As in previous reviews, the majority of recommendations made within this review continue to be based on a 50:50 RN to HCSW split which meets the required 1:8 RN to patient ratio on days.

The current review has been undertaken using the Telford Model of professional judgement triangulated with a number of quantitative measures including rosters, bank use, incident reporting and care hours per patient day (CHPPD). The Deputy Director of Nursing held staffing review meetings with Ward Managers and Quality Improvement Lead Nurses (Matrons) to inform the review.

### 5.2 Summary of Safer Staffing Review Meetings

The following common themes were identified across all wards:

- All wards recognised that 2021/22 continued to be a very difficult year due to the continued challenges of the COVID-19 pandemic.
- Vacancies have remained constant with an average of 30.00 WTE Registered Nurse vacancies across all inpatient areas.
- Acuity had frequently been high, particularly within the working age adult acute admission wards – Wards 1, 2, 3 and PICU.

- Ward Managers welcomed the additional training in the use of SafeCare which will assist in supporting real-time staffing decisions and future establishment reviews.

- All areas continue to rely on university graduates to fill a majority of Registered Nurse vacancies. This continues to present challenges when completing rosters and attempting to balance the skill mix as well as provide an appropriate level of preceptorship.

**Recommendation 1: This recommendation remains ongoing from 2020/21.** The E-rostering Team will continue to provide training and support confirm and challenge sessions with Ward Managers around roster completion. Updates will be provided to the Trust Safe Staffing Group.

- Daily safe staffing huddles have proved invaluable in supporting staff deployment to maintain safe staffing levels. This daily meeting is attended by all Ward Managers, Matrons and Senior Managers from the Operational and Nursing Directorates. It creates a highly effective environment where frontline staff can speak up freely about daily patient safety and staffing concerns.

**Recommendation 2: This recommendation remains ongoing from 2020/21.** Building upon the success of recruiting a number of apprentice nurses the Head of Nursing will continue to build a sustainable strategy for nurse apprenticeships.

- Comparable to previous years, all ward areas reported recruitment challenges. There was broad acknowledgement that a majority of the RN vacancies are, and will continue to be, filled by nursing graduates. Recruitment processes have been refined during 2021/22 to ensure that new starters can be recruited as efficiently and as safely as possible.

- Recruitment to the nursing bank remains a challenge. The process for on boarding bank staff who are new to the Trust is the same as for a substantive member of staff. This can create frustration in some areas especially when managers are keen for someone to commence, such as a student nurse who may be familiar with the area but are not currently employed by the Trust.

- It was also recognised that the workload of the Temporary Staffing and E-Rostering Team has increased significantly during the past two years; to the point where additional staff and the support of the Trust recruitment team has been required to support bank staff employment.

**Recommendation 3:** Deputy Director of Nursing and Head of Nursing will explore how recruitment to, and management of, the nursing bank can be streamlined. Current systems will be reviewed to support the recruitment and on-boarding of student nurses and other learners. Consideration will be given to releasing this element from the Temporary Staffing Team enabling them to focus their attention on shift allocation and e-rostering.

- The Trust has supported a number of recruitment and retention initiatives during 2021/22; these are summarised in section 13 of this report.

Other findings which were identified on single or smaller groups of wards are discussed in the section below.

### 3.2.1 Acute and Urgent Care Directorate Wards

Towards the end of 2020/21 and during 2021/22 a review of the ward staffing levels was undertaken in a number of the Adult Acute Wards (Ward 1, 2 and PICU) using the Mental Health Optimal Staffing Tool (MHOST). This helps to calculate the clinical staffing requirements in mental health wards based on patients' needs (acuity and dependency). Together with professional judgement this helps to provide guidance for managers and ward based clinical staff when making decisions relating to safe staffing levels. A review of acuity and dependency took place in April/May 2021. The results indicated that staffing requirements were appropriate in each area.

Acuity began to increase in these areas during the first part of 2022 and remains high. Staffing establishments have frequently needed to be increased to ensure that a safe staffing level can be maintained. Completion of the Safecare Module within Healthroster will assist Ward Managers and Matrons in making decisions about real-time staff deployment. It also provides live visibility of staffing levels by matching staffing with patient demand, providing an instant view of whether the actual staffing levels are deemed safe to meet the clinical need. Going forward this will positively support ward establishment reviews.

### 3.2.2 Ward 1

Ward 1 is a 13 bedded mixed gender adult mental health acute admissions ward. The wards staffing establishment is 5/5/3, this reduced from 5/5/4 following the opening of the PICU in 2018 and a reduction in bed numbers from 14 to 13.

Daytime staffing levels can increase, usually to 6 per shift during periods of higher acuity; although there have been occasions in 2021/22 when staffing levels have required escalation as high as 9/9/7.

During 2021/22, Ward 1 averaged 2.00 WTE Registered Nurse vacancies. During the same period sickness absence and staff turnover both improved.

The ward receives a good level of multi-disciplinary support, including a Consultant Psychiatrist and a core trainee, both who are shared with PICU. The ward have a fulltime Advanced Nurse Practitioner who provides consistent support. The ward also receives Occupational Therapy support and they are currently recruiting to a Consultant Psychologist vacancy.

The Ward Manager identified that the ward would benefit from a Discharge Coordinator, having seen this role work well in other areas. Plans are currently in place to remodel a vacant Assistant Practitioner position to support the development of this new role.

The Ward Manager and Matron are currently supporting the National Sexual Safety Collaborative which aims to improve the environment and how patients feel when they are on the ward.

The Matron is also a regular member of the Reducing Restrictive Practice Group and continues to be a strong advocate of the 'Safewards' initiative across all of the Adult Acute Wards. This is a person centred model of care which improves patient experience and recognises the need to identify proactive and less restrictive initiatives to supporting a safe and therapeutic environment.

**Recommendation 4:** Recognising the challenges of recruitment, the Ward 1 Manager and Matron for the Acute Wards will work with the Head of Psychology to further the recruitment to the Consultant Psychologist vacancy.

**Recommendation 5:** Ward 1 Manager will explore the development of a Discharge Coordinator role from the remodelling of current vacancies.

### 3.2.3 Ward 2

Ward 2 has 20 beds. The staffing establishment reflects the requirement for a staffing level of 6/6/4. During 2021/22 this has at times increased to 7/7/5 to support acuity. Two Registered Nurses are identified for the night-time shift; this sometimes presents a challenge to fill with the busier daytime shifts having to take priority over the second Registered Nurse on nights. When a second night Registered Nurse can be secured this is often through a nursing agency.

Ward 2 has experienced high levels of occupancy during the past 12 months, usually between 80-90%. Coupled with high acuity, this will often initiate an increase in clinically required staffing levels; especially if more than two patients require level 3 observations.

The Ward reported similar RN recruitment challenges to those of other acute inpatient areas, namely a difficulty in attracting experienced RN's to the service. RN vacancies for 2021/22 have averaged at 3.00 WTE per month. Shortfalls are supported with temporary staffing and by the Ward Manager and members of the multi-disciplinary team being included in the staffing numbers when required. There are 4.00 WTE graduate nurses scheduled to commence on the ward in October 2022.

The ward has a strong culture of team cohesiveness. Fostered by a Ward Manager who clearly understands the value of staff wellbeing and the wider impact on delivering good patient care. Recent wellbeing initiatives have included a staff 'shout out' board, staff wellbeing boxes, a sunflower growing competition, healthy lifestyle support, and various outdoor activities including: climbing Snowdon and a virtual bike ride. As a result staff turnover and sickness absence levels on the ward remain low.

The Ward Manager is supported by a 'solid core' MDT which includes a full-time Consultant Psychiatrist, an Occupational Therapist, an Exercise and Wellbeing Practitioner and Activity Worker who all help to support patient recovery. There is a vacancy for a Consultant Psychologist (a post which is shared with Ward 1). The ward are also keen to recruit a Peer Support Worker.

**Recommendation 6:** Ward 2 Manager will link with the Trust Patient Experience and Recovery Lead to discuss support and advice for recruitment to a Peer Support Worker position.

### 3.2.4 Ward 3

Ward 3 has 20 beds and a staffing level of 6/6/4. Staffing levels are often increased in response to patient acuity. In February 2022 there was a significant staffing increase to 9/9/7 to support high acuity within the ward. A majority of these additional shifts were accommodated through temporary staffing or through flexing and movement of staff from other inpatient areas.

The ward have supported four patients with a learning disability in the second half of 2021/22. The patient's mental health needs have always been the primary focus when deciding admission however, the team have reported that the general admission ward environment does not always meet the specific needs that a person with a learning disability may have. During these times additional staff support has been provided from the Intensive Support Service and Community Learning Disabilities Team.

Recruitment continues to be challenging. Ward 3 is a female only ward and it is recognised that supporting female mental health sometimes requires a unique skill set which should be clearly identified and considered during recruitment. The ward had an average of 5.00 WTE RN vacancies throughout 2021/22 and have been allocated 5.00 WTE nursing graduates who will commence in October 2022; in the meantime shortfalls continue to be offset through bank and agency nursing and an over-establishment of HCSW's.

Staff turnover for Ward 3 is relatively stable; when people do leave it is usually for career progression opportunities; these can be internal or external openings. To support staff retention the Ward have adopted a number of initiatives including, continuing to support the system wide rotational apprenticeship programme; developing staff retire and return opportunities and supporting nurses to undertake additional training.

The ward has a settled MDT with a recently appointed whole time Consultant Psychiatrist providing 4 ward-based sessions per week, a whole time Advanced Nurse Practitioner and Occupational Therapist. Furthermore, the successful appointment of a Clinical Psychologist has enabled the Dialectical Behavioural Therapy (DBT) skills group to recommence.

Regular dietetic support continues to be sought following the withdrawal of the service by Royal Stoke University Hospital (RSUH) in 2019/20. This is currently being supported on an as required basis through the Trust's part-time community based Dietician.

**Recommendation 7:** The Directorate should continue to review the specialist dietetic support requirements for each patient as appropriate. Risks should be escalated through the Directorate structure. The Head of AHP will continue to review any shortfalls in support and will work alongside the Quality Improvement Lead (Matron) to recruit the required level of dietetic support.

### 3.2.5 PICU

The PICU has 6 beds and operates on a staffing establishment of 7/7/5. The ward continue to remain responsive to the level of acuity and dependency and will adjust the staffing level accordingly based upon risk assessment and professional judgement.

The PICU has carried a high number of RN vacancies during 2021/22; averaging 9.00 WTE throughout the year. Despite this increased vacancy level the ward has a consistent and skilled temporary staffing establishment who regularly undertake shifts to the point where they are very experienced in the day to day functioning of the unit. When new bank staff are introduced, this is carefully considered to ensure that an adequate skill mix and level of experience is maintained within the ward. 5.00 WTE graduate RN's are due to commence in October 2022.

Staff sickness absence levels are low within the PICU. There is also a low level of staff turnover. The ward benefits from a good level of MDT support: Consultant Psychiatry support is shared with Ward 1; a Consultant Nurse and Advanced Nurse Practitioner also work between PICU and Ward 1. The ward has the support of GP trainees and a 1.00 WTE Clinical Psychologist and Occupational Therapist.

The patient experience is very positive with very few concerns being raised through the PALS. The ward continue to remain strong advocates for the Safewards initiative and have developed a number of good practice initiatives in the last 12 months including 'tea instead of PRN', training in the use of seclusion, HCSW competences training which include - the management of the clinical room, use of Lorenzo and good practice in observation and engagement.

The Staff Wellbeing Team have also provided a number of sessions for the PICU.

## 3.3 Older Persons Wards

### 3.3.1 Ward 4

Ward 4 has 15 beds and operates on a staffing ratio of 6/6/4. This can increase 7/7/5 and at times can go up to 8/8/6. The ward has 4 winter pressures beds. The ward work closely with the Older Persons Outreach Team to support admissions from RSUH and also directly from the community.

Over the past 12 months staffing levels on Ward 4 have continued to remain stable. A 50:50 ratio of Registered Nurse to HCSW is frequently achieved and the ward benefits from having two Registered General Nurses (RGN) in the team as well as one dual qualified Registered Nurse. The ward has a Senior Advanced Nurse Practitioner and consistent Consultant Psychiatrist provision for one session per week. A whole time Occupational Therapist and a whole time Physiotherapist also provide an important MDT function.

Ward 4 have averaged 2.00 WTE RN vacancies during 2021/22. There are reports of many students enjoying their final placements on the ward and are often keen to return once they graduate.

Activity Worker cover is provided 6 days per week and the ward continues to receive a high level of compliments for their holistic approach to supporting patients.

During the 2020/21 staffing review the ward identified that they occasionally experience very slow Wi-Fi speeds. This has remained an issue throughout 2021/22. It is understood that improvement works will be undertaken as part of the Project Chrysalis building developments.

The Ward Manager has highlighted that nursing staff spend a significant amount of time in the completion of the Decision Support Tool for patients which can limit their availability in other areas. The team are currently exploring if some of this work can be undertaken by a dedicated non-registered professional.

**Recommendation 8:** Ward 4 Manager and Quality Improvement Lead (Matron) to work with the HIS to improve reliability of Wi-Fi connections.

**Recommendation 9:** Ward 4 Manager to explore the potential recruitment of a Band 4 position to support the completion of the Decision Support Tool (DST).

### 3.3.2 Ward 6

Ward 6 is an older person's dementia ward. It has 15 beds and works on a staffing level of 7/7/5, this was increased following an establishment review at the end of 2020/21.

Vacancies on the ward remain low; at the end of 2021/22 the ward were operating with 2.00 Registered Nurse vacancies and an over establishment of 2.00 WTE HCSW's. The ward have successfully recruited to a number of vacancies including, a Deputy Ward Manager (due to commence July 2022), Activity Worker and a fulltime Occupational Therapist, a post that will be shared with Ward 7.

MDT support is provided by a Clinical Psychologist, Occupational Therapist and Physiotherapist who have joint roles with Ward 7. The Consultant Psychiatrist provides three sessions per week. There is also a whole time F1 (Foundation Year 1) Doctor. Additional GP support is provided to support the winter surge across a number of wards.

Staffing turnover is reported as being generally good. The ward does experience some short-term and long-term sickness and this is appropriately managed with the support of the workforce team.

Bank staff usage is less than 20% of the total establishment and agency staff are rarely used at Ward 6.

Patient experience of the Ward is very good with one area of note being the work that is undertaken by the Ward Clerk to proactively support families, provide introductions, and arrange virtual and in person family visits.

### 3.3.3 Ward 7

Ward 7 has 18 beds, this was reduced from 20 beds to support social distancing in the dormitory area. The current ward clinical staffing is appropriate and provides a staffing level of 6/6/4. There is a strong MDT presence and although Physiotherapy and Psychology input is shared with Ward 6, this is deemed to be adequate and appropriate. The Ward has an Assistant Practitioner, this role is highly valued and provides an important function to support discharge co-ordination.

Ward 7 was significantly challenged during 2020 by being the first area within the Trust to declare a COVID outbreak. Since this time and throughout 2021/22 the ward team have been developing in reach work with the Older Persons Outreach Team to support early discharge post COVID. This takes the form of rapid handovers with the Outreach Team and assists with early facilitated discharge as well as admission prevention.

The ward has a Band 6 RGN and the Ward Manager is keen to develop some specific mental health focussed competencies to support their development.

A newly recruited Activity Worker in 2021/22 has enabled the provision of 7 day Activity Worker cover. A recently graduating Trainee Nursing Associate has transferred to the full RN training programme.

**Recommendation 10:** Ward 7 Manager to work with the Head of Nursing and Practice Education Team to develop a competency framework for RGN's working within an older person's mental health ward setting.

### 3.4 Specialist Services

#### 3.4.1 Ward 5

Ward 5 currently operates with 10 beds and has the capacity to increase to 15 beds if required. The staffing level for the ward is set at 6/6/4; this can increase to 7/7/5 in response to increases in patient acuity.

The ward reported an average of 2.00 WTE RN vacancies during 2021/22 however, overall staffing levels have been supported through an over-establishment of HCSW positions and staffing turnover remains very low.

Ward acuity increased in 2021/22 when support was provided to patients who had been discharged at very short notice from a local provider following concerns raised by the CQC. The Ward Manager reported an impact on staff morale at this time and a difficulty in identifying appropriate discharge packages.

The challenges around discharge from ward 5 are not unusual due to the complexity of need and the specialist requirements that have to be included to provide a sustainable package of care.

The ward has a good level of MDT support consisting of a Consultant Psychiatrist, a highly valued full-time F1 Doctor, whole time Occupational Therapist and Physiotherapy Technician and a part time registered Physiotherapist.

Good practice was noted within previous annual reviews in the development of links with a similar unit in Newcastle-upon-Tyne. It is recommended that as we begin to emerge from the COVID-19 pandemic these links should be re-established to enable good practice and learning to continue to be shared.

Psychology input has been difficult to secure in the past at Ward 5. This support is now provided from within the Community Neuropsychiatry Team and is just one example of how the service is working closely with the community team to provide a cohesive pathway of care.

**Recommendation 11:** Ward 5 Manager to re-establish links with existing or new neuropsychiatry services to enable the shared learning and the development of further good practice.

### 3.4.2 Edward Myers Unit

During 2021/22, the service provided 12 beds (10 detoxification and 2 within the Intoxication Observation Unit (IOU). Operating on a 3/3/2 staffing model and a 50:50 RN to HCSW ratio, staffing levels remain unchanged from 2020/21. Staffing can increase to 4/4/3 dependant on occupancy levels.

More recently patient acuity has increased. The team feel that this is due to new framework agreements with local authorities and Public Health England as well as private referrals. This has resulted in referrals being received from across England with a majority of patients now being out of area.

The IOU is supported by HCSW's however, if the unit is unoccupied the staff are transferred to within the main Edward Myers Unit (EMU). The unit has a low staff turnover and retention is good. At the end of 2021/22 the unit reported just 0.60 WTE RN vacancy.

Access to training and completion of mandatory training performance is high. Morale on the unit is also good. Positive feedback continues and is often received through the Friends and Family Test. There are infrequent clinical incidents although when these do occur it is not uncommon for them to relate to a medical emergency.

Good practice continues to be noted around the implementation of physical health checks pre and post admission. Due to the nature of the admissions to the unit physical health deterioration is a significant risk and these checks contribute to the mitigation of this risk to safely care for patients during their detoxification.

The unit has a full complement of medical staff although it is noted that they do not operate to a traditional MDT model. The team are also currently exploring initiatives to recommence Physiotherapy on the unit and are looking at the potential for Occupational Therapy input.

**Recommendation 12:** EMU Ward Manager to link with AHP Leads to explore the opportunities to recommence Physiotherapy on the unit and the potential for Occupational Therapy input.

### 3.4.3 Darwin Centre

The Darwin Centre is a Tier 4 CAMHS inpatient unit. It has 15 beds, all commissioned by NHS England & Improvement (NHSE/I) Acuity can be very high at times; this is usually to support clinical interventions.

Staffing levels are established at 6/6/4 although this will often increase to 7/7/5 and at times has been as high as 10/10/8. At the end of 2021/22 the unit is operating on a staffing level of 8/8/5.

The unit provide a 24 hour gatekeeping function for NHSE/I; during busier periods this can take the Ward Manager away from other duties. The service is planning to employ a clinical lead who would take a key role in bed management freeing up time from the Ward Manager.

The Darwin Centre reported a vacancy level of 7.00 WTE Registered Nurses at the time of the review. RN recruitment continues to remain challenging for this service. Turnover has reduced from 2020/21 however, it was felt by the Ward Manager that high acuity and the challenges of working long term in a noisy and difficult environment will, eventually have an impact on turnover.

During 2021/22 a small number of young people who have very specific and often complex presentations have been difficult to discharge. The reasons for these delays are multifaceted but the overriding difficulty is a lack of specialist providers. To support the team during this time a specialist nursing agency have been employed by NHSE/I to support the staffing levels.

Bank and agency staff are regularly used to maintain daytime staffing numbers both for RN's and HCSW's. Agency support is often required to support night-time establishments. Approximately 30% of staffing shortfalls are covered by temporary staff however, many temporary staff are familiar with the unit and have undertaken shifts for several months.

MDT support is good, consisting of a Consultant Psychiatrist, Speciality Trainee (ST4), two Clinical Psychologists, a Family Systemic Worker, an Activity Worker and a Dietician.

**Recommendation 13:** The Darwin Centre Ward Manager will work with Service Managers to explore the recruitment of a clinical lead who can take a lead on bed management.

**Recommendation 14:** Darwin Centre Ward Manager to support any planned review of the existing care pathway and service provision, highlighting the current staffing challenges and future workforce requirements.

### 3.4.4 Assessment & Treatment Unit

The staffing levels for the Assessment and Treatment service are identified at 6/6/5. This enables the provision for a ratio of 1:1 support. Despite this high staffing ratio it is not unusual for service users to require a significantly higher ratio, particularly during the first few days following admission; as a result there is a lot of fluidity in the staffing levels within the unit. This position is unchanged from 2020/21. Staffing levels

on the unit have been 7/7/5 for the second half of 2021/22 with an occupancy of 50% (3 patients).

The Ward Manager has highlighted challenges in meeting the required fill rates; with both the Ward Manager and Activity Worker frequently having to be included in the staffing numbers. Weekends are reported as the easier shifts to fill due to the flexibility of temporary staff. Day shifts are more challenging with the Intensive Support Team (IST) being used to fill urgent shortfalls.

In 2020/21 it was highlighted that incidents of violence and aggression, requiring prolonged physical intervention were a frequent occurrence. This situation has continued into 2021/22 and is attributed to increases in patient acuity and reflects the high levels of support that some of the service users require.

Staff welfare remains paramount. The newly appointed Ward Manager has made this a priority and is working hard to provide support, adequate breaks and recovery time during periods of high acuity. The Safewards initiative and mindfulness approaches have continued to be used alongside supervision and critical incident debrief to support the team.

At the end of 2021/22 the unit had 2.00 WTE Registered Nurse vacancies and 1.00 WTE Nursing Associate vacancy. The Unit has 2.00 WTE Trainee Nursing Associates and 1.00 WTE HCSW Apprentice.

There continues to be a strong MDT presence on the unit, this is provided by a Consultant Psychiatrist, Occupational Therapist, Consultant Psychologist, Consultant Nurse and full-time Activity Worker.

A number of areas of good practice have been noted, these include: Daily Service User Meetings, the development of a sensory room and an increase in staffing support and critical incident debriefs.

### 3.4.5 Summers View

Summers View is a rehabilitation service, it has 10 beds and works to a staffing level of 4/4/3. Staffing increased to 5/5/3 following an emergency admission from a local provider.

The unit has a number of vacancies; 2.00 WTE RN’s and 2.00 WTE HCSW’s. There is a vacancy for 1.00 WTE Clinical Lead and 1.00 WTE Clinical Psychologist. Medical support is provided by a Consultant Psychiatrist for two days per week and an Advanced Nurse Practitioner for two days per week. The wider MDT consists of Occupational Therapy – Registered and a Technician and a Support Time and Recovery Worker.

Staffing shortfalls are supported by temporary bank staff who are predominantly HCSW’s. The unit struggles to obtain agency staff possibly due to the geographical location in relation to the Harplands Hospital.

The service receives very positive feedback from service users. The model of rehabilitation supports service users to live as independently as possible. A swipe

access was introduced this year to enable independent access to bedrooms and the front door of the unit.

The unit has plans to develop a dedicated garden activity area which will include a 24 hour activity room; plans and funding have been approved awaiting for planning application to be agreed.

**Recommendation 15:** Summers View Ward Manager to provide updates on the development of service user activity space to the safer Staffing Group.

### 3.5 Summary of staffing level recommendations

The outcome of the review, in relation to staffing levels is detailed below:

| Ward | Recommendation |
|---|---|
| 1 | No change |
| 2 | No change – Explore the opportunity for the employment of a Peer Support Worker |
| 3 | No change |
| 4 | No change |
| 5 | No change |
| 6 | No change |
| 7 | No change |
| PICU | No change |
| EMU | No change – Explore potential to recruit Physiotherapy and Occupational Therapy support |
| Darwin | No change – Explore potential to recruit clinical lead to support with bed management |
| A&T | No change |
| Summers View | No change |

## 4. Comparing staffing with peers - Care hours per patient day (CHPPD)

The publication of Lord Carter's review, 'Operational Productivity and Performance in English Acute Hospitals: Unwarranted Variations', in February 2016 highlighted the importance of ensuring that efficiency and quality are embedded across the whole NHS health economy. One of the obstacles identified to eliminating unwarranted variation in clinical staff distribution across and within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment.

In order to provide this consistent way of recording and reporting deployment of staff providing care on inpatient wards, the Care Hours per Patient Day (CHPPD) metric was developed. Initially for Acute hospitals, the CHPPD metric has been tested and adapted for use in Mental Health and Community inpatient wards. Since April 2018 all mental health in-patient wards in England have been required to submit data to enable CHPPD to be captured.

The data captured includes planned staffing, actual staffing, number of beds, clinical speciality and the number of patients at 23:59 each day. This information is then used to determine the CHPPD for each ward. In summary, CHPPD are calculated by dividing the number of actual nursing hours (both registered and unregistered) by the number of patients. This provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards.

Benchmarking for CHPPD is then available through the Model Hospital for Mental Health Trusts. The two charts (4 & 5) below show a summary of NSCHT wards in comparison to the national average and also regional peer Trusts. Chart 4 clearly establishes a positive position, placing the Trust in the upper quartile and well above the national median throughout 2021/22, when compared to similar organisations.

Chart 5 demonstrates the annual trend of CHPPD in 2021/22 and shows that NSCHT was providing patients with an average of 14.5 (an increase from 13.7 in 2020/21) CHPPD. In comparison the national median was 11.3 hours and the peer median which was also 11.3 hours.

**Chart 4:**

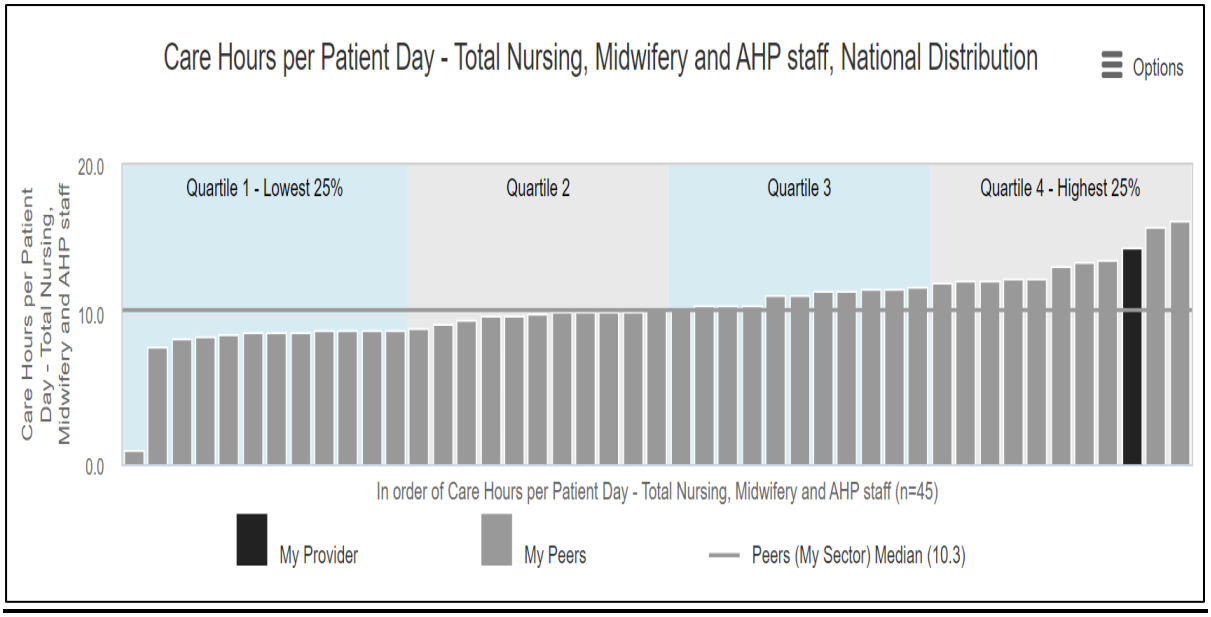
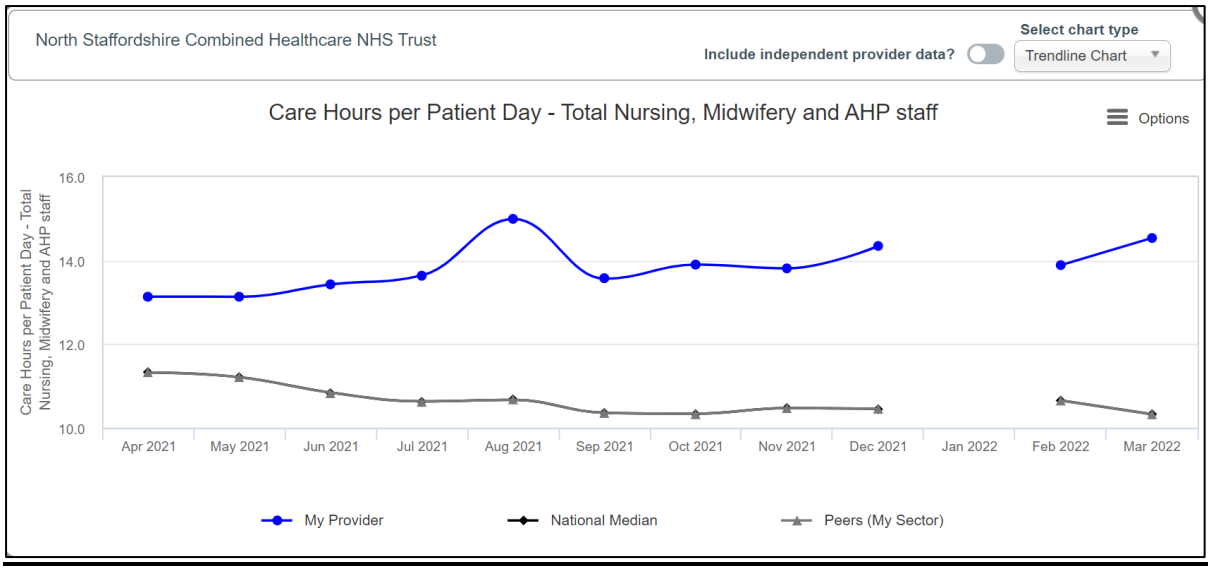


**Chart 5:**




The significant increase in CHPPD during August 2021 is most likely attributable to a lower bed occupancy percentage during this month. We can also see a steady increase in CHPPD from September 2021 in line with staffing fill rates; this was most likely due to the employment of a number of graduate nurses during the autumn.

## 5. Extending Safer Staffing to the Community

In early 2020 the Trust began to undertake safe staffing discussions with community teams. Currently there is no nationally mandated approach for safe staffing reviews in NHS community mental health and learning disability services. To gain more assurance in relation to the Trust's community services and resilience in relation to caseload and patient demand vs workforce available, the Trust Community Mental Health Teams (CMHT's) previously undertook a process of data collection using a model developed by Dr Keith Hurst. This approach consisted of the collection of weighed benchmarking data via the use of a diary exercise over a week time frame.

This work was placed on hold as a result of the ongoing challenges of the COVID-19 pandemic and will recommence during 2022/23. Building upon the information that we already have we will be working with the Performance Information Team to review a number of community team metrics including caseload size, vacancy level, absence rate, training and supervision. All of which are important indictors in providing positive assurance that issues

## 6. Development and Education

Registered professionals have over 40 statutory and mandatory competencies that are required to be completed. 23 of these are monitored through monthly Performance

Meetings with Directorate leads alongside Clinical Supervision and Appraisal rates. Throughout 2021/22 compliance exceeded the Trust target of 85%.

In addition to mandatory training nurses and AHPs must have access to Continued Professional Development (CPD) to develop knowledge and skills; keeping abreast of evidence based practice and contemporary practice. However, in the past few years, the Health Education England budget for CPD has fallen by 40% from £205 million to £84 million. The House of Commons Health Committee (2018) recommended that this funding be re-instated and that it is ring-fenced for nursing and AHP's CPD. This was followed by a 17% increase in 2018-19, which was maintained in 2019/20. Sir Simon Stevens, CEO of NHSE, confirmed that CPD funding would be restored over the next five years, and as a result, specific CPD funding for nurses and AHP's has been agreed upon and set for 2020/23 This will support the Trust in uplifting the academic qualifications of the nursing and AHP work force and as it's the final tear year that this fund will be available the priority remains with aligning the funds to meet the demands of the work force plan 2022/2023.

The modules/programmes that nurses and AHP's undertake, as CPD, support the delivery of high quality care, career progression, and retention. They also support nurses to work towards undergraduate and postgraduate degrees. Due to developments within registered professional training, the current workforce consists of RNs and AHP's whose pre-registration training was either certificate, diploma, or degree level. Since 2013 all pre-registration nursing students' have been educated to a degree level. However, the Director of Nursing (DoN) has previously identified that there are a large proportion of Trust professionals who are not educated beyond the diploma level. Educating these professionals to a degree level brings advanced critical analysis and decision making skills which are essential in meeting the challenges of the transforming health and social care landscape. Additionally, graduate professionals have been shown to improve patient safety. The DoN is a strong advocate of higher level education and increasing the number of graduate professionals within the Trust which is incorporated in the Nursing and AHP Strategies. The resultant CPD funding will support these educational needs enhancing professional roles and capabilities.

The Trust has supported nurses and AHP's in undertaking the following academic modules/programmes during 2021/22:

- 4 Advanced Nurse/Clinical Practitioners
- 21 Level 6 & 7 academic modules
- 5 Sensory Integration modules
- Physical health assessments

Additionally, our professionals have completed over 100 high level clinical courses in a variety of specialities:

- Connects Leadership Gold/platinum
- Sensory Integration Modules
- Compassion Focused Therapy
- Independent Nurse Prescriber
- DBT- Dialectic Behaviour Therapy
- ACT- Acceptance and Commitment Therapy (ACT)
- APT- Association for Psychological Therapies modules.

Further to this, we have invested money in Keele University to improve access to academic CPD opportunities. To ensure fair access to these opportunities Inclusive development and talent management remain embedded within our education and development framework.

The Trust has also invested in its coaching and quality improvement training opportunities and has joined the West Midlands Coaching Pool and is committed to building quality improvement and coaching skills across our workforce.

We have continued to develop our Suicide Mitigation programme and 45% of our clinical staff have now received advanced suicide mitigation training. We now have 23 trainers to be able to deliver the training Trust wide. This gives the Trust a strengthened position in terms of a standardised approach to suicide prevention with the ability to deliver Suicide Awareness, Suicide Risk Assessment, and Safety Care Planning Trust wide.

Additionally, we have continued to develop our apprenticeship programme to increase our workforce skills. In 2021/22 six apprenticeships were completed (level 3 to level 5); twenty-six apprenticeships were commenced (level 3 to level 7).

**7. Preceptorship of Newly Qualified Registered Nurses and AHP's**

Investing in our Trust preceptorship programme has delivered a variety of benefits during 2020/21, these include:

- Enhanced patient care and experience
- Improved recruitment and retention
- Reduced sickness absence
- Developed more confident practitioners
- Increased staff satisfaction and morale

In 2021/22 we have employed and supported 26 Registered Mental Health Nurses and 6 Registered Learning Disability Nurses 4 Nursing Associates, and 5 Occupational Therapists as part of Trust Preceptorship Programme. Furthermore, In March 2022 we have employed and supported 5 Mental Health Nurses, 0 Nursing Associates and 0 Occupational Therapists with preceptorship.

We have seen a number of our preceptorship nurses already progress into band 6 roles and to date we currently have maintained 100% retention throughout preceptorship.
Our Trust Preceptorship Programme provides:

- A trained preceptor for each individual
- 5 days face to face clinician delivered 'Prep for Practice' skills days.
- 1 day 'Leading Care' work shop at 3 months
- 1 day 'Leading on Preceptorship' work shop at 6 months
- Myers Briggs Personality Type Inventory (MTBI) questionnaire, 1:1 or group feedback to support their career development plan
- Afternoon celebration at 12 months, including 'what next' discussions, support available and retention options.

MBTI has been a welcomed addition to the Trust preceptorship programme, it has enabled newly qualified registrants to become more self-aware and have focussed time to consider a career development plan.

A Clinical Leadership Programme has been developed to support personal development and career progression, which will follow on from the preceptorship programme. This clinically tailored leadership programme helps individuals to commence their development and leadership journey within North Staffordshire Combined Healthcare NHS Trust. The programme intends to offer a structured stepping stone to the recently established partnership with the University Hospitals of North Midlands (UHNM) Systems Connect Leadership programme.

11 Band 5 nurses & AHP's have successfully progressed through the programme, all of which have undertaken a Quality Improvement project; examples of these are:

- Increasing Service user engagement in the community hospital alcohol team
- Improving quality of referrals from Stoke-on-Trent community drug and alcohol service for inpatient alcohol detoxification;
- Do Quality improvement tools improve compliance (hand hygiene);
- Rehab Services, service development;
- staff wellbeing with improvement in more staff taking breaks;
- Improving staff morale and working relationships amongst staff and patients on Summers view;
- To improve oral assessment uptake on Ward 4;
- Decreasing incidents of violence and increasing meaningful activity on acute inpatient ward;
- Improving the rate of uptake of Naloxone kits for patients being released from HMP Stoke Heath;
- Working to Improve quality of Risk Assessments completed by ward one.

### 7.1 BAME Practice Education Facilitator

In 2019 we recruited a 0.20 WTE BAME Practice Education Facilitator to undertake specific project work and develop career and academic support for our BAME workforce. The role has been a fantastic addition to the practice education team, therefore in 2021 we recruited into the role on a full time basis. This has now progressed into a Band 5 BAME staff development post, with an opportunity for Band 5 nurses / registered professionals to be seconded on a part-time basis into a Band 6 position within the Practice Education Team, the intention is to offer them dedicated development and coaching support for a 12 month period, whilst they are also offering dedicated development and support to BAME Student Nurses, and Preceptees; with the hope that they will be in a stronger position to secure for band 6 clinical posts in the future.

Additionally, we have included unconscious bias and allyship training into our preceptorship programme and responded to discrimination in the workplace in a timelier way, offering increased support and supervision to our Black Asian Minority Ethnic colleagues.

## 8. New Roles

### 8.1 Nursing Associates

The Nursing Associate was introduced in 2017. It is still a relatively new role. The Trust currently has 10 active Trainee Nursing Associates (TNA's). The first cohort of 4 TNA's completed training and registered in March 2021 and a further 2 registered September 2021 and 1 in March 2022.

Nursing Associates are educated to foundation degree level and the role supports Registered Nurses in delivering patient care. In 2019 the role became regulated by the NMC. However the Nursing Associate is not a Registered Nurse and will be required to work under the supervision of a Registered Nurse at all times.

The Nursing Associate training costs are funded via the apprenticeship levy. In terms of pay costs, following national guidance, during training the Trainee Nursing Associate is paid at Band 3 (or band 4 if currently in a clinical band 4 role) and a qualified Nursing Associate is paid at band 4. The Nursing Associate role is a role within its own right but also provides a pathway into shortened apprenticeship pre-registration nursing courses.

Throughout 2022/23 we will be exploring all opportunities to ensure that we can grow our Trainee Nurse Associate offer and Nursing Associate roles within the Trust.

### 8.2 Pre-registration Nursing Apprenticeships

There is now a pre-registration nursing apprenticeship standard which takes 3 years to complete. In March 2021 the Trust recruited 14 mental health BSc Apprentice Student Nurses, working in a newly formed partnership with The University of Derby. In September 2021 the Trust advertised an MSc in learning disability nursing; this is a 2 year programme as opposed the traditional 3 year programme and successfully recruited 3 apprentices onto the programme, they are due to register as nurses in 2023.

The Trust continue to work closely with local HEI's whilst they have been developing their MSc pathway for mental health and learning disabilities students. Keele successfully recruited 13 mental health and 1 learning disabilities student onto their MSc programmes and Staffordshire University successfully recruited 7 mental health students onto the MSc programme. With a further 30 being recruited onto the BSc programme in September 2022.

Transition from Nursing Associate / Assistant Practitioner to RN is a shortened 19 month pre-registration nursing programme. Six learners started in training during September 2021. Funding was used from an existing business case, with a view to advertising their existing posts as Trainee Nursing associate posts, to enable a new cohort of Trainee Nursing Associates to commence in September 2021. This secured 5 individuals onto the TNA programme in September 2021 and 1 in March 2022.

Directorates will need to consider the role of the Trainee Nursing Associate and how they will foster the growth of this role within their current establishment and future re-design of roles, as advised in recommendation 2.

## 9. E-Rostering

Throughout 2021/22 regular e-rostering reviews continued to be carried out with wards areas. These reviews highlight where rostering can be improved and the actions that can be taken by the roster creators to improve our key performance indicators (KPI's). A monthly report of how ward rosters are performing against KPI's is published through RosterPerform (this is an e-Rostering management information system). The RosterPerform report can be accessed by Directorate Ward Managers, Quality Improvement Nurses (Matrons) and Senior Managers.

RosterPerform is able to provide many different reports; some examples of the KPI's that are reported upon from HealthRoster are as follows:

- Unfilled shift percentage
- Bank and Agency percentage
- Time out percentage – sickness, annual leave, study leave, other leave
- Number of shifts with the wrong grade cover

Performance thresholds are set based on overall Trust and Directorate performance targets; an advantage being that these can be reviewed and if required amended to ensure they reflect any on-going service changes or improvement initiatives.

The HealthRoster system is capable of storing data about an individual's contracted hours as well as information on annual leave, study leave and sickness absence and ward profiles such as establishment, vacancy, skill mix, Working Time Directive information and staffing levels. The use of the Autoroster function can then be used to generate a roster using these rules and improving the amount of time spent creating rosters. Autoroster is yet to be rolled out and will be a priority for 2022/23.

During 2021/22, Safecare training was provided to all Ward Managers and Matrons. Training was provided by Allocate, the company who provide our Healthroster system. Safecare supports staffing decisions by providing a 'real-time' perspective of patient acuity and staffing skill mix to identify the requirements of each ward. During 2022/23 there will be a continued support to ensure ward compliance with the completion of Safecare.

The E-rostering Team will be developing a programme of training priorities for the next 12 months to improve rosters and rostering practices. Roster creator training will assist in helping the roster creator to identify what is required when writing a roster, how to write a roster and how the system can be used more efficiently to reduce the time spent writing the rosters.

## 10. Temporary Staffing

There has been a significant growth in the temporary staffing workload during 2021/22. A particularly high increase has been seen in Agency usage which, during the past 12 months has increased by 106.38%. Staff redeployments have also increased from an average of 30 per week in 2020/21 to 50 per week in 2021/22. In addition the team continue to meet agency demand and fill 10.00 WTE of RMN shifts each month within the Acute and Urgent Care Directorate. All of these shifts remain within the NHS Framework.

The Temporary Staffing Team attend daily staffing meetings and redeploy Agency staff across three Pool Rosters (General Pool, Acute Pool and Access Pool).

Bank staff continue to able to book their own shifts through the Employee Online (EOL) service and the access and fill rate to this system has stayed steady throughout the year.

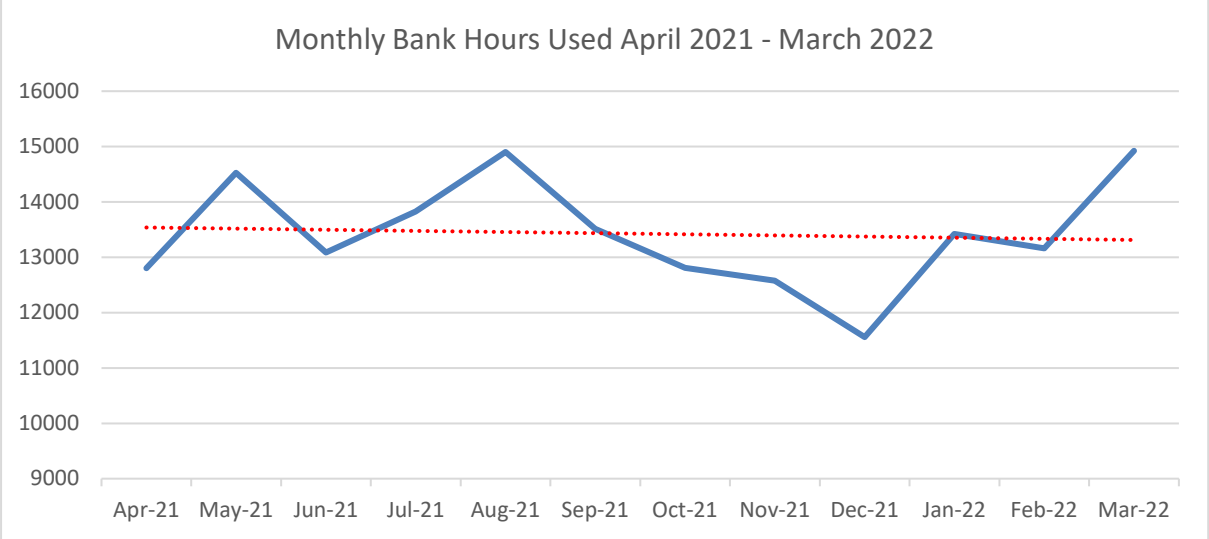
Adverts for the recruitment of Bank Staff continue to be placed regularly through NHS Jobs and we continue to receive a large number of applications for positions on the Nursing Bank.

The team have experienced a challenge with Agency worker ID checks and training compliance during the past 12 months. A renewed process and support from the Health Informatics Service and Directorate Management Teams has assisted with improving this important element of Agency Staff on boarding and we expect to now

continue unhindered. Following discussions with our Agencies and communication with Agency staff, we expect this improved position to continue into next year.

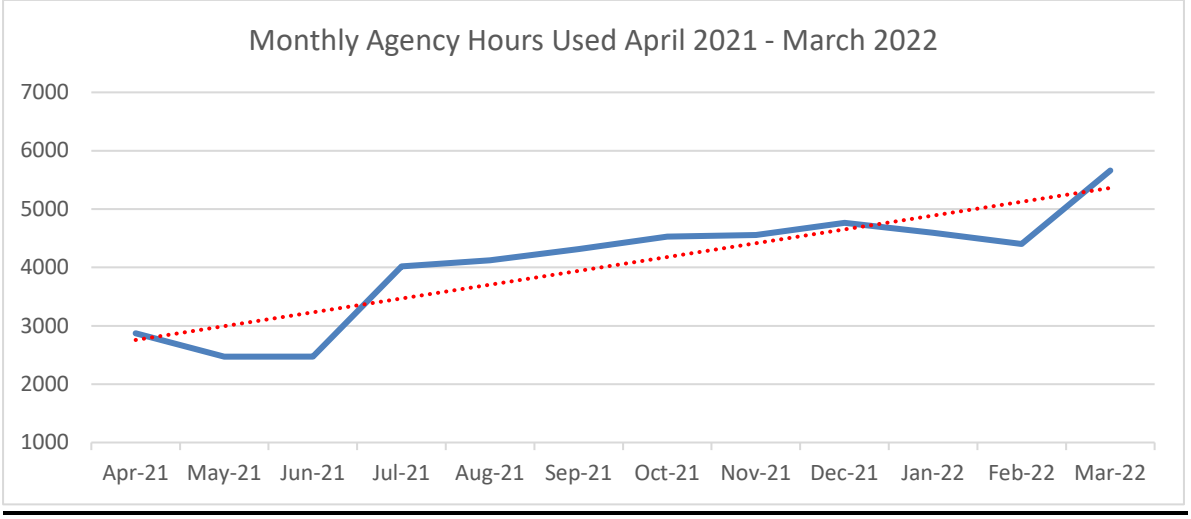
Charts 6 and 7 below show the total bank and agency nurse usage each month during 2021/22. In chart 6 we can see that there has been an overall decline in bank staff usage during 2021/22. However, there is a marked increase of approximately 3,500 hours between December 2021 and March 2022. During his period the Trust experienced an increase in sickness absence as a result of COVID-19 coupled with increases in patient acuity and the need to increase staffing levels in a number of ward areas.

**Chart 6:**




Similarly, chart 7 below shows an increased reliance on agency nursing throughout 2021/22. We would not expect to see a significant reduction in either bank or agency usage until patient acuity and sickness levels decrease and the next cohort of graduate nurses commence with the Trust in October 2022.

**Chart 7:**



## 12. Quality Assurance of Services

### 12.1 External inspections during 2021/22

The Trust received an overall rating of 'Outstanding' from the 2018 Care Quality Commission (CQC) inspection and all in-patient units have been rated 'Good' or 'Outstanding' for Caring and Responsive domains. The Trust is fully compliant with the registration requirements of the CQC and continues to maintain the overall "Outstanding" rating. Well led inspections were placed on hold during the COVID-19 pandemic and subsequent lockdown. In the absence of routine CQC inspections the Trust continued to hold regular engagement meetings with the CQC.

Our older persons wards continue to be rated as 'Requires Improvement' for Effective and Well-Led. The Trust are fully assured that all of the CQC requirements have been fully met and improvements continued to be sustained throughout 2021. The CQC carried out a focused, unannounced inspection in March 2020, in response to concerns relating to a cluster of serious incidents over a 12-18 month period. Their key focus was in relation to care planning, risk assessment and observation management within the Acute Inpatient wards. The findings of this targeted inspection were published in June 2020, with the CQC reporting that they were fully assured that safe, good quality of care was being provided.

In the absence of scheduled CQC inspections due to COVID -19, the CQC have carried out their Transitional Monitoring Approach (TMA) calls which focus on safety, how effectively services are led and how easily people can access the services. The Trust had TMA calls to the Primary Care Services in November 2020 and a further overall Trust TMA call in February 2021, both with positive feedback on how Trust services are operating.

The CQC carried out announced Mental Health Act onsite inspections at Darwin Centre, Assessment & Treatment and PICU. All received positive feedback and action plans have been implemented and progressed by each of the wards following the outcome of their inspections. These action plans are monitored by the Performance Team supported by the Trust Governance Team and through Directorate Performance Meetings.

The CCG have led five announced virtual quality visits since April 2021. This consisted of three community teams and two inpatient teams. The visits were prioritised based on the length of time since any previous visits to that area and any other intelligence which is picked up via the CCG and Healthwatch networks which may indicate that additional assurances would be beneficial.

Following each visit, the team lead has an opportunity to validate the report produced by the CCG Quality Lead and a final draft is then forwarded to the services Directorate

meeting; where any additional support which may be required regarding the recommendations can be discussed and agreed.

### 12.2 External accreditation

The Royal College of Psychiatry AIMS accreditation provides a comprehensive review of Acute (Working Age) and Older Adult Mental Health Wards. It is an opportunity for services to determine that the level of care provided to service users and carers is of the highest quality. All Acute and Older Person Wards (Wards 6 & 7) and our inpatient CAMHS ward (Darwin Centre) has achieved the similar QNIC Accreditation.

### 12.3 Internal Accreditation (SPAR Framework)

The Trust SPAR accreditation framework was initially launched in 2019. The accreditation process was placed on hold during 2021/22 in response to the COVID-19 pandemic and is currently being re-designed and will be relaunched in 2022/23.

The aim of the framework is to enable wards to work towards the Trust vision 'To be Outstanding in all that we do and how we do it'. The 12 domains included within the SPAR accreditation framework are aligned to a range of quality indicators and CQC requirements and have been developed in consultation with our Ward Managers. The framework is designed to stretch ambitions and therefore wards are not expected to achieve the highest rating in all standards immediately, rather they will work towards achieving Gold Ward status over a period of time. The domains are:

- Person centred care
- Safety and security
- Harm free care
- Medicines management
- Physical health
- Therapeutic interventions
- Communication
- Safeguarding
- Environmental safety
- Patient experience
- Staff experience
- Organisation, management and leadership

The SPAR accreditation framework is a supportive process which encourages Ward Managers to proactively work towards the Gold Ward status. This status will assure service users and the Board that high quality care is being delivered within the Trust. Wards are assessed and rated against each standard. The Head of Nursing (or Quality Assurance and Improvement Manager), a Quality Improvement Lead Nurse (QILN) and a service user or carer undertake the assessments. The outcome of the assessment will be based on:

- Observation of care given, environment and electronic patient record patients
- Discussion with patients and staff

**Recommendation 16:** Head of Nursing and Ward Managers to review the current SPAR Accreditation Framework and prepare a relaunch in 2022/23.

### 12.4 Internal Reviews

Internal scrutiny during 2020/21 included the following:

- Weekly safety huddles led by the Quality Improvement Leads (Matrons) and supported by the Head of Nursing an Deputy Director of Nursing
- Monthly safer staffing reporting to Trust Board

This range of scrutiny provides the Trust Board with assurance that whilst staffing has been challenging patient safety has been prioritised, safe staffing maintained and quality improvement has been enhanced.

In addition

- Ward Manager Roster review meetings
- Monthly Ward Manager and Matron 'Reflect and Connect' forums

## 13. Recruitment and Retention

Despite the continued impact of COVID-19 in 2021/22 we continued to develop and relaunch our 5 year People Strategy. The workforce priorities of which focus on ensuring that as a Trust, we attract, develop and retain the best people, to enable the delivery of high quality, safe and effective care. Our people practices are underpinned by the commitments as set out in the NHS People Plan and aligned in our People Strategy, with a particular focus on:

- Looking after our people – providing quality health and wellbeing support for everyone
- Belonging in the NHS – focusing on tackling discrimination that some staff face
- New ways of working and delivering care – making effective use of the full range of our peoples' skills and experience
- Growing for the future – effectively challenging how we recruit and keep our people and welcome back colleagues who want to return

Despite great strides, in line with the national RN shortages there remains continued challenges in recruiting to RN posts locally. In response to these challenges, we are working closely with our ICS partners, Health Education England (HEE) and partner Universities to actively address supply issues and looking to increase the number of

internal student placements available and broadening the opportunities available. Consequently we are developing a number of alternative roles and maximising the use of apprenticeships to support our current workforce as we focus on 'growing our own' and enhancing non-medical roles tailored to meet local needs.

The Trust's ambition with regard to developing diversity and inclusion is clear: to offer outstanding inclusion for all. We are committed to providing excellent employment experiences for those who work within our services and are taking a positive action approach to developing our diverse and representative workforce at every level. This includes specifically encouraging applications from under-represented groups, such as those with black, Asian and minority ethnic (BAME) heritage, those with disabilities and those who are LGBT+. We have developed our commitment to our Staff Networks and continue to develop the work of these groups as powerful vehicles for positive change through the organisation.

In response to the COVID-19 pandemic we have also actively contributed to the system workforce mobilisation response, supporting system providers as part of mutual aid arrangements and temporarily redeploying internal colleagues to support work streams such as the Staffordshire COVID vaccination delivery programme.

The Trust has developed at pace our digital recruitment approach and has held a number of successful recruitment events throughout 2021/22 including a virtual Nursing Apprenticeship event and an onsite Newly Qualifies Nurse (NQN) Recruitment Event. The Nursing Apprenticeship event attracted over 50 attendees and yielded 20 successful applications. From the NQN Recruitment event 44 Nurses have been offered placements. There have also been a number of successful virtual recruitment events to appoint HCSW's into our Trust either through permanent posts or onto the Bank.

Despite this high profile recruitment campaign RN and flexible appointments process, recruitment remains an ongoing challenge. The Trust has introduced a number of initiatives to support the recruitment of staff, these include specialised events for difficult to fill vacancies; the use of computer software to monitor the number of applicants from website submissions and the use of assessment centres to support some of our more popular vacancies. The Trust is also participating as part of the Staffordshire ICS, to undertake 6 high impact actions to support timely and high quality recruitment of staff.

The Trust continues to support national return to practice campaigns. These campaigns target former registered nurses who have left practice and allowed their nurse registration to lapse; providing academic and placement support to enable them to re-register with the NMC.

23 newly qualified nurses commenced with the Trust in October 2021. They are supported by a robust preceptorship programme; this programme is regularly refined

and strengthened and the Trust continues to maintain an excellent retention rate with the preceptorship cohorts.

The Practice Education Team have worked with Teams to increase student placements from Staffordshire University in order to attract a wider pool of newly qualified nurses in the future. This has enabled the Trust to 'home' students from the beginning of their studies, helping to familiarise them with Trust service and develop loyalty prior to graduation. The Trust has made 44 offers to Newly Qualified Nurses due to commence in October 2022

In terms of retention the Trust remains part of the NHSI Retention Support Programme and this has informed the Trust's Recruitment and Retention Action Plan which details the actions that are being taken by the Trust to attract and retain Registered Nurses. These include recruitment incentives such as refer a friend, continued professional development offer, flexible hours and flexible retirement options to support greater retire and return opportunities. These incentives are included in all RN job adverts.

### 13.1 Leavers

The Trust's turnover rate for 2021/22 was 14.22 % of total whole-time equivalent (WTE). This is showing a reduction of 1.64% from the 2020/21 twelve month rolling average turnover rate, however this is currently tracking at +4.22% above the Trust's 10% turnover rate target.

Turnover and retention activities continue to be reported at the Trust's People, Culture & Development Committee which takes place every two months.

From reviewing the reasons provided by staff who have left the Trust in the last 12 months, the top three reasons given are:

- Retirement age
- Work life balance
- Promotion opportunities

These reasons for leaving remain the same as for the previous year(s) suggesting that the employees with the longest service are leaving predominantly due to retirement and therefore natural turnover rather than other factors i.e. culture, team dynamic, line management etc.). Further analysis shows that of the total retirements during the year 24% of these were done via retire and return process.

However, we cannot overlook those leaving due to work life balance as this could be an indicator of culture and attitude towards flexible working. We also need to recognise that as a Trust we are not retaining potential talent with individuals citing promotion opportunities as a reason for leaving.

Acknowledging the associated costs and workforce instability that high turnover brings, during the last year key work around retention has been undertaken via the Trust's Vacancy Management Plan, related schemes include:

- Recruitment campaigns; with a focus on time to higher and speedier on boarding to welcome colleagues in to the Trust thus providing a better experience
- Targeted recruitment campaigns; to attract and retain new talent
- Introduce a friend – offer of financial incentives
- Recruitment & Retention Premia (RRP) for nurses in Acute Services – service specific
- Development of the Trust's Agile Working Policy

The RRP is to support the current staff and newly appointed staff in post over an 18 month period. The 10% RRP is for 12 months increasing to 15% for the final 6 months. This would result in a mid-point Band 5 receiving an additional £4,862 (excluding deductions) and a Band 6 mid-point receiving an additional £5,980 (excluding deductions) at 2021/22 pay rates.

The Vacancy Management Plan is currently subject to a benefits realisation and ROI review with the report being available at the end of May 2022.

Work around flexible working and health & wellbeing was also a focus for the Trust's Regroup, Reflect and Recharge Campaign. In particular the Flexible Working and Agile Working Policy was reviewed and updated. Health and wellbeing offers were widely promoted across the Trust.

Looking forward to this year's activities the Trust is part of the Staffordshire and Stoke-on-Trent Integrated Care System Retention Programme (SSOT ICS). The retention project aims to improve retention and enable transformation in flexible working practice across the SSOT ICS. Led by ICS Retention Coordinators, the project will focus on hardest hit clinical services to analyse, diagnose and implement changes in practice to improve retention, flexible working, staff experience, health and wellbeing, service delivery and patient experience. The aim is to have better retention strategies, linking to national, regional and local aims with the end goal being focused on delivering exceptional service and patient care.

A key focus of the project is to better understand the employee experience, looking to measure the effectiveness of initiatives in place (such as the Preceptorship programme) to ensure these are fit-for-purpose considering role type, future generational needs and the diversity of employees.

There will also be a focused piece of work in the Community Directorate with an action plan developed from 'stay conversations' that will sit alongside the directorate's staff survey action plan.

Within the Trust and as part of our commitment to reduce attrition we will continue to focus:

- Health and wellbeing; continued promotion to wellbeing support including the enhanced psychological wellbeing offer
- Flexible / agile ways of working; continuing the work undertaken in 2020/21 with policy development and review, developing awareness of options and opportunities
- Talent and succession management; developing and embedding processes to identify and support potential talent
- Inclusion; continuing with our range of initiatives to support growth and awareness e.g. New Futures Programme, Inclusion School and Comfortable Being Uncomfortable

Notwithstanding the excellent 2021 National Staff Survey results the Trust remains committed to improving staff experience, all directorates have been asked to review their staff survey results to identify actions for improving staff engagement and retention across their workforce profile. It is worth noting that individuals reported that they feel the organisation is committed to helping them achieve a work life balance (64%) and that they felt confident that they could discuss flexible working with their line manager (82%).

## 15. Summary of Safer Staffing Recommendations 2021/22 to be implemented in 2022/23

The following section summarises the recommendations made throughout this report.

**Recommendation 1: This recommendation remains ongoing from 2020/21.** The E-rostering Team will continue to provide training and support confirm and challenge sessions with Ward Managers around roster completion. Updates will be provided to the Trust Safe Staffing Group.

**Recommendation 2: This recommendation remains ongoing from 2020/21.** Building upon the success of recruiting a number of apprentice nurses the Head of Nursing will continue to build a sustainable strategy for nurse apprenticeships.

**Recommendation 3:** Deputy Director of Nursing and Head of Nursing will explore how the recruitment to and management of the nursing bank can be streamlined. Current systems will be reviewed to support the recruitment and on-boarding of student nurses and other learners. Consideration will be given to releasing this element from the Temporary Staffing Team enabling them to focus their attention on shift allocation and e-rostering.

**Recommendation 4:** Recognising the challenges of recruitment, the Ward Manager and Matron will work with the Head of Psychology to further the recruitment to the Consultant Psychologist vacancy.

**Recommendation 5:** The Ward Manager will explore the development of a Discharge Coordinator role from the remodelling of current vacancies.

**Recommendation 6:** Ward 2 Manager to link with the Trust Patient Experience and Recovery Lead to discuss support and advice for recruitment to a Peer Support Worker position.

**Recommendation 7:** The Directorate should continue to review the specialist dietetic support requirements for each patient as appropriate. Risks should be escalated through the Directorate structure. The Head of AHP will continue to review any shortfalls in support and will work alongside the Quality Improvement Lead (Matron) to recruit the required level of dietetic support.

**Recommendation 8:** Ward 4 Manager and Quality Improvement Lead (Matron) to work with the HIS to improve reliability of Wi-Fi connections.

**Recommendation 9:** Ward manager to explore the potential recruitment of a Band 4 position to support the completion of the Decision Support Tool (DST).

**Recommendation 10:** Ward Manager to work with the Head of Nursing and Practice Education Team to develop a competency framework for RGN's working within an older person's mental health ward setting.

**Recommendation 11:** Ward 5 to re-establish links with existing or new neuropsychiatry services to enable the shared learning and the development of further good practice.

**Recommendation 12:** EMU Ward Manager to link with AHP Leads to explore the opportunities to recommence Physiotherapy on the unit and the potential for Occupational Therapy input.

**Recommendation 13:** The Darwin Centre Ward Manager will work with Service Managers to explore the recruitment of a clinical lead who can take a lead on bed management.

**Recommendation 14:** Darwin Centre Ward Manager to support any planned review of the existing care pathway and service provision, highlighting the current staffing challenges and future workforce requirements.

**Recommendation 15:** Summers View Ward Manager to provide updates on the development of service user activity space to the safer Staffing Group.

**Recommendation 16:** Head of Nursing and Ward Managers to review the current SPAR Accreditation Framework and prepare a relaunch in 2022/23.

## 16. Statement for Executive Director of Nursing & Quality and Medical Director

In line with NHSE/I requirements the recommendations included within this report have been agreed by the Executive Director of Nursing & Quality and the Medical Director who have confirmed that they are satisfied with the outcome of the review and that staffing is safe, effective and sustainable.

## 17. Conclusion

In light of the national shortage of Registered Nurses, the increasing dependency and acuity of service users and the on-going management of the COVID-19 pandemic it has been challenging to maintain safe staffing levels during 2021/22. However, Quality Improvement Leads (Matrons), Ward Managers and their teams have continued to deliver safe care and also demonstrate areas of notable practice and are commended for their achievement in doing so.

The Board are asked to:

- Receive this report as assurance that the Trust is meetings its accountability to provide safe nursing staffing to inpatient areas.
- Note the continued challenge with the recruitment of Registered Nurses
- Note the planned (and completed) work to be undertaken by the Directorates to support safer staffing levels within the Trust.
- Approve the recommendations detailed in section 15 of this report

## 19. Appendix One

### 2020/21 Safer Staffing Recommendations Progress Summary

**Recommendation 1:** The E-rostering Team will continue to provide training and support confirm and challenge sessions with Ward Managers around roster completion. Updates will be provided to the Trust Safe Staffing Group. **Ongoing**

**Recommendation 2:** The Preceptorship programme will be reviewed annually to ensure continuous improvement in response to feedback. **Complete**

**Recommendation 3:** Work should continue to between the Operational, Nursing and Workforce Directorates to consider the development of a redeployment register and transfer window. This will assist in supporting staff development and will help to retain staff in the Trust who may otherwise seek out external employment opportunities. **Complete**

**Recommendation 4:** Building upon the success of recruiting a number of apprentice nurses the Head of Nursing will explore the development of a longer term recruitment strategy for nursing apprentices. **Ongoing**

**Recommendation 5:** Within the Acute and Urgent Care Directorate, Service Managers and QILN's should revisit a review of the Directorate recruitment process in conjunction with the Ward Managers to identify how processes can be further

streamlined whilst also ensuring that the Ward Manager's maintain full ownership and oversight of their ward establishments and vacancies. **Complete**

**Recommendation 6:** Directorate Managers and Quality Improvement Lead Nurse (Matron) to identify new roles and flexible working opportunities to support recruitment and retention across the Acute and Urgent Care Directorate. **Complete**

**Recommendation 7:** Ward Managers and Quality Improvement Lead Nurse (Matron) from inpatient Directorates will continue to continue to explore and deliver bespoke recruitment events with the support of the Recruitment Manager and Head of Nursing. **Complete**

**Recommendation 8:** The Nursing and Quality and Operations Directorate will work together to develop a plan to support the recruitment and retention of the nursing workforce; this will provide short, medium and longer term goals and actions. **Complete**

**Recommendation 9:** Ward Managers from all four acute wards should continue to engage with the Reducing Restrictive Strategy and the Safewards initiative. **Complete**

**Recommendation 10:** The Head of AHP in conjunction with the Head of Nursing to support all inpatient areas access staff development and apprentice pathways for AHP's. **Complete**

**Recommendation 11:** The Ward 2 Manager to explore the potential of developing a Peer Mentor or Peer Volunteer role within the team, initially to support patient activities. **Ongoing**

**Recommendation 12:** The Acute and Urgent Care Directorate should continue to review the specialist dietetic support requirements for each patient as appropriate. Risks should be escalated through the Directorate structure. The Head of AHP will continue to review any shortfalls in support and will work alongside the Quality Improvement Lead (Matron) to recruit the required level of dietetic support. **Ongoing**

**Recommendation 13:** The PICU Ward Manager and Quality Improvement Lead (Matron) to explore opportunities to provide an on-site staff break facility. **Complete**

**Recommendation 14:** Ward 4 Manager and Quality Improvement Lead (Matron) to work with the HIS to improve reliability of Wi-Fi connections. **Ongoing**

**Recommendation 15:** Ward 4 Manager and Quality Improvement Lead (Matron) to explore availability of additional laptops to support HSCW access to email, training, etc. **Complete**

**Recommendation 16:** To support recruitment and employment opportunities, the Specialist Directorate should explore strategies to increase the profile of Ward 5 and the work of a neuropsychiatry inpatient unit. **Complete**

**Recommendation 17:** At Ward 5, good practice was noted within previous annual reviews of the development of links with a similar units to share learning. It is recommended that these links are strengthened and developed. **Complete**

**Recommendation 18:** Ward 5 Manager, Quality Improvement Lead (Matron) in conjunction with the AHP lead for Neuropsychiatry should explore the opportunities to increase AHP support to the ward. A potential business case for additional funding should be considered if there is deemed to be a shortfall within the existing AHP establishment. **Complete**

**Recommendation 19:** Ward 5 Manager and Quality Improvement Lead (Matron) should explore the opportunities to increase Activity Worker support to the ward. **Complete**

**Recommendation 20:** The EMU Ward Manager should explore opportunities to develop a Nursing Associate role for the unit. This post could provide a useful development opportunity and can be used to provide additional support during night shifts and may be considered as an alternative to a second Registered Nurse. **Complete**

**Recommendation 21:** Assessment and Treatment Ward Manager and Quality Improvement Lead (Matron) to work with the recruitment team to explore the opportunities to provide a nuanced recruitment programme for learning disability nurses and HCSW's. **Ongoing**

**Recommendation 22:** Summers View Ward Manager to explore the potential of developing a designated staff break area. **Complete**

# REPORT TO PUBLIC TRUST BOARD

Enclosure 6

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Q1 Serious Incident report | | |
| Presented by: | Dr Dennis Okolo. Interim Medical Director | | |
| Author: | Jackie Wilshaw. Head of Patient and Organisational Safety | | |
| Executive Lead Name: | Dr Dennis Okolo. Interim Medical Director | **Approved by Exec** | ☒ |

| Executive Summary: | **Purpose of report** | |
|---|---|---|
| This report is the Q1 (April –June 2022) Serious Incident Report. It provides the Trust with assurance relating to the nature and status of SI's currently open and the trend data for Q4 2021/22 and Q1 2022/23.<br><br>There were total of 15 Sis during this period, which is comparable to the numbers for Q1 and Q2 for the preceding year. There were 2 incidents each in Acute and urgent care and North Staffordshire directorates whilst there were 4 incidents in the specialist directorate and 7 incidents in the Stoke community directorate.<br><br>The report also includes information regarding themes, learning and any changes arising from Serious Incident investigations. The Duty of Candour report is also included. | **Approval** | ☐ |
| | **Information** | ☒ |
| | **Discussion** | ☐ |
| | **Assurance** | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: 26/07/2022 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Resource Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☐<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☐<br>2. We will actively promote partnership and integrated models of working ☐<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | Nil | | |
| Resource Implications:<br><br>Funding Source: | Nil | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | | |
| Shadow ICS Alignment / Implications: | N/A | | |
| Recommendations: | To receive for assurance and information | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | CSIG | 14/07/22 |

# Serious Incident (SI) Report Q1 (April –June 2022)

## 1. Purpose of the report

This report provides assurance to the Quality committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour (DoC). The report covers the Q1 period from 1st April 2022 to 30th June 2022 and details the following:

- The status of SIs currently open and trend data for Q4 2021/22 and Q1 2022/23.
- Serious Incidents by category reported by quarter
- Themes, learning and changes arising from Serious Incident investigations.
- The Duty of Candour report.

## 2. Serious Incidents

Responding appropriately when things go wrong in healthcare is a key part of the way that the Trust can continually improve the safety of the services we provide to our patients. We know that healthcare systems and processes can have weaknesses that can lead to errors occurring and, tragically, these errors sometimes have serious consequences for our patients, staff, services users and/or the reputation of the organisations involved. It is therefore essential that we continually strive to reduce the occurrence of avoidable harm.

SI reviews are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 6 months. Reviews of the care provided are completed for incidents where death, serious injury or serious event has occurred. For the purposes of this report, reviews are not undertaken for those service users whose deaths are determined by HM Coroner to be the result of natural causes. These deaths are subject to reviews under the mortality surveillance process.

At present the Trust uses a blended mix of formal reports, the Learning Lessons framework, forums across the directorates and the Weekly Incident Review Group to share the learning from incident reviews.

The table below illustrates the total number of SIs reported by quarter for the period April 2021 to June 2022.

^ indicates categories used for the first time in Q4 2021/22: Categories chosen result from limitations within the StEIS recording system and do not accurately reflect the nature of the incident.

| StEIS Incident category | Q1 | Q2 | Q3 | Q4 | Total 2021/22 | Q1 | Q2 | Q3 | Q4 | Total 2022/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| Apparent/actual abuse | 1 | 1 | 0 | 1 | 3 | 0 | | | | 0 |
| ^ Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare (new Q4 2021/22) | | | | 2 | 2 | 0 | | | | 0 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| ^ Incident demonstrating existing risk that is likely to result in harm (new Q4 2021/22) | | | | 1 | 1 | 0 | | | | 0 |
| Unexpected potentially avoidable injury causing serious harm: This is subdivided as shown below | | | | | | | | | | |
| Apparent/actual/suspected self-harm criteria meeting SI criteria | 2 | 3 | 2 | 3 | 10 | 4 | | | | 4 |
| Slip, trip, fall | 1 | 2 | 1 | 1 | 5 | 0 | | | | 0 |
| Disruptive, aggressive behaviour meeting SI criteria | 0 | 1 | 0 | 0 | 1 | 1 | | | | 1 |
| Unexpected/Potentially avoidable serious assault (inc Suspected Homicide) | 0 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| Unexpected/potentially avoidable injury causing serious harm ( New Q3 2021/22) | | | 1 | 0 | 1 | 0 | | | | 0 |
| Unexpected, potentially avoidable death: This is subdivided as shown below | | | | | | | | | | |
| Pending review | 9 | 8 | 6 | 8* | 31 | 7 | | | | 7 |
| Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide) | 3 | 1 | 10 | 6 | 20 | 3 | | | | 3 |
| Hospital Acquired infection | 0 | 1** | 0 | 1 | 2 | 0 | | | | 0 |
| Total | 16 | 17 | 20 | 23* | 76 | 15 | | | | 15 |

**multiple Covid-19 deaths

*One death was later transferred to the mortality surveillance process following the determination of a natural cause death. Therefore, this figure represents the actual number of reports made to StEIS.

## 2.1 Suspected Suicides, including the impact of COVID-19 in relation to suspected suicides.

Since the onset of the pandemic the Trust has asked the SI reviewers to take into account any Covid-19 related factors which may have contributed to the mental health distress of the people who died by suicide or who significantly self-harmed during this period. For incidents reported from March 2020, early learning does not indicate that factors relating to the pandemic specifically impacted upon the majority of the events reported.

As stated in previous quarterly reports and the 2021/22 Annual Report, the possible impact of the Covid-19 pandemic as a driver for an increase in suicides has fortunately not demonstrated an increase in suicides nationally. However, together with the whole of the NHS, social care and the voluntary/3rd sector, the trust remains vigilant to a potential increase in suicide rates as a result of on-going issues that can impact upon the mental health of a person i.e. poor physical health, social and economic pressures. The factors that increase suicide risk are well documented and the Trust has been proactive in support of mitigating practices. With regards to suicide rates and the impact of Covid-19, it is also important to note that suicide rates in the general population have continued to rise since 2018 and so any subsequent rises will have to take this into consideration and not simply determine that any increase is due to issues relating to Covid-19. The latest

consultation paper *Mental health and wellbeing plan: discussion paper* (DHCS, updated April 2022) asks stakeholders to consider the following questions:

- How can we all promote positive mental wellbeing?
- How can we all prevent the onset of mental health conditions?
- How can we all intervene earlier when people need support with their mental health?
- How can we improve the quality and effectiveness of treatment for mental health?
- How can we all support people with mental health conditions to live well?
- How can we all improve support for people in crisis?

Whilst this paper and the ambition for better mental health could be linked to the risk factors identified through the Covid-19 analysis (and are covered in the national Covid-19 mental health and well-being recovery action plan), many of the issues faced by the general population are of a much more long standing nature. Therefore it is expected that the Trust/ICS will be proactive in the response to this consultation document, working in partnership across the system to support better mental health and our continuing commitment to suicide mitigation.

### 2.2 Serious Incident Data by Team and Directorate

The table below shows the incidents reported in Q1 by team.

| Team/date | April 22 | May 22 | June 22 | Total |
|---|---|---|---|---|
| CDAS*/Lymebrook/Greenfields | 2 | 1 | | **3** |
| Ward 1 | 1 | | | **1** |
| Sutherland | 1 | 1 | | **2** |
| Access*/Mental Health Liaison | 1 | | | **1** |
| Stoke OPMHT | | 1 | | **1** |
| Greenfields | | 2 | 1 | **3** |
| Intensive support team/CLDT | | 1 | | **1** |
| Lymebrook | | 1 | | **1** |
| North Staffs CAMHS | | | 1 | **1** |
| IAPT Newcastle | | | 1 | **1** |

*denotes the lead team/directorate for purposes of SI review process. Joint reviews and learning processes established.

*The table below shows the incidents reported by Directorate*.

| Directorate/Date | April 22 | May 22 | June 22 | Total |
|---|---|---|---|---|
| Acute and Urgent Care | 2 | | | 2 |
| N Staffs Community | | 1 | 1 | 2 |
| Specialist Services | 2 | 2 | | 4 |
| Stoke Community | 1 | 4 | 2 | 7 |

During Q1, 15 incidents have been reported onto StEIS and have undergone or are in the process of undergoing SI reviews. The main points to note are:

- There were four incidents in the Specialist Services Directorate.
    - Three of the incidents involved people under the care of drugs and alcohol services, two cases had their care shared with adult community services.
    - There was *one incident* of self-inflicted harm within the LD service.
- There were two incidents reported for North Staffordshire Community Directorate
    - There was one incident of self-inflicted harm in CAMHS services and one unexpected death of a person under the care of the CMHT.
- There were two incidents in the Acute and Urgent Care Directorate.

    - There was one incident of self-harm in one of the in-patient areas and one incident of unexpected death involving a person in the community.
- In Stoke Community Directorate, seven SI reviews were commenced.
    - There were six unexpected deaths and one incident of violent behaviour meeting SI criteria.

## 3. Themes and trends

During Q1, there have been fewer SIs (15) reported than during Q3 (20) or Q4 (23), 2021/22. However, it is noted that over recent years that this pattern is repeated with more SIs reported during quarters 3 and 4 than in quarters 1 and 2. Therefore fewer SIs in Q1 is not significant.

Stoke Community Directorate reported the highest number of incidents of unexpected deaths. Of these deaths 4 are thought to be related to misadventure through the use of illegal drugs, 1 case may be regraded to a natural cause death and 2 cases are suspected suicides (1 case may be regraded to a natural cause death) and 1 case of violence and aggression meeting SI criteria. Therefore, whilst the directorate is the highest reporter during this period, there is no concerns raised regarding specific teams and learning has identified areas of good practice by individual members of staff.

Of these cases, one person died in a house fire. To date the possibility of arson has not been excluded , however as a result of several fires in domestic residences and involving people known to mental health services, Staffordshire Police have set up a working group to look at the issues surrounding this group of people. The early discussions have highlighted positive work by our teams however the use of illegal drugs and a refusal to engage with CDAS leading a subsequent deterioration in mental health and anti-social behaviours appears to be a theme for future consideration.

## 4. Learning from Serous Incident reviews

Recommendations and learning from SI reviews are disseminated upon completion by the Directorate Quality Improvement Lead Nurses. This process includes the production, implementation and evaluation of action plans and information is reported back, discussed, and actioned through individual meetings, team meetings and directorate forums. Learning is also discussed at the Trust Clinical Safety Improvement Group and with the CCG quality commissioners at the monthly SI Sub-group. The learning that was found from closed SIs during Q4 2021/22 and Q1 2022/23 includes the following outcomes:

- Work is planned as part of the community transformation project to extend the implementation of evidence-based care pathways, focusing on the recovery process and transition into community-based support post diagnosis and treatment from the teams in the Trust. The aim of the process is to incorporate the recovery pathway approach into the specific diagnostic care pathways, thereby bringing the CMHTs closer to wider communities.
- Ensuring that families and carers are supported with regards to Covid-19 guidance i.e. restrictions and testing.
- Improved use of digital technology to ensure that all people present at a ward, or multidisciplinary (MDT) meeting are sighted on the clinical records during reviews and for information added to the clinical record in a timely manner by the person completing the review. This ensures that any lack of clarity can be addressed immediately by those present.
- Staff were also reminded to ensure that the name and professional title/role of each person present in a ward review or MDT meeting is clearly documented.
    - This is to ensure that the value that each discipline brings to an individual's care is recognised with the note's narrative
    - This standard has also been communicated to the staffing agencies used by Trust, to ensure that there is an accurate record of staff providing patient care. The expectations of the Trust have also been discussed to ensure that the narratives provided by agency staff meet the required standard in terms of the correct terminology used.

- Consideration of adding text messages to the electronic patient record as these messages are increasing used by staff to support patient engagement.
- Changes within service provision to support those people who do not attend for appointments is well established however the teams (CMHTs) are also to extend this discussion to include those people with Serious Mental Illness, who do not attend the physical health clinics.
- Consideration of the standardisation of the Duty Professional service is underway: this is not the provision of the same staffing model across each CMHT but instead ensuring that the processes are fully aligned.
- A pilot of a new telephone system at one of the CMHT bases will allow the monitoring of the volume of calls/call waiting etc. and will support the trust understanding re staffing and capacity.
- The management of unused medication which have been removed from a patient's home; processes to return to pharmacy and hospital management during out of hours.

## 5. Duty of Candour

The Trust policy Being Open, incorporating Duty of Candour (DoC) ensures that all staff are aware of their responsibilities with regards to DoC. However this is further supported by the secondary reviews provided through the Patient and Organisation Team reviews and the weekly Incident Review Group, which is attended by senior representatives from the directorates and corporate Nursing and Quality Teams.
In the case of SIs, it is not always possible to immediately determine which, if any of the deaths under investigation meet the Duty of Candour requirements. Letters are issued by the Directorate of the treating team, expressing the Trust condolences and explaining that the Trust will be undertaking a review of the care provided. However should any investigation identify causal links between patient harm and service delivered, the DoC process would be initiated and a letter outlining the issues sent to the patient or next of kin. The current ongoing SI investigations may identify issues that meet the DoC criteria and therefore the requirements for DoC would be met through the SI process.

During Q1 there have been no incidents that have met the criteria for immediate action regarding the DoC requirements. Ongoing investigation may identify areas for concern and these will be managed through Trust policy.

## 6. Conclusion

The Board is asked to note this report which highlights the processes undertaken to review all incidents meeting the SI criteria. The Trust continues to monitor all Serious Incidents monthly through the Clinical Safety Improvement Group, demonstrating compliance with Trust policies and processes.

The learning from investigations is cascaded across the Trust through a variety of governance processes. These are through the internal team and directorate processes, to full Trust cascade, and the Learning Lessons framework. This is to ensure that the learning from investigations is not completed in isolation and that a positive learning culture is maintained, through supporting staff with the opportunity to reflect and share learning.

# REPORT TO PUBLIC TRUST BOARD

Enclosure: 7

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Q1 Mortality Surveillance Report | | |
| Presented by: | Dr Dennis Okolo. Interim Medical Director | | |
| Author: | Jackie Wilshaw. Head of Patient and Organisational Safety | | |
| Executive Lead Name: | Dr Dennis Okolo. Interim Medical Director | **Approved by Exec** | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This report provides the Trust with assurance regarding the mortality surveillance process for people open to Trust services who have died of natural causes before the age of 75 years. This report refers to Q1 2022/23. (1st April to 30th June 2022). There were 14 patients during this review, all were rated good or excellent.<br><br>There was no evidence of deficits in the healthcare provided by the Trust that may be considered to have contributed to the death of any individuals. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: 26/07/2022 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Resource Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☐<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives (please indicate) | 1. We will attract, develop and retain the best people ☐<br>2. We will actively promote partnership and integrated models of working ☐<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | N/A | | |
| Resource Implications:<br><br>Funding Source: | N/A | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | | |
| Shadow ICS Alignment / Implications: | N/A | | |
| Recommendations: | The Board to receive and note the report for assurance. | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Jackie Wilshaw | 14/07/2022 |

# Mortality Surveillance Report Q1 (April – June 2022)

## 1. Introduction

In 2017 the National Quality Board published guidance on learning from deaths. As a result the Trust implemented a process to ensure that we can be confident that all unexpected deaths are reported and investigated appropriately. Additionally, information contained within its databases must be accurate and comply with the Trust standard of transparency and accountability. The deaths reviewed under the remit of mortality surveillance (MS) are those categorised as natural cause deaths and are not subject to reviews under the Serious Incident policy or Inquest at HM Coroner's Court. This report is for the Q1 reporting period 2022/23 and provides information for the time frame April to June 2022.

## 2. Trust reporting and data collection

During Q1 the mortality surveillance group reviewed the care of 14 people (meetings took place on 12th April and 10th May 2021). The June meeting was postponed due to several factors: only small number of cases available for review, group members sickness and annual leave. The analysis of these deaths is shown in the table below.

| Meeting date | Identifier | Death Category | Level of care | Death occurred as a result of problems in healthcare? | DoC applies? | Domain |
|---|---|---|---|---|---|---|
| May 2022 | 39388 | UN1 Unexpected Natural | 4. Good Care | No | No | Physical Health/ Learning Disability |
| | 41890 | EN1 Expected Natural | 4. Good Care | No | No | Physical Health/ Drugs and alcohol |
| | 41912 | UN1 Unexpected Natural | 4. Good Care | No | No | Physical Health |
| | 42264 | UN2 Unexpected Natural | 5.Excellent Care | No | No | Physical Health |
| | 43097 | EN1 Expected Natural | 4. Good Care | No | No | Physical Health |
| | 43034 | EU Expected Unnatural | 4. Good Care | No | No | Drugs and alcohol |
| | 43503 | UN1 Unexpected Natural | 4. Good Care | No | No | Physical Health |
| April 2022 | 42795 | UN1 Unexpected Natural | 4.Good Care | No | No | Physical Health |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 42690 | UN1 Unexpected Natural | 4.Good Care | No | No | Physical Health |
| | 42600 | EN1 Expected Natural | 4.Good Care | No | No | Physical Health/ Learning Disability |
| | 42805 | UN1 Unexpected Natural | 4.Good Care | No | No | Physical Health |
| | 42762 | EN1 Expected Natural | 4.Good Care | No | No | Physical Health |
| | 41875 | EU Expected Unnatural | 5.Excellent Care | No | No | Drugs and alcohol |
| | 41594 | UN1 Unexpected Natural | 4.Good Care | No | No | Physical Health/ Learning Disability |

*denotes people who died and Covid-19 was written on the death certificate.

The definitions used for the death category are shown below:

- EN1 - Expected Natural. Deaths that were expected to occur in an expected timeframe e.g., terminal illness.
- EU - Expected Unnatural. Deaths that are expected but not from the cause expected or timescale e.g., misuse of drugs, alcohol dependant, eating disorders.
- UN1 – Unexpected Natural. Death from natural causes e.g., sudden cardiac condition, stroke.
- UN2 – Unexpected Natural. Death from natural causes but didn't need to be e.g., alcohol and drug dependency, care concerns.
- UU – Unexpected Unnatural. Suicide, homicide, abuse/neglect – investigation to be completed under the Serious Incident Framework.

The mortality surveillance group considered that good care had been provided where there was evidence of the staff providing a good level of support, had responded quickly and appropriately to situations where deterioration in physical health was noted. Adequate care is determined to be care where the basic standards of expected support are given. Poor Care is determined where the group consider that the actions of the clinicians did not meet the standards required by the Trust. However in part these determinations are dependent upon the quality of the documentation contained within the mortality surveillance review tools and the electronic patient records. Where issues are identified, feedback is given to the directorate/team on the quality of documentation and sent to the clinical teams in order to improve future entries in patient records.

Of the reviews undertaken during this timeframe, all cases were rated as either good or excellent care.

The care was rated to be good in twelve cases; it was agreed by the group that there was evidence of care being provided in a timely manner and that the actions taken by Trust staff demonstrated their compassion and support to people who were physically unwell.

In two cases the care was rated to be excellent:

- High Volume Users team delivered excellent care to a person with alcohol misuse problems. There is good evidence of exceptional efforts by the team in supporting this person to access physical health appointments while also helping with maintaining good mental health.
- It was noted that Ward 6 team delivered excellent care throughout the person's admission and also during the emergency event. It was noted that the documented care delivered was compassionate and the physical health deterioration was noted and acted upon in timely manner.

There were no cases in Q1 that the group considered to have been poor care or adequate care.

Mortality surveillance is completed for people known to the Trust who have alcohol related issues, as drug related deaths are reviewed through the Serious Incident Framework. Therefore, of the deaths reviewed during Q1, 21%, or 3 people, were known to Stoke Community Drug and Alcohol Services (CDAS) for alcohol related issues. In each case the person also had underlying physical health co-morbidities associated with long-term alcohol abuse.

## 3. LeDeR

There were three people with a learning disability whose care were reviewed during this time frame. In addition to the mortality surveillance reviews completed by the Trust all deaths of people with Learning Disabilities are reported to a national reviewing board. The deaths are then allocated to regional offices for review and where necessary additional mortality reviews may be undertaken. To ensure oversight of all deaths of people known to the Trust, the decision was made to include the deaths of people with Learning Disabilities in the mortality surveillance process.

During the latter part of 2020, the regional team requested further information regarding the Trust reviews of a few people with Learning Disabilities however we are still to receive any reviews completed by the regional teams.

In June 2021, the process for LeDeR reviews changed (see paper submitted to June SLT and QC. *Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) policy 2021).* From October 2021, People over 18 years with a diagnosis of autism will now also qualify for LeDeR review.

However, the basic process of the Trust completing our own mortality surveillance reviews will continue to take place to ensure that any initial learning is captured in a timely manner. With the change in process, it is expected that the national review team will utilise the Trust mortality surveillance reviews to determine if an additional review is required. However, from the initial response to the Trust MS reviews it is anticipated that very few additional reviews will be undertaken by the national team.

## 4. Conclusion

The Trust continues to monitor the deaths of people whose deaths are outside of the Serious Incident process. The monthly Mortality Surveillance Group receives and reviews investigations in order to provide assurance as to the quality of the care provided by the Trust. The group identifies any learning from the reviews and offers recommendations for practice when required. In the deaths reviewed during Q1, there was no evidence of deficits in the healthcare provided by the Trust that may be considered to have contributed to the death of any individuals**.**

NHS North Staffordshire Combined Healthcare NHS Trust

Keele University Teaching Trust

# REPORT TO PUBLIC TRUST BOARD

Enclosure No: 8

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Quality Committee Summary Report | | |
| Presented by: | Patrick Sullivan, Non-Executive Director | | |
| Author: | Patrick Sullivan, Non-Executive Director/ Justine Scotcher Executive PA. | | |
| Executive Lead Name: | Dr Dennis Okolo, Interim Medical Director<br>Kenny Laing, Executive Director of Nursing and Quality | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| The attached assurance report describes the business and outputs from the meeting of the Quality Committee on 1 September 2022 | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☒<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☐<br>2. We will actively promote partnership and integrated models of working ☒<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | To provide assurance to the Board on quality of services, issues of concern and remedial action being taken. | | |
| Resource Implications:<br><br>Funding Source: | None highlighted | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | | |
| Shadow ICS Alignment / Implications: | None as part of this report | | |
| Recommendations: | Receive for assurance purposes and ratify policies highlighted | | |

| Version | Name/group | Date issued |
|---|---|---|
| | | |

# Report from the Quality Committee meeting held on 1 September 2022 for the Trust Board meeting on 8 September 2022

## 1. Introduction

This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee with items aligned to the Trust's SPAR objectives. The meeting was completed using Microsoft teams. The meeting commenced with a patient's story in respect of the Transforming Care Programme. This is a very positive story about an individual who has been hospitalised for 36 years. He has now been moved to his own accommodation with 2.1 support in the community with additional involvement from community learning disability services.

## 2. Reports received for assurance, review, information and/or approval

- **COVID-19 Update**
  The Committee received a verbal update regarding the current situation. The Director of Nursing explained that the Trust is still identifying patients who are positive for Covid-19, the Psychiatric Intensive Care Unit (PICU) is currently subject to outbreak measures.

- **Safe Staffing Report –July 2022**
  The Committee received this report which outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during July 2022 in line with the National Quality Board requirements. During July 2022, an overall fill rate of 94.4% was achieved; this has increased from 93.5% in June 2022. The fill rate for RN shifts was 74.0% in July 2022, a decrease from 79.3% in June 2022. This report is on today's Board agenda.

- **Safe Staffing Annual Report 202/23**
  The Committee received this report which provides assurance of safe nurse staffing levels. Ward staffing numbers have been determined using nationally validated tools. All ward staffing plans have been subject to professional review by Ward and Service Managers, QILN's (Matrons) and the Deputy Director of Nursing before final approval by the Director of Nursing. The report is also on today's Board agenda.

- **Risk Register**
  The Committee reviewed the risks contained in the Trusts Risk Register that fall under the remit of the Quality Committee. The risks are as follows:
  - Impact of COVID 19 on the quality of services
  - Anchored ligature points
  - Non- anchored ligature points
  - Compliance with Mental Health Act and Mental Capacity Act
  - Meeting the 3-hour target for assessment in the place of safety
  - Quality and capacity of the pharmacy services due to recruitment challenges and the impact of Covid 19

- Pharmacy will not be able to dispense/order medications through the pharmacy IT system (Ascribe) - ***recommendation to reduce risk approved***
- Lack of a commissioned for adult ADHD diagnostic service
- Trust becoming a commissioner replacing cohort patients with provider's in relation to TCP and P86 - ***recommendation to reduce approved.***

As noted above, the Committee approved changes to the current scoring for two of the identified risks.

- **IQPR M4 2022/23**
The Committee received this report. In Month 4 there are 20 rated measures that have met the required standard (18 in M3) and 12 that have not met the required standard and highlighted as exceptions (12 in M3).

There are 3 special cause variations (orange variation flags) - signifying concern, compared to 7 in M3:
  - Referral to Assessment within 4 weeks
  - CAMHS compliance within 4 week waits (Referral to Assessment)
  - Agency Cost per month (£000)

There are 5 special cause variation (blue variation flags - signifying improvement):
  - IAPT: patients wait no longer than 90 days between 1st and 2nd treatment (PIP in place)
  - Numbers of CPA service users in employment
  - Numbers of CPA service users in accommodation
  - Vacancy Rate
  - Statutory and Mandatory Training

There are 21 metrics flagged with a common cause variation (grey variation flag), 24 during M3.

- **Trust's Learning Disability and Autism Services**
The committee received a summary of current learning disability and autism services provided by the Trust identifying current challenges, how services are integrated with mainstream services, how we are assured about the quality of these services and service user and carer involvement.

## 3. Directorate Dashboards

Each Clinical Director (or nominated deputy) presented their report and the balanced scorecard for their area of responsibility. There was no representation from the Stoke directorate. The written information from this directorate was reviewed.

Overall, a number of themes were identified across directorates. These included:

- waiting times
- challenges and pressures in community services, particularly Lymbrook
- detailed assurances provided in relation to learning disability and autism services
- workforce and impact on the capacity to meet demands on services
- infection control audit in one of the primary care practices
- poor patient survey results in primary care

- safety in the inpatient wards based on high level of incidents, increased acuity, and bed occupancy
- impact of changing leadership in acute and urgent care
- agency spend

Specific issues reported by each directorate are summarised below:

**Acute and Urgent Care Directorate**

Achievements
NHSE/I visited the acute wards as part of the work around the Therapeutic Inpatient Environment

Shortlisted for a Nursing Times Award: Enhancing patient Dignity: Recovery

Commenced positive work with community teams/crisis services around enhanced community offer

Challenges
Meeting CIP target

Challenge around agency spend

**North Staffordshire Community**

Achievements
Older Adults Team Nominated for a “Your Heroes’ Award”

CASTT – Consulting and supporting across Directorates

Team Away Days

Challenges
Waiting times (4WW & 18WW)

Identification of CIP

Environments & Space

Sickness

**Stoke Community**

Achievements
Multiple disadvantage – system wide opportunities

Confirmation of additional investment into SMI Physical Health Checks Improvement in IAPT Recovery Metric

Challenges

4 week waits – Older Peoples and CAMHS

SNOMED Coding

IAPT data integrity

**Specialist Services**

Achievements
Darwin Centre - successful discharge of two very complex individuals

Embedding Directorate governance structure

Awarded Positive Behaviour Support Development Programme (CYP 0-25 years old) bid for Staffordshire

Challenges
Medical Staffing Learning Disability

Clinical Supervision hot spots

Neuro Community Vacancy impact

Non CPA care plan position

**Primary Care**

Achievements
Successful recruitment campaign for ANPs –really strong candidates and 2 WTE recruited with a mixed skill set who will work 0.5 WTE at either site.

Sorted out rotas at both sites to enable more staff to take leave over the summer without significantly impacting access –improved staff morale and wellbeing.

Holmcroft passed IPC inspection after aborting it the first time –significant work carried out which result reflects.

Challenges

Sickness within the PCN team at Moorcroft impacting access.

Next meeting: 7 October 2022
Committee Chair, Mr Patrick Sullivan, Non-Executive Director – 2 September 2022

Keele UNIVERSITY TEACHING TRUST

NHS North Staffordshire Combined Healthcare NHS Trust

# REPORT TO PUBLIC TRUST BOARD

Enclosure No 8 a

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Quality Committee Summary Report | | |
| Presented by: | Patrick Sullivan, Non-Executive Director | | |
| Author: | Patrick Sullivan, Non-Executive Director. | | |
| Executive Lead Name: | Dr Dennis Okolo, Interim Medical Director<br>Kenny Laing, Director of Nursing and Quality | Approved by Exec | ☒ |

| | | | |
|---|---|---|---|
| Executive Summary: | | Purpose of report | |
| The attached assurance report describes the business and outputs from the meeting of the Quality Committee on 4 August 2022 | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☒<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☐<br>2. We will actively promote partnership and integrated models of working ☒<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | To provide assurance to the Board on quality of services, issues of concern and remedial action being taken. | | |
| Resource Implications:<br><br>Funding Source: | None highlighted | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | | |
| Shadow ICS Alignment / Implications: | None as part of this report | | |
| Recommendations: | Receive for assurance purposes and ratify policies highlighted | | |

| Version | Name/group | Date issued |
|---|---|---|
| | | |

**Report from the Quality Committee meeting held on 4 August 2022 for the Trust Board meeting on 8 September 2022**

## 1. Introduction

This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee with items aligned to the Trust's SPAR objectives. The meeting was completed using Microsoft teams. The meeting was quorate.

## 2. Reports received for assurance, review, information and/or approval

- **COVID-19 Update**
  The Committee received a verbal update regarding the current situation. There has been a rise in cases and community transmissions. During July, the Trust had to implement outbreak measures for 5 areas; Hilda Johnson House, Ward 4 and 5, EMU and the Sutherland Centre. All outbreaks have been successfully managed and have been lifted. During mid-June restrictions were stepped down with face masks, however this has now reverted back from 6 July and remains in place in line with national guidance and system partners. Flu and COVID vaccine booster planning is underway for mid- September in partnership with UHNM.

- **Safe Staffing Report – June 2022**
  The Committee received this paper which outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during June 2022 in line with the National Quality Board requirements. During June 2022, there was an overall fill rate of 93.5%; this has increased from 91.6% in May 2022. The fill rate for RN shifts was 79.3% in June 2022, a small decrease from 80.0% in May 2022.

- **Learning from Experience Report Q1 2022/23**
  The Committee received this report which provided a summary of incidents reported and all patient related incidents/events for Q1 2022/23: April to June 2022. The report notes a high number of incidents although a high proportion of these incidents are the result of the actions of a small number of patients. Violence and aggression, self-harm and safeguarding are the highest reported incidents. There are a high number of assaults directed at staff and an increase in racial abuse has been noted.

- **Self-Harm Annual Report 2021/22**
  The Committee received this report which provided information and analysis of self- harm incidents reported through the Trust incident reporting system during 2021/22. The reporting period has seen an increase in self harm incidents, which are at pre-pandemic levels in the inpatient units. The vast majority of incidents resulted in no harm or minor harm; a small number of patients are responsible for a high number of the incidents. The highest reporting areas are the Darwin Centre, Ward 3, and Ward 5.

- **TCP and Project 86**
  The Committee received a verbal update regarding the current situation and the Board will be provided with a detailed update at the next Board Development session on 11 August 2022.

- **Mortality Surveillance Report Q1 2022/23**
  The Committee received this report which provided the Trust with assurance as to the mortality surveillance process with regards to the scrutiny of people open to Trust services who have died of natural causes before the age of 75 years. This report refers to Q1 2022/23. (1st April to 30th June 2022). There were 14 patients considered during this review, all were rated good or excellent.

- **Risk Register –**
  The Committee reviewed the risks contained in the Trusts Risk Register that fall under the remit of the Quality Committee. There were no new risks and no score changes: The risks are as follows:
  - Impact of COVID 19 on the quality of services
  - Anchored ligature points
  - Non- anchored ligature points
  - Compliance with Mental Health Act and Mental Capacity Act
  - Meeting the 3-hour target for assessment in the place of safety
  - Quality and capacity of the pharmacy services due to recruitment challenges and the impact of Covid 19
  - Pharmacy will not be able to dispense/order medications through the pharmacy IT system (Ascribe)
  - Lack of a commissioned for adult ADHD diagnostic service

  It was noted that there may be a requirement for a new risk in respect of unavailability of some medicines. This is a developing issue.

- **IQPR M3 2022/23**
  The Committee received this report at M3. In M3 there are 18 rated measures that have met the required standard (17 in M2) and 12 that have not met the required standard and highlighted as exceptions (13 in M2).

  There are 7 special cause variations (orange variation flags) - signifying concern, compared to 3 in M2:
  - Referral to Assessment within 4 weeks
  - Referral to Treatment within 18 weeks
  - CAMHS compliance within 4 week waits (Referral to Assessment)
  - Length of Stay (Adult)
  - Agency spend
  - Staff Turnover
  - Safer Staffing

  There are 2 special cause variation (blue variation flags - signifying improvement):
  - IAPT: patients wait no longer than 90 days between 1st and 2nd treatment (PIP in place)
  - Numbers of CPA service users in employment

There are 24 metrics flagged with a common cause variation (grey variation flag), 23 during M2.

- **Serious Incident Report Q1 2022/23 –**
The Committee received this report which provides information in respect of Q1 (April –June 2022) Serious Incident Report. It provides the Trust with information relating to the nature and status of SI's currently open and the trend data for Q4 2021/22 and Q1 2022/23.
- **Board Assurance Framework Report Q1 2022/23**
The Committee received the BAF Q1 2022/23 update. The Board Assurance Framework (BAF) for 2022/23 aligns the Trusts strategic objectives with its quality priorities and key risks. The BAF provides oversight of the key control and assurances to be introduced and mapped against our four strategic objectives.

- **CQC update**
The Committee received a verbal update. There are some changes forthcoming with the current Engagement Team and the process of inspections. The Trust continues to meet monthly and continues to review outcomes of other areas, to help the Trust maintain standards and constantly learn from the outcomes of reviews undertaken by the CQC.

- **Clinical Effectiveness Report Q1 2021/22**
The Committee received this report which provided information and assurance on the programme of work undertaken by a number of sub-committees. The report covers outputs from the: Medicines Optimisation Group, Mental Health Law Governance Group; Research and Development Steering Group; Clinical Effectiveness Group.

**Pharmacy Annual Report 2021/22**
The Committee received the Annual Medicines Optimisation report which provided an account of medicines management and optimisation activities undertaken within the year 2021/2022. It is intended to update to the Quality Committee on the Trust's medicines optimisation arrangements, outlining progress made in year, as well the key areas of concern and plans going forward for the next year.

- **Clinical Professional Advisory Group (CPAG)**
The Committee received this summary which provided information and assurance to the Quality Committee regarding the activities and outputs from The Clinical Professional Advisory Group (CPAG).

3. **Policy Report Policy Report**
The following policy was approved for 3 years

- 5.46 Mortality Surveillance Policy

The Board is asked to ratify this policy.

Next meeting: 1 Sept 2022
Committee Chair, Mr Patrick Sullivan, Non-Executive Director, 5 August 2022

# REPORT TO PUBLIC TRUST BOARD

Enclosure 9

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Improving Quality & Performance Report (IQPR) Month 4 2022/23 | | |
| Presented by: | Eric Gardiner, Director of Finance, Performance & Estates | | |
| Author: | Victoria Boswell, Associate Director of Performance | | |
| Executive Lead Name: | Eric Gardiner, Director of Finance, Performance & Estates | **Approved by Exec** | ☒ |

| Executive Summary: | | **Purpose of report** | |
|---|---|---|---|
| In Month 4 there are 20 rated measures that have met the required standard (18 in M3) and 12 that have not met the required standard and highlighted as exceptions (12 in M3).<br><br>There are 3 special cause variations (orange variation flags) - signifying concern, compared to 7 in M3:<br>• Referral to Assessment within 4 weeks<br>• CAMHS compliance within 4 week waits (Referral to Assessment)<br>• Agency Cost per month (£000)<br><br>There are 5 special cause variation (blue variation flags - signifying improvement):<br>• IAPT: patients wait no longer than 90 days between 1st and 2nd treatment (PIP in place)<br>• Numbers of CPA service users in employment<br>• Numbers of CPA service users in accommodation<br>• Vacancy Rate<br>• Statutory and Mandatory Training<br><br>There are 21 metrics flagged with a common cause variation (grey variation flag), 24 during M3. | | **Approval** | ☐ |
| | | **Information** | ☒ |
| | | **Discussion** | ☐ |
| | | **Assurance** | ☒ |
| Seen at: | SLT ☒ Execs ☐<br>Performance Review meeting – 16.08.22 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Resource Committee ☒<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☐<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives (please indicate) | 1. We will attract, develop and retain the best people ☒<br>2. We will actively promote partnership and integrated models of working ☒<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☒ | | |

**Risk / legal implications:**
Risk Register Reference

Performance Improvements Plans (PIPs) may be put in place for those national and contractual measures that have not achieved target. In addition, they may be required for those measures showing a special cause variation indicating concern.

**PIPs in place in M4:**

| Metric | Directorate | Status |
|---|---|---|
| **Referral to Assessment within 4 weeks** | Specialist Services – Neuro community – Long Covid | The trajectory in place aims for the standard to be achieved in March 2023 due to workforce pressures in the team. |
| **Referral to Assessment within 4 weeks** | Stoke Community | A new PIP has been issued in M4, the trajectory in place aims for the standard to be achieved in November 2022 for Adult and Older People and March 2023 for Children and Young People. |
| **Referral to Assessment within 4 weeks** | North Staffs Community | A new PIP has been issued in M4, the trajectory in place aims for the standard to be achieved in October 2022. |
| **Referral to Treatment within 18 weeks** | North Staffs Community | A new PIP has been issued in M4, the trajectory in place aims for the standard to be achieved in October 2022. |
| **IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment** | Stoke Community | A new PIP that was issued for completion in M2 has not been refreshed pending review of the impact of an IG breach on activity data. The PIP will be reissued for review and refresh in M5. |

**Resource Implications:**

**Funding Source:**

A Data Quality Improvement Plan is in place and monitored through the Data Quality Forum. There is a particular focus on maintaining the Trust's performance in meeting the DQMI standard (Data Quality Improvement Index).

The Trust's DQMI rating remains stable at 97.8% from the latest published national data. The Trust continues to be placed in the top providers of Mental Health services in the country.

| | | |
|---|---|---|
| | The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.<br><br>This will support the Heath Equity Assessments being undertaken at PCN level to inform the Mental Health Community Transformation programme and address health inequalities at a local level. | |
| Shadow ICS Alignment / Implications: | None directly. | |
| Recommendations: | Trust Board is asked to:<br>• Receive the report as outlined<br>• Note the Management actions | |
| Version | Name/group | Date issued |
| 1.1 | Finance & Resource Committee | 01.09.22 |

North Staffordshire Combined Healthcare NHS Trust

# IQPR

# Improving Quality & Performance Report

# Board Report

# Month 4: July 2022

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Met - Referral to Treatment within 18 weeks ..... 10

Not Met - CAMHS Compliance with 4 week waits (Referral to Assessment) ..... 11

Met - CAMHS Compliance with 18 week waits (Referral to Treatment) ..... 11

- CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week ..... 12

- CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks ..... 12

Met- Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment ..... 13

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Not Met - MH Liaison 1 Hour Response (Emergency) ..... 14

Met - MH Liaison 4 Hour Response (Urgent) ..... 14

Met - MH Liaison 24 Hour Response (Urgent from General Hospital Ward) ..... 15

Met - IAPT: Referral to Treatment (6 weeks) ..... 15

Met - IAPT: Referral to Treatment (18 weeks) ..... 16

Met - Care Programme Approach (CPA) 7 day follow up ..... 16

Met - 7 Day Follow up (All Patients) ..... 17

Met - 48 Hour Follow Up ..... 17

- Individual Placement Support ..... 18

Met - Average Length of Stay - Adult ..... 20

Met - Average Length of Stay - Older Adult ..... 20

Met - Delayed Transfers of Care (DTOC) ..... 21

Met - Emergency Readmissions rate (30 days) ..... 21

Not Met - Place of Safety assessment carried out within 3 hours (where clinically appropriate) ..... 22

Not Met - Friends and Family Test - Recommended ..... 22

Not Met - Out of Area ..... 23

Not Met - Care Plan Compliance ..... 25

Met - Risk Assessment Compliance ..... 25

Not Met - CPA 12 Month Review Compliance ..... 26

Met - IAPT: Recovery ..... 26

Met - Service Users on CPA in settled accommodation ..... 27

Met - Service Users on CPA in Employment ..... 27

Met - Serious Incidents ..... 28

- Data Quality Maturity Index (DQMI) ..... 28

Not Met - Perinatal: Number of women accessing specialist community perinatal mental health services ..... 29

Not Met - Complaints Open Beyond Agreed Timescale ..... 31

- Sickness Absence ..... 31

Met - Vacancy Rate ..... 32

Not Met - Staff Turnover ..... 32

Not Met - Safe Staffing ..... 33

Met - Clinical Supervision ..... 33

Met - Appraisal ..... 34

Met - Statutory & Mandatory Training ..... 34

Not Met - Agency cost per month (£000) ..... 35

Appendix 1 ..... 37

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## 1. Balanced Scorecard

### Access & Waiting Times

| | Metric | Standard | Performance |
|---|---|---|---|
| SPC variations signifying concern | RTA 4 weeks | 95% | 92.8% |
| | CAMHS 4 week | 95% | 89.6% |
| RAG rated standards | 10 met, 4 unmet | | |
| Highlights | RTT 18 weeks<br>CAMHS 18 week waits<br>EIP<br>MH Liaison 4 and 24 hour<br>IAPT 6 and 18 weeks<br>CPA 7 day follow up<br>7 day follow up (all patients)<br>48 hour follow up | | |
| Exceptions | Metric | Standard | Performance |
| | RTA 4 weeks | As above | As above |
| | CAMHS 4 weeks | As above | As Above |
| | IAPT 90 day | <10% | 15.0% |
| | MH Liaison 1 hour | 95% | 94.9% |

### Inpatient & Quality

| | Metric | Standard | Performance |
|---|---|---|---|
| SPC variations signifying concern | Nothing significant to note | | |
| RAG rated standards | 2 met, 1 Unmet | | |
| Highlights | Delayed Transfers of Care (DTOC)<br>Emergency Re-admissions | | |
| Exceptions | Metric | Standard | Performance |
| | Place of Safety | 100% | 43.7% |
| | Out of Area Placements | 0 | 2.0 |

### Community

| | Metric | Standard | Performance |
|---|---|---|---|
| SPC variations signifying concern | Nothing significant to note | | |
| RAG rated standards | 4 met, 2 unmet | | |
| Highlights | Risk Assessment<br>IAPT Recovery<br>Accommodation<br>Employment | | |
| Exceptions | Metric | Standard | Performance |
| | Care Plan Compliance | 95% | 94.7% |
| | CPA 12 month review | 95% | 93.8% |

### Organisational Health & Workforce

| | Metric | Standard | Performance |
|---|---|---|---|
| SPC variations signifying concern | Agency Cost | £0 | £730k |
| RAG rated standards | 4 met, 2 unmet | | |
| Highlights | Vacancy<br>Clinical Supervision<br>Appraisal<br>Statutory & Mandatory Training | | |
| Exceptions | Metric | Standard | Performance |
| | Complaints | 0 | 1 |
| | Staff Turnover | <10% | 13.3% |
| | Safe Staffing | 100% | 94.4% |
| | Agency Cost | As above | As Above |

| **Performance Improvement Plans (PIPs)** | Metric | Standard | Performance |
|---|---|---|---|
| Specialist Services: | 4 week waits **PIP*** - Neuro Community (Long Covid) | 95% | 76.5% |
| Stoke Community | IAPT 90 day **PIP*** - IAPT | 10% | 14.0% |
| Stoke Community | 4 week waits PIP* | 95% | 76.1% |
| North Staffs Community | 18 week waits PIP* | 95% | 85.9% |
| North Staffs Community | 4 week waits PIP | 95% | 91.7% |

## 2. Highlights and Exceptions

In Month 4 there are 20 rated measures that have met the required standard (18 in M3) and 12 that have not met the required standard and highlighted as exceptions (12 in M3).

There are 3 special cause variations (orange variation flags) - signifying concern, compared to 7 in M3:

- Referral to Assessment within 4 weeks
- CAMHS compliance within 4 week waits (Referral to Assessment)
- Agency Cost per month (£000)

There are 5 special cause variation (blue variation flags - signifying improvement):

- IAPT: patients wait no longer than 90 days between 1st and 2nd treatment (PIP in place)
- Numbers of CPA service users in employment
- Numbers of CPA service users in accommodation
- Vacancy Rate
- Statutory and Mandatory Training

There are 21 metrics flagged with a common cause variation (grey variation flag), 24 during M3.

## 3. Performance Improvement Plans (PIPs)

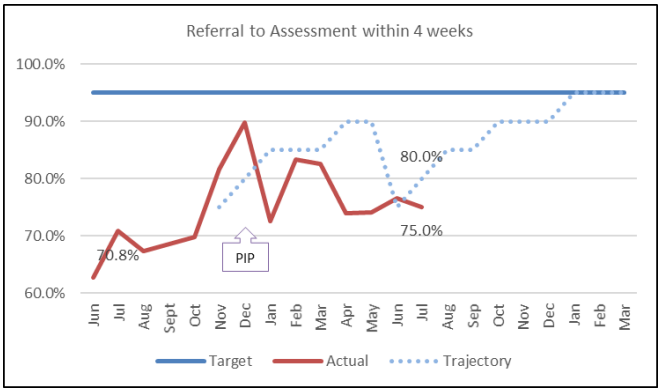
Performance Improvements Plans (PIPs) may be put in place for those national and contractual measures that have not met the target. In addition, they may be required for those measures showing a special cause variation indicating concern.

The PIPs require directorates to set out the issues, actions and a trajectory for improvement to mitigate any risks in achieving compliance and maintaining the standard required.

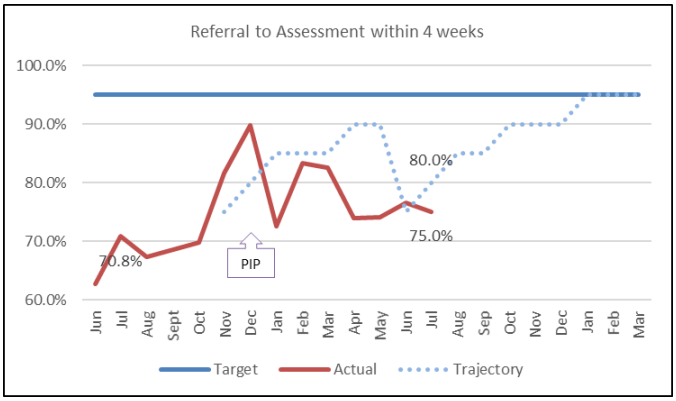
The PIPs are monitored on a monthly basis through the monthly Executive Performance Review meetings until the standard has been achieved for 3 consecutive months, or otherwise agreed. This will ensure that the actions outlined by the Associate Director are embedded and performance levels are sustained. This process takes into account that performance is unpredictable and often across multiple teams.

**PIPs currently in place**

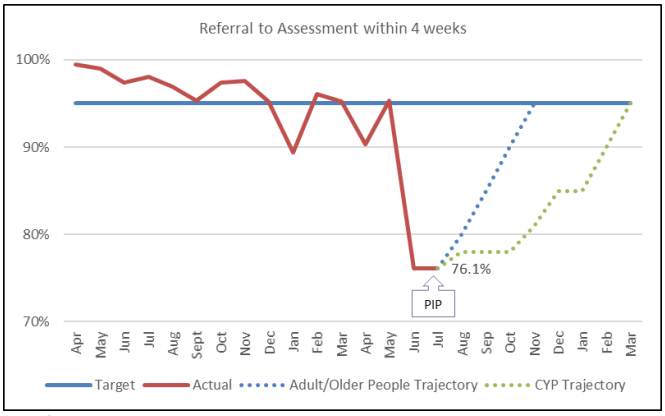
| Metric | Directorate | Status |
|---|---|---|
| **Referral to Assessment within 4 weeks** | Specialist Services | The trajectory in place aims for the standard to be achieved in March 2023 due to workforce pressures in the team. |
| | Stoke Community | A new PIP has been issued in M4, the trajectory in place aims for the standard to be achieved in November 2022 for Adult and Older People and March 2023 for Children and Young People. |
| | North Staffs Community | A new PIP has been issued in M4, the trajectory in place aims for the standard to be achieved in October 2022. |
| **Referral to Treatment within 18 weeks** | North Staffs Community | A new PIP has been issued in M4, the trajectory in place aims for the standard to be achieved in October 2022. |
| **IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment** | Stoke Community | A new PIP that was issued for completion in M2 has not been refreshed pending review of the impact of an IG breach on activity data. The PIP will be reissued for review and refresh in M5. |



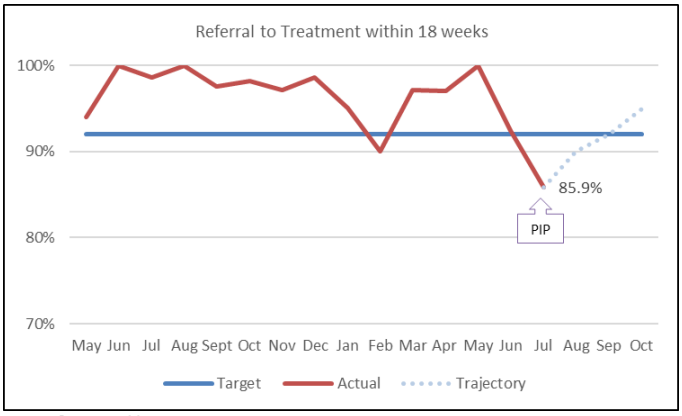

**Specialist**




**North Staffs**




**Stoke**




**North Staffs**

## 4. Activity against Plan 22/23

M4 activity against plan is included as Appendix 1 and sets out:

- 2019/20 inpatient activity against plan – as the last plan agreed with commissioners prior to the Covid pandemic. The inpatient activity plan is based on the levels funded by the CCGs which are detailed in the contractual service specifications.
- 2022/23 plan for community and outpatient services based on activity planning assumptions for Covid recovery, and incorporating service developments.
- Summary narrative of exceptional variances.

## 5. Performance against Operational Planning Forecasts Q1 2022-2023

Performance against the national Mental Health Operational Planning Forecasts is reported in the IQPR for Q1 as Appendix 2. This is the local data extracted from Lorenzo or primary care systems (for dementia diagnosis and SMI physical health checks (not yet received).

It should be noted that performance will be assessed from nationally reported data, such as MHSDS. As there is a delay in this being published, this report provides assurance to the Board on performance against plans. The nationally reported data will be reported in the IQPR once available.

All plans are being achieved and exceeded in Q1, with the exception of Perinatal access activity which is slightly under plan. The recording and reporting for this metric is being further investigated with the service.

## 6. CQUIN Progress Report: Q1 2022/23

An update on performance against CQUIN targets for Q1 is included in the IQPR as Appendix 3. This includes data and a narrative for each CQUIN.

| Measure | Met/Not Met | Assurance | Variation | Exception | Narrative |
|---|---|---|---|---|---|
| 1 - Referral to Assessment within 4 weeks | Not Met |  |  | * | Performance has declined to 92.8% for M4. ***A PIP is in place for Specialist Services with a trajectory to meet the standard in March 2023. A new PIP was issued to North Staffs and Stoke Community during M4.*** |
| 2 - Referral to Treatment within 18 weeks | Met |  |  | | Performance is at 96.5% during M4. All directorates with the exception of Specialist Services and North Staffs Community have achieved the required standard. ***A new PIP has been issued to North Staffs for completion in M4 with a trajectory to meet the standard in October 2022.*** |
| 3 - CAMHS Compliance with 4 week waits (Referral to Assessment) | Not Met |  |  | * | Performance is at 89.6% during M4 and is operating outside of the lower control limits. |
| 4 - CAMHS Compliance within 18 week waits (Referral to Treatment) | Met |  |  | | Performance is at 93.5% during M4. |
| 5 - CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week | | | | | Performance is at 100% during Quarter 1. |
| 6 - CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks | | | | | Performance is at 100% during Quarter 1. |
| 7 - Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment | Met |  |  | | Performance is at 83.3% during M4 and is operating well above the national standard of 60%. |
| 8 - IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment | Not Met |  |  | * | Performance continues to exceed the 90 day waiting time standard between the first and second treatment at 15% during M4. ***A new PIP that was issued for completion in M2 has not been refreshed pending review of the impact of an IG breach on activity data. It will be updated in M5.*** |
| 9 - MH Liaison 1 Hour Response (Emergency) | Not Met |  |  | * | Performance is at 94.9% and has not met the required standard during M4. |
| 10 - MH Liaison 4 Hour Response (Urgent) | Met |  |  | | Performance is at 100% during M4. |
| 11 - MH Liaison 24 Hour Response (Urgent from General Hospital Ward) | Met |  |  | | Performance is at 100% during M4. |
| 12 - IAPT: Referral to Treatment (6 weeks) | Met |  |  | | Performance is at 98.1% and remains well above target. |
| 13 - IAPT: Referral to Treatment (18 weeks) | | | | | Performance remains predictably stable at 99.4% during M4. |

| Measure | Met/Not Met | Assurance | Variation | Exception | Narrative |
|---|---|---|---|---|---|
| 14 - Care Programme Approach (CPA) 7 day Follow Up | Met |  |  | | Performance is at 97% during M4. All directorates, with the exception to Stoke Community having met the required standard. |
| 15 - 7 Day Follow Up (All Patients) | Met |  |  | | Performance is at 98.6% during M4 and is meeting the required standard across all directorates. |
| 16 - 48 Hour Follow Up | Met |  |  | | Performance is at 97.1% and is meeting the required standard across all directorates. |
| 17 - IPS (individual placement and support) | | | | | 600 patients received individual placement and support during Quarter 1. |
| 18 - Average Length of Stay - Adult | | | | | The average length of stay for inpatients on an adult ward is 30 days and continues to operate outside of the upper control limit. |
| 19 - Average Length of Stay - Older Adult | | | | | The average length of stay for inpatients on an older adult ward is 37 days. |
| 20 - Delayed Transfers of Care (DTOC) | Met |  |  | | There are no delayed transfers of care during M4. |
| 21 - Emergency Readmissions rate (30 days) | Met |  |  | | The emergency readmission rate is 3.5% and remains within the threshold. |
| 22 - Place of Safety assessment carried out within 3 hours (where clinically appropriate) | Not Met |  |  | * | Out of 16 assessments, 9 occurred outside of the 3 hours with no agreed clinical grounds for delay during M4. |
| 23 - Friends and Family Test - Recommended | | | | | There have been 196 FFT returns, of which 89% rated the Trust as good. |
| 24 - Out of Area Placements | Not Met | | | | There are two PICU out of area admissions during M4 outside Staffordshire. |
| 25 - Care Plan Compliance | Not Met |  |  | * | Performance is at 94.7% during M4, under target. All directorates with the exception of North Staffs Community and Specialist Services have achieved the required standard. |
| 26 - Risk Assessment Compliance | Met |  |  | | Performance is at 95.9% during M4 and is operating within normal control limits. All directorates, with the exception of Specialist Services, having met the required standard. |
| 27 - CPA 12 Month Review Compliance | Not Met |  |  | * | Performance is at 93.8% during M4 below standard across all directorates. |
| 28 - IAPT : Recovery | Met |  |  | | Performance is at 50.3% during M4 and is meeting the required standard. |
| 29 - Service Users on CPA in settled accommodation | Met |  |  | | Performance is at 77.1% and continues to operate above the national average. |
| 30 - Service Users on CPA in Employment | Met |  |  | | Performance is at 17.5% and continues to operate above the national average. |
| 31 - Serious Incidents | | | | | There are 12 serious incidents Trust wide reported during M4. |

| Measure | Met/Not Met | Assurance | Variation | Exception | Narrative |
|---|---|---|---|---|---|
| 32 - DQMI | | | | | The Trust's DQMI rating during April was 97.8% from the latest published national data. |
| 33 - Perinatal: Number of women accessing specialist community perinatal mental health services | | | | | There were 42 women accessing perinatal services during M4. |
| 34 - Complaints Open Beyond Agreed Timescale | Not Met | | | * | There is one outstanding complaint response, which is in the final review stage. |
| 35 - Sickness Absence | | | | | July figures are not yet available. |
| 36 - Vacancy Rate | Met |  |  | | The vacancy rate is 9.9% which is within the 10% threshold but continues to remain challenging for most directorates. |
| 37 - Staff Turnover | Not Met |  |  | * | Performance is consistently above the 10% threshold at 13.3% and remains challenging for all directorates with the exception to North Staffs Community. |
| 38 - Safe Staffing | Not Met |  |  | * | An overall staffing fill rate of 94.4% was achieved during M4. |
| 39 - Clinical Supervision | Met |  |  | | Performance is at 88% during M4. |
| 40 - Appraisal | Met |  |  | | Performance is at 87% during M4. All directorates are achieving the required standard with the exception to Primary Care. |
| 41 - Statutory & Mandatory Training | Met |  |  | | Performance is at 90% during M3 and all directorates with the exception of Primary Care are achieving the required standard. |
| 42 - Agency cost per month (£000) | Not Met |  |  | * | The agency cost has increased from £377k in M1 to £430k in M3 to £723k in M4. |

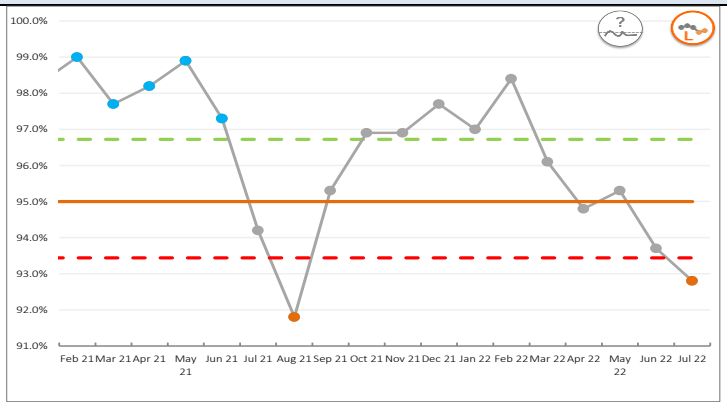
There are no under 18 admissions to adult wards during M4.

# Access & Wait Times

**Not Met - Referral to Assessment within 4 weeks** ↘

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 92.8% | #N/A | **Executive Director of Operations** | Responsive |
| **Target:** | 95.0% | Monthly | Trust Measure | |




-- Context --

Trust indicator to ensure that service users referred receive a timely assessment and access to services - based on time between referral and first successful contact for current service users with an incomplete pathway

-- Monthly Narrative (Key Issues and Actions) –

Performance has declined to 92.8% during M4. No directorates have met the required standard, with the exception of Acute and Urgent Care. A special cause variation has been triggered. There are challenges across a range of teams including Adult CMHTs and CAMHS Community teams, Dementia Primary Care and Care Home Liaison teams as well as Neuro Community referenced below.

***A PIP is in place for Specialist Services (due to long Covid rates in Neuro Community). This was refreshed in M2 with a new trajectory to meet the standard in March 2023. A new PIP has been issued to North Staffordshire and Stoke Community directorates in M4 with new trajectory and actions.***

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 91.8% | 95.3% | 96.9% | 96.9% | 97.7% | 97.0% | 98.4% | 96.1% | 94.8% | 95.3% | 93.7% | 92.8% |

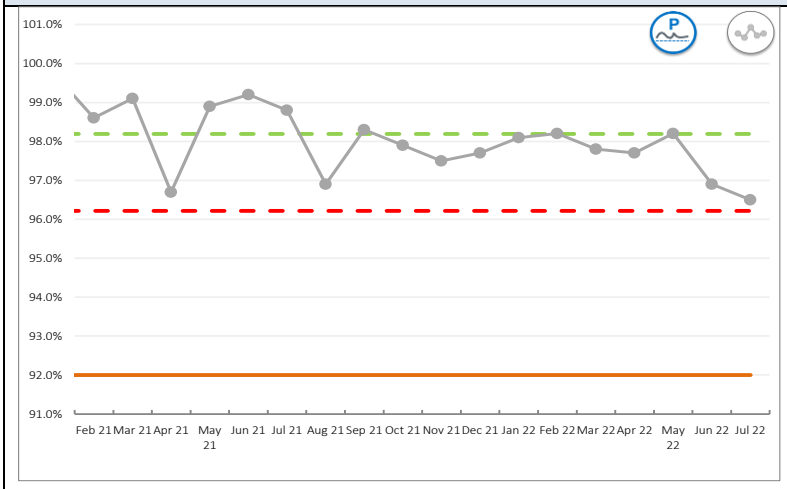
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✗ | ✗ | ✗ | ✗ | ✓ |
| 92.8% | 91.7% | 76.1% | 75.0% | 99.3% |

***1***

**Met - Referral to Treatment within 18 weeks** ↘

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 96.5% | #N/A | **Executive Director of Operations** | Responsive |
| **Target:** | 92.0% | Monthly | CCG | |




-- Context --

CCG and Trust indicator to ensure that service users referred receive timely treatment - based on time between referral and 2nd successful contact in current service users with an incomplete pathway.

-- Monthly Narrative (Key Issues and Actions) --

Performance is at 96.5% during M4. All directorates with the exception of Specialist Services and North Staffordshire Community have achieved the required standard.

The exception in Specialist Services is due to the demand and workforce challenges in the Neuro Community team.

***A new PIP has been issued to North Staffordshire Community in M4 with new trajectory and actions.***

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 96.9% | 98.3% | 97.9% | 97.5% | 97.7% | 98.1% | 98.2% | 97.8% | 97.7% | 98.2% | 96.9% | 96.5% |

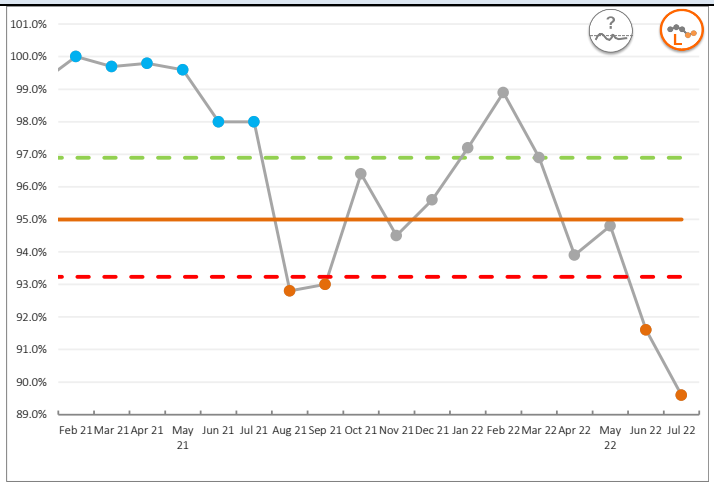
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✗ | ✓ | ✗ | ✓ |
| 96.5% | 85.9% | 93.9% | 87.8% | 99.8% |

***2***

**Not Met - CAMHS Compliance with 4 week waits (Referral to Assessment)** ↘

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 89.6% | #N/A | **Executive Director of Operations** | Responsive |
| **Target:** | 95.0% | Monthly | Trust Measure | |




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 92.8% | 93.0% | 96.4% | 94.5% | 95.6% | 97.2% | 98.9% | 96.9% | 93.9% | 94.8% | 91.6% | 89.6% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✗ | ✗ | ✗ | ✓ | ✓ |
| 89.6% | 12.5% | 4.3% | 100.0% | 98.0% |

-- Context --
Trust indicator to ensure that service users referred receive a timely assessment and access to services - based on time between referral and first successful contact for current service users with an incomplete pathway

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 89.6% during M4 and is operating outside of the lower control limits. The under-performance is due to individuals not being seen within 4 weeks in North Staffs and North & South Stoke CAMHS teams:

- North Staffs CAMHS – 0% (0/7)
- North Stoke CAMHS – 7.7% (1/13)
- South Stoke CAMHS – 0% (0/10)

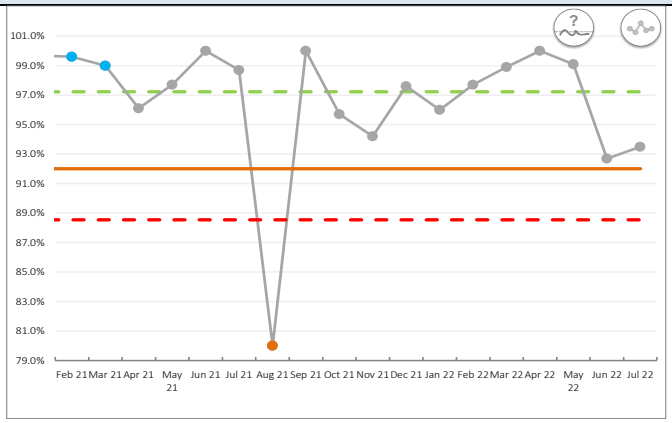
This Trust aspirational target remains challenging for CYP teams given the increase in demand in Stoke and North Staffs CAMHS, and workforce issues due to vacancies. The Directorates are taking action to innovate the workforce by introducing new professional groups and will embed the Thrive model, a framework for providing a person centred and needs-led approach.

***3***

**Met - CAMHS Compliance with 18 week waits (Referral to Treatment)** ↗

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 93.5% | #N/A | **Executive Director of Operations** | Responsive |
| **Target:** | 92.0% | Monthly | CCG | |




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 80.0% | 100.0% | 95.7% | 94.2% | 97.6% | 96.0% | 97.7% | 98.9% | 100.0% | 99.1% | 92.7% | 93.5% |

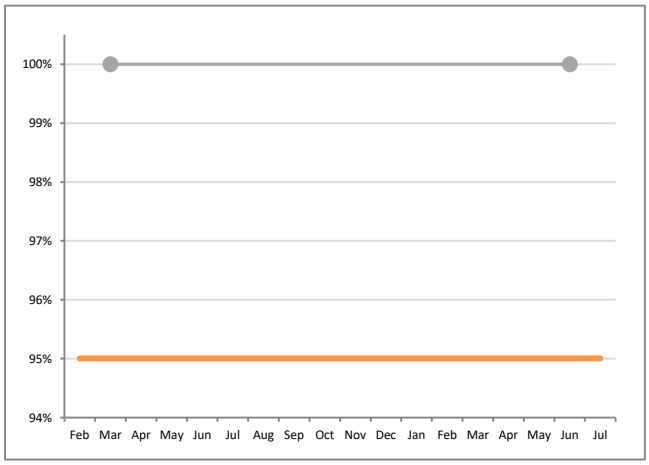
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✗ | ✗ | ✓ | ✓ |
| 93.5% | 70.6% | 79.4% | 100.0% | 99.3% |

-- Context --
CCG and Trust indicator to ensure that service users referred receive timely treatment - based on time between referral and second successful contact in current service users with an incomplete pathway.

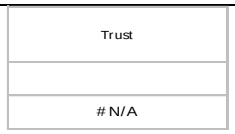
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 93.5% during M4 with Specialist Services and Acute and Urgent Care directorates having achieved the required standard.

***4***

| - CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week<br><br>A Higher Value Is Better | Actual #N/A #N/A<br><br>Target: 95.0% Monthly | Executive Director of Operations Responsive<br><br>National |
|---|---|---|




12 Month Trend

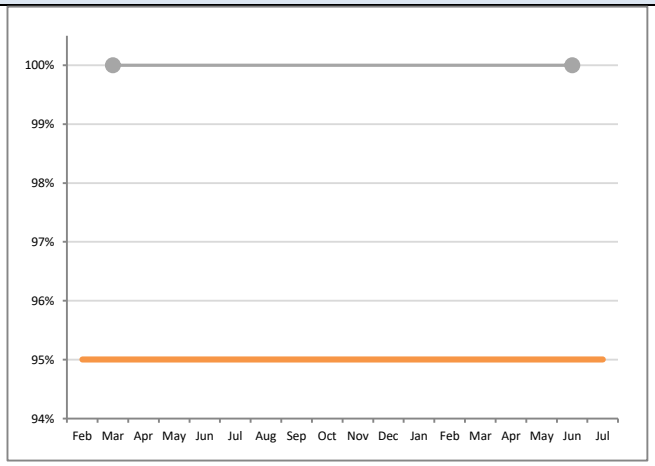




-- Context --
National target - 1 week or less from referral to entering a course of treatment under urgent ED cases is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as second successful contact.

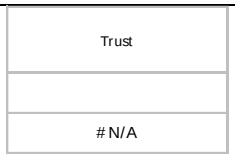
-- Monthly Narrative (Key Issues and Actions) --
All urgent assessments for Children and Young People with eating disorders have been seen within 1 week of their referral during quarter 1.

***5***

| - CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks<br><br>A Higher Value Is Better | Actual #N/A #N/A<br><br>Target: 95.0% Monthly | Executive Director of Operations Responsive<br><br>National |
|---|---|---|




12 Month Trend


-- Context --
National target - 4 weeks or less from referral to entering a course of treatment under routine ED cases is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as second successful contact.

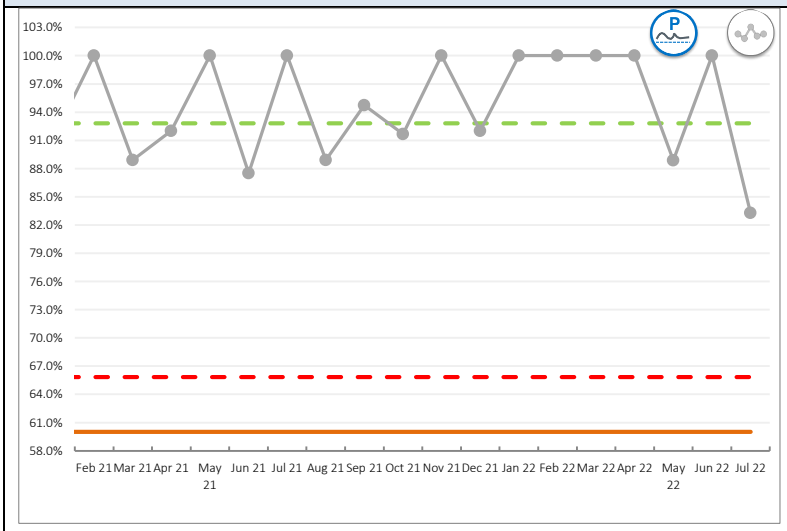
-- Monthly Narrative (Key Issues and Actions) --
All routine assessments for Children and Young People with eating disorders have been seen within 4 weeks of their referral during quarter 1.

***6***

**Met- Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment**

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 83.3% | #N/A | **Executive Director of Operations** | Responsive |
| **Target:** | 60.0% | Monthly | National | |




-- Context --
National target - 2 weeks or less from referral to entering a NICE compliant course of treatment under EIP is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as second successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 83.3% during M4 and is predictably operating within normal control limits, well above the national standard of 60%.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 88.9% | 94.7% | 91.7% | 100.0% | 92.0% | 100.0% | 100.0% | 100.0% | 100.0% | 88.9% | 100.0% | 83.3% |

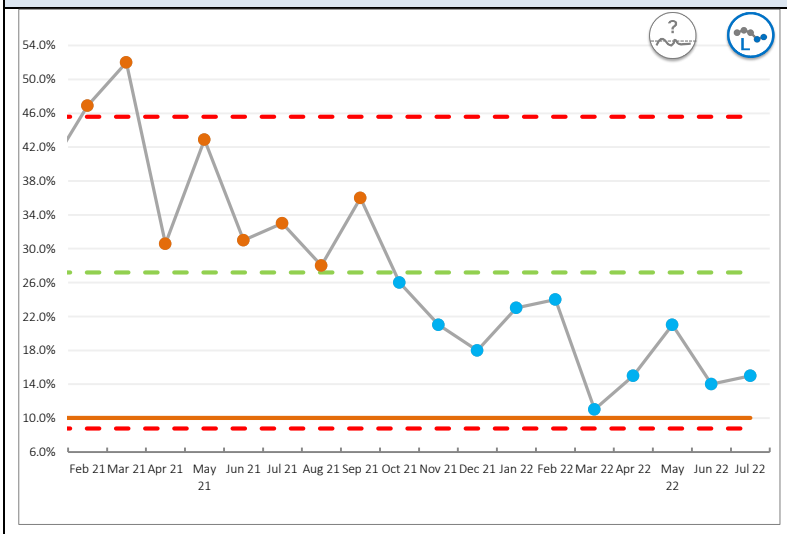
| Trust |
|---|
| ✓ |
| 83.3% |

***7***

**Not Met - IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment** ↘

A Lower Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 15.0% | #N/A | **Exec. Director of Operations** | Safe |
| **Target:** | 10.0% | Monthly | National | |




-- Context --
National indicator-IAPT services provide support for adults with depression and anxiety disorders that can be managed effectively. Services are delivered using a stepped-care model.

-- Monthly Narrative (Key Issues and Actions) --
The Stoke Wellbeing Service is now entering Year 3 of the contract (April 22/23) and there has been an uplift in the prevalence rate so that the numbers of people accessing the service has increased. The workforce expansion to meet the uplift requires an increase in the number of Health Education training places to train therapists as well as an increase in the availability of the Post Graduate courses which is being negotiated with HEE and the CCG. Alongside the recruitment plan a long term condition training plan is being developed in the service to expand the range of clinical skills for core therapists.

***A new PIP that was issued for completion in M2 has not been refreshed pending review of the impact of an IG breach on activity data. This will be updated in M5.***

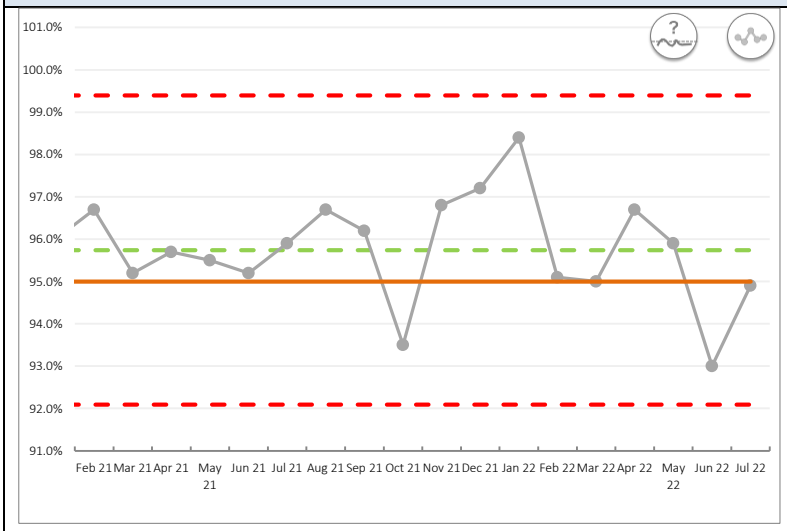
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 28.0% | 36.0% | 26.0% | 21.0% | 18.0% | 23.0% | 24.0% | 11.0% | 15.0% | 21.0% | 14.0% | 15.0% |

| Stoke Community |
|---|
| ✘ |
| 15.0% |

***8***

| Not Met - MH Liaison 1 Hour Response (Emergency) ↗ | Actual 94.9% #N/A | Executive Director of Operations Responsive |
|---|---|---|
| A Higher Value Is Better | Target: 95.0% Monthly | CCG |




-- Context --
CCG measure - Of those who are emergency referrals, the percentage of which where the referral is assessed and care plan in place, transferred, discharged or MHA commenced within 1 hour - emergency is classified as an unexpected, time critical situation that may threaten life, long-term health, or safety of an individual or others.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.9% and has not met the required standard during M4.

The primary reason for breaches was a high volume of referrals and exceptionally busy time periods on 30/06, 01/07 and 05/07, due to an increase in referrals from UHNM, and those taken by ambulance to ED requiring MH Liaison assessment.

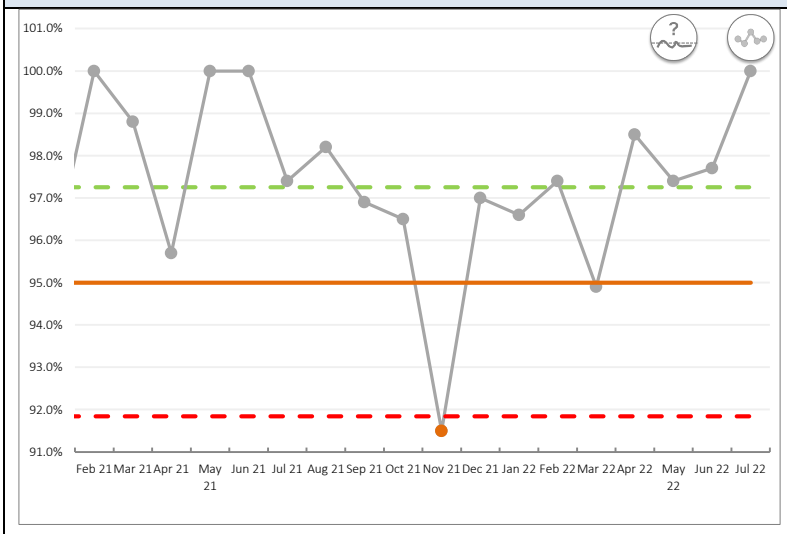
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 96.7% | 96.2% | 93.5% | 96.8% | 97.2% | 98.4% | 95.1% | 95.0% | 96.7% | 95.9% | 93.0% | 94.9% |

| Trust |
|---|
| ✖ |
| 94.9% |

***9***

| Met - MH Liaison 4 Hour Response (Urgent) ↗ | Actual 100.0% #N/A | Executive Director of Operations Responsive |
|---|---|---|
| A Higher Value Is Better | Target: 95.0% Monthly | CCG |




-- Context --
CCG measure - Of those who are urgent referrals, the percentage of which where the referrals is assessed and care plan in place, transferred, discharged or MHA commenced within 4 hours - urgent is classified as when a situation is serious and an individual may need timely attendance but it is not immediately life threatening.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 100% during M4.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 98.2% | 96.9% | 96.5% | 91.5% | 97.0% | 96.6% | 97.4% | 94.9% | 98.5% | 97.4% | 97.7% | 100.0% |

| Trust |
|---|
| ✓ |
| 100.0% |

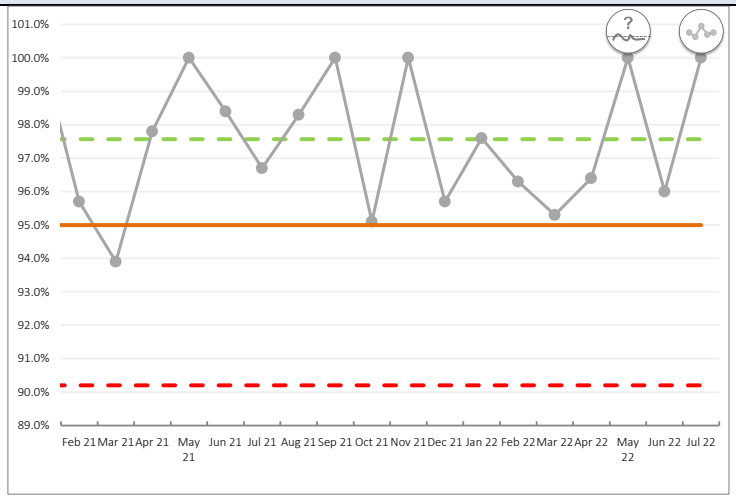
***10***

**Met - MH Liaison 24 Hour Response (Urgent from General Hospital Ward)** ↗

A Higher Value Is Better

| | | |
|---|---|---|
| **Actual** | 100.0% | #N/A |
| **Target:** | 95.0% | Monthly |

| | |
|---|---|
| **Executive Director of Operations** | Responsive |
| CCG | |




-- Context --
CCG measure - Of referrals, the percentage of which where the referral is assessed and care plan in place, transferred, discharged or MHA commenced within 24 hours. This target increased from 90% last year (as reported in the PQMF) to 95% in 2019/20.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 100% during M4.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 98.3% | 100.0% | 95.1% | 100.0% | 95.7% | 97.6% | 96.3% | 95.3% | 96.4% | 100.0% | 96.0% | 100.0% |

| Trust |
|---|
| ✓ |
| 100.0% |

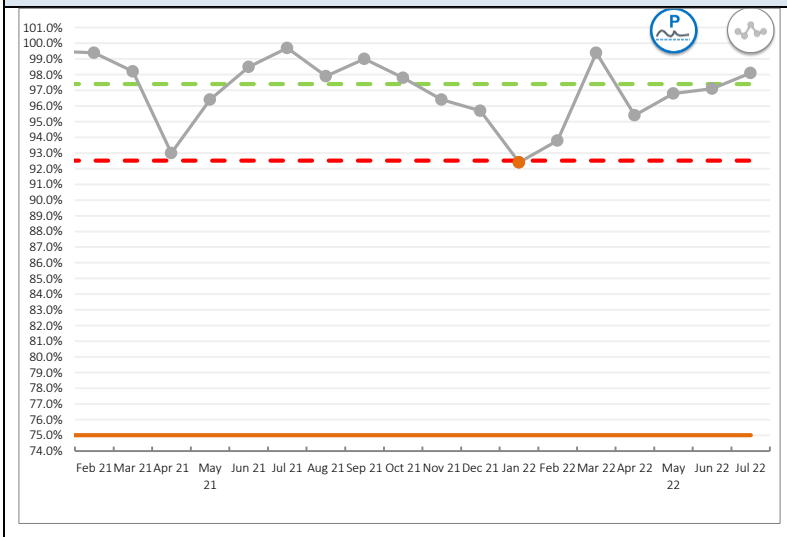
***11***

**Met - IAPT: Referral to Treatment (6 weeks)** ↗

A Higher Value Is Better

| | | |
|---|---|---|
| **Actual** | 98.1% | #N/A |
| **Target:** | 75.0% | Monthly |

| | |
|---|---|
| **Executive Director of Nursing and Quality** | Safe |
| National | |




-- Context --
National indicator - 6 weeks or less from referral to entering a course of talking treatment under IAPT - treatment is defined as the2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 98.1% and remains well above target during M4.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 97.9% | 99.0% | 97.8% | 96.4% | 95.7% | 92.4% | 93.8% | 99.4% | 95.4% | 96.8% | 97.1% | 98.1% |

| Trust |
|---|
| ✓ |
| 98.1% |

***12***

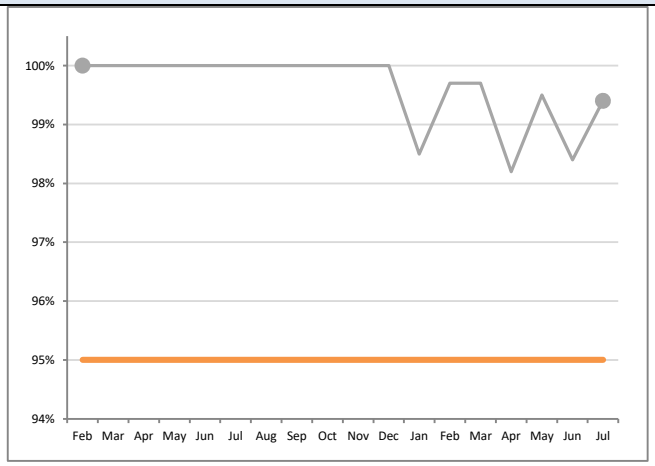
## Met - IAPT: Referral to Treatment (18 weeks) ↗

A Higher Value Is Better

| | | | |
|---|---|---|---|
| **Actual** | 99.4% | #N/A | |
| **Target:** | 95.0% | Monthly | |

**Executive Director of Nursing and Quality** — Safe

National




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.5% | 99.7% | 99.7% | 98.2% | 99.5% | 98.4% | 99.4% |

-- Context --
National indicator - 18 weeks or less from referral to entering a course of talking treatment under IAPT - treatment is defined as the2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance remains predictably stable at 99.4% during M4.

| Trust |
|---|
| ✓ |
| 99.4% |

***13***

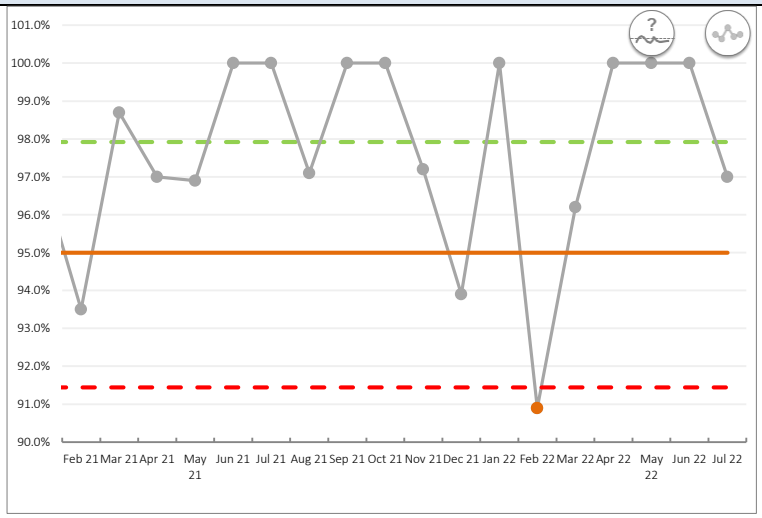
## Met - Care Programme Approach (CPA) 7 day follow up ↘

A Higher Value Is Better

| | | | |
|---|---|---|---|
| **Actual** | 97.0% | #N/A | |
| **Target:** | 95.0% | Monthly | |

**Medical Director** — Safe

National




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 97.1% | 100.0% | 100.0% | 97.2% | 93.9% | 100.0% | 90.9% | 96.2% | 100.0% | 100.0% | 100.0% | 97.0% |

-- Context --
National target - This is an important safety measure, showing the link between inpatient and community teams, as the immediate period after discharge is a time of significant suicide and self-harm risk.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 97% during M4. All directorates, with the exception of Stoke Community having met the required standard.

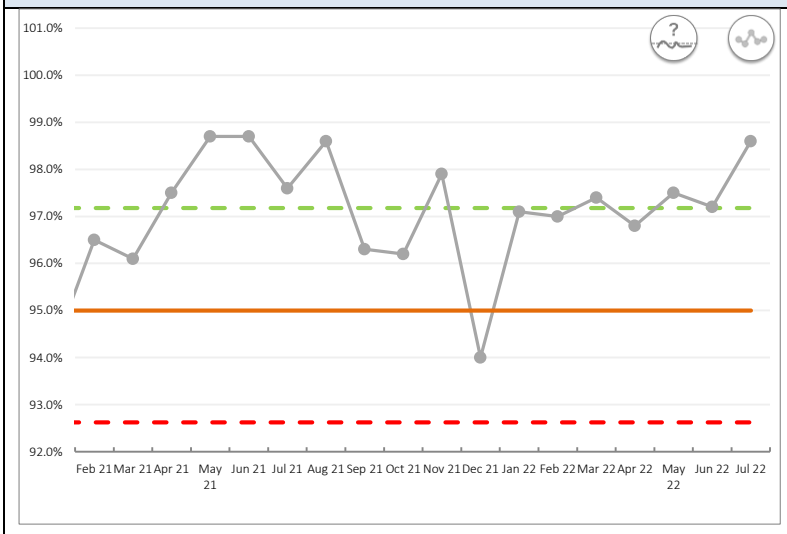
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✓ | ✗ | ✓ | ✓ |
| 97.0% | 100.0% | 93.3% | 100.0% | 100.0% |

***14***

**Met - 7 Day Follow up (All Patients)** ↗

A Higher Value Is Better

| | | | | | |
|---|---|---|---|---|---|
| **Actual** | 98.6% | #N/A | **Medical Director** | Safe |
| **Target:** | 95.0% | Monthly | CCG | |




-- Context --
CCG target - This is an important safety measure, showing the link between inpatient and community teams, as the immediate period after discharge is a time of significant suicide and self-harm risk.

-- Monthly Narrative (Key Issues and Actions) --
Performance is 98.6% during M4 and is meeting the required standard across all directorates.

Breach notification forms were completed for all and no risks or issues were identified.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 98.6% | 96.3% | 96.2% | 97.9% | 94.0% | 97.1% | 97.0% | 97.4% | 96.8% | 97.5% | 97.2% | 98.6% |

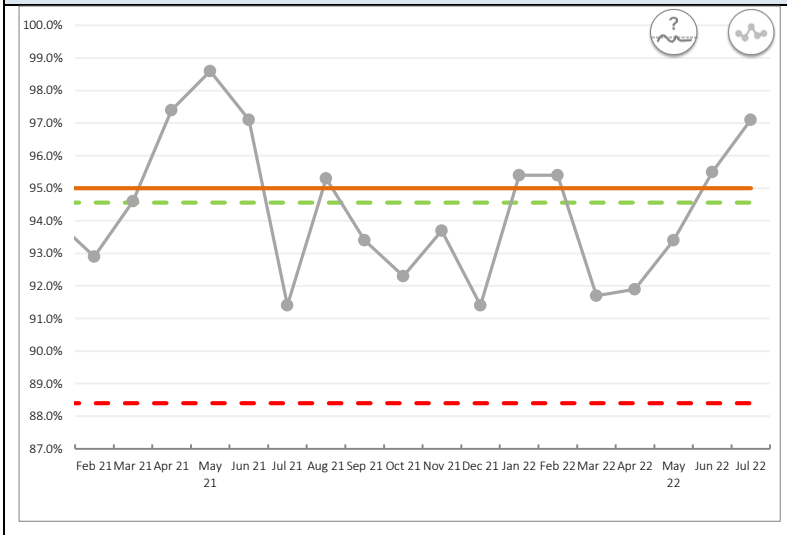
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ |
| 98.6% | 96.6% | 100.0% | 100.0% | 100.0% |

***15***

**Met - 48 Hour Follow Up** ↗

A Higher Value Is Better

| | | | | | |
|---|---|---|---|---|---|
| **Actual** | 97.1% | #N/A | **Medical Director** | Safe |
| **Target:** | 95.0% | Monthly | Trust Measure | |




-- Context --
This is an important safety measure showing the link between inpatient and community teams, as the immediate period after discharge is a time of significant suicide and self-harm risk.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 97.1% during M4 and is meeting the required standard across all directorates.

Breach notification forms were completed for all and no risks were identified.

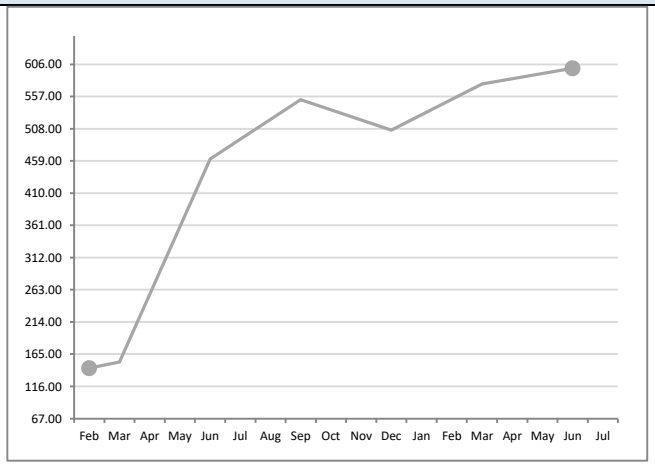
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 95.3% | 93.4% | 92.3% | 93.7% | 91.4% | 95.4% | 95.4% | 91.7% | 91.9% | 93.4% | 95.5% | 97.1% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ |
| 97.1% | 96.6% | 96.8% | 100.0% | 100.0% |

***16***

| | | | |
|---|---|---|---|
| **- Individual Placement Support**<br><br>A Higher Value Is Better | **Actual** #N/A #N/A<br><br>**Target:** Quarterly | **Executive Director of Operations** Safe<br><br>National | |




12 Month Trend

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 552 | | | 506 | | | 576 | | | 600 | |
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

| Trust |
|---|
| |
| #N/A |

-- Context --
IPS is an employment support service integrated within community mental health teams for people who experience severe mental health conditions. It is an evidence-based programme that aims to help people find and retain employment.

-- Monthly Narrative (Key Issues and Actions) --
600 patients received individual placement and support during Quarter 1.

***17***

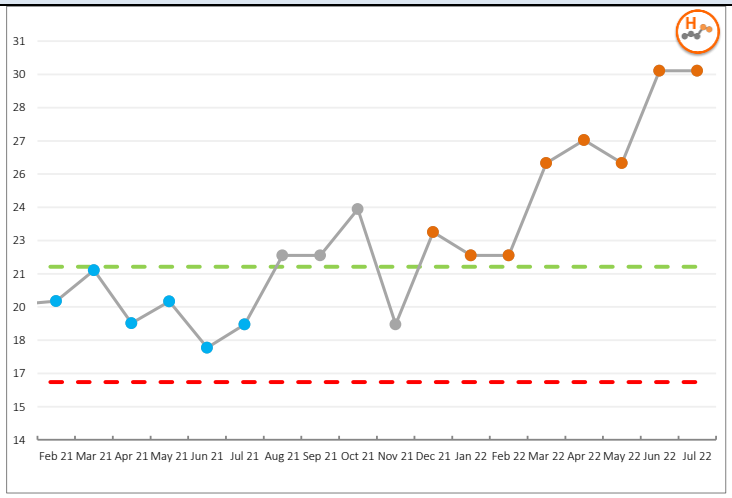
# Inpatient & Quality

## Met - Average Length of Stay - Adult

↔

A Lower Value Is Better

| | | |
|---|---|---|
| **Actual** 30.00 #N/A | **Executive Director of Operations** | Responsive |
| **Target:** Monthly | Trust Measure | |




-- Context --
Reducing the length of stay aims to provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay

-- Monthly Narrative (Key Issues and Actions) --
The average length of stay for inpatients on an adult ward during M4 is 30 days, operating outside of the upper control limit.

This compares to a national average of 35 days in the 2020 NHS Mental Health Benchmarking report, with the Trust located in the upper quartile for performance in 2021.

There are 46 patients with a length of stay of longer than 60 days and 76 patients with a length of stay longer than 90 days during July.

12 Month Trend

| 22 | 22 | 24 | 19 | 23 | 22 | 22 | 26 | 27 | 26 | 30 | 30 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

| Trust |
|---|
| |
| 30.00 |

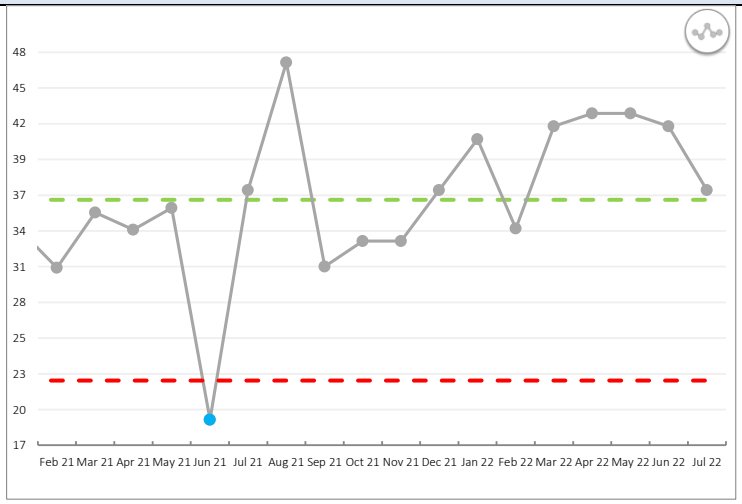


## Met - Average Length of Stay - Older Adult

↗

A Lower Value Is Better

| | | |
|---|---|---|
| **Actual** 37.00 #N/A | **Executive Director of Operations** | Responsive |
| **Target:** Monthly | Trust Measure | |




-- Context --
Reducing the length of stay aims to provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay

-- Monthly Narrative (Key Issues and Actions) --
The average length of stay for inpatients on an older adult ward during M4 is 37 days.

This compares to a national average of 74 days in the 2020 NHS Mental Health Benchmarking report with the Trust located in the upper quartile for performance.

There are 69 patients with a length of stay longer than 60 days and 55 patients with a length of stay longer than 90 days during July.

12 Month Trend

| 47 | 31 | 33 | 33 | 37 | 41 | 34 | 42 | 43 | 43 | 42 | 37 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

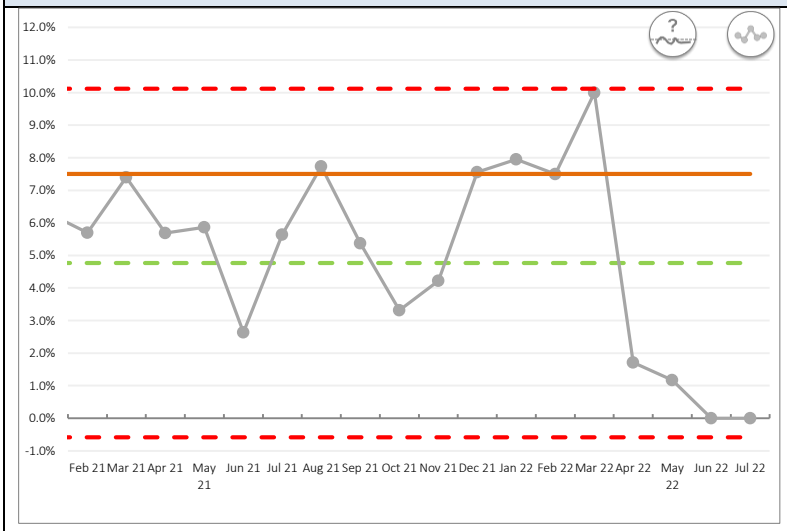
| Trust |
|---|
| |
| 37.00 |

## Met - Delayed Transfers of Care (DTOC) ↔

A Lower Value Is Better

| | | |
|---|---|---|
| **Actual** | 0.0% | #N/A |
| **Target:** | 7.5% | Monthly |

| | |
|---|---|
| **Executive Director of Operations** | Responsive |
| National | |




-- Context --
National target - To understand the number of patients who have been declared medically fit for discharge but remain in inpatient service - has care quality and resource use implications.

-- Monthly Narrative (Key Issues and Actions) --
There are no delayed transfers of care reported during M4.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 7.7% | 5.4% | 3.3% | 4.2% | 7.6% | 8.0% | 7.5% | 10.0% | 1.7% | 1.2% | 0.0% | 0.0% |

| Trust | Specialist Services | Acute and Urgent Care |
|---|---|---|
| ✓ | ✓ | ✓ |
| 0.0% | 0.0% | 0.0% |

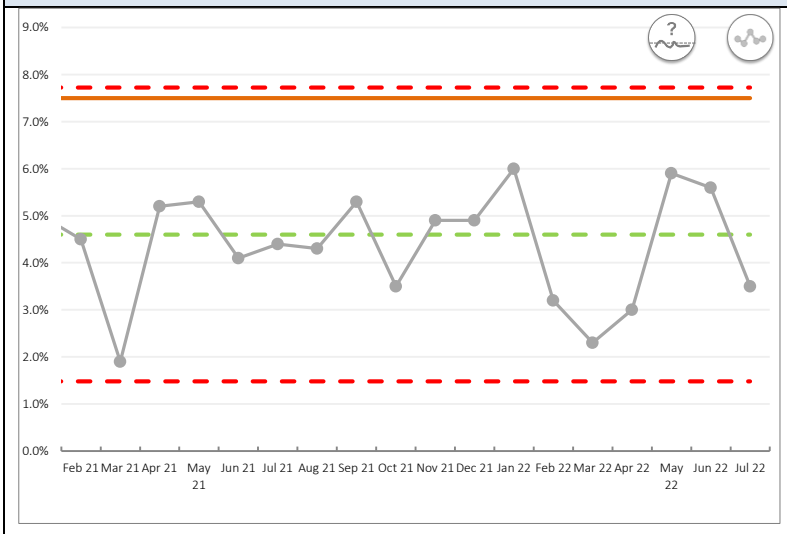
***20***

## Met - Emergency Readmissions rate (30 days) ↗

A Lower Value Is Better

| | | |
|---|---|---|
| **Actual** | 3.5% | #N/A |
| **Target:** | 7.5% | Monthly |

| | |
|---|---|
| **Medical Director** | Responsive |
| Trust Measure | |




-- Context --
To measure the prevalence of emergency readmissions - linked to patient outcomes and use of resources

-- Monthly Narrative (Key Issues and Actions) --
The emergency readmission rate during M4 is 3.5% and remains within the threshold.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.3% | 5.3% | 3.5% | 4.9% | 4.9% | 6.0% | 3.2% | 2.3% | 3.0% | 5.9% | 5.6% | 3.5% |

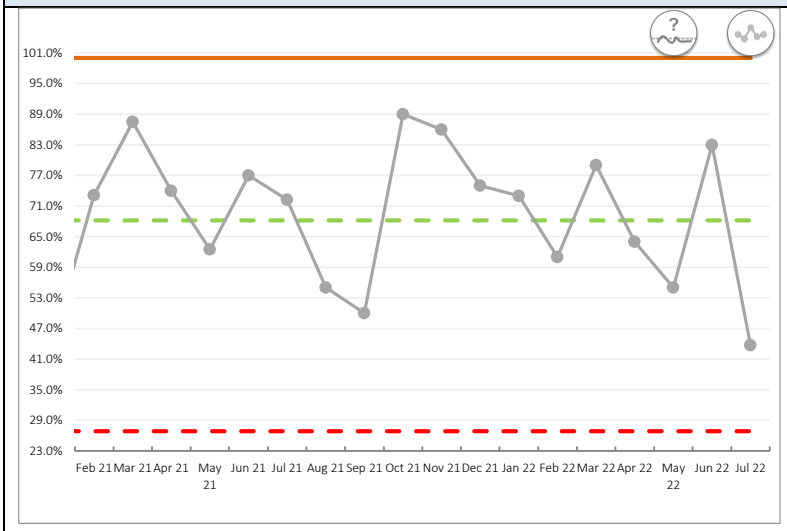
| Trust | Specialist Services | Acute and Urgent Care |
|---|---|---|
| ✓ | ✓ | ✓ |
| 3.5% | 0.0% | 3.7% |

***21***

**Not Met - Place of Safety assessment carried out within 3 hours (where clinically appropriate)** ↘

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 43.7% | #N/A | **Medical Director** | Safe |
| **Target:** | 100.0% | Monthly | Trust Measure | |




-- Context --
The recommendation that PoS assessments are carried out within 3 hours is driven by service user experience and clinical outcomes, as well as availability of PoS for other service users.

-- Monthly Narrative (Key Issues and Actions) --
Out of 16 assessments, 9 occurred outside of 3 hours with no agreed clinical grounds for delay.

These were due to Staffs EDS, Stoke EDT, Staffs AMHP team and no ambulances available to transfer patient from A&E.

All cases which are non-compliant with the 3 hour target without clinical grounds for delay are being investigated by the appropriate local social services authority. This information is being fed into both the Section 136 forum and a task and finish group which includes representatives from NSCHCT, MPFT, UHNM, Staffs LSSA and Stoke LSSA.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 55.0% | 50.0% | 89.0% | 86.0% | 75.0% | 73.0% | 61.0% | 79.0% | 64.0% | 55.0% | 83.0% | 43.7% |

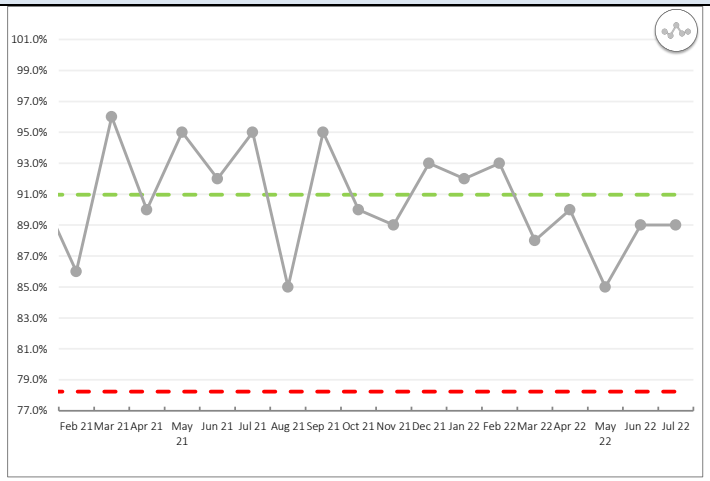
| Trust |
|---|
| ✖ |
| 43.7% |

***22***

**Not Met - Friends and Family Test - Recommended** ↔

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 89.0% | #N/A | **Executive Director of Nursing and Quality** | Caring |
| **Target:** | | Monthly | National | |




-- Context --
National indicator - This measure is a proxy for patient experience, and measures where the services user would recommend the Trust to others.

-- Monthly Narrative (Key Issues and Actions) --
There have been 196 FFT returns received of which 89% rated the Trust as good.

The Trust has deployed a digital solution to help to support an increase in patient engagement with the friends and family test. To date this has not significantly increased return rates. Actions are being taken, including a poster campaign and direct text links to the survey to improve engagement and the piloting of electronic FFT via tablets in the Crisis Care Centre and CMHT Bases. A QR code to link directly to FFT has now been included as part of the discharge letter template in Lorenzo. The Trust have also commenced some additional work with a company who already provide a survey tool; the aim is that return rates can be improved.

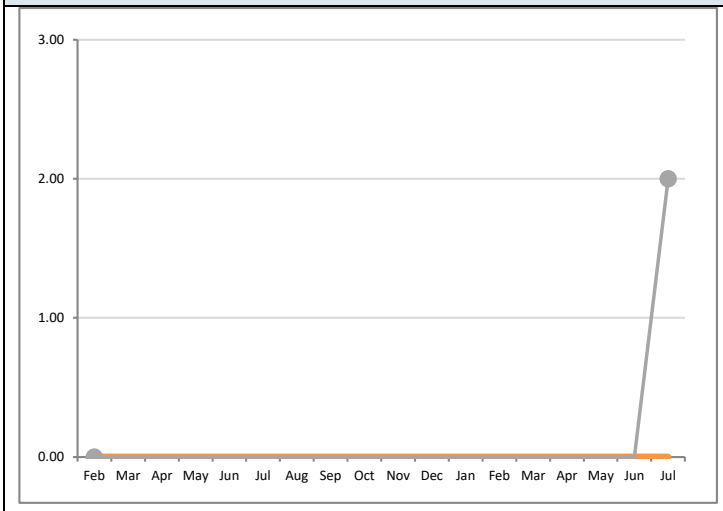
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 85.0% | 95.0% | 90.0% | 89.0% | 93.0% | 92.0% | 93.0% | 88.0% | 90.0% | 85.0% | 89.0% | 89.0% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| | | | | |
| 89.0% | 90.0% | 96.0% | 100.0% | 85.0% |

***23***

| | | |
|---|---|---|
| **Not Met - Out of Area** ↘<br>A Lower Value Is Better | **Actual** 2.00 #N/A<br>**Target:** Monthly | **Executive Director of Operations** Responsive<br>National |




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |

| Trust |
|---|
| |
| 2.00 |

-- Context --
National indicator - Number of inappropriate OAA bed days that are either "internal" or "external" to the sending provider in the reporting period. This new national metric for 20/21 combines both adult/older adult acute and PICU out of area placements who were inappropriately redirected to out of area beds. For our reporting purposes this would be outside Staffordshire. This replaces the 4x OOA measures reported in 2019/20.

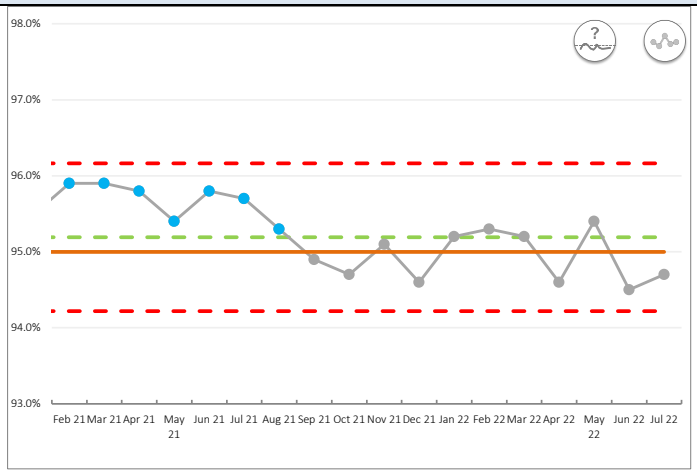
-- Monthly Narrative (Key Issues and Actions) --
There are two inappropriate (and reportable) PICU out of area admissions during M4 outside Staffordshire (considered to be local beds as accessible to family, friends and care coordinator). These have a combined number of bed days of 23 (11 and 12 bed days respectively).

There was also one appropriate OOA of 23 days in month (not reportable nationally).

***24***


Community and
Quality

| | | | | | |
|---|---|---|---|---|---|
| **Not Met - Care Plan Compliance** ↗<br><br>A Higher Value Is Better | **Actual** | 94.7% | #N/A | **Executive Director of Nursing and Quality** | Safe |
| | **Target:** | 95.0% | Monthly | Trust Measure | |




-- Context --
Service users are entitled to have a care plan that's regularly reviewed. A care plan sets out what support will be provided day to day and who will provide it. The care plan should include details of what should happen in an emergency or crisis.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.7% during M4, under target. All directorate with the exception of North Staffs Community and Specialist Services have achieved the required standard.

The under-performance is mainly associated with non CPA care plan compliance in Adult and CAMHS teams in North Staffs and in the Neuro Community, Neuro Oncology Psychology and Paediatric psychology teams in Specialist Services.

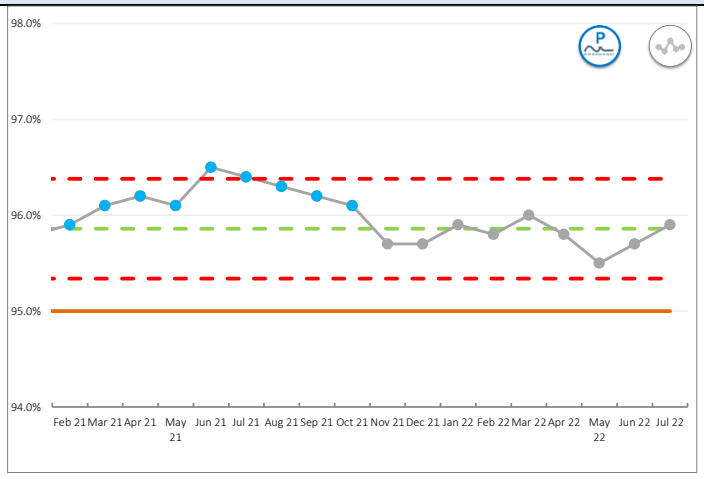
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 95.3% | 94.9% | 94.7% | 95.1% | 94.6% | 95.2% | 95.3% | 95.2% | 94.6% | 95.4% | 94.5% | 94.7% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✗ | ✗ | ✓ | ✗ | ✓ |
| 94.7% | 93.2% | 96.3% | 93.4% | 98.6% |

***25***

| | | | | | |
|---|---|---|---|---|---|
| **Met - Risk Assessment Compliance** ↗<br><br>A Higher Value Is Better | **Actual** | 95.9% | #N/A | **Executive Director of Nursing and Quality** | Safe |
| | **Target:** | 95.0% | Monthly | Trust Measure | |




-- Context --
To measure availability of risk assessments for all service users - patients who have been accepted into service and had a first contact are expected to have a risk assessment (exception is Memory Clinic where it is expected after second appointment) - intended to minimise harm to service users and others.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 95.9% during M4 and is operating within normal control limits. All directorates, with the exception of Specialist Services have met the required standard, mainly due to risk assessments required in Neuro Community and some specialist psychology teams.

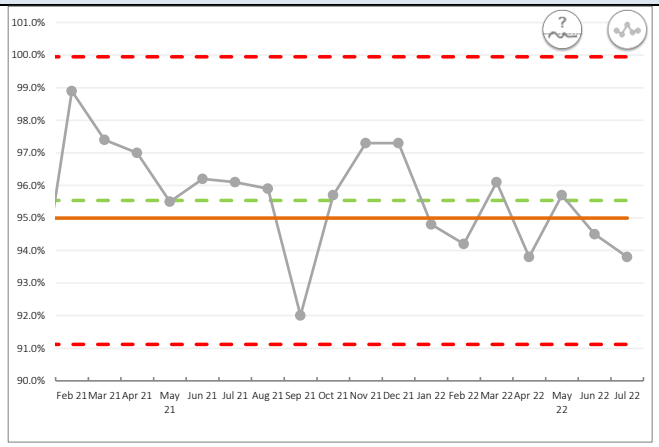
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 96.3% | 96.2% | 96.1% | 95.7% | 95.7% | 95.9% | 95.8% | 96.0% | 95.8% | 95.5% | 95.7% | 95.9% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✗ | ✓ |
| 95.9% | 96.7% | 96.3% | 92.8% | 98.7% |

***26***

| | | | | | |
|---|---|---|---|---|---|
| **Not Met - CPA 12 Month Review Compliance** ↘ | **Actual** | 93.8% | #N/A | **Executive Director of Nursing and Quality** | Safe |
| A Higher Value Is Better | **Target:** | 95.0% | Monthly | National | |




-- Context --
National indicator - There is a requirement for all services users on a CPA pathway to receive a review of their care plan as a minimum within 12 months of the care plan being agreed.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 93.8% during M4, below standard across all directorates. The largest number of those whose reviews are overdue are located in Newcastle CMHT, and Early Intervention teams (North Staffs) and Greenfields CMHT (Stoke).

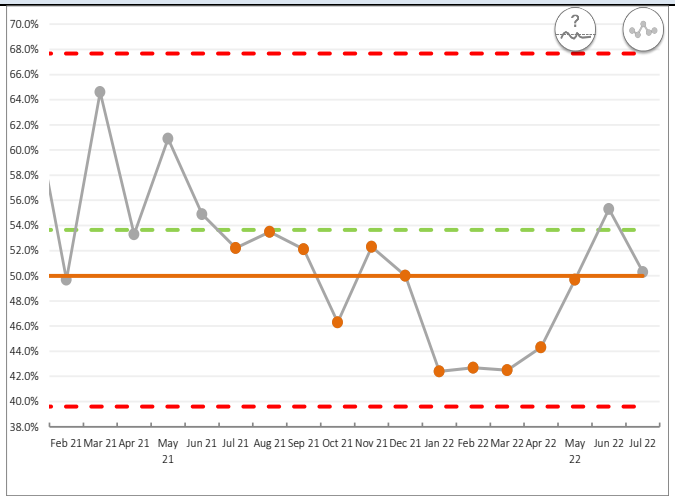
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 95.9% | 92.0% | 95.7% | 97.3% | 97.3% | 94.8% | 94.2% | 96.1% | 93.8% | 95.7% | 94.5% | 93.8% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✗ | ✗ | ✗ | ✗ | |
| 93.8% | 93.9% | 92.4% | 93.3% | #N/A |

***27***

| | | | | | |
|---|---|---|---|---|---|
| **Met - IAPT: Recovery** ↘ | **Actual** | 50.3% | #N/A | **Executive Director of Nursing and Quality** | Safe |
| A Higher Value Is Better | **Target:** | 50.0% | Monthly | National | |




-- Context --
National indicator - This indicator shows how many people have shown a real movement in symptoms large enough to warrant the judgement that the person has recovered, moving from above the clinical threshold to below.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 50.3% during M4 and is meeting the required standard.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 53.5% | 52.1% | 46.3% | 52.3% | 50.0% | 42.4% | 42.7% | 42.5% | 44.3% | 49.7% | 55.3% | 50.3% |

| Trust |
|---|
| ✓ |
| 50.3% |

***28***

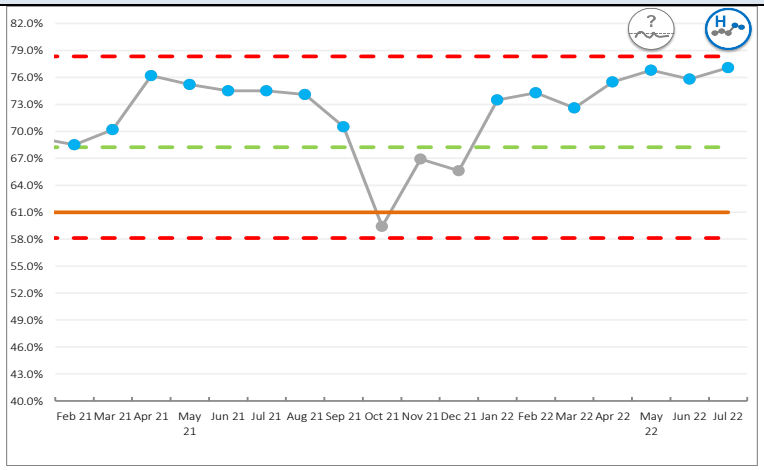
## Met - Service Users on CPA in settled accommodation

A Higher Value Is Better

| | | |
|---|---|---|
| **Actual** | 77.1% | #N/A |
| **Target:** | 61.0% | Monthly |

**Executive Director of Nursing and Quality** | Safe

National




-- Context --
National metric - This overall indicator measures the proportion of adults in contact with secondary mental health services who have been recorded as being in settled accommodation the last 12 months - stable housing is critical for recovery and maintained health.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 77.1% during M4 and continues to operate above the national average. All directorates have achieved the required standard.

12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 74.1% | 70.5% | 59.4% | 66.9% | 65.6% | 73.5% | 74.3% | 72.6% | 75.5% | 76.8% | 75.8% | 77.1% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ |
| 77.1% | 74.2% | 81.3% | 83.1% | 100.0% |

***29***

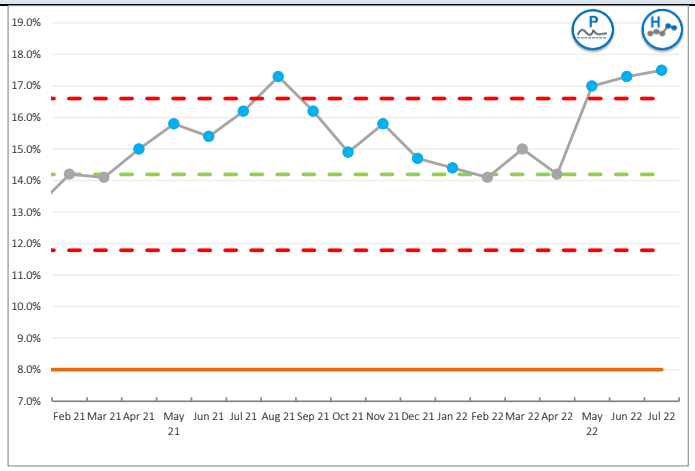
## Met - Service Users on CPA in Employment

A Higher Value Is Better

| | | |
|---|---|---|
| **Actual** | 17.5% | #N/A |
| **Target:** | 8.0% | Monthly |

**Executive Director of Nursing and Quality** | Safe

National




-- Context --
National indicator - This overall indicator measures the proportion of adults in contact with secondary mental health services who are in paid employment (as of the last 12 months) - employment outcomes are a predictor of quality of life and are indicative of whether care and support is personalised.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 17.5% and continues to operate above the national average. Performance has improved for the last 17 months and consideration will be given to rebasing the control limits in Q2.

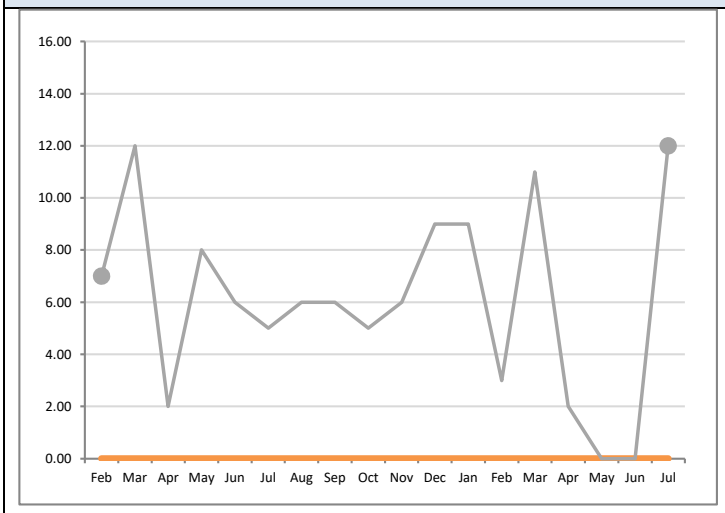
12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 17.3% | 16.2% | 14.9% | 15.8% | 14.7% | 14.4% | 14.1% | 15.0% | 14.2% | 17.0% | 17.3% | 17.5% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| ✓ | ✗ | ✓ | ✗ | |
| 17.5% | 7.8% | 29.9% | 7.1% | # N/A |

***30***

| | | | |
|---|---|---|---|
| **Met - Serious Incidents** ↘<br>A Lower Value Is Better | **Actual** 12.00 #N/A<br>**Target:** Monthly | **Medical Director** Safe<br>Trust Measure | |




-- Context --
Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services we provide to our patients.

-- Monthly Narrative (Key Issues and Actions) --
There are 12 serious incidents Trust wide reported during M4.

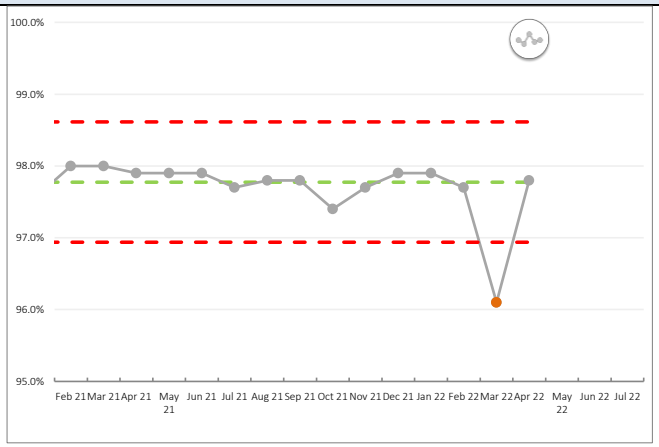
12 Month Trend

| 6 | 6 | 5 | 6 | 9 | 9 | 3 | 11 | 2 | 0 | 0 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care |
|---|---|---|---|---|
| | | | | |
| 12.00 | 5.00 | 2.00 | 2.00 | 3.00 |

***31***

| | | | |
|---|---|---|---|
| **- Data Quality Maturity Index (DQMI)**<br>A Higher Value Is Better | **Actual** #N/A #N/A<br>**Target:** Monthly | **Director of Finance, Performance & Estates** Caring<br>National | |




-- Context --
The DQMI supports commissioners by demonstrating the quality of providers' submissions and identifying areas for improvement. A provider's DQMI score is based upon several measures of data quality including coverage, completeness, validity, and default values.

-- Monthly Narrative (Key Issues and Actions) --
The Trust's DQMI rating during April was 97.8%, which is the latest published national data.

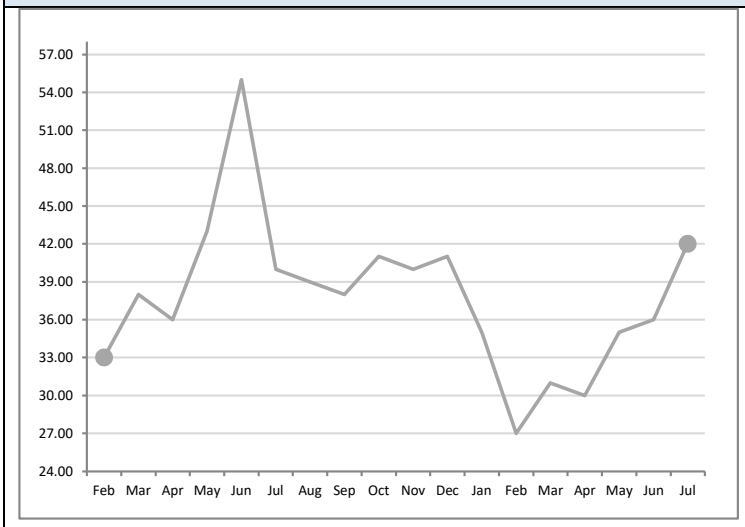
12 Month Trend

| 97.8% | 97.8% | 97.4% | 97.7% | 97.9% | 97.9% | 97.7% | 96.1% | 97.8% | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

| Trust |
|---|
| |
| # N/A |

***32***

| | | | |
|---|---|---|---|
| **Not Met - Perinatal: Number of women accessing specialist community perinatal mental health services** ↗<br>A Higher Value Is Better | **Actual** 42.00 #N/A<br>**Target:** Monthly | **Executive Director of Operations** Responsive<br>National | |




12 Month Trend

| 39 | 38 | 41 | 40 | 41 | 35 | 27 | 31 | 30 | 35 | 36 | 42 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

| Trust |
|---|
| |
| 42.00 |

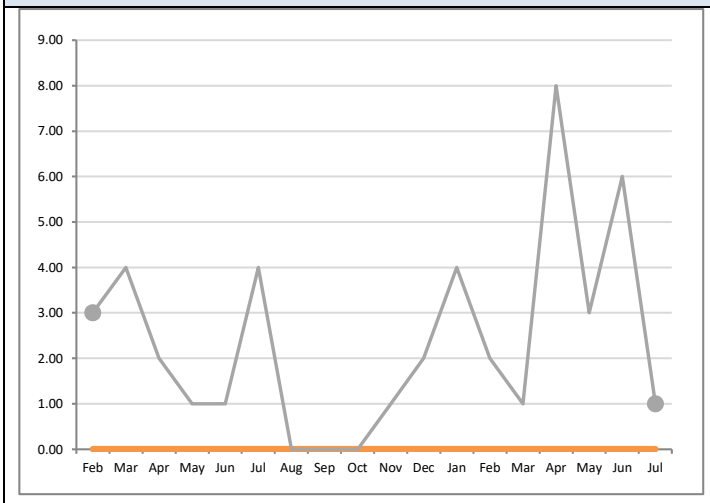
-- Context --
This metric is designed to demonstrate the Trust's progress in increasing access to NHS funded specialist community perinatal mental health (PMH) services.

-- Monthly Narrative (Key Issues and Actions) --
There were 42 women accessing the Trust's perinatal service during M4.

***33***

# Organisational Health and Workforce

| | | | | |
|---|---|---|---|---|
| **Not Met - Complaints Open Beyond Agreed Timescale** ↗ | **Actual** | 1.00 | #N/A | **Executive Director of Nursing and Quality** Caring |
| A Lower Value Is Better | **Target:** | 0.00 | Monthly | Trust Measure |




-- Context --
All formal complaints will receive a response detailing the outcome of investigation within 40 working days or, where an alternative timescale has been agreed with the complainant.

-- Monthly Narrative (Key Issues and Actions) --
There is one complaint response outside of the 40 working day deadline during M4 and is in its final review stage.

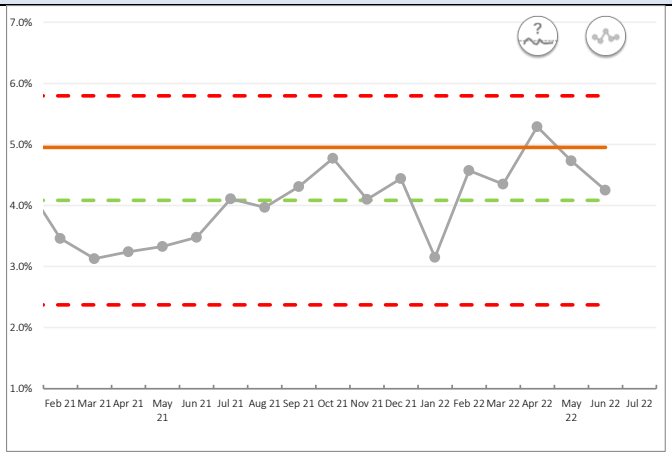
12 Month Trend

| 0 | 0 | 0 | 1 | 2 | 4 | 2 | 1 | 8 | 3 | 6 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

| Trust |
|---|
| ✖ |
| 100 |

***34***

| | | | | |
|---|---|---|---|---|
| **- Sickness Absence** | **Actual** | #N/A | #N/A | **Executive Director of Workforce** Organisational Health |
| A Lower Value Is Better | **Target:** | 4.95% | Monthly | Trust Measure |




-- Context --
12 Month Rolling - Trust measure - Sickness absence represents a strain on the organisation that should be minimised to allow for efficient use of resources and less strain on other members of staff.

-- Monthly Narrative (Key Issues and Actions) --
April sickness figures have been confirmed. July figures are not yet available.

There is a key focus on Health and Wellbeing support to staff, particularly in light of the recent increase in proportion of sickness due to Mental Health.

It should be noted that these figures do not contain absences relating to Covid which are not classed as "sickness" e.g. isolation due to symptomatic family member, track and trace, shielding and other associated absences. Such instances are being recorded as other absence codes such as medical suspension (in accordance with the national guidelines).

12 Month Trend

| 3.97% | 4.31% | 4.77% | 4.10% | 4.44% | 3.15% | 4.57% | 4.35% | 5.29% | 4.73% | 4.25% | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

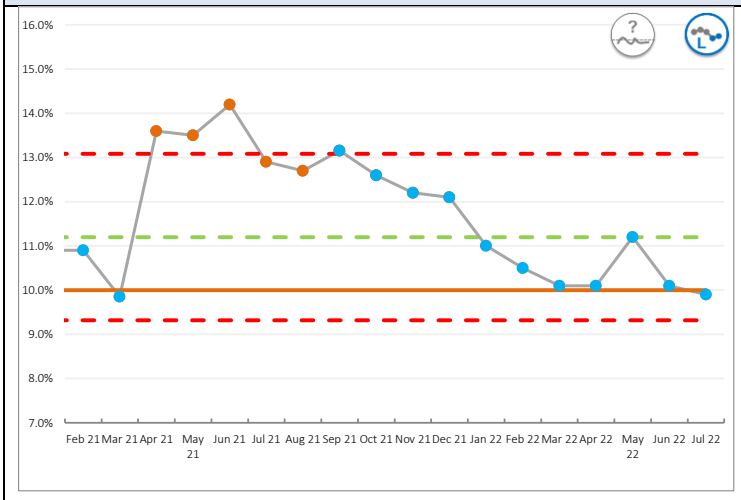
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care | Primary Care | Corporate |
|---|---|---|---|---|---|---|
| | | | | | | |
| #N/A | #N/A | #N/A | #N/A | #N/A | #N/A | #N/A |

***35***

**Met - Vacancy Rate** ↗

A Lower Value Is Better

| | | | |
|---|---|---|---|
| **Actual** | 9.9% | #N/A | **Executive Director of Workforce** Organisational Health |
| **Target:** | 10.0% | Monthly | Trust Measure |




-- Context --
Trust measure - High vacancy rates has an impact on care quality and the finances within the trust due to reliance on bank and locum staff.

-- Monthly Narrative (Key Issues and Actions) --
The vacancy rate is 9.9% in M4 and is within the threshold, but remains challenging for most directorates, with the exception of North Staffs Community and Corporate services.

It is noted that a number of service development schemes have adversely affected the vacancy position. In Q3/4, 20/21 there was a 5% growth in workforce and in Q1, 21/22 there was an additional 6% growth in workforce. This is set against a national and local backdrop of workforce supply shortages for Nursing, AHP and Medical professions.

A Vacancy Management Plan has been developed which consists of a number of short/medium and long terms initiatives to address the position. Performance against the plan is being actively monitored.

12 Month Trend

| 12.7% | 13.2% | 12.6% | 12.2% | 12.1% | 11.0% | 10.5% | 10.1% | 10.1% | 11.2% | 10.1% | 9.9% |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

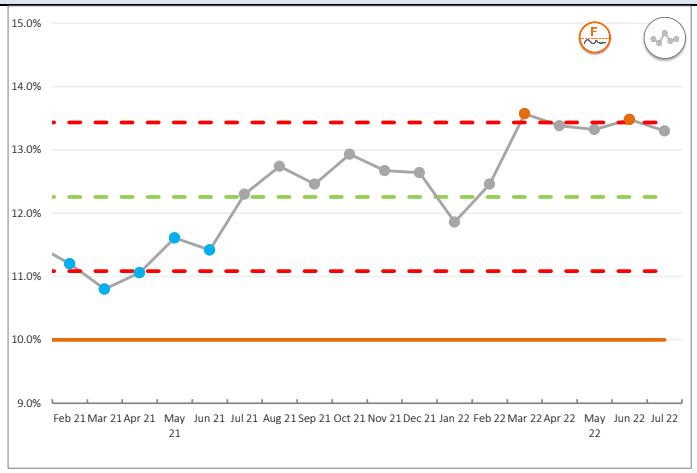
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care | Primary Care | Corporate |
|---|---|---|---|---|---|---|
| ✓ | ✓ | ✗ | ✗ | ✗ | ✗ | ✓ |
| 9.9% | 6.7% | 11.0% | 14.5% | 14.3% | 12.7% | -1.5% |

***36***

**Not Met - Staff Turnover** ↗

A Lower Value Is Better

| | | | |
|---|---|---|---|
| **Actual** | 13.3% | #N/A | **Executive Director of Workforce** Organisational Health |
| **Target:** | 10.0% | Monthly | Trust Measure |




-- Context --
Trust measure - High turnover represents an unstable workforce with high costs associated with turnover - retention represents a more stable organisation that is a positive place to work and provides continuity of care to service users.

-- Monthly Narrative (Key Issues and Actions) --
Performance is consistently above the 10% threshold at 13.3% during M4 and continues to remain challenging for all directorates with the exception of North Staffs Community.

The top three reported reasons for leaving the Trust include: Retirement, Promotion and Work Life balance. The Vacancy Management Plan contains a number of strategies which are expected to improve retention.

12 Month Trend

| 12.7% | 12.5% | 12.9% | 12.7% | 12.6% | 11.9% | 12.5% | 13.6% | 13.4% | 13.3% | 13.5% | 13.3% |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |

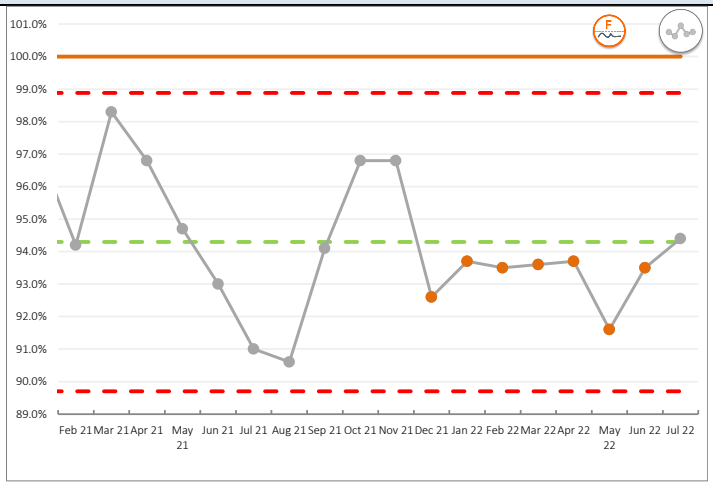
| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care | Primary Care | Corporate |
|---|---|---|---|---|---|---|
| ✗ | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ |
| 13.3% | 8.7% | 10.3% | 18.8% | 12.8% | 21.1% | 12.4% |

***37***

**Not Met - Safe Staffing** ↗

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 94.4% | #N/A | **Executive Director of Nursing and Quality** | Responsive |
| **Target:** | 100.0% | Monthly | National | |




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 90.6% | 94.1% | 96.8% | 96.8% | 92.6% | 93.7% | 93.5% | 93.6% | 93.7% | 91.6% | 93.5% | 94.4% |

| Trust |
|---|
| ✘ |
| 94.4% |

-- Context --
National measure (Trust target) - This measures the total planned hours divided by the actual hours.

-- Monthly Narrative (Key Issues and Actions) --
Safe staffing performance is at 94.4% during M4.

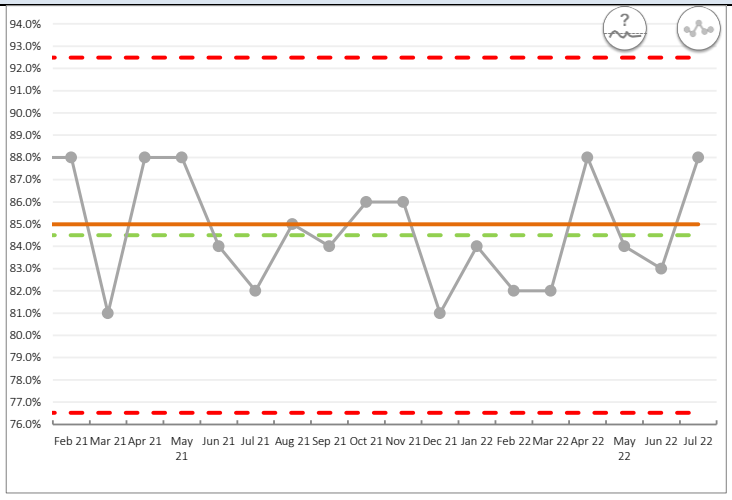
Ward Managers, Service Managers and Quality Improvement Nurses (Matrons) continue to review staffing levels on a daily basis. Bank and Agency staff continue to be used to fill shortfalls. Several short and longer term actions are being undertaken to support recruitment and retention. Fill rates are currently averaging 93.4% each month from January – July 2022..

***38***

**Met - Clinical Supervision** ↗

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 88.0% | #N/A | **Executive Director of Workforce** | Organisational Health |
| **Target:** | 85.0% | Monthly | Trust Measure | |




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 85.0% | 84.0% | 86.0% | 86.0% | 81.0% | 84.0% | 82.0% | 82.0% | 88.0% | 84.0% | 83.0% | 88.0% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care | Primary Care | Corporate |
|---|---|---|---|---|---|---|
| ✓ | ✘ | ✓ | ✘ | ✓ | ✘ | ✓ |
| 88.0% | 84.0% | 90.0% | 82.0% | 87.0% | 82.0% | 86.0% |

-- Context --
Clinical Supervision is key to the delivery of quality patient care.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 88% in M4. All directorates, with the exception of North Staffs Community, Specialist Services and Primary Care are below the required standard.

All Associate Directors receive details regarding their Directorate position, identifying those who are non-compliant for them to take appropriate action to remedy.

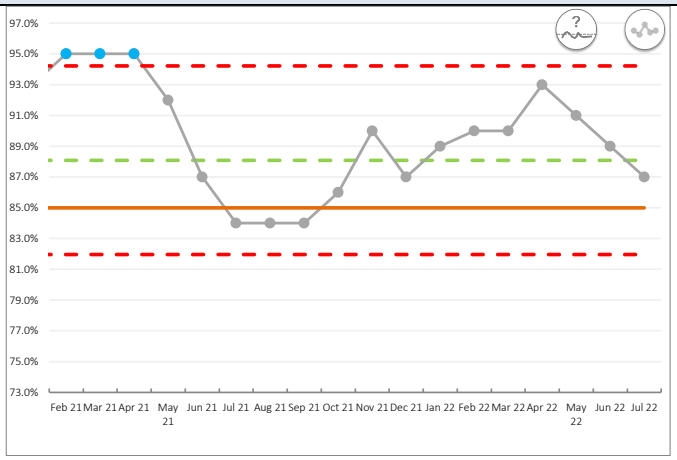
All Directorate teams receive the fortnightly clinical supervision report identifying percentage compliance rates and individuals who are non-compliant to support action going forward.

***39***

**Met - Appraisal** ↘

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 87.0% | #N/A | **Executive Director of Workforce** | Organisational Health |
| **Target:** | 85.0% | Monthly | Trust Measure | |




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 84.0% | 84.0% | 86.0% | 90.0% | 87.0% | 89.0% | 90.0% | 90.0% | 93.0% | 91.0% | 89.0% | 87.0% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care | Primary Care | Corporate |
|---|---|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ | ✖ | ✓ |
| 87.0% | 89.0% | 87.0% | 910% | 89.0% | 70.0% | 88.0% |

-- Context --
Trust measure - Appraisals and PDR's have been linked to staff performance and patient outcomes, as well as linking to staff turnover by reflecting a supportive environment that helps staff to develop.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 87% in M4 and is operating within normal control limits. All directorates are achieving the required standard with the exception of Primary Care.

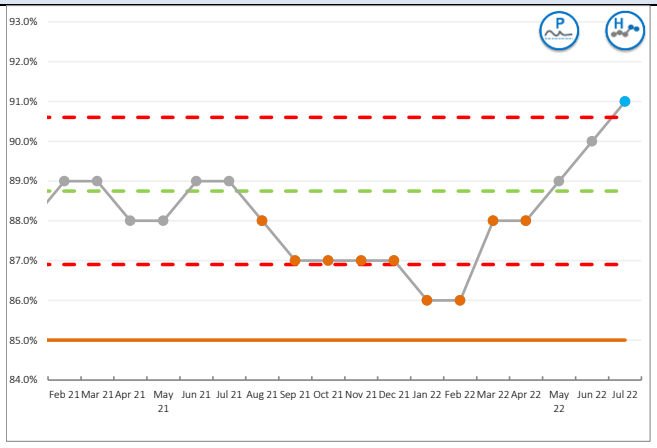
Regular reminders are sent to managers/staff 30 days prior to compliance due to expire, with the window to complete the appraisal open for a further 60 days, giving managers 90 days to complete with the appraisee. All Directorate senior teams receive the fortnightly appraisal report identifying percentage compliance rates and individuals who are non-compliant to support action going forward.

***40***

**Met - Statutory & Mandatory Training** ↗

A Higher Value Is Better

| | | | | |
|---|---|---|---|---|
| **Actual** | 91.0% | #N/A | **Executive Director of Workforce** | Organisational Health |
| **Target:** | 85.0% | Monthly | Trust Measure | |




12 Month Trend

| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 88.0% | 87.0% | 87.0% | 87.0% | 87.0% | 86.0% | 86.0% | 88.0% | 88.0% | 89.0% | 90.0% | 91.0% |

| Trust | North Staffs Community | Stoke Community | Specialist Services | Acute and Urgent Care | Primary Care | Corporate |
|---|---|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ | ✖ | ✓ |
| 910% | 93.0% | 92.0% | 90.0% | 89.0% | 79.0% | 92.0% |

-- Context --
Trust measure - Statutory and mandatory training is determined essential to the safe and efficient delivery of services, therefore completion links directly to care quality and efficiency.

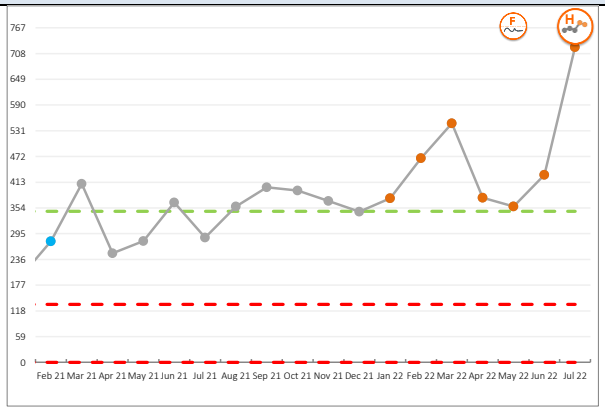
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 91% during M4 and is currently operating outside of the upper control limit. All directorates, with the exception of Primary Care, are achieving the required standard.

Primary Care figures impacted by taking on Holmcroft and they are working hard to improve their compliance

Statutory training compliances continue to improve. Face to face sessions still feeling the impact of Covid 19 absences with staff having to cancel or not being able to attend planned face to face sessions. Face to face training continues to be delivered in Lawton House. Mental Capacity Act refresher training is pending completion but is a highlighted priority. . Existing staff will need only to complete the refresher once launched.

***41***

| | | | |
|---|---|---|---|
| **Not Met - Agency cost per month (£000)** ↘<br><br>A Lower Value Is Better | **Actual** 723.00 #N/A<br><br>**Target:** 0.00 Monthly | **Executive Director of Operations** Organisational Health<br><br>Trust measure | |




-- Context --
Measure is under development – this is a temporary table for Agency Cost per month in 2022/23 (£000) pending agreement of the Agency cap for the current year.

-- Monthly Narrative (Key Issues and Actions) --
The agency cost has increased from £377k in M1 to £430k in M3 to £723k in M4.

Of the month 4 agency costs £291k related to medical, £373k to nursing, £32k to other clinical and £28k to non-clinical.

Of the £291k medical agency spend, £108k related to Stoke Community, £66k Specialist Services, £65k North Staffordshire Community, £36k Acute & Urgent Care & £16k related to Primary Care.

Of the £373k nursing agency spend £152k related to Acute & Urgent Care, £210k Specialist Services, £5k Covid & £4k Stoke Community.

12 Month Trend

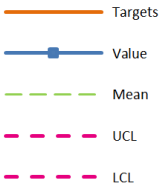
| Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 358 | 402 | 394 | 370 | 346 | 376 | 468 | 548 | 377 | 358 | 430 | 723 |

| Trust |
|---|
| ✖ |
| 723.00 |

***42***

## Interpreting the Report

| Variation | | | Assurance | | |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| Common cause - no significant change | Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values | Special cause of improving nature or lower pressure due to (H)igher or (L)ower values | Variation indicates inconsistently hitting passing and falling short of the target | Variation indicates consistently (P)assing the target | Variation indicates consistently (F)alling short of the target |




**Variation icons:** Orange indicates concerning special cause variation requiring action; **Blue** indicates where improvement appears to lie, and Grey indicates no significant change (common cause variation).

**Assurance icons:** **Blue** indicates that you would consistently expect to achieve a target. Orange indicates that you would consistently expect to miss the target. A Grey icon tells you that sometimes the target will be met and sometimes missed due to random variation - in a RAG report this indicator would flip between Red and Green.

### Directional Arrows:

↗ If performance this month is **positive** when compared to last month's performance (a higher value is better or a lower value is better)

↘ If performance this month is **negative** when compared to last month's performance (a higher value is better or a lower value is better)

↔ when there has been **no change** in performance levels when compared to last month

# Activity Plan 2022/23

**Impact of Covid in Activity**

It is difficult to forecast activity for 2022/23 given that the impact of the Covid pandemic. This has resulted in Covid suppressed demand during the various lockdowns and restrictions from March 2020, and then Covid generated demand in many areas due to the emerging effects of the Covid pandemic on mental health.

There has been a significant impact on inpatient services activity over the last two years as wards were closed at times due to Covid outbreaks. In addition, the Trust has seen a marked change in community contacts away from face to face to digital (telephone and video conferencing) with some community services seeing a significant increase in contact numbers of shorter duration.

Although it is hard for services to predict with any certainty the pattern of activity following the restoration and recovery of services anticipated in 2022/23, each community service has reviewed activity to provide a plan for 2022/23 taking into account the impact of Covid pandemic on the activity baseline and planning assumptions for 22/23. In some cases, this looks markedly different at team level from the 19/20 plan (representing the last position agreed with commissioners).

With this in mind, there will be quarterly reviews of the Activity plans in each Directorate to take into account changing circumstances and need.

**Activity Planning Process and Assumptions**

The work to develop an activity plan for 2022/23 was undertaken with a series of meeting with Directorates. The work undertaken will be used to produce a revised forwards plan for 23/24 once a new trends baseline has settled. The work to date was developed in stages:

- Inpatient and community activity aligned to agree with the specifications within the North Staffs and Stoke contracts
- 19/20 inpatient plan adopted for inpatient services as agreed in the Contract
- agreeing a baseline for community services for 2022/23 based on 21/22 YTD data (the first 8 months activity was the starting point)
- Demand and capacity issues were taken into account
- Activity planning assumptions about Covid impact were made
- Activity planning assumptions agreed for new service developments 2022/23 where possible
- Engagement with and sign off by Heads of Directorate following review with Senior Teams

**Plan**

Specifically, the Plan for 2022/23 sets out:

- 2019/20 inpatient activity plan – as the last plan agreed with commissioners prior to the Covid pandemic. The inpatient activity is planned based on the levels funded by the CCGs which are detailed in the service specifications, plus any Out of area work undertaken in 21/22.
- 2022/23 Directorate plan for community and outpatient services based on activity planning assumptions for Covid recovery and incorporating service developments

The Plan will be reported on a monthly basis from Q2 in the IQPR Board report and at Directorate level in Performance packs for Executive review.

The Plan includes Substance misuse inpatient activity and the Trust is working to include community activity in year through the integration of the substance misuse Halo data. In addition IAPT data will also be included in year (as a sub-contractor IAPTUs data is returned through the Lead Trust MPFT).

**M4 2022/23 Activity**

**Trust Level Summary**

| Point of Delivery | Currency | Plan | Activity | Var | |
|---|---|---|---|---|---|
| Inpatient | Admissions | 73 | 39 | -34 | -46.72% |
| Inpatient | Contacts | 89 | 91 | 2 | 2.35% |
| Inpatient | OBDs | 18325 | 16483 | -1842 | -10.05% |
| Community | Cases | 292 | 284 | -8 | -2.87% |
| Community | Contacts | 73249 | 67474 | -5775 | -7.88% |
| Day Services | Contacts | 2589 | 2122 | -467 | -18.04% |
| Outpatient | Contacts | 7586 | 7684 | 98 | 1.30% |

**Inpatient**

| Point of Delivery | Currency | Service Specification | Plan | Activity | Var | |
|---|---|---|---|---|---|---|
| Inpatient | Admissions | Intoxication Observation Unit | 73 | 39 | -34 | -46.72% |
| Inpatient | Contacts | Place of Safety | 89 | 91 | 2 | 2.35% |
| Inpatient | OBDs | Acute Inpatient Service | 6578 | 5435 | -1143 | -17.38% |
| Inpatient | OBDs | Children's Learning Disability Respite Service/Specialist Short Breaks | 575 | 540 | -35 | -6.13% |
| Inpatient | OBDs | Learning Disability Inpatient Provision | 624 | 461 | -163 | -26.13% |
| Inpatient | OBDs | Mental Health Rehabilitation Service | 1932 | 2048 | 116 | 6.01% |
| Inpatient | OBDs | Neuropsychiatry Service | 1064 | 990 | -74 | -6.98% |
| Inpatient | OBDs | NHSE Child Inpatient Service | 1502 | 1154 | -348 | -23.15% |
| Inpatient | OBDs | Older Adults In-patient provision - Assessment and Complex Needs | 3711 | 3441 | -270 | -7.28% |
| Inpatient | OBDs | Older People's Shared Care Service | 1680 | 1733 | 53 | 3.14% |
| Inpatient | OBDs | Psychiatric Intensive Care Unit - PICU | 659 | 681 | 22 | 3.37% |

IOU admissions - there has been a reduction in activity during the Covid pandemic. There are recent efforts to promote the service to UHNM with the aim of increasing referrals.

Learning Disability Inpatient provision (A&T) - 4 beds (out of 6) are currently utilised and this fluctuates between 3 or 4 beds at any time. Environment and patient acuity are the limiting factors.

NHSE Child inpatient service (Darwin) - NHSE supported closure of 5 beds to support 2x complex young people in Q1, both now discharged. Closure of 5 beds will remain in place to support bathroom and flooring updates with work to be completed in November 2022. Once open the ward will provide 14 beds not 15.

Acute inpatient service – there are reduced beds due to IPCC Covid requirements, acuity of patients has increased and so has LOS due to this.

**Community**

| Point of Delivery | Currency | Service Specification | Plan | Activity | Var | |
|---|---|---|---|---|---|---|
| Community | Cases | Autism Assessment Service (non LD) | 32 | 30 | -2 | -6.25% |
| Community | Cases | Children and Young People's Mental Health Services: Community Services | 98 | 81 | -17 | -17.63% |
| Community | Cases | High Volume Users | 140 | 156 | 16 | 11.12% |
| Community | Cases | Intensive Support Service for People with Learning Disabilities Presented w | 22 | 17 | -5 | -21.54% |
| Community | Contacts | Access Service (Including Crisis Resolution) | 10886 | 8557 | -2329 | -21.40% |
| Community | Contacts | Acute Home Treatment Team | 3929 | 3519 | -410 | -10.43% |
| Community | Contacts | Acute Inpatient Service | 103 | 138 | 35 | 33.58% |
| Community | Contacts | Adult Community Mental Health Team | 16764 | 17412 | 648 | 3.86% |
| Community | Contacts | Cancer Psychology Service | 165 | 84 | -81 | -49.09% |
| Community | Contacts | Care Home Physiotherapy | 755 | 1152 | 397 | 52.58% |
| Community | Contacts | CASTT | 416 | 699 | 283 | 67.97% |
| Community | Contacts | Children and Young People's Mental Health Services: Community Services | 12257 | 10105 | -2152 | -17.56% |
| Community | Contacts | Children's Learning Disability Respite Service/Specialist Short Breaks - Drag | 93 | 75 | -18 | -19.35% |
| Community | Contacts | Community Outreach Team - People with Dementia and Older Adults | 2937 | 1856 | -1081 | -36.82% |
| Community | Contacts | Community Triage Team | 137 | 130 | -7 | -4.91% |
| Community | Contacts | Criminal Justice Mental Health Team (CJMHT) | 721 | 770 | 49 | 6.80% |
| Community | Contacts | Dementia Primary Care Liaison Service (DPCLS) | 288 | 79 | -209 | -72.55% |
| Community | Contacts | Early Intervention in Psychosis Team | 3304 | 3058 | -246 | -7.45% |
| Community | Contacts | Eating Disorder Services for Children and Young People | 1157 | 1481 | 324 | 27.97% |
| Community | Contacts | Individual Placement & Support | 1019 | 1179 | 160 | 15.70% |
| Community | Contacts | Liaison and Diversion | 2042 | 1800 | -242 | -11.86% |
| Community | Contacts | Memory Assessment and Diagnosis Service | 1257 | 1382 | 125 | 9.96% |
| Community | Contacts | Mental Health and Vascular Wellbeing Team (MHVW) | 302 | 27 | -275 | -91.07% |
| Community | Contacts | Neuropsychiatry Service | 1272 | 1332 | 60 | 4.70% |
| Community | Contacts | No Service Specification. | 0 | 2 | 2 | 0.00% |
| Community | Contacts | North Staffordshire Community Learning Disability Team & Stoke on Trent | 4128 | 3845 | -283 | -6.86% |
| Community | Contacts | Older People's Community Mental Health Teams | 4366 | 3750 | -616 | -14.11% |
| Community | Contacts | Older Person's Mental Health Services – Care Home Liaison Team | 925 | 1116 | 191 | 20.69% |
| Community | Contacts | Resettlement and Repatriation Team | 121 | 332 | 211 | 173.63% |
| Community | Contacts | SAEDS - Specialist Adult Eating Disorder Service | 915 | 924 | 9 | 0.97% |
| Community | Contacts | Urgent Emergency Liaison Mental Health Services | 2987 | 2443 | -544 | -18.23% |
| Day Services | Contacts | Parent & Baby Day Service | 2589 | 2122 | -467 | -18.04% |

Access service and Crisis Resolution - Impact of COVID recovery across wider services. A pilot to route routine referrals to Greenfields CMHT has ensured that routine referrals are rapidly referred to the right place, first time. Previously routine referrals may have been held in the Access Team and had more contacts in this service. This change is now been rolled out in two additional CMHTs as part of Community transformation.

Crisis Café - there have been a number of vacancies that could be impacting on contacts, however there is a strong recruitment offer. The service is also working alongside partner agencies as part of the community hub offer.

Cancer psychology – this is a small service and has been challenged due to vacancies in Q1.

Community Outreach team & Dementia Primary Care Liaison – these teams have a transient workforce and have held a number of vacancies which are being recruited to. There is increased demand for MH support in care homes.

Vascular Wellbeing team – referrals are slowing for this service and there is a review of the pathway

**Outpatient**

| Point of Delivery | Currency | Service Specification | Plan | Activity | Var | |
|---|---|---|---|---|---|---|
| Outpatient | Contacts | Adult Community Mental Health Team | 3720 | 3962 | 242 | 6.51% |
| Outpatient | Contacts | Children and Young People's Mental Health Services: Community Services | 1040 | 857 | -183 | -17.62% |
| Outpatient | Contacts | Dementia Primary Care Liaison Service (DPCLS) | 30 | 19 | -11 | -35.97% |
| Outpatient | Contacts | Early Intervention in Psychosis Team | 173 | 167 | -6 | -3.47% |
| Outpatient | Contacts | Memory Assessment and Diagnosis Service | 1399 | 1660 | 261 | 18.69% |
| Outpatient | Contacts | Neuropsychiatry Service | 203 | 173 | -30 | -14.70% |
| Outpatient | Contacts | North Staffordshire Community Learning Disability Team & Stoke on Trent ( | 388 | 352 | -36 | -9.33% |
| Outpatient | Contacts | Older People's Community Mental Health Teams | 281 | 269 | -12 | -4.27% |
| Outpatient | Contacts | Parent & Baby Day Service | 188 | 69 | -119 | -63.33% |
| Outpatient | Contacts | Urgent Emergency Liaison Mental Health Services | 164 | 156 | -8 | -4.75% |

Parent and baby service – this data is being validated as the team suggests that there is activity that is not being reported

# Performance against Operational Planning Forecasts Q1 2022-2023

| | | Data Quality Maturity Index (DQMI) | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 1 | Count | Mental Health Services Dataset DQMI score achieved in the relevant time period | *Forecast* | 97% | 97% | 97% | 97% | 97% |
| | Count | | *Actual* | | 98% | | | |

| | | 72 Hour Follow up | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 2 | Numerator | Of the denominator number, those who have been followed up within 72 hours (commencing at 12am the day after discharge) | *Forecast* | 246.75 | 246 | 257 | 246 | 238 |
| | Denominator | Number of people discharged from an ICS-commissioned adult mental health inpatient setting | | 282 | 281 | 296 | 274 | 277 |
| | Rate | % | | 88% | 88% | 87% | 90% | 86% |
| | Numerator | Of the denominator number, those who have been followed up within 72 hours (commencing at 12am the day after discharge) | *Actual* | 199 | 199 | | | |
| | Denominator | Number of people discharged from an ICS-commissioned adult mental health inpatient setting | | 207 | 207 | | | |
| | Rate | % | | 96% | 96% | | | |

| | | Out of Area Bed days | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 3 | Count | Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider | *Forecast* | 0 | 0 | 0 | 0 | 0 |
| | Count | | *Actual* | | 0 | | | |

| | | Dementia Diagnosis | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 5 | Numerator | Number of people aged 65 or over diagnosed with dementia | *Forecast* | 14,173 | 13,967 | 14,192 | 14,257 | 14,277 |
| | Denominator | Estimated prevalence of dementia based on GP registered populations | | 19,067 | 18,869 | 19,020 | 19,160 | 19,220 |
| | Rate | % | | 74% | 74% | 75% | 74% | 74% |
| | Numerator | Number of people aged 65 or over diagnosed with dementia | *Actual* | 14490 | 14490 | | | |
| | Denominator | Estimated prevalence of dementia based on GP registered populations | | 19366 | 19366 | | | |
| | Rate | % | | 75% | 75% | | | |

| | | CYP Eating Disorders Waits for Routine cases | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 6 | Numerator | The number of CYP with ED (routine cases) referred with a suspected ED that start treatment within four weeks of referral in the reporting period (rolling 12 | *Forecast* | 21.5 | 24 | 16 | 22 | 24 |
| | Denominator | The number of CYP with a suspected ED (routine cases) that start treatment within the reporting period (rolling 12 months) | | 22.5 | 25 | 17 | 23 | 25 |
| | Rate | % | | 95% | 96% | 94% | 96% | 96% |
| | Numerator | The number of CYP with ED (routine cases) referred with a suspected ED that start treatment within four weeks of referral in the reporting period (rolling 12 | *Actual* | 5 | 5 | | | |
| | Denominator | The number of CYP with a suspected ED (routine cases) that start treatment within the reporting period (rolling 12 months) | | 5 | 5 | | | |
| | Rate | % | | 100% | 100% | | | |

| | | CYP Eating Disorders Waits for Urgent cases | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 7 | Numerator | The number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within one week of referral in the reporting period (rolling 12 months) | *Forecast* | 3 | 2 | 3 | 4 | 3 |
| | Denominator | The number of CYP with a suspected ED (urgent cases) that start treatment within the reporting period (rolling 12 months) | | 3 | 2 | 3 | 4 | 3 |
| | Rate | % | | 100% | 100% | 100% | 100% | 100% |
| | Numerator | The number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within one week of referral in the reporting period (rolling 12 months) | *Actual* | 11 | 11 | | | |
| | Denominator | The number of CYP with a suspected ED (urgent cases) that start treatment within the reporting period (rolling 12 months) | | 11 | 11 | | | |
| | Rate | % | | 100% | 100% | | | |

| | | Physical Health checks for SMI | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 8 | Count | The number of people on the General Practice SMI registers who have receive a physical health assessment in the 12 months to the end of the period | *Forecast* | 4,186 | 4,170 | 4,181 | 4,191 | 4,201 |
| | Count | | *Actual* | | tba | | | |

| | | Perinatal access | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 9 | Count | Number for women accessing specialist community PMH and MMHS services in the reporting period | *Forecast* | 122 | 120 | 122 | 125 | 120 |
| | Count | | *Actual* | 112 | 112 | | | |

| | | Individual Placement Support | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 10 | Count | Number of people accessing IPS services as a rolling total each quarter | *Forecast* | 682 | 484 | 616 | 748 | 881 |
| | Count | | *Actual* | 491 | 491 | | | |

| | | Overall access to Core Community Mental Health Services for Adults with SMI | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 11 | Count | Number of people who receive two or more contacts from the NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses | *Forecast* | 21,835 | 21,501 | 21,869 | 22,152 | 21,816 |
| | Count | | *Actual* | 23,034 | 23,034 | | | |

| | | Early Intervention in Psychosis | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 12 | Numerator | The number of referrals to and within the Trust with suspected first episode of psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral | *Forecast* | 30 | 29 | 32 | 29 | 30 |
| | Denominator | The number of referrals to and within the Trust with suspected first episode of psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period | | 33.25 | 32 | 36 | 34 | 31 |
| | Rate | % | | 90% | 91% | 89% | 85% | 97% |
| | Numerator | The number of referrals to and within the Trust with suspected first episode of psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral | *Actual* | 23 | 23 | | | |
| | Denominator | The number of referrals to and within the Trust with suspected first episode of psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period | | 24 | 24 | | | |
| | Rate | % | | 96% | 96% | | | |

| | | Numbers of CYP in contact | | FY 22/23 Average | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 |
|---|---|---|---|---|---|---|---|---|
| 13 | Count | Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact | *Forecast* | 4,887 | 4,683 | 4,817 | 5,078 | 4,971 |
| | Count | | *Actual* | 5,838 | 5,838 | | | |

## CQUIN Progress Report: Q1 2022/23

| Ref. | Title | Objective | Min. Target | Max. Target | Progress Narrative | Current RAG |
|---|---|---|---|---|---|---|
| CCG1 | Flu Vaccinations for Frontline Healthcare Workers | Uptake of flu vaccinations by frontline staff with patient contact. | 70% | 90% | This CQUIN target is not applicable at Q1. The preferred option is to link in with UHNM to deliver the vaccination programme. The possibility of providing "mop up" clinics at the Harplands is also being considered. Processes for recording vaccinations and sharing this data continue to be discussed. | |
| CCG9 | Cirrhosis and Fibrosis Tests for Alcohol Dependent Patients | Refer unique inpatients with at least one-night stay aged 16+ with a primary or secondary diagnosis of alcohol dependence for testing to diagnosis cirrhosis or advanced liver fibrosis. | 20% | 35% | Preliminary data collection at Quarter 1 suggests compliance of **40%,** however this is currently undergoing validation prior to submission so is subject to change. There is a very small number of patients in scope (<10 per quarter), which means that each individual case has a significant effect on performance. | |
| CCG10a | Routine Outcome Monitoring in CYP and Perinatal Mental Health Services | Use outcome measures for children / young people and women in the perinatal period accessing mental health services at least twice during referral. | 10% | 40% | Compliance against this CQUIN is calculated from MHSDS data, for which there is a considerable time lag. The most recent data available shows the Trust's performance at May 2022 at **66%**. It should be noted that this data is largely based on Clinician Reported Outcome Measures (CROMS) and it is a requirement of the CQUIN that Patient Reported Outcome Measures (PROMS) are implemented in year – work is currently ongoing to develop a rollout plan to address this | |
| CCG10b | Routine Outcome Monitoring in Community Mental Health Services | Use outcome measures for adults and older adults accessing select community mental health services at least twice during | 10% | 40% | Compliance against this CQUIN is calculated from MHSDS data, for which there is a considerable time lag. The most recent data available shows the Trust's performance at May 2022 at **15%**. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | referral (to include the use of Patient Reported Outcome Measures). | | | There was a known coding issue for CYP outcome measures in Lorenzo, which impacted on overall compliance. This has now been addressed and it is anticipated that compliance will improve going forward as a result of this and other actions agreed to improve outcome monitoring. | |
| CCG12 | Biopsychosocial Assessments by Mental Health Liaison Services | Undertake a biopsychosocial assessment concordant with NICE Guidance for self-harm referrals to liaison psychiatry teams. | 60% | 80% | Quarter 1 audit of case notes has identified **82** compliant cases to date out of a sample of 100, therefore meeting the requirements of the CQUIN (though as compliance data has not yet been received from one data collector due to annual leave and therefore a final performance figure cannot be provided at this stage). | |
| PSS6 | Formulation or Review in Tier 4 CYPMH Settings | Deliver formulation or review within 6 weeks of admission as part of a dynamic assessment process for admissions within Tier 4 settings. | 50% | 80% | The Q1 submission required a narrative update in relation to the development and implementation of formulation and how this will be monitored going forward. A response was submitted in accordance with contractual requirements and will be discussed with NHSE in M5. | |
| PSS7 | Supporting Quality Improvement in the Use of Restrictive Practice in Tier 4 CYPMH Settings | Achieve data quality score for specified MHSDS fields relating to restrictive interventions. | 65% | 80% | The requirements of this CQUIN have now been changed, meaning that the target is not applicable at Q1. However, baseline data released by NHS Digital on 5 August suggests that there may be a risk to achievement due to the way the algorithm is calculated and how data flows from NSCHT to MHSDS. The Performance Team are currently liaising with the national CQUIN team and NHS Digital around this as it is understood that this issue affects a number of providers. This will be discussed further with NHSE in M5 | |

# REPORT TO PUBLIC TRUST BOARD

Enclosure 10

| | | | |
|---|---|---|---|
| Date of Meeting: | 8th September 2022 | | |
| April | Service User & Carer Council Report | | |
| Presented by: | Kenny Laing, Executive Director of Nursing, AHP & Quality | | |
| Author: | Sue Tams, Chair Service User & Carer Council / Veronica Emlyn, Patient Experience Facilitator / Jayne Simner Recovery and Experience Lead | | |
| Executive Lead Name: | Kenny Laing Executive Director of Nursing, AHP & Quality | **Approved by Exec** | ☒ |

| Executive Summary: | | **Purpose of report** | |
|---|---|---|---|
| This report has been prepared to provide an update to Trust Board of the work of the Service User & Carer Council and Patient Experience Team since the last meeting. | | **Approval** | ☐ |
| | | **Information** | ☒ |
| | | **Discussion** | ☐ |
| | | **Assurance** | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Resource Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☒<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☒<br>2. We will actively promote partnership and integrated models of working ☒<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | None identified | | |
| Resource Implications:<br><br>Funding Source: | None identified | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The Service User & Carer Council supported the principle of increasing representation across the Protected characteristics when reviewing the Diversity and Inclusion Strategy.<br><br>They also committed to supporting inclusive services and workforce in their review of the Strategy | | |
| STP Alignment / Implications: | As part of ongoing service user/carer engagement, service user and carer views are encouraged within the STP work streams | | |
| Recommendations: | The Trust Board receives the update for information and assurance | | |
| Version | Name/Group | Date issued | |
| | | | |

## 1. Introduction

A number of national surveys and reports (Five Year Forward View, The NHS Plan) have identified that more can be done to involve people in their own health and care. Indeed, it is only by involving people in their health and care that we will improve their overall health and wellbeing as well as improving the quality of our services that we provide.

The following report provides an update on the discussions from the Service User and Carer Council and the current Trust developments and progress in respect to Service User and Carer Engagement.

## 2. Service User Carer Council

The aim of the Service User and Carer Council (SUCC) is to involve service users and people with lived experience in the delivery of our services by strengthening the working relationships between service users and our services. The SUCC provide an important role in maintaining and developing service user engagement. It is recognised that strong service user engagement significantly supports a service user's recovery and ensures the care they receive is truly holistic.

We are continuing to meet virtually in line with Trust recommendations, which we are aware, does have an impact for some of our service users and carers. This will be kept under review and these alternative ways of connecting. This was discussed at the August meeting with those there feeling it would be good to meet face to face again, the option of also having a hybrid meeting of TEAMs and face-to-face impacts on where the council can meet

We have a new member attending the council as well as several enquiries to get involved with the council. This is really beneficial to the council as it bring a diverse range of people and experiences of our services together

It is valuable when there is not representation and updates from the directorates in person to have a written update to keep the council up to date with all their developments that are happening across the trust

SUCC representation continues at Trust meetings and interview panels etc.

The concerns re discharge letters patients receive will continue to be discussed, also support for people who are discharged , as although can refer back into service or contact duty that is not always the best for the service user themselves and concerns about how we offer a flexible , patient centred care in the community is an ongoing

discussion . Concerns were also raised about the telephone systems at CMHT, which is an issue that has been discussed over the last few years. The decision was made to invite Dave Hewitt to next meeting to discuss further what actions are being taken to resolve the impact on service users and carers.

This was also the final Service User and Carer Council that Alastair Forrester would be attending, as he is retiring. He was thanked for his work with the council, members felt listened to when raised concerns and Alastair would respond and follow up with people; his attitude and support has been much appreciated

## 3. Transformation Programme

Service users and carers from various teams across the Trust have been involved in different aspects of service delivery including the Community Mental Health Framework Transformation program, service user pathways and service redesign. People who access services are part of the evaluation, procurement group and delivery committee

The work for involvement has continued to develop a consistent process, for people across the trust and the system continues with service users from Combined and MPFT as well as involvement staff. There is a piece of work on developing a coproduction logo that will be going out to people for them to design , this can be in written form, drawn or audio description this will then be turned into a graphic by designer at MPFT. The Involvement Co Lab will shortlist those responses and then design will go back out to communities to decide final choice for a logo that will be used to demonstrate co production has happened with various work across the services in the system

## 4. Volunteers and Volunteer Peer Mentors

The Trust continues to recognise the huge value that volunteer peer mentors and peer support workers (PSW) provide to the Trust and to people who use our services. Likewise, the work of all volunteers continues to provide a valuable supplementary service, enhancing the experience of patients and visitors and supporting staff across the Trust. Volunteers are returning as part of the agreed phased return.

The peer support network meetings have continued to ensure that we have standardised and high quality training, supervision, support and shared experience. All PSW will be able to access PSW training through HEE funded places delivered by ImRoc session start in October and is open to volunteers who have lived experience

The review of the Volunteer policy is almost complete and will go to the service user and carer council as soon as completed and then follow due process for policies in the trust.

We have selected two Volunteer Patient Safety Partners in line with the descriptors in the NHSE Patient Safety Framework. They will start when the volunteer process is completed, DBS, Occupational Health, mandatory training. They will also be attending online training on the new patient safety framework and their role

## 5. Service User and Carer Engagement Strategy

To support the implementation of the Service User and Carer Engagement Strategy the Patient Experience and Recovery Lead is currently developing a Steering Group of Key professionals and Service Users to plan and assist in the implementation of the strategy. As above we have decided to meet to review and plan next steps. Jayne Simner continues to meet with all SU involvement trust staff to plan how we can support and develop patient feedback and involvement opportunities.

## 6. Recovery and Living Well Strategy

We are commencing work to Co-Produce an organisation wide Recovery and Living Well Strategy. We have presented an initial launch to the Trusts leadership academy and have a following up session in September 2022.

We will be looking to foster support from service users, community members with lived experience and our staff within both clinical and corporate services. We will base this around 10 evidence based organisational challenges, starting with assessing our current position in each team, ensuring the assessments are conducted with staff, service users / people with lived experience and any other relevant stakeholders.

Progress updates will also be reported via the service user and carer council

## 7. Internal Reviews

There will be Observe and Act training on September 30th. Places are available for anyone who is interested, staff from any directorate, volunteers, service users and carers

Triangle of care application has been signed off and year one will start with baseline assessments on support for carers which will be carried out with inpatient units in October. In year 2, we will complete baseline assessments with community teams.

Carer's link meetings continue 1/4rly for updates on anything carer related

## 8. Wellbeing College

The Wellbeing College Autumn prospectus for will be available from wb5th September

There is a variety of sessions identified for all to take part in and enjoy as well as learn.

There is an official launch for the Wellbeing College on Monday 26th September to share the event with all those who have been involved so far

## 9. Recommendations

The Trust Board are requested to:

- Receive the report
- Be assured that enhancing our service user engagement continues to be maintained and remains central to the work of the Trust.

# REPORT TO PUBLIC TRUST BOARD

Enclosure: 11

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Freedom to Speak up – Annual Report | | |
| Presented by: | Marie Barley (Freedom to Speak up Guardian) | | |
| Author: | Zoe Grant & Marie Barley (previous and current Freedom To Speak Up Guardians) | | |
| Executive Lead Name: | Laurie Wrench, Associate Director of Governance/Trust Board Secretary | **Approved by Exec** | ☒ |

| Executive Summary: | | **Purpose of report** | |
|---|---|---|---|
| This annual Freedom to Speak Up Report is submitted to the committee for information. It provides an assessment of the key concerns; numbers of concerns and themes which have been addressed by the FTSU Guardian during 2021/22. The report also provides progress taken to improve the Trusts speak up culture and highlights the key next steps going into 2022/23. | | **Approval** | ☐ |
| | | **Information** | ☒ |
| | | **Discussion** | ☐ |
| | | **Assurance** | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Resource Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☒<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☒<br>2. We will actively promote partnership and integrated models of working ☐<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | None | | |
| Resource Implications:<br>Funding Source: | None | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | This report highlights the need for more work to support more respectful and professional behaviours in line with our Trust values for everyone. The FTSU Guardians role, is to help to ensure that all staff within the organisation have equitable support, and responses, ensuring that everyone's voice is heard with any concerns raised | | |
| Shadow ICS Alignment / Implications: | N/A | | |
| Recommendations: | Trust Board to receive for information and assurance | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1.0 | PCDC | June 2022 |

**Annual Freedom to Speak Up (FTSU) Report**
**For the Period 1st April 2021 – 31st March 2022**

**30 May 2022**

## 1.0 Introduction

1.1 Zoe Grant was appointed as the Trust's Freedom to Speak up Guardian in June 2018 with one day per week dedicated to the Guardian role. From 1st June 2022 there is a new guardian in place; Marie Barley. Marie has 3 days per week dedicated to this substantive role, allowing more dedicated time to focus on driving our being open cultural improvement work forward, whilst supporting staff who are raising concerns via FTSU mechanisms.

1.2 Since the launch of the Freedom to Speak up Champions in 2018, the Trust has successfully appointed 22 Champions undertaking this role on a voluntary basis. The Champions comprise of multi-disciplinary professionals and diverse staff groups in addition to being from across all of the Trusts Directorates.

1.3 In line with the nationally recommended guidance, the Trusts Freedom to Speak Up Guardian now has standalone quarterly reports which are reported through to the People Culture and Development Committee (PCDC) and the Trusts Joint Negotiation and Consultation Committee (JNCC).

1.4 In January 2021, the Trust Board reviewed the self-assessment for Speaking Up, issued by the National Guardian's office. The review acknowledged progress of the actions, which were overseen by the Trust Board Secretary, with assurance to sign off the self-assessment as complete.

1.5 This report provides an update of the Freedom to Speak Up issues which have been raised during 2021/22; any potential patient safety or staff experience issues and actions taken to improve the Speaking Up culture. This report will also provide an update of learning and improvements, alongside recommendations for further improvements for 2022/23.

1.6. Throughout the year there has been a theme of staff raising concerns in relation to line management issues, this goes hand in hand with the highest sub theme being linked to behaviour and relationship issues. Insights from the FTSU Guardian gleaned from discussions with staff raising their concerns, suggests a link to staff experiencing challenges when their line manager has an authoritative, more transactional leadership style.

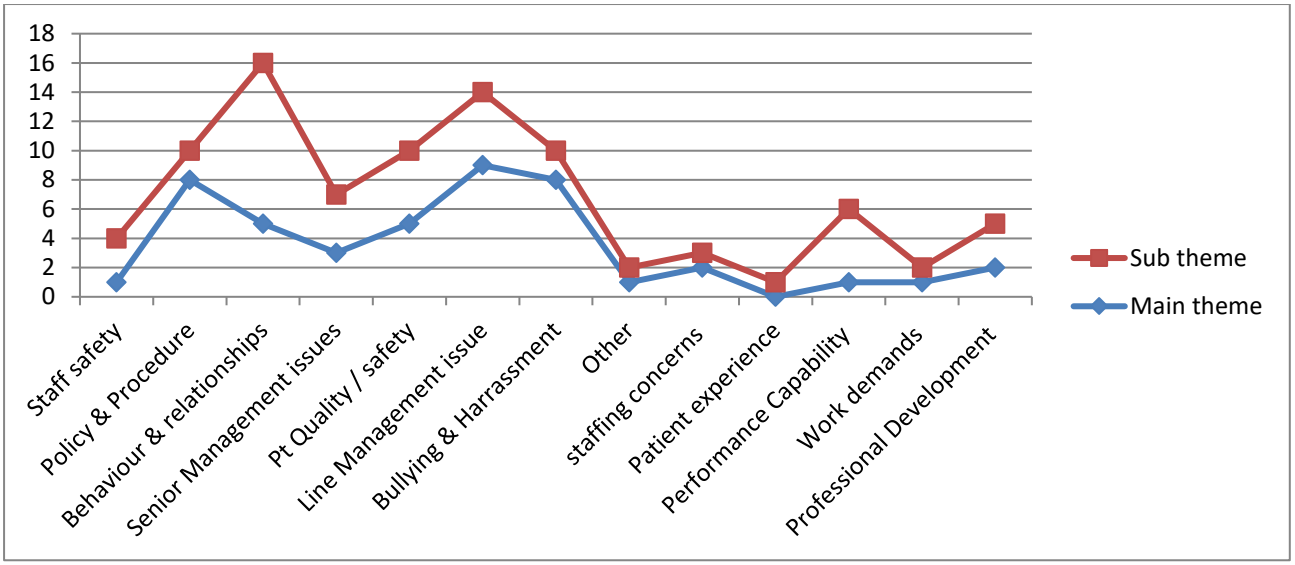
## 2.0 Assessment of Issues

## 2.1 Number / Type of Freedom to Speak Up Issues

- The Freedom to Speak Up Guardian received 46 concerns between 1st April 2021 and 31st March 2022. This shows an increase when compared to 36 concerns reported throughout 2020/2021.

- 89% of the concerns raised during 2021/2022 were raised directly to the Freedom To Speak up Guardian, with 11% raised via the Freedom to Speak up Champions. This increase from 2020/2021 where 72% of concerns continued to be raised directly with the FTSU Guardian, suggests that more engagement and visibility of the FTSU Champions is required going forward into 2022/23.

## 2.2 Themes




The highest main theme of concern throughout 2021/22 was related to line management issues, closely followed by staff reporting bullying and harassment behaviours and concerns regarding policy and procedure.

The nine line management issues were varied, however, all issues linked back to them having a negative impact on staff members wellbeing and mental health. Staff raised issues regarding:

- Unfairness
- Feeling undermined
- Unsupported and
- Disrespected with suggestions of unprofessional, divisive and derogatory behaviours in some cases.

All staff were offered pastoral support by the FTSU Guardian and options discussed about how to address their concerns either directly or indirectly with their

line managers. In the majority of cases, staff were concerned about the potential for detriment, as a result of them raising their concern. This led to five of the nine staff not progressing their concern beyond the support they received from the FTSU guardian, although it is not clear if this support helped staff to address their concerns independently from the FTSU process.

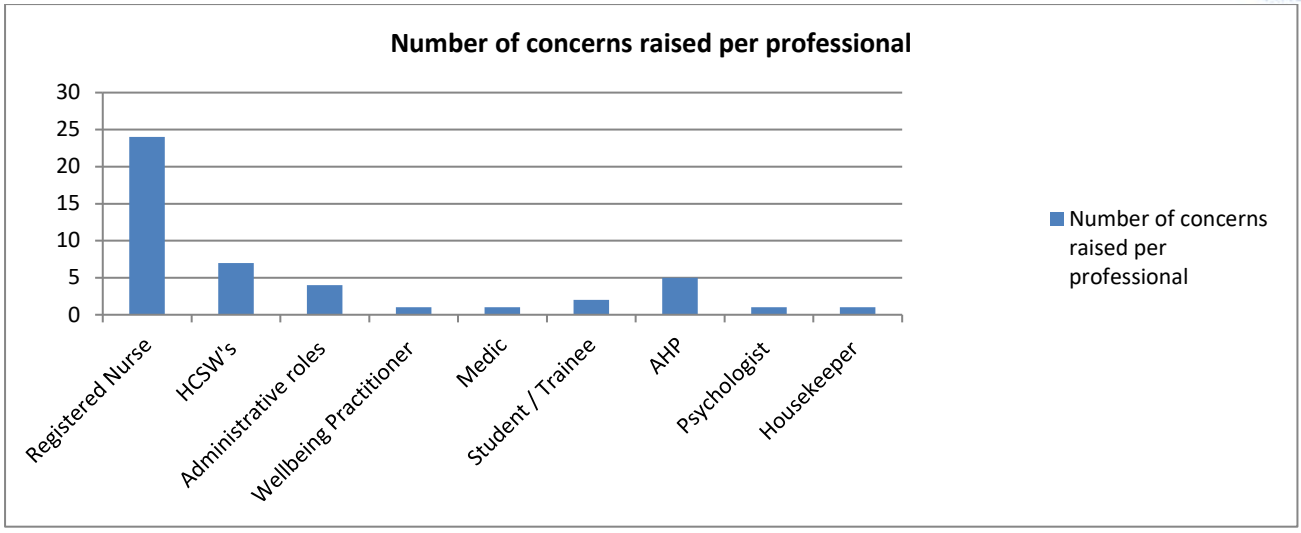
Of the eight bullying and harassment concerns, two progressed into a formal investigation process via the bullying and harassment policy and one was resolved via a mediation process, supported by the line manager's manager. Three of the eight concerns were racially driven:

- One by patients with a concern that staff were by standers and did not support the individual. This issue was addressed by the team manager, who took a supportive approach, once the FTSU Guardian supported the staff member in a conversation with their line manager.
- One is being formally investigated (as referenced above)
- One staff member, who remained anonymous to the FTSU Guardian was too fearful to take her concerns regarding racial abuse from staff forward; they are however being supported by the Trusts BAME PEF Lead.
- The other cases linked to staff feeling bullied by their line / senior manager with too high expectations and excessive pressure to meet role demands without acknowledgement or support around capacity concerns which they have raised.
- Two of these individuals have since left the organisation, both claiming that it was as a direct consequence of their concerns being unresolved.
- Four of the policy and procedure issues linked to a collective group of staff raising concerns about a corporate position, which had not been recruited into and the potential impact it had on them within their operational issues. This was responded to appropriately and the post has since been filled.

Behaviours and relationships and line manager issues remain the highest sub-themes of concerns. This links to staff feeling unfairly treated, unsupported or experiencing unwanted and / or unprofessional behaviours.

Last year's annual report noted that 58% of concerns raised during 2020/21 related to issues around bullying and harassment, behaviours and relationships linked to line managers and senior managers. This remains a similar picture for 2021/22, with 54% of all main themes and 59% of all subthemes linked to bullying and harassment, behaviours and relationships associated with line and senior managers.

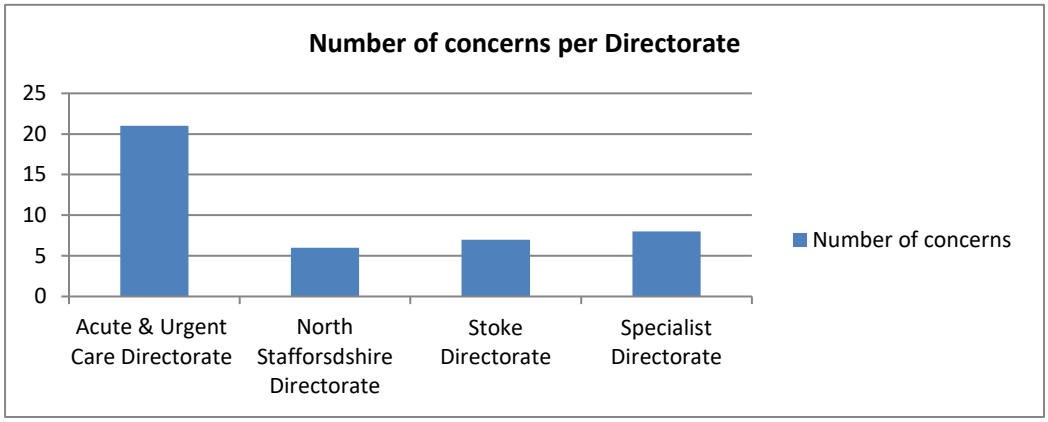
## 3.0 Staff Group Raising Concerns




The highest proportion of staff raising concerns throughout 2021/22 was Registered Nursing staff, representing 52% of all concerns. This is expected, given the number of nurses working in the Trust, compared to staff in other roles. It is reassuring to see that staff from other registered and non-registered disciplines are utilising the FTSU avenue to raise their concerns, suggesting good organisational awareness of FTSU.

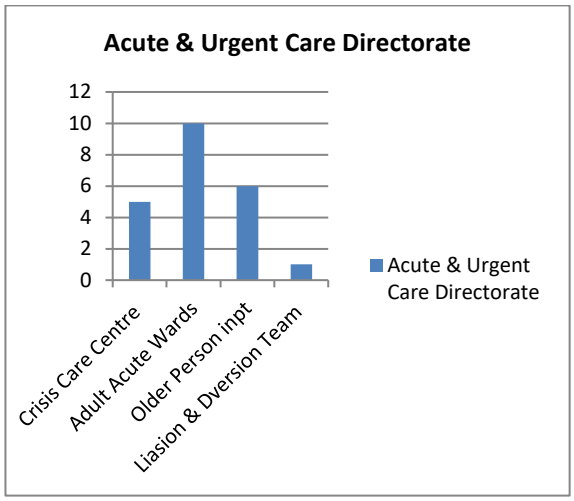
57% of concerns were raised openly via the FTSU Guardian; this is similar to 2020/21 where 56% of concerns were raised openly. 41% were raised confidentially and 2% were anonymous to the FTSU Guardian, although being supported via a FTSU Champion. For the previous two years there has been a reduction of concerns being raised openly, this is likely to be due to the high number of concerns linked to line management, bullying, and harassment, with staff being concerns about potential detriment as a result of them raising a concern.

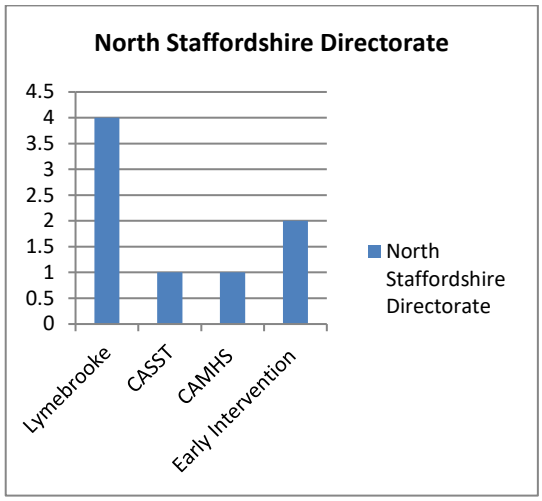
## 3.1 **Areas of the Organisation where Concerns have been raised**

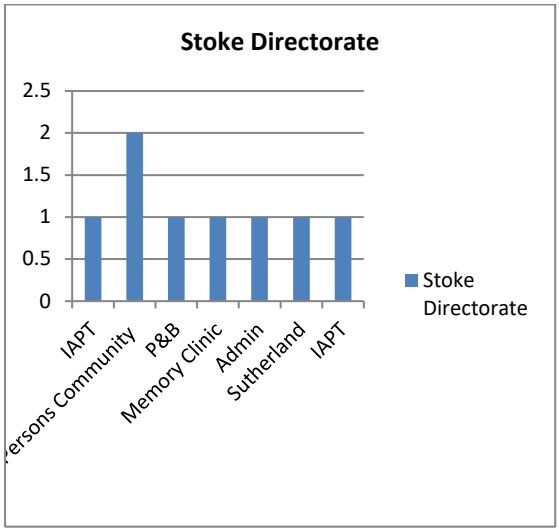


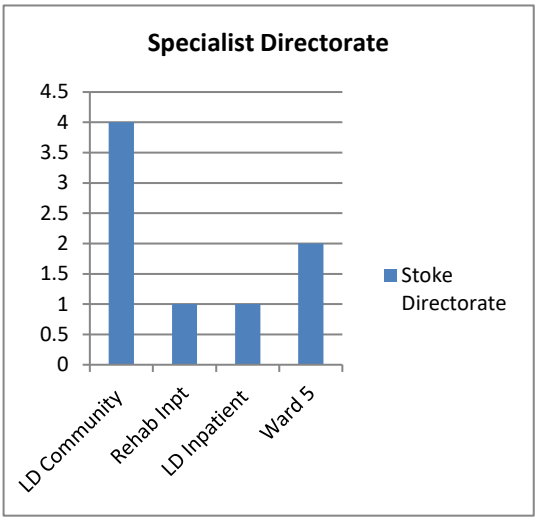

The highest proportion of concerns raised throughout 2021/2022 continue to be from the Acute and Urgent Care Directorate.

3.2 The following tables give an overview of the teams within each Directorate where concerns have been raised:



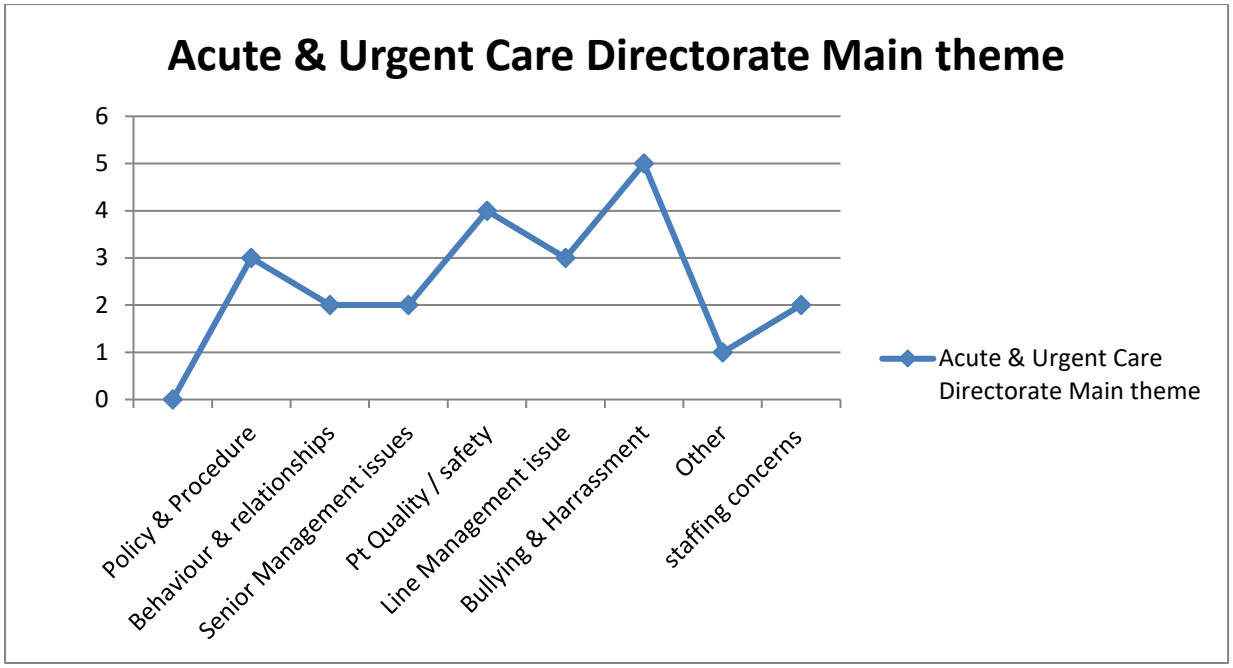




## 4.0 Break down of main themes per Directorate

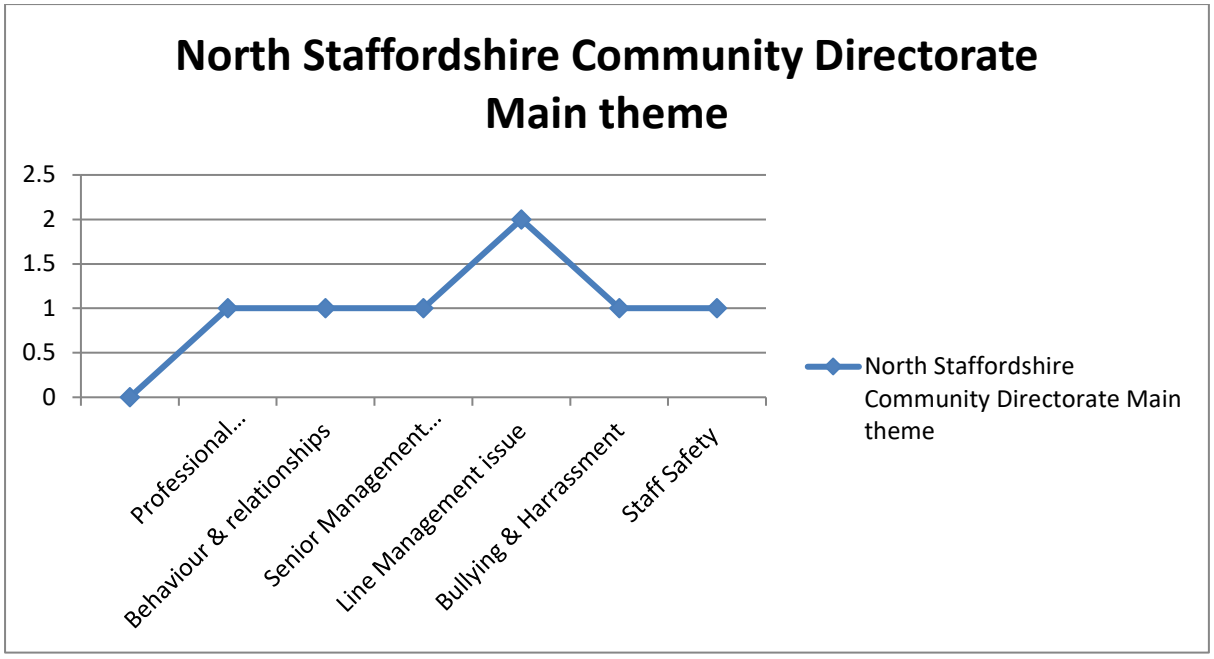
### 4.1 Acute and Urgent Care




The highest main theme within the Acute and Urgent Care Directorate was bullying and harassment. All but one of these concerns from this Directorate have been adequately responded to. One concern was picked up as part of an ongoing formal investigation; one resolved with a very supportive approach from the individuals line manager; one was investigated and an apology offered to the staff member who highlighted they had received a false allegation about them and a further concern was addressed with a supportive mediation approach, although the staff member concerned was not entirely happy with the outcome. The staff member whose concern was not fully addressed, took up another position in the Organisation and relayed their concerns in an exit interview with HR team member.

There were 4 patient safety / quality issues raised in this Directorate. These will be discussed in more detail in section 6 below.

### 4.2 North Staffordshire Community




The majority of concerns in North Staffordshire Community Directorate related to the manner in which staff felt they were being treated by their leadership team members. The senior management and one of the line management concerns were in relation to the same concern; this was eventually resolved via the Trusts formal grievance processes. Whilst a positive outcome was reached for the staff member concerned, they fed back negatively about the grievance process and the undue stress this had caused.

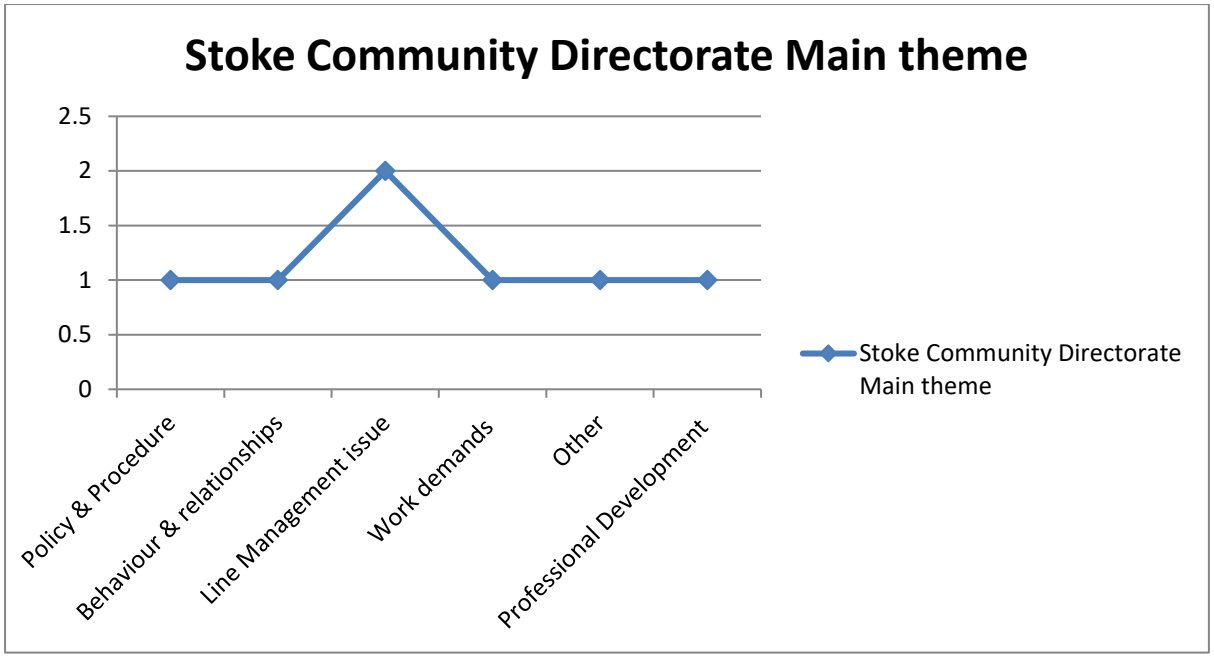
The Professional Development issue related to a staff member in a new role to the Trust not receiving supervision, as set out in the role standards. This remains unresolved, despite escalation to their senior lead.

The Bullying and Harassment case remains under formal investigation and a further line manager issue was raised with the FTSU Guardian. However, the staff member decided not to take further action.

The staff safety issue is under investigation with the Trusts HR team in support of this process.

The behaviour and relationship concern linked to a staff member raising concerns about how they were treated by another professional to the individual's line manager, yet no suitable action was taken and the staff member encountered another incident where they were treated in an unprofessional manner.

### 4.3 **Stoke Community**




The highest theme for Stoke Community was line management issues. One of the concerns went unresolved, resulting in the staff member leaving the Organisation. They advised the FTSU Guardian that they would be open regarding their concerns in their exit interview.

The other concern was resolved and linked to a secondment opportunity which was eventually supported by the staff member's line manager.

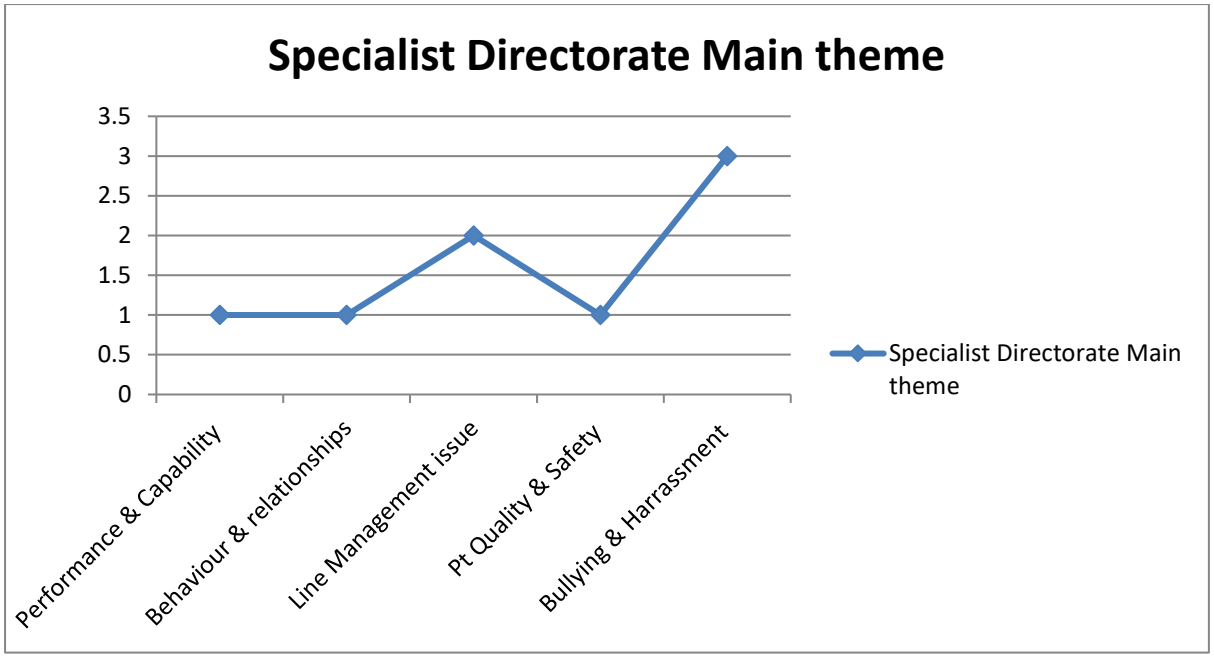
A further staff member contacted the FTSU Guardian about a secondment not being supported, but following discussion and support, they advised they would raise their concern via the Trusts Grievance process.

The Policy and procedure issue was resolved by the staff member's line manager. The staff member was new to post and challenged practice which was not in line with the Policy / procedure and they sought the FTSU Guardians support to raise this issue.

The Behaviour and relationship concern was partially resolved with the staff member concerned making an apology, following an unprofessional altercation, although the individual who raised the concern remained upset by the incident and additional support was advised by the FTSU Guardian.

Another staff member contacted the FTSU Guardian to state they had not received their long service award, they were signposted and this was addressed.

### 4.4 Specialist Directorate




There were three staff members raising concerns about feeling bullied or harassed within the Specialist Directorate.

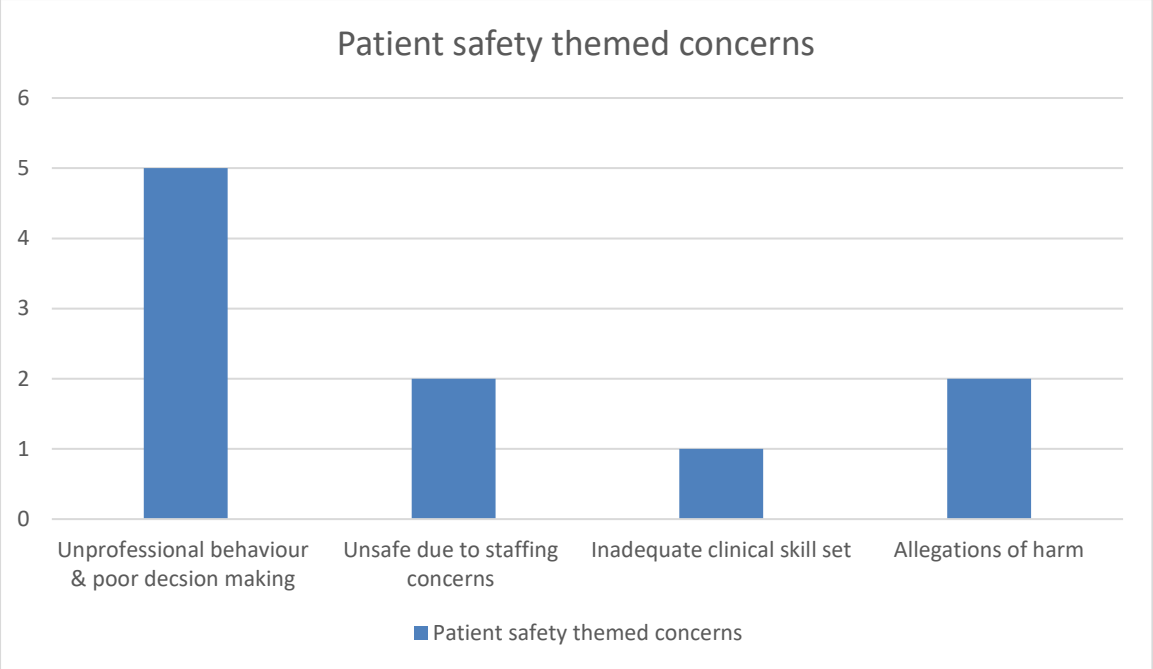
One staff member has left the Organisation as a result of this and advised that they would voice their concerns at their exit interview.

A further is under investigation in line with the Trusts Bullying and Harassment Policy and the other concern has not been formally addressed due to the staff members fear of detriment. They have since requested a move to another team and are being supported by the Trusts Black, Asian, Minority, Ethnic Practice Education Lead.

The two line manager issues and behaviour and relationship issues were linked with two staff members raising concerns about their team leads approach, expectations and manner in which they were being supported, both describing a transactional, performance driven leadership approach which was impacting on their own wellbeing. They both received support and advice from FTSU Guardian and the services senior lead was made aware, due to the staff members not wishing to address their concerns in a more formal capacity.

There were no concerns raised throughout 2021 / 2022 from the Trusts Primary care Directorate or Corporate Services.

## 5.0 Potential Patient Quality and / or Safety concerns




There were ten concerns raised which were either directly related to patient quality and safety issues, or which featured as part of the concern being raised.

Four of the concerns regarding unprofessional behaviour and concerns regarding clinical decision making were all linked; these issues are sighted by the relevant Trusts Executive Team leaders and the FTSU Guardian was informed have been considered as part of a wider investigation.

A further unrelated concern was raised due to a manager from a different area approaching a ward and requesting that a patients' care was delivered in a manner which was not in line with their care plan. Following advice and guidance from the FTSU Guardian, the staff Nurse addressed this independently with the individual concerns and assurance was obtained that despite the challenge, the team maintained care which was in accordance with the individuals care plan.

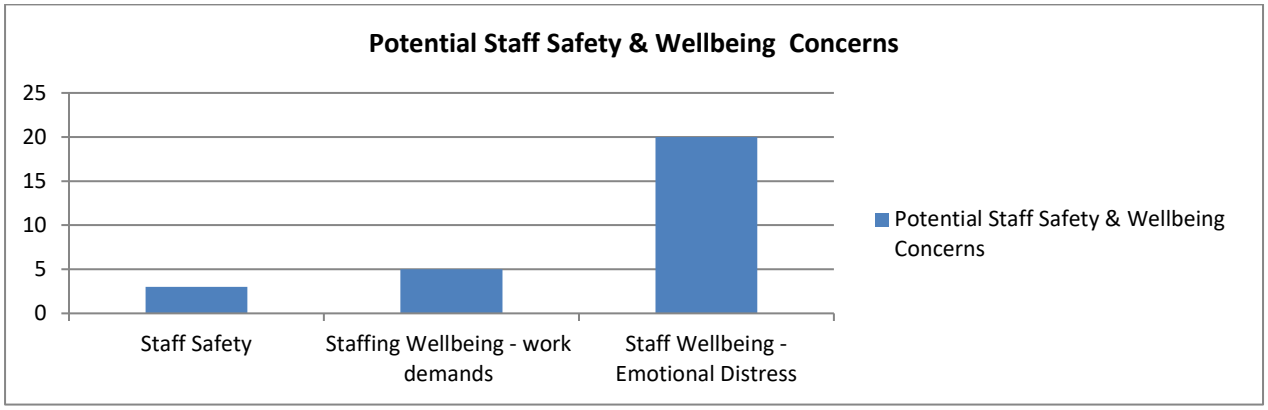
There were two concerns raised from Acute Inpatient areas regarding staffing levels, particularly during the night shift; both underwent a local investigation and staff were responded to by the senior lead, with evidence to support that action had been taken to make improvements. For example, improved induction process for agency staff.

One staff member raise concerns about an inappropriate admission to their ward area and feeling vulnerable, due to not having the skills or experience of nursing somebody with the needs that the patient had. The staff member was sign posted for extra supervision and training materials which would help.

There were two concerns which were directly linked to allegations of harm, both of were investigated in line with the Trusts managing allegations process and both were

proved to be unfounded. However, both concerns did identify additional learning and support needs for the staff concerned. Both of these concerns were responding to efficiently and appropriately and staff raising these issues were adequately supported by the team they were working with.

## 6.0 Potential Staff Safety & Wellbeing Concerns;




The above chart is designed to highlight where staff have identified they felt their safety and / or wellbeing had been compromised as a result of the concerns they had.

Of the 46 concerns raised throughout 2021 2022; 59% of the staff who raised Concerns, displayed evidence that their wellbeing was impacted on as a result of the concerns they were experiencing. There were three occasions where staff felt their safety was compromised. One was a staff member who was asked to escort a patient for treatment at another hospital site, the patient was becoming increasingly aggressive, yet despite a request for additional support there was none offered. The staff member did not come to harm but felt their safety was compromised. A further incident was in relation to the inappropriate admission (reference above in section 6) and the staff member feeling vulnerable to harm from the patient, again no harm was caused. The third links to allegation of potential sexual assault of a staff member, this is under investigation with HR service involved.

There were five staff members who felt their wellbeing had been compromised due to feeling work related stress, as a result of the work demands placed upon them.

Twenty staff members were experiencing varying forms of emotional distress as a result of their concerns/ These all linked to staff who raised issues in relation to potential bullying and / or harassment; behaviour and relationship issues and line and senior manager concerns.

It is difficult to quantify the emotional impact that some of these concerns have had on staff working at North Staffordshire Combined. There is evidence to support staff

mental wellbeing being impacted on negatively, which has also had an impact on their home life, sleep patterns and anxiety levels. All staff members who have raised concerns via FTSU processes, have done so appropriately and demonstrated alliance to the Trusts Values. All of the staff have been sign posted to additional support for their Wellbeing, however, the key priority needs to be focused around early detection of concerns and efficient supportive approaches to ensuring all Trust staff behave and lead in accordance with Trust values and mission to be Outstanding in all that we do.

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## 7.0 Actions Taken to Improve the Trusts FTSU Culture

### 7.1 **FTSU Champion's**

During quarter one, all champions were encouraged to attend the summer school events linked to the Trusts inclusion and diversity agenda. The regular FTSU champion meetings have since been reinstated and the FTSU Guardian has continued to provide advice and support to champions as required and requested.

During 2021 /22 posters were developed, highlighting all of the FTSU Champions and these were issued to all clinical areas to further promote the individual FTSU Champions.

### 7.2 **System Wide Diversity and Inclusion staff Networks**

There has been FTSU representation at the Diversity and inclusion staff networks, which have been established. Alongside the FTSU Guardian and Champions, Trusts staff network leads meet regularly to raise the diversity and inclusion profile and consider collectively how to improve staff experiences. These remain in their infancy, however and it is anticipated that FTSU Champions could be a crucial support in ensuring all staff have a safe voice and have opportunities to be heard. This is supported by our diverse range of champions who are representative of each of our staff groups.

### 7.3 **FTSU National Training for Organisations released**

During 2021 /22, the National Guardians office launched their full range of training; Speak Up, Listen up and Follow up training which is available nationally.

The Trust currently promotes the Speak up and Listen Up training sessions via E-Learning for Health, with the associated links on our Learning Management System. Training in relation to the Follow Up training, will be promoted and will follow during 2022.

Over 150 staff members have accessed the training. During 2022/23 the aim is to promote these training sessions and encourage a stronger focus on staff compliance.

### 7.4 **Substantive FTSU Guardian Role**

Due to capacity issues related to the existing FTSU Guardian holding a full time role as the Head of Nursing; there was a supportive decision to review the FTSU role within the Trust, with a view of having more dedicated substantive time for the FTSU role. In August 2021 it was agreed that there would be 0.6 WTE position for a dedicated Guardian and the recruitment process for a new Guardian commenced.

This has now been appointed to and the new FTSU Guardian took up their position from June 1st 2022, allowing greater proactive focus on improving the Trusts speak up culture amongst line and senior leaders.

### 7.5 **National Learning and Improvement**

#### 7.5.1 National Case Study Review

In December 2021, the National Guardian's office published an overview of areas for national learning, following a review of Freedom To Speak Up cases from a selection of organisations. The FTSU Guardian has reviewed this report in line with local / internal knowledge and intelligence and has identified the following areas for learning:

- Review of policy & procedures of all policies which overlap/connect with FTSU policy
- Review of the FTSU policy
- More targeted promotion of Speak up at Operational level
- Improved awareness of staff ability to speak up and as full as possible investigations to be carried out, whilst maintaining confidentiality

- Promotion and monitoring of FTSU staff training compliance
- Improved processes and procedure to identify and address detriment; whilst promoting a zero tolerance
- A dedicated & more visible programme of work re: Bullying & Harassment; poor working relationships & unwanted unprofessional behaviours
- Revisit FTSU Strategy
- Agree how and where to oversee FTSU effectiveness measures within the Trust

#### 7.5.2 Ockenden Enquiry

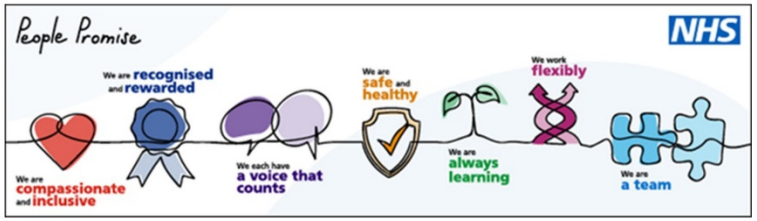
The Ockenden review into the Shrewsbury and Telford Hospital NHS Trust maternity services, spans the period from 2000 to 2019 and was commissioned by the then Secretary of State for Health at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families in the summer of 2017.

The final independent report highlights failings in Maternity services and a failure to listen to families and learn from critical incidents. This was published in March 2022.

There has been a National response to the findings of the report in relation to poor cultures of Speaking up, Listening up and Following up. The National FTSU Guardian offered the following relevant points within response to published findings:

- Donna Ockenden and her team amplifies the voices of workers who share they were fearful of speaking up about concerns.
- The report highlights the tragic consequences of a culture where workers are fearful of the consequences if they speak up.
- People will not feel they can speak up unless they are shown in practice that their voices are welcomed. This means not only for leaders to say that they are listening, but to show how they are taking action as a result.
- Speaking up saves lives if listening up and following up happens as a result.
- We (National Guardians Office) are supporting leaders across the sector to make the changes needed to improve their understanding of the benefits and drivers of fostering a healthy speaking up culture.
- The National Guardian's Office has worked with NHS England/Improvement who are due to publish an updated Freedom to Speak Up policy and guidance for leaders across the sector.
- In addition, we (National Guardians Office) have launched a new module as part of our Freedom to Speak Up e-learning package, in association with Health Education England – "Follow Up" – aimed at senior leaders.

## 8.0 Local Intelligence for Learning




### 8.1 National Staff Survey Results (2021)

Our National Staff Survey results this year have been aligned to the NHS People Promise. Published in **July 2020** by NHS England and NHS Improvement, the NHS People Plan's aim is to have more people, working differently, in a compassionate and inclusive culture within the NHS.

Promise 3: We each have a voice that counts is the most significant promise associated with FTSU.

Our results for the subscore: Raising Concerns is presented below

**Promise 3: We each have a voice that counts**

| People Promise 3: Subscore 2 | Question | Comparitor Benchmark 2021 | Organisation 2021 | NSCHT 2020 | Improvement /decline in result from 2020-2021 |
|---|---|---|---|---|---|
| P3.2: Raising concerns | I would feel secure raising concerns about unsafe clinical practice. | 80% | 84% | 77% | 7% |
| P3.2: Raising concerns | I am confident that my organisation would address my concern. | 66% | 70% | 67% | 3% |
| P3.2: Raising concerns | I feel safe to speak up about anything that concerns me in this organisation. | 67% | 71% | 69% | 2% |
| P3.2: Raising concerns | If I spoke up about something that concerned me I am confident my organisation would address my concern. | 56% | 64% | N/A | New Q |

The table above provides us with feedback to show that 81% of staff feel safe to raise a concern about unsafe clinical practices and only 71% feel safe to speak up about anything in our organisation that concerns them.

When reviewing the data to assess the confidence level of staff feeling their concerns would be addressed, this shows that only 70% would feel confident in the Trust addressing their concern in relation to clinical practices and only 66% staff feeling confident that that any other type of concern would be addressed.

Although when benchmarked against other organisations in our sector who used Quality Health as their provider, we have better scores, this still leaves one third of staff feeling unsafe to raise any concern and almost 40% with a lack of confidence that their concerns would be addressed, indicting a culture of staff not having their voice heard or lack of follow up in relation to the concern raised.

These results clearly show there is further work to be done to support our being open culture and in particular with the behaviours of staff in more senior positons within our Trust as described earlier in this report.

## 8.2 **FTSU Staff Feedback**

Of the 46 staff members who raised concerns, 13 responded to the Trusts anonymous feedback survey:

**1. When raising you concern did you feel you were treated with respect by the FTSU Guardian / FTSU Champions who you spoke to?**

| | Answer Choices | | Response Percent | Response Total |
|---|---|---|---|---|
| 1 | Strongly agree |  | 84.62% | 11 |
| 2 | Agree |  | 15.38% | 2 |
| 3 | Neither agree nor disagree | | 0.00% | 0 |
| 4 | Disagree | | 0.00% | 0 |
| 5 | Strongly disagree | | 0.00% | 0 |

Comments: (7)

| | |
|---|---|
| 1 | easy to access and friendly in their approach |
| 2 | I felt respected and valued all the way through |
| 3 | They Listened |
| 4 | extremely respectful and ensured I felt at ease at all times |
| 5 | I was listened to, respected and felt validated about my concerns. |
| 6 | The FTSU guardian was approachable, understanding and acknowledged my concerns with respect. |
| 7 | I was listened to and felt like my concerns were taken into account. |

**2. When raising your concern did you feel you were treated with respect by your line managers / managers who you spoke to?**

| Answer Choices | Response Percent | Response Total |
|---|---|---|

**2. When raising your concern did you feel you were treated with respect by your line managers / managers who you spoke to?**

| | | | | |
|---|---|---|---|---|
| 1 | Strongly agree |  | 30.77% | 4 |
| 2 | Agree |  | 38.46% | 5 |
| 3 | Neither agree nor disagree |  | 23.08% | 3 |
| 4 | Disagree | | 0.00% | 0 |
| 5 | Strongly disagree |  | 7.69% | 1 |

Comments: (4)

| | |
|---|---|
| 1 | listened investigated |
| 2 | Some difficulty with line manager initially - gained new line manager and has improved |
| 3 | I was treated with respect. |
| 4 | I did feel that initially I was listened to and it felt as though the issues would be addressed. As time went by, I realised that to get closure on the situation I would have to leave the ward where I was based as it became clear that the issues wouldn't be fully solved. |

**3. when raising your concern were you treated with empathy by the FTSU Guardian / Champion that you spoke to?**

| Answer Choices | | | Response Percent | Response Total |
|---|---|---|---|---|
| 1 | Strongly agree |  | 84.62% | 11 |
| 2 | Agree |  | 7.69% | 1 |
| 3 | Neither agree nor disagree |  | 7.69% | 1 |
| 4 | Disagree | | 0.00% | 0 |
| 5 | Strongly disagree | | 0.00% | 0 |

Comments: (4)

## 3. when raising your concern were you treated with empathy by the FTSU Guardian / Champion that you spoke to?

| | |
|---|---|
| 1 | none |
| 2 | Full empathy given and felt supported and understood at all times |
| 3 | Absolutely. I was treated with empathy at all times. |
| 4 | At times I became quite emotional talking over what had upset me and I felt that I was treated with empathy at all times. |

## 4. When raising your concern were you treated with empathy by your line manager / managers that you spoke to?

| Answer Choices | | | Response Percent | Response Total |
|---|---|---|---|---|
| 1 | Strongly agree |  | 30.77% | 4 |
| 2 | Agree |  | 30.77% | 4 |
| 3 | Neither agree nor disagree |  | 15.38% | 2 |
| 4 | Disagree |  | 15.38% | 2 |
| 5 | Strongly disagree |  | 7.69% | 1 |

Comments: (4)

| | |
|---|---|
| 1 | My concerns went to a very senior manager and the correspondence was not empathic, leaving me feeling blamed and like I should not have raised the concern. |
| 2 | Some difficulty with line manager initially - gained new line manager and has improved |
| 3 | I do not feel that my manager treated me with empathy. I felt at times that my concerns were somewhat minimised. My manager also raised other issues unrelated to my concerns during these conversations which was worrying. |
| 4 | I felt like I was heard at first but once the issue was looked into with the person who I was having issues with, I felt like I was dismissed and had to get on with it. |

## 5. Were you given feedback by your line manager regarding how your concern would be investigated and in what time frame?

| | Answer Choices | | Response Percent | Response Total |
|---|---|---|---|---|
| 1 | Yes | | 38.46% | 5 |
| 2 | No | | 61.54% | 8 |

## 6. Was your concern resolved to your satisfaction? (if not, please state why in the comments box)

| | Answer Choices | | Response Percent | Response Total |
|---|---|---|---|---|
| 1 | Yes | | 30.77% | 4 |
| 2 | No | | 69.23% | 9 |

Comments: (10)

| | |
|---|---|
| 1 | No clear or formal plan was identified |
| 2 | open and transparent process |
| 3 | I raised concerns in March and they have still not yet been investigated, despite a formal investigation being initiated. |
| 4 | I've said no, as the issues are still on going. But steps have been made to change and this takes time. Staff need to be hired and the agency staff are still having issues with regards to accessing incident forms, feeling overwhelmed, understaffed etc |
| 5 | Yes and no .It is still in process but adequate actions have been taken.Therefore I am positive that it will be resolved very soon! |
| 6 | I feel that was treated as though I had lied, and from now on if anything occurs I will feel comfortable reporting it. |
| 7 | Concern was fully resolved after new line manager came to post |
| 8 | My concern has still not been fully investigated or resolved and I have had no recent update or communication. I initially raised my concern in Jan 2022. |

| 6. Was your concern resolved to your satisfaction? (if not, please state why in the comments box) | |
|---|---|
| 9 | Unsure of resolution |
| 10 | I felt like the issue was brushed under the carpet and it has taken me to leave the ward to get away from the situation. |

| 7. Do you feel that you have experienced any form of detriment or reprisals as a result of you raising your concern? (if yes; please state why and how in the comments box) | | | | |
|---|---|---|---|---|
| **Answer Choices** | | | **Response Percent** | **Response Total** |
| 1 | Yes |  | 41.67% | 5 |
| 2 | No |  | 58.33% | 7 |

Comments: (5)

| | |
|---|---|
| 1 | Not as yet. Hopefully I won't. |
| 2 | Raising the concern resulted in me going off sick and I have been re-deployed away from the members of staff I have raised concerns about (despite them now being formally investigated). This has been humiliating and has resulted in me leaving my job- I am currently working my notice. |
| 3 | I came to work to find myself working with the person, who made myself and other person feel uncomfortable not speaking or repyling when we spoke to him. This was witnessed by another agency nurse. |
| 4 | Overly scrutinised and my honesty was brought in to question |
| 5 | Potentially although I don't feel I've not seen the full impact yet as not yet concluded.<br>I have experienced negative treatment from my direct manager as a result.<br>Performance issues with my team have been raised as a consequence if me raising concerns. |

**8. Given your experience; would you be confident and feel safe to speak up again in the future? (if not; please state why in the comments box)**

| Answer Choices | | | Response Percent | Response Total |
|---|---|---|---|---|
| 1 | Yes |  | 84.62% | 11 |
| 2 | No |  | 15.38% | 2 |

Comments: (6)

| | |
|---|---|
| 1 | I doubted that an 'admin issue' would be taken seriously. I am very happy with the steps that Zoe took to understand my concerns and I am thankful for the outcome. |
| 2 | I felt I had no choice but to raise a concern, it would have been unethical not to do so. However, the personal and professional cost has been huge and is ongoing. |
| 3 | Definitely, a very positive experience which I will strongly recommend to fellow colleagues! |
| 4 | I was informed that he hadn't been told who had reported him . which is not true because on a shift, he spoke to me and a male staff member calling us you people, grassed me up. |
| 5 | I would speak up as FTSU support was there to encourage me to be open - I may be more reluctant following recent incidents though outcome has now improved |
| 6 | Yes but only due to the level of support from the FTSU guardian. |

**Please add any other comments that you would like to make here. Our FTSU Guardian will use your feedback to inform the quality of staff experiences when speaking up here at Combined.**

| Answer Choices | | Response Percent | Response Total |
|---|---|---|---|
| 1 | Open-Ended Question | 100.00% | 8 |

| | Please add any other comments that you would like to make here. Our FTSU Guardian will use your feedback to inform the quality of staff experiences when speaking up here at Combined. |
|---|---|
| 1 | As above, wasn't sure that an 'admin issue' would be taken seriously. Thought FTSU was just for nursing/clinical queries and practises. Very impressed with how Zoe took the time to understand my issue and the effort Zoe put in regarding speaking to various people within the Trust to gain an insight into what the correct processes are regarding my issue. Thank you Zoe - very much appreciated. |
| 2 | The FTSU Guardian is very supportive, knowledgeable and understanding about the process and the impact of raising a concern. Unfortunately the concerns needed to be escalated and it is since then that there have been numerous problems. As stated though, I cannot fault the FTSU team. |
| 3 | I really appreciated the prompt responses and feedback in a manner that was flexible around the fact I'm not at work mon-fri. Thankyou |
| 4 | After the meeting I felt very encouraged and motivated, I felt that I had done the right thing and felt very valued and listened to. I felt accepted. This straight away increased my work motivation and productivity .All in all the best outcome for myself and service. I feel though that the Freedom to speak up Service needs to be promoted/advertised more!!!!I was not aware of it in detail! Please keep up the excellent work you are doing!!!! |
| 5 | This is not the first time I have reported something on a different subject. |
| 6 | Regarding FTSU I have no other comments as the support and guidance was outstanding. However, with line managers I feel further training and understanding would be beneficial regarding being open and encouraging staff to express their concerns without the fear of reprisal |
| 7 | This has been a really difficult experience. I have faced a great deal if negativity and pressure to resolve issues informally. My issues remains unresolved and communication has been poor.<br>I can fully understand why people may struggle to go through the process without the right support. |
| 8 | I felt that the FTSU champion I contacted was very good. However, my line managers on the ward where I was based at the time of me having issues were helpful at first. As the issue was looked into, it was clear that it wasn't going to be fully resolved and it was going to take me leaving to get closure. |

The above FTSU survey results indicate that all staff raising concerns via the FTSU Guardian felt well supported, respected and treated with empathy.

The survey outcomes suggest a more varied experience when staff concerns were referred to their line managers, with some staff not feeling supported, respected or adequately listened to.

This indicates the need for a greater focus on line and senior manager's responses to staff raising concerns, to ensure that all staff within the Trust feel safe and able to raise concerns openly and transparently without fear of detriment or retribution.

## 9.0 Conclusion

Staff have continued to access Freedom To Speak Up to raise concerns that they have otherwise found difficult to raise with their line manager or gain resolution from concerns they have raised with their line manager. The Freedom To Speak Up Guardian has provided pastoral support, advice and guidance to staff raising concerns via the FTSU process and where appropriate, has ensured suitable escalation to line and senior Trust members; including the Trusts Executive team.

The FTSU profile continues to be maintained within the Trust, with ongoing efforts to further improve proactive levels of support offered by the FTSU Champions.

There is a high prevalence of staff raising concerns, which could be mitigated by line and senior managers behaving in a manner that is in line with the Trusts values and with a less autocratic, more supportive leadership style.

The impact on staff wellbeing when experiencing and raising concerns, should not be underestimated by leaders within the Trust. More focus around early detection and early supportive intervention for staff experiencing unprofessional and unwanted behaviours is needed.

A dedicated FTSU Guardian with 0.6WTE hours will allow for a more detailed and proactive focus on improving the Trusts Speak up, Listen up and Follow up culture within the Trust.

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**-End-**

# REPORT TO PUBLIC TRUST BOARD

Enclosure 12

| | | | |
|---|---|---|---|
| Date of Meeting: | 8 September 2022 | | |
| Title of Report: | Finance Position M4 | | |
| Presented by: | Eric Gardiner – Executive Director of Finance, Performance & Estates | | |
| Author: | Michelle Wild – Financial Controller / Lisa Dodds – Assistant Director of Finance/ Rachel Heath – Project Accountant | | |
| Executive Lead Name: | Eric Gardiner – Executive Director of Finance, Performance & Estates | **Approved by Exec** | ☒ |

| Executive Summary: | | **Purpose of report** | |
|---|---|---|---|
| The report summarises the finance position at month 4 (July 2022) | | **Approval** | ☐ |
| | | **Information** | ☒ |
| | | **Discussion** | ☐ |
| | | **Assurance** | ☒ |
| Seen at: | SLT ☒ Execs ☒ | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Resource Committee ☒<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☐<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives (please indicate) | 1. We will attract, develop and retain the best people ☐<br>2. We will actively promote partnership and integrated models of working ☐<br>3. We will provide the highest quality, safe and effective services ☐<br>4. We will increase our efficiency and effectiveness through sustainable development ☒ | | |
| Risk / legal implications: Risk Register Reference | Links to Trust risks around delivery of recurrent cost improvement target and delivery of trust financial position. | | |
| Resource Implications:<br><br>Funding Source: | If the trust does not deliver recurrent CIP, it impacts on future sustainability,<br><br>Not applicable | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. | | |
| Shadow ICS Alignment / Implications: | Part of the aggregate STP/Shadow ICS reported financial position | | |
| Recommendations: | Trust Board are asked to:<br>Receive the Month 4 position noting:<br>• The year-to-date deficit of £1,305k.<br><br>• Note the 2022/23 agreed capital plan, forecast and month 4 position. | | |

| | | |
|---|---|---|
| | • The cash position of the Trust as at 31st July 2022 with a balance of £18.7m.<br><br>• Agency expenditure of £1,888k year to date against the agency ceiling of £1,033k; an adverse variance of £854k to the share of the ICB agency ceiling, and a £554k adverse variance against the 10% target reduction.<br><br>• Note identified CIP schemes of £1,510k against a target for the year of £2,736k. | |
| Version | Name/group | Date issued |
| | | 17/08/2022 |

North Staffordshire Combined Healthcare NHS Trust

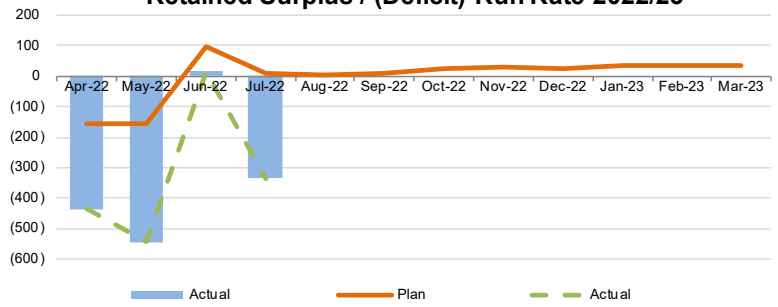
# Finance and Resource Committee – 1st September 2022
# Finance Position Month 4

## Financial Overview as at 31st July 2022

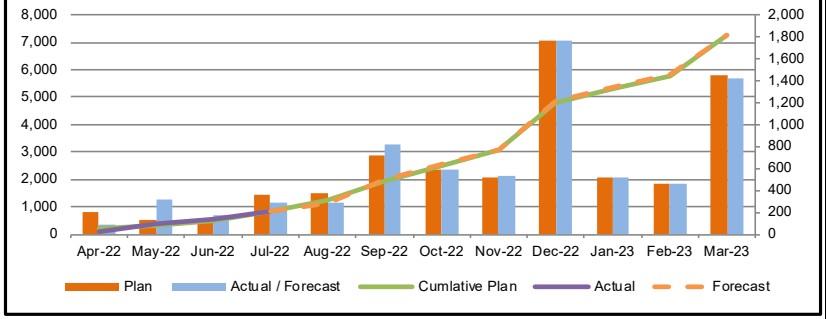
### Key Metrics

| | | Plan £000 | Actual £000 | Var £000 | % | RAG |
|---|---|---|---|---|---|---|
| **Financial Position** | YTD | (208) | (1,305) | (1,097) | (528) | R |
| | FOT | 0 | 0 | 0 | 0 | G |
| **Charge to CRL** | YTD | 833 | 854 | 21 | 3 | R |
| | FOT | 7,250 | 7,250 | (0) | (0) | G |
| **Cash Balances** | YTD | 23,262 | 18,691 | (4,571) | (20) | R |
| | FOT | 23,292 | 23,762 | 470 | 2 | G |
| **CIP Programme** | YTD | 912 | 419 | (493) | (54) | R |
| | FOT | 2,736 | 2,736 | 0 | 0 | G |
| *Identified Schemes* | Full Year | 2,736 | 1,510 | | | G |

### Retained Surplus / (Deficit) Run Rate 2022/23



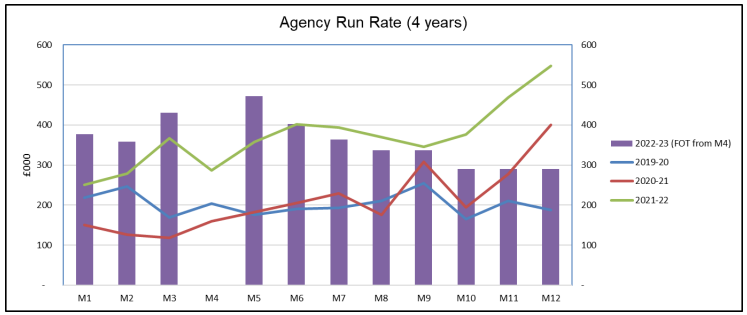

### Net Capital Expenditure - Plan / Actual 2022/23




### Better Payment Practice Code

| | In month | | YTD | |
|---|---|---|---|---|
| | Number | £000 | Number | £000 |
| Total trade invoices paid in period | 1,323 | 7,210 | 5,082 | 35,365 |
| Total trade invoices paid within target | 1,260 | 6,905 | 4,636 | 33,471 |
| % paid within target | 95% | 96% | 91% | 95% |

### Agency Run Rate (4 years)



## Executive Summary

The NHSE/I final plan for 2022/23 was submitted on 20th June and shows a breakeven position. This is agreed as part of the system position.

As at month 4, the Trust is reporting an in-month deficit position of £336k against a planned surplus of £8k giving an adverse variance of £344k. This mainly due to an increase in the bad debt provision and high levels of agency. As a result of the vacancies across the Trust and a high acuity patient in the Darwin, agency expenditure was £718k in month 4. Non-pay has overspent by £283k mainly due to the increase in the bad debt provision and patient placement costs although is this offset by income.

In month 4 the Trust delivered £281k of CIP efficiencies against a plan of £177k giving an in month over achievement of CIP of £104k. Year to date CIP delivery is £419k against a plan of £587k, giving an under-achievement year to date of £168k.

Trade receivables have remained at similar levels to last month in month 4, however this remains high because of outstanding TCP invoices to the Local Authorities remaining unsettled and further CCG invoices awaiting settlement. This has influenced the cash position which is £4.6m behind plan at £18.7m. The majority of the outstanding CCG invoices have been settled during August.

In month 4, the Trust achieved the Better Payment Practice Code target of 95% overall on both the total value and number of invoices paid, however NHS invoices were below target at 86% on the number of invoices paid within target and 87% on the value of invoices paid. This has not adversely affected the total in month due to low value and number of NHS invoices in comparison to the Non NHS totals.

The Trust's capital expenditure for month 4 was £284k against a CRL of £358k giving an under spend of £74k in month.

| High Level Analysis | Annual Plan | Month 4 Budget | Month 4 Actuals | Variance | Year to Date Budget | Year to Date Actuals | Variance | Forecast Budget | Forecast Actuals | Variance |
|---|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Income from Patient Care Activities | 137,018 | 11,331 | 11,579 | 249 | 45,985 | 46,255 | 270 | 137,783 | 139,139 | 1,356 |
| Income from Other Operating Activities | 11,051 | 1,174 | 1,183 | 9 | 4,715 | 4,970 | 255 | 13,459 | 14,280 | 821 |
| **Income** | **148,069** | **12,505** | **12,762** | **257** | **50,701** | **51,225** | **524** | **151,242** | **153,419** | **2,177** |
| Pay Costs | (81,495) | (6,851) | (7,238) | (387) | (27,535) | (27,904) | (369) | (83,119) | (82,945) | 174 |
| Non Pay Costs | (60,544) | (5,190) | (5,473) | (283) | (21,423) | (22,659) | (1,236) | (62,305) | (64,573) | (2,268) |
| Finance & Other Non Operating Costs | (6,030) | (455) | (387) | 68 | (1,950) | (1,967) | (17) | (5,819) | (5,902) | (83) |
| **Expenditure** | **(148,069)** | **(12,496)** | **(13,098)** | **(602)** | **(50,908)** | **(52,530)** | **(1,621)** | **(151,242)** | **(153,419)** | **(2,177)** |
| **Retained Surplus / (Deficit)** | **0** | **8** | **(336)** | **(344)** | **(208)** | **(1,305)** | **(1,097)** | **(0)** | **(0)** | **(1)** |

## 1. Forecast

The initial unmitigated forecast prepared at month 4 is £6.2m deficit. The main overspends driving this deficit are:

- £3.0m bad debt provision for the Local Authorities for TCP s.117 contributions.
- £2.7m ward overspends due to acuity and sickness.
- £1.3m of unidentified CIP.
- £0.8m of non-recurrent expenditure (£0.5m CAMHS deep dive/ASD, £0.2m A&T doors, £0.1m project chrysalis revenue costs).
- £0.4m on direct drugs.
- £0.2m room hire.
- (£2.0m) vacancies

The Trust has reviewed and mitigated this position at month 4 to report a breakeven year-end position. To achieve breakeven at year-end there are several actions that are required:

- Resolution of the bad debt issues with the Local Authorities.
- Delivery of CIP above current identified levels.
- Reduction in discretionary expenditure.
- Reduction in agency expenditure.

The Trust have risk assessed the initial year end forecast which ranges from a best-case scenario at £2.9m surplus and a worst-case scenario at £7m deficit. This will be reviewed monthly in line with the forecast and updates brought to the committee.

| Mitigations | Worse Case £000 | Best Case £000 | Most Likely £000 |
|---|---|---|---|
| **Baseline** | **(6,210)** | **(6,210)** | **(6,210)** |
| 22/23 bad debt provisions | (600) | 2,826 | 707 |
| 21/22 bad debt provision | (600) | 2,674 | 2,674 |
| 21/22 release annual leave accrual | 397 | 596 | 596 |
| 22/23 cost out CIP delivery | 0 | 1,227 | 500 |
| Agency (DE Impact) | 0 | 117 | 117 |
| Agency (recruitment) | 0 | 100 | 0 |
| Acuity reduction | 0 | 412 | 312 |
| Vacancy factor | | 1,200 | 578 |
| Improvement in NP expenditure | | | 300 |
| COVID costs | | | 427 |
| **Total** | **(7,013)** | **2,941** | **(0)** |

## 2. Income

The table below shows the Trust's 2022/23 income position as at 31st July 2022.

- Most of the CCG/NHSE income is fixed for 2022/23 under the block payments arrangements. In month 4 block contract income totalled £7,389k.
- Patient Placements income relates to TCP and Community Rehab Placements income from the CCGs and Local Authorities per appendix E, this is separate from the CCG block. The in-month over recovery of income is offset by a reduction in placement provider expenditure.
- Other income is under recovered due to the phasing of income relating to the regional health and well-being project which is offset by under-spends in non pay expenditure on the project

| Income | Annual Plan | Month 4 Budget | Month 4 Actuals | Variance | Year to Date Budget | Year to Date Actuals | Variance | Forecast Budget | Forecast Actuals | Variance |
|---|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Income From CCGs, ICBs and NHSE / Block Contract Income | 88,346 | 7,230 | 7,389 | 159 | 29,354 | 29,642 | 289 | 88,177 | 88,697 | 521 |
| Local authorities | 3,508 | 203 | 203 | (0) | 1,444 | 1,423 | (21) | 3,942 | 3,991 | 49 |
| Patient Placements Income | 39,684 | 3,307 | 3,411 | 104 | 13,228 | 13,220 | (8) | 39,684 | 40,514 | 830 |
| Non-NHS: Private Patients | 0 | 0 | 8 | 8 | 0 | 8 | 8 | 0 | 8 | 8 |
| Non-NHS: other | 5,482 | 238 | 216 | (22) | 1,608 | 1,610 | 2 | 4,660 | 4,871 | 211 |
| **Total Income From Patient Care Activities** | **137,019** | **10,978** | **11,227** | **249** | **45,633** | **45,903** | **270** | **136,462** | **138,081** | **1,620** |
| Research and development | 102 | 9 | 9 | (0) | 35 | 41 | 6 | 106 | 108 | 2 |
| Education and training | 2,491 | 301 | 394 | 93 | 1,254 | 1,585 | 331 | 3,685 | 4,305 | 620 |
| Non-patient care services to other bodies | 8,074 | 716 | 745 | 29 | 2,784 | 2,794 | 10 | 8,454 | 8,556 | 102 |
| Other Income | 384 | 148 | 35 | (113) | 643 | 551 | (92) | 1,213 | 1,310 | 97 |
| **Total Income from Other Operating Activities** | **11,051** | **1,174** | **1,183** | **9** | **4,715** | **4,970** | **255** | **13,459** | **14,280** | **821** |
| **Total Income** | **148,069** | **12,152** | **12,410** | **257** | **50,348** | **50,873** | **524** | **149,921** | **152,362** | **2,441** |

## 3. Expenditure

The table below shows the Trust's expenditure split between pay, non-pay and non-operating cost categories.

- Pay costs in month 4 are £7,238k, £387k above the budget mainly due to high levels of agency partly offset by vacancies. In month 4 there were 175.86 wte vacancies (budgeted wte less contracted wte, the figures in the table below show budgeted wte and worked wte to show the inclusion of overtime, bank and agency). 103.28 wte of these vacancies are in nursing and 52.19 wte are in other clinical. Agency was £718k in month, plus a further £5k included in COVID pay costs, though £150k of this relates to NHSEI funded agency on Darwin which relates to months 2 and 3.

- Non-Pay is overspent by £283k in month 4 against plan mainly due to an increase in the bad debt provision and over spends on patient placements.

| Expenditure | Annual Plan | Month 4 Budget | Month 4 Worked | Month 4 Budget | Month 4 Actuals | Variance | Year to Date Budget | Year to Date Actuals | Variance | Forecast Budget | Forecast Actuals | Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000 | WTE | WTE | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Medical | (7,752) | (87.02) | (80.38) | (810) | (722) | 88 | (3,217) | (2,825) | 392 | (9,844) | (8,364) | 1,480 |
| Nursing | (28,169) | (588.32) | (506.85) | (2,429) | (2,130) | 300 | (9,870) | (8,577) | 1,293 | (29,802) | (24,043) | 5,759 |
| Other Clinical | (25,712) | (704.02) | (715.76) | (2,262) | (2,336) | (75) | (9,055) | (9,314) | (259) | (27,273) | (29,403) | (2,130) |
| Non-Clinical | (15,482) | (392.19) | (382.76) | (1,340) | (1,313) | 27 | (5,351) | (5,254) | 97 | (16,075) | (16,322) | (247) |
| Agency | (4,380) | 0.00 | (75.78) | (2) | (718) | (716) | (9) | (1,883) | (1,875) | (26) | (4,674) | (4,648) |
| COVID-19 Direct Pay Costs | 0 | (3.01) | (5.47) | (8) | (19) | (11) | (33) | (50) | (17) | (99) | (138) | (39) |
| **Total Pay** | **(81,495)** | **(1,774.56)** | **(1,767.00)** | **(6,851)** | **(7,238)** | **(387)** | **(27,535)** | **(27,904)** | **(369)** | **(83,119)** | **(82,945)** | **174** |
| Drugs & Clinical Supplies | (2,472) | | | (186) | (197) | (10) | (834) | (907) | (73) | (2,480) | (2,822) | (341) |
| Establishment Costs | (878) | | | (86) | (69) | 17 | (345) | (288) | 57 | (1,008) | (935) | 73 |
| Premises Costs | (4,768) | | | (409) | (382) | 27 | (1,437) | (1,716) | (279) | (4,695) | (5,237) | (542) |
| Private Finance Initiative | (3,537) | | | (240) | (287) | (47) | (1,124) | (1,132) | (8) | (3,331) | (3,388) | (58) |
| Services Received | (6,234) | | | (551) | (546) | 5 | (2,475) | (2,632) | (157) | (6,901) | (7,484) | (583) |
| Patient Placements | (41,484) | | | (3,457) | (3,561) | (104) | (13,828) | (13,819) | 9 | (41,484) | (42,313) | (830) |
| Consultancy & Prof Fees | (12) | | | (3) | 20 | 23 | (14) | (50) | (36) | (41) | (86) | (45) |
| External Audit Fees | (108) | | | (9) | (8) | 1 | (35) | (31) | 4 | (104) | (92) | 12 |
| COVID-19 Direct Non Pay Costs | 0 | | | 0 | (2) | (2) | 0 | (12) | (12) | 0 | (43) | (43) |
| Other | (1,051) | | | (197) | (442) | (246) | (1,825) | (2,071) | (246) | (3,377) | (2,673) | 704 |
| Unmet Cost Improvement | 0 | | | (53) | 0 | 53 | 493 | 0 | (493) | 1,116 | 500 | (616) |
| **Total Non-Pay** | **(60,544)** | | | **(5,190)** | **(5,473)** | **(283)** | **(21,423)** | **(22,659)** | **(1,236)** | **(62,305)** | **(64,573)** | **(2,268)** |
| Finance Costs | (2,862) | | | (291) | (258) | 33 | (998) | (1,033) | (35) | (3,036) | (3,080) | (44) |
| Dividends Payable on PDC | (422) | | | (35) | (35) | 0 | (141) | (141) | 0 | (422) | (422) | 0 |
| Investment Revenue | 74 | | | 6 | 16 | 9 | 25 | 56 | 31 | 74 | 177 | 102 |
| Depreciation & Amortisation | (2,820) | | | (135) | (110) | 26 | (836) | (849) | (13) | (2,435) | (2,576) | (141) |
| **Total Non-operating Costs** | **(6,030)** | | | **(455)** | **(387)** | **68** | **(1,950)** | **(1,967)** | **(17)** | **(5,819)** | **(5,902)** | **(83)** |
| **Total Expenditure** | **(148,069)** | **(1,774.56)** | **(1,767.00)** | **(12,496)** | **(13,098)** | **(602)** | **(50,908)** | **(52,530)** | **(1,621)** | **(151,242)** | **(153,419)** | **(2,177)** |

## 4. Agency Utilisation

### Headlines - Trust Agency Use

For 2022/23 the Trust will be monitored against its share of the ICB agency ceiling at £3,100k for the year which is based on the expectation that the ICB reduces agency costs by 30% compared to last year as part of the system plan. The report below also shows a 'soft' shadow agency ceiling set at a 10% reduction against last year's costs. The agency costs to month 4 are shown below.

Month 4 expenditure on agency is £722k (including COVID costs); **which is over the in-month agency ceiling by £464k**, however, £150k of nurse agency reported in month 4 relates to months 2 and 3.

34% of agency costs to date were incurred in the two community directorates, with 24% in Specialised and 31% in Acute and Urgent Care, the remainder related to Primary Care and Corporate areas.

The table below shows total agency expenditure by staffing group.

| Total Agency | Actual | | | | | Forecast | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-22 £000 | May-22 £000 | Jun-22 £000 | Jul-22 £000 | YTD £000 | Aug-22 £000 | Sep-22 £000 | Oct-22 £000 | Nov-22 £000 | Dec-22 £000 | Jan-23 £000 | Feb-23 £000 | Mar-23 £000 | Total £000 |
| Medical | (260) | (107) | (214) | (273) | (854) | (264) | (255) | (236) | (236) | (236) | (218) | (213) | (218) | (2,729) |
| Nursing | (51) | (131) | (126) | (337) | (646) | (105) | (57) | (42) | (39) | (39) | (39) | (39) | (39) | (1,045) |
| Other Clinical | (37) | (38) | (38) | (67) | (180) | (60) | (60) | (54) | (54) | (54) | (24) | (24) | (24) | (531) |
| Non Clinical | (4) | (10) | (24) | (17) | (55) | (16) | (16) | (16) | (1) | (1) | (1) | (1) | (1) | (107) |
| **Sub Total** | **(352)** | **(287)** | **(401)** | **(695)** | **(1,735)** | **(444)** | **(388)** | **(347)** | **(329)** | **(329)** | **(282)** | **(277)** | **(282)** | **(4,413)** |
| Primary Care | (25) | (71) | (29) | (28) | (153) | (27) | (15) | (17) | (8) | (8) | (8) | (13) | (8) | (258) |
| **Total Agency** | **(377)** | **(358)** | **(430)** | **(722)** | **(1,888)** | **(472)** | **(403)** | **(364)** | **(337)** | **(337)** | **(290)** | **(290)** | **(290)** | **(4,670)** |
| Agency Ceiling (based on 30%) | (258) | (258) | (258) | (258) | (1,033) | (258) | (258) | (258) | (258) | (258) | (258) | (258) | (258) | (3,100) |
| **Surplus / (Deficit)** | **(119)** | **(99)** | **(172)** | **(464)** | **(854)** | **(213)** | **(145)** | **(105)** | **(79)** | **(79)** | **(32)** | **(31)** | **(32)** | **(1,570)** |
| ***Total Agency*** | ***(377)*** | ***(358)*** | ***(430)*** | ***(722)*** | ***(1,888)*** | ***(472)*** | ***(403)*** | ***(364)*** | ***(337)*** | ***(337)*** | ***(290)*** | ***(290)*** | ***(290)*** | ***(4,670)*** |
| *Soft Agency Ceiling (based on 10%)* | *(333)* | *(333)* | *(333)* | *(333)* | *(1,333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(4,000)* |
| ***Surplus / (Deficit)*** | ***(44)*** | ***(24)*** | ***(97)*** | ***(389)*** | ***(554)*** | ***(138)*** | ***(70)*** | ***(30)*** | ***(4)*** | ***(4)*** | ***43*** | ***44*** | ***43*** | ***(670)*** |

The table below shows total agency expenditure by Directorate.

| | Actual | | | | | Forecast | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total Agency** | **Apr-22 £000** | **May-22 £000** | **Jun-22 £000** | **Jul-22 £000** | **YTD £000** | **Aug-22 £000** | **Sep-22 £000** | **Oct-22 £000** | **Nov-22 £000** | **Dec-22 £000** | **Jan-23 £000** | **Feb-23 £000** | **Mar-23 £000** | **Total £000** |
| Acute Services & Urgent Care | (108) | (147) | (142) | (188) | (585) | (150) | (105) | (84) | (81) | (81) | (81) | (81) | (81) | (1,328) |
| North Staffordshire Community | (38) | (27) | (44) | (65) | (173) | (51) | (59) | (40) | (40) | (40) | (45) | (40) | (45) | (531) |
| Specialist Care | (70) | (40) | (70) | (276) | (456) | (69) | (69) | (69) | (69) | (69) | (69) | (69) | (69) | (1,004) |
| Stoke Community | (133) | (64) | (120) | (145) | (462) | (159) | (156) | (156) | (156) | (156) | (104) | (104) | (104) | (1,557) |
| Workforce & OD | 0 | (1) | 0 | 0 | (1) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1) |
| Central Services | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 17 | 17 | 17 | 17 | 17 | 17 | 117 |
| Covid-19 | 0 | 0 | 0 | (5) | (5) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (5) |
| Quality & Nursing | (0) | (1) | (0) | (1) | (2) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (5) |
| Finance, Performance & Estates | (4) | (9) | (24) | (15) | (51) | (15) | (15) | (15) | 0 | 0 | 0 | 0 | 0 | (98) |
| **Total Agency** | **(352)** | **(287)** | **(401)** | **(695)** | **(1,735)** | **(444)** | **(388)** | **(347)** | **(329)** | **(329)** | **(282)** | **(277)** | **(282)** | **(4,413)** |
| Primary Care | (25) | (71) | (29) | (28) | (153) | (27) | (15) | (17) | (8) | (8) | (8) | (13) | (8) | (258) |
| **Total Agency** | **(377)** | **(358)** | **(430)** | **(722)** | **(1,888)** | **(472)** | **(403)** | **(364)** | **(337)** | **(337)** | **(290)** | **(290)** | **(290)** | **(4,670)** |
| Agency Ceiling | (258) | (258) | (258) | (258) | (1,033) | (258) | (258) | (258) | (258) | (258) | (258) | (258) | (258) | (3,100) |
| **Surplus / (Deficit)** | **(119)** | **(99)** | **(172)** | **(464)** | **(854)** | **(213)** | **(145)** | **(105)** | **(79)** | **(79)** | **(32)** | **(31)** | **(32)** | **(1,570)** |
| | | | | | | | | | | | | | | |
| ***Total Agency*** | ***(377)*** | ***(358)*** | ***(430)*** | ***(722)*** | ***(1,888)*** | ***(472)*** | ***(403)*** | ***(364)*** | ***(337)*** | ***(337)*** | ***(290)*** | ***(290)*** | ***(290)*** | ***(4,670)*** |
| *Soft Agency Ceiling* | *(333)* | *(333)* | *(333)* | *(333)* | *(1,333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(333)* | *(4,000)* |
| ***Surplus / (Deficit)*** | ***(44)*** | ***(24)*** | ***(97)*** | ***(389)*** | ***(554)*** | ***(138)*** | ***(70)*** | ***(30)*** | ***(4)*** | ***(4)*** | ***43*** | ***44*** | ***43*** | ***(670)*** |

The table below shows the percentage of agency usage that has been provided by off framework agency providers.

| **% Agency off framework** | **Apr-22 %** | **May-22 %** | **Jun-22 %** | **Jul-22 %** | **2022/23 YTD %** |
|---|---|---|---|---|---|
| Medical | 15% | 16% | 5% | 17% | 14% |
| Nursing | 0% | 0% | 0% | 0% | 0% |
| Other Clinical | 0% | 0% | 0% | 0% | 0% |
| Non Clinical | 3% | 0% | 0% | 0% | 0% |
| **Overall Total** | **7%** | **11%** | **2%** | **9%** | **7%** |

## 5. COVID Costs

During the 2022/23 planning rounds, the ICS was challenged to submit a breakeven plan. To help achieve this, the non-recurrent COVID costs were reduced by £428k from month 3 in the plan in line with national expectations. The table below details the COVID expenditure to month 4. COVID expenditure is overspent against the plan by £264k YTD mainly because of additional pay costs due to staff absences.

The year-end forecast includes COVID costs of £981k. This assumes a reduction in COVID related staff absences.

| YTD Expenditure | COVID related staff absences £000 | Exisiting workforce additional shifts £000 | Decontamination £000 | Remote management of patients £000 | Total £000 |
|---|---|---|---|---|---|
| Nursing | 138 | 16 | | | **154** |
| Other Clinical | 150 | 16 | | | **166** |
| Non-Clinical | 39 | 13 | | | **52** |
| Agency | 0 | 5 | | | **5** |
| **Total Pay** | **327** | **50** | **0** | **0** | **377** |
| Drugs & Clinical Supplies | | | 2 | | **2** |
| Establishment Costs | | | 10 | | **10** |
| **Total Non Pay** | | | **12** | **0** | **12** |
| **Total Expenditure** | **327** | **50** | **12** | **0** | **389** |
| Plan | 69 | 33 | 0 | 23 | **125** |
| **Variance** | **(258)** | **(17)** | **(12)** | **23** | **(264)** |

## 6. CIP

The below table shows the identified schemes to date against the target of £2.7m for 2022/23 following the submission of the plan. The Directorates have identified a total of £1.5m CIP schemes to date against the target, therefore there is an additional £1.2m CIP schemes that require identifying. Of the £1.5m identified schemes £1.3m have been transacted, £0.1m are ready for CIP Oversight Group / QIA & £0.1m are in development (see appendix D). Year to date CIP delivery is £419k against a plan of £587k, giving an under-achievement year to date of £168k.

| 2022/23 CIP Target £000 | Acute | Stoke | N Staffs | Speciali st | CEO | Q&N | S&D | FPE | MACE | Operatio nal | Workfor ce | Trust-wide | 22/23 Total | Recurrent Schemes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *BAU Housekeeping - 2.5% Base Expectation* | 438 | 367 | 267 | 346 | 22 | 71 | 97 | 105 | 39 | 4 | 71 | | 1,828 | |
| **Trustwide Themes:** | | | | | | | | | | | | | | |
| Digital | | | | | | | | | | | | 100 | 100 | |
| Estates | | | | | | | | | | | | 100 | 100 | |
| Grip & Control | | | | | | | | | | | | 100 | 100 | |
| Corporate | | | | | | | | | | | | 200 | 200 | |
| Share of additional CIP & remaining unallocated | 98 | 82 | 60 | 77 | 5 | 16 | 22 | 23 | 9 | 1 | 16 | | 408 | |
| **Total CIP target - 2022/23** | **536** | **449** | **327** | **424** | **27** | **87** | **119** | **128** | **48** | **4** | **87** | **500** | **2,736** | |
| Identified Schemes | 135 | 329 | 194 | 130 | 10 | 62 | 56 | 53 | 0 | 0 | 12 | 529 | **1,510** | **1,252** |
| **Remaining CIP Requirement** | **401** | **120** | **133** | **294** | **17** | **25** | **63** | **75** | **48** | **4** | **75** | **(29)** | **1,226** | |

## 7. Statement of Financial Position

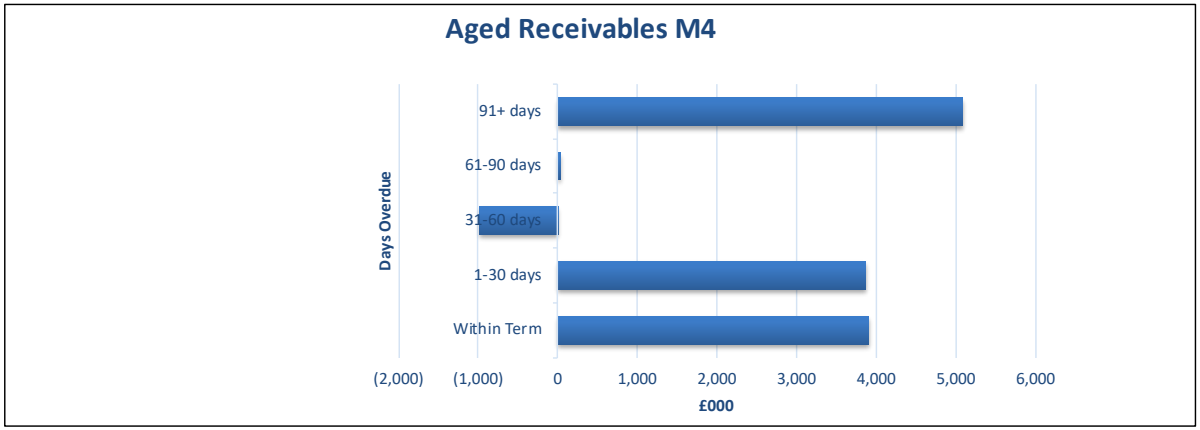
The table below shows the Statement Financial Position of the Trust.

| SOFP | May-22 £000 | Jun-22 £000 | Jul-22 £000 |
|---|---|---|---|
| **Non-Current Assets** | | | |
| Property, Plant and Equipment - PFI | 15,585 | 15,709 | 15,933 |
| Property, Plant and Equipment | 25,785 | 25,492 | 25,461 |
| Intangible Assets | 1,828 | 1,818 | 1,799 |
| NCA Trade and Other Receivables | 190 | 190 | 190 |
| Other Financial Assets | 0 | 0 | 0 |
| **Total Non-Current Assets** | **43,389** | **43,209** | **43,383** |
| **Current Assets** | | | |
| Inventories | 140 | 145 | 145 |
| Trade and Other Receivables | 17,160 | 14,381 | 14,969 |
| Cash and Cash Equivalents | 16,338 | 17,787 | 18,689 |
| Non-Current Assets Held For Sale | 0 | 0 | 0 |
| **Total Current Assets** | **33,638** | **32,313** | **33,803** |
| **Current Liabilities** | | | |
| Trade and Other Payables | (23,417) | (22,051) | (24,177) |
| Provisions | (270) | (279) | (273) |
| Borrowings | (633) | (633) | (633) |
| **Total Current Liabilities** | **(24,320)** | **(22,963)** | **(25,083)** |
| **Net Current Assets / (Liabilities)** | **9,318** | **9,350** | **8,720** |
| **Total Assets less Current Liabilities** | **52,707** | **52,559** | **52,104** |
| **Non Current Liabilities** | | | |
| Provisions | (1,642) | (1,642) | (1,642) |
| Borrowings | (16,892) | (16,729) | (16,610) |
| **Total Non-Current Liabilities** | **(18,534)** | **(18,371)** | **(18,252)** |
| **Total Assets Employed** | **34,173** | **34,188** | **33,852** |
| **Financed by Taxpayers' Equity** | | | |
| Public Dividend Capital | 11,936 | 11,936 | 11,936 |
| Retained Earnings reserve | 15,529 | 15,544 | 15,208 |
| Other Reserves (LGPS) | 0 | 0 | 0 |
| Revaluation Reserve | 6,707 | 6,707 | 6,707 |
| **Total Taxpayers' Equity** | **34,173** | **34,188** | **33,852** |

Current receivables are £14,969k of which:

- £3,050k is based on accruals (not yet invoiced) relating to income for services invoiced retrospectively at the end of every quarter.
- £11,919k is trade receivables; based on invoices raised and awaiting payment of invoice (£3,905k within terms).
- The CCG has settled £4,400k of invoices relating to TCP/P86 from previous months during August.
- Invoices overdue by more than 31 days are subject to routine credit control processes.
- Non-NHS invoices overdue by 91+ days are included in the bad debt provision. This includes invoices to the local authorities for TCP.

| | | Days Overdue | | | | |
|---|---|---|---|---|---|---|
| *Aged Receivables/Payables* | Within Term £000 | 1-30 Days £000 | 31-60 Days £000 | 61-90 Days £000 | 91+ Days £000 | Total £000 |
| Receivables Local Authority | 112 | 356 | (174) | 0 | 4,286 | **4,580** |
| Receivables Non NHS | 384 | 282 | 338 | 40 | 70 | **1,114** |
| Receivables NHS | 3,409 | 3,231 | (1,138) | 0 | 723 | **6,225** |
| Payables Local Authority | 0 | 0 | (9) | 0 | (64) | **(73)** |
| Payables Non NHS | (2,524) | (1,215) | (182) | (370) | (1,008) | **(5,299)** |
| Payables NHS | (137) | (39) | 0 | (123) | (258) | **(557)** |



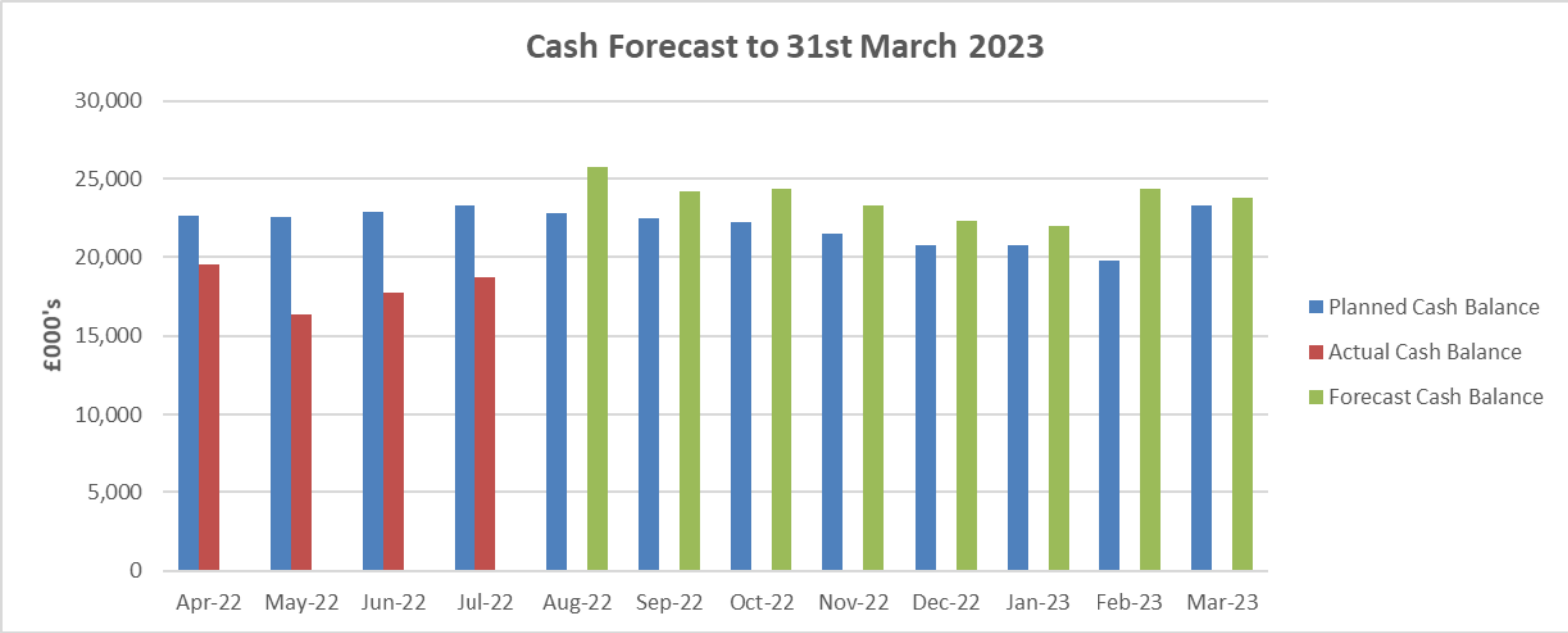
## 8. Cash Flow Statement

The Trust's cash balance at 31st July is £18.7m. This is below plan by £4.6m due to a delay in TCP income from the local authorities, delays with CCG processes following the creation of the ICB and higher than expected payment runs in the first 4 months of the year.

A cash forecast was prepared for 2022/23 based on the Trust's final submitted plan and budget setting assumptions. This gave a plan as at 31st March 2023 of £23.3m. The detailed cash flow will be updated each month and any changes will be reflected in the cash forecast. The Trust is currently forecasting to achieve slightly above the planned cash balance at 31st March 2023 at 23.8m.

| | Cashflow summary - Apr 22 - Mar 23 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actuals | | | | Forecast | | | | | | | |
| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Balance b/fwd** | **25,920** | **19,471** | **16,337** | **17,789** | **18,683** | **25,752** | **24,188** | **24,345** | **23,279** | **22,291** | **21,971** | **24,367** |
| Patient Income ICB, CCG & NHSE | 7,485 | 9,535 | 12,198 | 7,582 | 15,404 | 10,083 | 10,814 | 10,171 | 10,251 | 10,105 | 10,206 | 9,485 |
| Local Authority Income | 129 | 52 | 426 | 1,755 | 2,313 | 600 | 1,416 | 539 | 539 | 1,416 | 4,087 | (61) |
| Other income | 1,911 | 1,639 | 914 | 3,568 | 3,043 | 1,832 | 1,242 | 1,293 | 1,833 | 1,293 | 1,244 | 794 |
| PDC Funding | 0 | 0 | 0 | 0 | 0 | 698 | 0 | 0 | 0 | 0 | 0 | 3,110 |
| **Total Receipts** | **9,525** | **11,227** | **13,538** | **12,906** | **20,760** | **13,213** | **13,472** | **12,003** | **12,623** | **12,814** | **15,537** | **13,328** |
| | | | | | | | | | | | | |
| Monthly Pay | (6,021) | (6,372) | (6,380) | (6,383) | (6,432) | (7,974) | (6,631) | (6,631) | (6,657) | (6,657) | (6,683) | (6,683) |
| Non Pay | (6,731) | (7,727) | (5,594) | (5,390) | (6,169) | (6,128) | (6,107) | (5,931) | (6,097) | (5,978) | (6,016) | (5,926) |
| Capital | (3,222) | (262) | (113) | (237) | (1,091) | (464) | (577) | (507) | (857) | (499) | (442) | (1,122) |
| PDC | 0 | 0 | 0 | 0 | 0 | (211) | 0 | 0 | 0 | 0 | 0 | (211) |
| **Total Payments** | **(15,974)** | **(14,361)** | **(12,086)** | **(12,011)** | **(13,692)** | **(14,777)** | **(13,315)** | **(13,069)** | **(13,611)** | **(13,134)** | **(13,141)** | **(13,942)** |
| | | | | | | | | | | | | |
| **Closing Cash Balance - Main Accounts** | **19,471** | **16,337** | **17,789** | **18,683** | **25,752** | **24,188** | **24,345** | **23,279** | **22,291** | **21,971** | **24,367** | **23,753** |
| **Unpresented cheques/uncleared deposits** | **98** | **(8)** | **(11)** | **(1)** | | | | | | | | |
| **Cash in Hand (Petty Cash)** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** | **9** |
| **Total Reported Cash Book Balance** | **19,578** | **16,338** | **17,787** | **18,691** | **25,760** | **24,196** | **24,353** | **23,288** | **22,300** | **21,980** | **24,376** | **23,762** |
| **Plan** | **22,634** | **22,526** | **22,858** | **23,262** | **22,761** | **22,480** | **22,216** | **21,464** | **20,759** | **20,761** | **19,779** | **23,292** |
| **Variance to Plan** | **(3,056)** | **(6,188)** | **(5,071)** | **(4,571)** | **2,999** | **1,716** | **2,137** | **1,824** | **1,541** | **1,219** | **4,597** | **470** |

The graph below shows the cash to date and forecast for the year against plan. Cash was lower than planned in month 1 to 4 due to a delay in the receipt of TCP and Project 86 income from the CCG's and Local Authorities. The Trust is forecasting to achieve the year end planned cash balance.



## 9. Capital Expenditure

The Trust's final gross capital expenditure plan for 2022/23 has been agreed at £7,250k including £3,808k PDC funding for Project Chrysalis. Capital expenditure at month 4 is £854k, £21k above plan due to expenditure relating to Project Chrysalis partly offset by slippage on reduced ligature and digital infrastructure schemes. The Trust is forecasting to spend in line with the agreed capital plan.

The table below shows the annual plan, forecast and capital spend at month 4

| | | Year to Date | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|
| **Capital Expenditure** | **Annual Plan £000** | **YTD Plan £000** | **Actual £000** | **Variance £000** | **Revised Plan £000** | **Outturn £000** | **Variance to Plan £000** |
| **Strategic Schemes** | | | | | | | |
| Dormitory Conversion Trust funded | 1,452 | 0 | 0 | 0 | 1,452 | 1,407 | 45 |
| **Operational Schemes** | | | | | | | |
| Environmental Improvements (Backlog Maintenance) | 150 | 0 | 5 | 5 | 150 | 155 | (5) |
| Environmental Improvements (Incl. Reduced Ligature Risk) | 170 | 170 | 69 | (101) | 170 | 170 | 0 |
| Medical Equipment | 20 | 0 | 13 | 13 | 20 | 20 | 0 |
| IFRS16 - New leases / renewals | 900 | 0 | 0 | 0 | 900 | 900 | 0 |
| Corporate Recovery (Lawton House/Ashtenne) | 125 | 0 | 0 | 0 | 125 | 120 | 5 |
| **Digital** | | | | | | | |
| Digital infrastructure- Placeholder | 100 | 100 | 0 | (100) | 100 | 100 | 0 |
| Digital Infrastructure - Digital Patient Monitoring | 235 | 0 | 2 | 2 | 235 | 235 | 0 |
| IT - Device Replacement | 200 | 0 | 0 | 0 | 200 | 200 | 0 |
| EPMA System Implementation | 50 | 40 | 53 | 13 | 50 | 95 | (45) |
| Capitalised Salaries - IT rolling replacement | 40 | 13 | 13 | 0 | 40 | 40 | 0 |
| **Contingency / Reactive** | | | | | | | |
| Contingency | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Trust Funded Capital Expenditure** | **3,442** | **323** | **156** | **(167)** | **3,442** | **3,442** | **0** |
| Dormitory Conversion PDC funded | 3,808 | 510 | 698 | 188 | 3,808 | 3,808 | 0 |
| **Total Gross Capital Expenditure** | **7,250** | **833** | **854** | **21** | **7,250** | **7,250** | **0** |

## 10. Better Payment Practice Code

The BPPC target is to pay at least 95% of invoices in terms of number and value within 30 days for NHS and Non-NHS suppliers.

During month 4, the Trust achieved the 95% target for Non-NHS suppliers in terms of the total number of invoices paid and the value of invoices paid within 30 days, achieving 96% on the value of invoices paid and 95% on the number of invoices paid. The Trust did not achieve the target of 95% for NHS suppliers, with 86% on the number of invoices paid and 87% on the value of invoices paid.

Overall, year to date the Trust has achieved 95% on the value of invoices paid but under-achieved on the number of invoices at 91%.
The main reasons for the under-achievement on the number paid is due to high volumes of delayed authorisation of agency invoices.

| | 2021/22 Total | | | 2022/23 Month 4 | | | 2022/23 Total | | |
|---|---|---|---|---|---|---|---|---|---|
| ***Better Payment Practice Code*** | **NHS** | **Non-NHS** | **Total** | **NHS** | **Non-NHS** | **Total** | **NHS** | **Non-NHS** | **Total** |
| **Number of Invoices** | | | | | | | | | |
| Total Paid | 455 | 13,882 | 14,337 | 35 | 1,288 | 1,323 | 118 | 4,964 | 5,082 |
| Total Paid within Target | 427 | 13,314 | 13,741 | 30 | 1,230 | 1,260 | 107 | 4,529 | 4,636 |
| % Number of Invoices Paid | 94% | 96% | 96% | 86% | 95% | 95% | 91% | 91% | 91% |
| % Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| **RAG Rating (Variance to Target)** | **-1%** | **1%** | **1%** | **-9%** | **0%** | **0%** | **-4%** | **-4%** | **-4%** |
| **Value of Invoices** | | | | | | | | | |
| Total Value Paid (£000s) | 6,849 | 76,244 | 83,093 | 796 | 6,414 | 7,210 | 2,472 | 32,893 | 35,365 |
| Total Value Paid within Target (£000s) | 6,483 | 70,245 | 76,728 | 690 | 6,215 | 6,905 | 2,272 | 31,199 | 33,471 |
| % Value of Invoices Paid | 95% | 92% | 92% | 87% | 97% | 96% | 92% | 95% | 95% |
| % Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| **RAG Rating (Variance to Target)** | **0%** | **-3%** | **-3%** | **-8%** | **2%** | **1%** | **-3%** | **0%** | **0%** |

The finance team will continue to review performance and act where necessary to improve timely authorisation of invoices and avoid retrospective raising of purchase orders. It is expected that if the Trust continues to achieve the target in future months that the year-to-date total will show the target achieved before the end of the year.

## 11. Recommendations

The Finance and Resource Committee are asked to:

**Receive the Month 4 position noting:**

- The year-to-date deficit of £1,305k.
- Note the 2022/23 agreed capital plan, forecast and month 4 position.
- The cash position of the Trust as at 31st July 2022 with a balance of £18.7m.
- Agency expenditure of £1,888k year to date against the agency ceiling of £1,033k; **an adverse variance of £854k to the share of the ICB agency ceiling, and a £554k adverse variance against the 10% target reduction.**
- Note identified CIP schemes of £1,510k against a target for the year of £2,736k.

# REPORT TO PUBLIC TRUST BOARD

Enclosure 13

| | | | |
|---|---|---|---|
| Date of Meeting: | 8th September 2022 | | |
| Title of Report: | Finance and Resource Committee Assurance Report | | |
| Presented by: | Russell Andrews- Chair/Non-Executive Director | | |
| Author: | Kimberli McKinlay – Deputy Director of Finance | | |
| Executive Lead Name: | Eric Gardiner – Executive Director of Finance, Performance & Estates | **Approved by Exec** | ☒ |

| Executive Summary: | | **Purpose of report** | |
|---|---|---|---|
| This paper details the items discussed at the Finance and Resource Committee meeting held on the 1st September 2022. | | **Approval** | ☐ |
| | | **Information** | ☒ |
| | | **Discussion** | ☐ |
| | | **Assurance** | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Performance Review | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Resource Committee ☐<br>• Audit Committee ☐<br>• People, Culture & Development Committee ☐<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. We will attract, develop and retain the best people ☒<br>2. We will actively promote partnership and integrated models of working ☒<br>3. We will provide the highest quality, safe and effective services ☒<br>4. We will increase our efficiency and effectiveness through sustainable development ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | Oversees the risk relevant to the Finance and Resource Committee | | |
| Resource Implications:<br><br>Funding Source: | None applicable directly from this report | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There are no direct impact of this report on the 10 protected characteristic of the Equality Act | | |
| Shadow ICS Alignment / Implications: | The Trust Finance performance feed into the overall STP Financial Position. | | |
| Recommendations: | The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee. | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Trust Board | 08/07/2022 |

# Finance and Resource Committee
# Assurance Report to the Trust Board
# 1st September 2022

## Finance and Resource Committee Report to the Trust Board – 8th September 2022.

This paper details the items discussed at the Finance and Resource Committee meeting held on the 1st September 2022. The meeting was quorate. The meeting was held as a MS Teams conference meeting and minutes were reviewed and approved from the previous meeting on the 4th August 2022. Progress was reviewed and actions confirmed from previous meetings. Declarations of interest were noted.

### Chairs Actions

There were no chairs actions to note since the previous committee meeting.

### Performance

- **IQPR**

The Committee received the IQPR report. The month 4 performance report was taken as read with attention drawn to some changes in appendices including activity against national operational planning priorities and the Q1 performance against CQUIN milestones. The main points to note are 20 rated measures that have met the required standard (18 in M3) and 12 that have not met the required standard and highlighted as exceptions (12 in M3). There are 3 special cause variations (orange variation flags) - signifying concern, compared to 7 in M3.

- Referral to Assessment within 4 weeks
- CAMHs compliance within 4 week waits (Referral to Assessment)
- Agency Spend

The Committee noted the contents of the report.

### Capital and Estates

- **Estates Update**

The Interim Associate Director of Capital and Estates provided the Committee with an Estates update. The main points highlighted were:

- The planned backlog maintenance programme was progressing well and was on track.
- The reduced ligature scheme at Darwin is due to commence in September 2022.
- A condition survey is being reviewed on the potential GP Practice the Trust are currently conducting due diligence on.
- Estates are supporting the Lawton Hub project.

- **Project Chrysalis Update**

The Committee took the report as read. The Executive Director of Finance, Performance & Estates updated the Committee on the funding sources and issues over the Public Liability insurance value with the lenders.

## Finance

- **Finance Update**

Month 4 Position - The Committee took the paper as read. There an in month and year to date deficit mainly due to CIP delivery, non-recurrent expenditure, ward acuity & sickness and bad debt provision. Agency costs remained high. Capital spend was slightly ahead of plan due to works on Project Chrysalis. The cash balance was behind plan mainly due to local authority debt and the late payments from the CCG's during their ICB transition process which have since been settled. The Committee noted that the Better Payment Practice Code was achieved in month. The Committee expressed their concern at the current in year position, in particular the level of LA debt not settled, the level of agency expenditure and the remaining CIP to identify.

The Committee noted the month 4 financial position.

- **IFPS Updated Principles**

The Committee took the paper as read, the Executive Director of Finance, Performance and Estates highlighted that there is an expected agreement to share specific system risks across system partners. There is a verbal agreement that the ICB would support us if we were at a breakeven position. Noted concerns, but in the sense of system working the Committee agreed the principles subject to a review for 2023/24.

## Strategy, Partnerships and Digital

- **Digital Update**

The Committee took the paper as read which included an update across key updates and all live projects. The main points highlighted to the Committee were:

- The cyber incident that impacted Advanced software users that occurred on the 4th August 2022. The Trust does not use any of the systems impacted by the Advanced cyber incident so is currently no experiencing any direct issues. The incident has affected System partners at UHNM and MPFT in regard to their financial systems but this has now been resolved.
- The closure of the Network device replacement and Windows 20H2 upgrade projects which have now been completed.
- The continued work around the HIS service review which is aligned with the development of the ICB Digital Strategy due by the end of September 2022.

The Committee took the Digital Aspirants report as read. The Chief Information Officer confirmed that the project has now finished and is in the process of being formally closed with the development of a project closure and lessons learned documents.

## Other

The Executive Director of Finance, Performance & Estates presented a business case for the car parking at Harplands to formally sign a lease for the old Ambulance Station. The Committee approved the business case.

The Director of Nursing presented a business case for overseas nurse recruitment. The Committee approved the business case.

The Committee received the risk register and discussed proposed score changes relating to the CIP plan delivery which was accepted.

## Recommendation

The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Russell Andrews
Chair of Finance and Resource Committee

# REPORT TO PUBLIC TRUST BOARD

Enclosure 14

| | | | |
|---|---|---|---|
| Date of Meeting: | 8th September 2022 | | |
| Title of Report: | Board Assurance Framework Report Quarter 1 2022/2023 | | |
| Presented by: | Laurie Wrench, Associate Director of Governance | | |
| Author: | Laurie Wrench, Associate Director of Governance | | |
| Executive Lead Name: | Dr Buki Adeyemo, Interim CEO | **Approved by Exec** | ☒ |

| Executive Summary: | **Purpose of report** | |
|---|---|---|
| The Board Assurance Framework (BAF) for 2022/23 aligns the Trusts strategic objectives to our quality priorities and key risks. The BAF provides oversight of the key control and assurances to be introduced and mapped against our four strategic objectives. This is the Q1 BAF for 2022/2023. | **Approval** | ☐ |
| | **Information** | ☒ |
| | **Discussion** | ☐ |
| | **Assurance** | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: 30th August 2022 (virtually) | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Resource Committee ☒<br>• Audit Committee ☒<br>• People, Culture & Development Committee ☒<br>• Charitable Funds Committee ☐ | | |
| Strategic Objectives (please indicate) | 1. We will attract, develop and retain the best people X<br>2. We will actively promote partnership and integrated models of working X<br>3. We will provide the highest quality, safe and effective services X<br>4. We will increase our efficiency and effectiveness through sustainable development X | | |
| Risk / legal implications: Risk Register Reference | The paper describes the Trust's strategic risks and associated trust wide 12+ risks | | |
| Resource Implications:<br><br>Funding Source: | N/A | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The BAF describes the ongoing work regarding diversity and inclusion | | |
| Shadow ICS Alignment / Implications: | N/A | | |
| Recommendations: | Members are asked to receive the BAF for information and assurance purposes noting the mapping of controls and assurances against the four strategic objectives | | |

| Version | Name/group | Date issued |
|---|---|---|
| | | |

# Board Assurance Framework (BAF) 2022/2023- Quarter 1

## Welcome to the Board Assurance Framework for North Staffordshire Combined Healthcare NHS Trust.

The Trust Board is responsible for ensuring that North Staffordshire Combined Healthcare NHS Trust consistently follows the principles of good governance applicable to NHS organisations. The Board does this through the development of systems and processes for financial and organisational control, clinical and information governance and risk management.

Our Board Assurance Framework identifies the procedures for risk management against our new key strategic objectives, encompassing the management of all types of risk to which the Trust may be exposed, our controls and the assurances we have in place. This includes the effective integration and management of clinical and non-clinical risk.

Those key risks, mapped against our current new four strategic ambitions are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR. A full refresh of the BAF will be undertaken following the publication of pending national guidance and the formal agreement of the new Trust strategic objectives to fully reflect the deliverables of the Trust's enabling strategies; Quality, People, Partnerships, and, Sustainability.

| Objective 1: Quality | We will provide the highest quality, safe and effective services | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **SPAR PRIORITY** |  | | | | | | | | | |
| **Exec owner:** | Director of Nursing and Quality and Medical Director | | | | | | | | | |
| **Assurance Committee:** | Quality Committee | | | | | | | | | |
| **Risk appetite** | Financial | | Quality (Innovation) | | Regulation | | Reputation | | | |
| | **Gross Risk (no mitigation)** | | | **Residual Risk (with mitigation)** | | | **Target Risk (31/03/23)** | | | |
| | LIKELIHOOD | IMPACT | SCORE | LIKELIHOOD | IMPACT | SCORE | LIKELIHOOD | IMPACT | SCORE | |
| ***RISK:*** *The Trust fails to collaborate with service user and carer involvement resulting in an inability to deliver responsive services.* *Risk Trend Arrow* | 4 | 3 | 12 | 3 | 3 | 9 | 2 | 3 | 6 | |
| ***RISK:*** *The Trust fails to deliver safe and effective services, resulting poor care, reputational harm and regulatory restrictions* *Risk Trend Arrow* | 4 | 4 | 16 | 3 | 4 | 12 | 2 | 4 | 8 | |
| ***RISK:*** *The Trust fails to exploit its potential in research and innovation,* | 4 | 3 | 12 | 3 | 3 | 9 | 2 | 3 | 6 | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| *resulting in a loss of credibility and a failure to improve services.*<br><br>*Risk Trend Arrow* ⟷ | | | | | | | | | |
| *COVID-19 Risk - There is a risk to the quality of the Trust's services due to the COVID-19 pandemic which will impact on the safety, wellbeing and capacity of staff and patients* | 4 | 5 | 20 | 3 | 5 | 15 | 2 | 5 | 10 |
| **Links to 12+ Trust Risks** | **Description of linked 12+ Trust Risks**<br>• 12 – Staffing<br>• 423 – Compliance with MHA/MCA<br>• 1112 – Ligature anchor points<br>• 1344 – Non anchored ligature self-harm<br>• 1113 – Community pathway for personality disorder<br>• 1383 – Covid-19 pandemic (quality of services)<br>• 440 – 3 hour assessment timescale (section 136)<br>• 1446 – Covid-19 pandemic (increasing demand)<br>• 1218 – LA funding for substance misuse services<br>• 1139 – Continuity of prescribing | | | | | | | | |

| **Internal Assurance Examples** | | **External Assurance Examples** |
|---|---|---|
| **Level 1** | **Level 2** | **Level 3** |
| • **Corporate Performance Report/ Dashboard**<br>• **Internal Performance**<br>• **Reportable Issues Alert**<br>• **Quality Account**<br>• **Practice Improvement & Lessons Learnt Report**<br>• **Complaints and Concerns Report**<br>• **Incident Reports**<br>• **SI Reports** | • **Strategy implemented**<br>• **Plan realised**<br>• **Clinical Audit**<br>• **Unannounced Assurance Visits**<br>• **Performance Scrutiny** | • **Internal Audit (linked to annual plan)**<br>• **National Patient Satisfaction Surveys (F & F Test)**<br>• **Healthwatch Reports**<br>• **Independent Reviews (e.g. Ombudsman Reports)**<br>• **External Visits / Inspection Reports**<br>• **CQC**<br>• **EY External Audit (e.g. Annual Governance Statement / Statement of Financial Control)**<br>• **NHS Benchmarking Club**<br>• **Quality Account**<br>• **Annual Governance Statement**<br>• **INSIGHT** |

| | | |
|---|---|---|
| | | • **NHSI Oversight**<br>• **AQUA** |

| SPAR Reference | CONTROLS to Mitigate Strategic Risk | Level of Assurance | Description of Assurance | Exec Owner | Year Start RAG | Qtr Due | Forward Plan/Progress | Q1 RAG | On Target RAG | Year End RAG |
|---|---|---|---|---|---|---|---|---|---|---|
| R | Enhance Service User & Carer Collaboration - Focus on Service Users Recovery. | 2 | Embed the Wellbeing Academy to support recovery with greater participation of peers. Aim to have SU attend at least one of the Well Being Academy's.<br><br>Measure SU experience of the Academy and report to QC. | DON | | Q3 | Business Case for the development of the Wellbeing Academy has received Executive approval and recruitment has commenced. Recruitment will have a strong focus on ensuring co-production and co-facilitation to maintain fidelity to the model.<br><br>Wellbeing academy model has been co-produced with service users and carers and summer school prospectus will be launched in Q1 2022/23 | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AR | | 2 | Further embed Peer Support Workers and Peer Support Mentor roles, as a key component of our workforce having lived experience.<br><br>This will be evidenced by increased numbers of service users and carers in our workforce on either a voluntary or paid basis year on year. | DON | | Ongoing Quarterly | An accredited training programme for Peer Support Workers has been secured.<br><br>Peer support workers have continued to work throughout Covid 19 restrictions.<br><br>Volunteer peer mentors have been on hold due to Covid 19 restriction<br><br>Accredited peer mentor training - level 2 OCN training has been secured. | | | |
| SPAR | | 3 | The Trust will achieve a year on year improvement for the overall indicator of "better" in the Community Mental Health Survey. 2018 score = 6.7 | DO | | Q4 | Trust is in the expected range of performance aligned to our benchmarked partners. A work plan has been developed for continuous improvement. | | | |
| SPAR | CQC Rating of 'Outstanding' is maintained. | 3 | A rating of 'good' for all core services in the Safe domain (Adult Inpatient Wards). | CEO | | Q4 | Inspection preparation well underway pre-covid now reinstated with amongst other things e.g. heatmap exercise, quality walk about targeted work with teams well led session with Board having occurred. Face to face inspections now in place nationally. However awaiting confirmation of new CQC methodology | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Primary Care inspection has occurred with positive report received.<br><br>TMA held and no issues identified. | | | |
| SPAR | | 3 | An increase in the number of core services rated as 'outstanding' currently 3/11). | CEO | | Q4 | See above | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| SPAR | Continue work to strengthen approach to risk management | 1 | Risk appetite analysis is undertaken for strategic risks. | ADG | | Q2 | to be incorporated into Q2 BAF update | | | |
| SPAR | Develop a Trust wide systematic approach to quality improvement. | 1 | Continue to strengthen relationship with the CQC via regular engagement meetings and new inspection team | DON | | Ongoing | Regular engagement meetings with the CQC have taken place through the COVID period. Including a successful TMA | | | |
| S | Continue Capital Plan for reduced ligature | 2 | Investment in environmental ligature improvements as per the capital plan. | DO | | Ongoing – Quarterly Update | National funding approved for Dormitory eradication. Inpatient Reconfiguration Programme established to oversee all inpatient investments and improvements. Project Chrysalis construction work has commenced on site | | | |
| SPAR | | 1 | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Every patient can expect Mental Health Law compliance including response to new reforms.<br><br>Zero tolerance for failure to comply with the MHA: | | 100% compliance with requirements for Section 17 leave. | MD | | Ongoing and quarterly update | Q1 –<br>Q2 –<br>Q3 –<br>Q4 - | | | |
| | | 1 | 100% compliance with requirements for consent. | MD | | Ongoing and quarterly update | Q1 –<br>Q2 –<br>Q3 –<br>Q4 - | | | |
| A | Services are responsive to the needs of service users. | 1 | 92% compliance for referral to treatment (2nd contact) in 18 weeks. | DO | | Quarterly | Q1 – 96.9%<br>Q2 –<br>Q3 –<br>Q4 - | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| SA | | 1 | 100% compliance with 3 hour assessment target for service users entering the Place of Safety (where clinically appropriate). | DO | | Quarterly | Aspirational target set by the Trust due to number of agencies involved in overall process.<br>Q1 – 83%<br>Q2 –<br>Q3 –<br>Q4 - | | | |
| A | | 1 | 95% compliance referral to assessment within 4 weeks (CAMHS). | DO | | Quarterly | Aspirational target set by the Trust.<br>Q1 – 91.6%<br>Q2 –<br>Q3 –<br>Q4 - | | | |
| A | | 1 | There are zero acute adult mental health out of area placements. | DO | | Quarterly | There have been no inappropriate out of area placement in Q1 | | | |
| | | 1 | Raise Awareness regarding ongoing work with Veterans | DO | | Q3 | Sign up to the veteran's charter and develop plan to raise awareness | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| SPAR | Implement a Trust wide innovation Strategy to support widespread engagement and to celebrate the successes achieved. | 1 | Develop and deliver the ambitions set out in the approved R&D Roadmap (2022/2025) | MD | | Q3 | The Combined Collective; a sharing and showcase event was held May 2021 with a further event held 19 May 2022 | | | |
| SPAR | ADHD Antipsychotic Prescribing | 2 | Requirement for a commissioned service to support ADHD pathway / clinical model and prescribing | DO | | Q3 | Negotiations underway with Commissioners | | | |

| Objective 2: People | We will attract, develop and retain the best people | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **SPAR PRIORITY** |  | | | | | | | | |
| **Exec owner:** | Director of Workforce, Organisational Development and Inclusion | | | | | | | | |
| **Assurance Committee:** | People and Culture Development Committee | | | | | | | | |
| **Risk appetite** | Financial | | Quality (Innovation) | | Regulation | | Reputation | | |
| | **Gross Risk (no mitigation)** | | | **Residual Risk (with mitigation)** | | | **Target Risk (31/03/23)** | | |
| | LIKELIHOOD | IMPACT | SCORE | LIKELIHOOD | IMPACT | SCORE | LIKELIHOOD | IMPACT | SCORE |
| ***RISK:*** *The Trust fails to continually learn and improve resulting in poor staff and service user experience.* *Risk Trend Arrow* ⟷ | 3 | 4 | 12 | 2 | 4 | 8 | 2 | 4 | 8 |
| ***RISK:*** *The Trust fails to attract, develop and retain talented people resulting in reduced quality and increased cost of services* *Risk Trend Arrow* ↑ | 4 | 4 | 16 | 4 | 4 | 16 | 3 | 4 | 12 |
| *COVID-19 Risk - There is a risk to the quality of the Trust's services* | 4 | 5 | 20 | 3 | 5 | 15 | 2 | 5 | 10 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| *due to the COVID-19 pandemic which will impact on the safety, wellbeing and capacity of staff and patients* | | | | | | | | | |

| | |
|---|---|
| **Links to 12+ Trust Risks** | **Description of linked 12+ Trust Risks**<br>• 12 – Staffing.<br>• 1011 – Exec capacity and ICB<br>• 900 – Diverse and Inclusive services.<br>• 901 – Diverse and inclusive workforce.<br>• 868 – Agency spend.<br>• 1313 – Psychological services.<br>• 992 – Lorenzo training. |

| **Internal Assurance Examples** | | **External Assurance Examples** |
|---|---|---|
| **Level 1** | **Level 2** | **Level 3** |
| • **Corporate Performance Report/ Dashboard**<br>• **Internal Performance**<br>• **Reportable Issues Alert**<br>• **Quality Account**<br>• **Practice Improvement & Lessons Learnt Report**<br>• **Complaints and Concerns Report**<br>• **Incident Reports**<br>• **SI Reports** | • **Strategy implemented**<br>• **Plan realised**<br>• **Clinical Audit**<br>• **Unannounced Assurance Visits**<br>• **Performance Scrutiny** | • **Internal Audit (linked to annual plan)**<br>• **National Patient Satisfaction Surveys (F & F Test)**<br>• **Healthwatch Reports**<br>• **Independent Reviews (e.g. Ombudsman Reports)**<br>• **External Visits / Inspection Reports**<br>• **CQC**<br>• **EY External Audit (e.g. Annual Governance Statement / Statement of Financial Control)**<br>• **NHS Benchmarking Club**<br>• **Quality Account**<br>• **Annual Governance Statement**<br>• **INSIGHT**<br>• **NHSI Oversight**<br>• **AQUA** |

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| **Number of Controls** | | | |

| SPAR Reference | CONTROLS to Mitigate Strategic Risk | Level of Assurance | Description of Assurance | Exec Owner | Year Start RAG | Qtr Due | Forward Plan/Progress | Q1 RAG | On Target RAG | Year End RAG |
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| SPAR | Clinical Professional Workforce strategies | 1 | Review of Clinical Strategies (overseen by MACE) and highlighting the opportunities to optimise new and diversifying roles | MD | | Q3 | Strategy group have decided to refocus on a face to face or hybrid conference event in late spring/early summer 2022<br><br>Strategies to review:<br>• Identify and promote new clinical roles<br>• Pursue educational funding mechanism<br>• Review establishing and develop plan to address any gaps | | | |
| SPAR | Maximise collaborative working across the ICB to build skills and capacity in the local health economy. | 1 | Continue to develop programmes in collaboration with delivery partners and other NHS Trusts and stakeholders. Cohorts of staff from local health economy learning together. | DPO DI | | Q4 | Cohort1 High Potential Scheme concluded in April 2022<br><br>Cohort 2 as buddy model with STW ICS launch spring 2022 .” year opportunity for successful applicants<br><br>The National People plan Belonging to the NHS references the drive to develop our workforce to become inclusive compassionate Leaders NSCHCT are a piviotal part of the system Inclusive Talent steering group which will enable NSCHCT to deliver a | | | |

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| | | | | | | | talent approach for the trust whilst contributing to the system collective strategy<br><br>Scope for Growth<br><br>"A system wide common framework of development pathways for all our people "<br><br>The scope for growth toolkit, piloted by SSOTICS will enable better conversations to be conducted capturing the ambition and drive of our people. This will enable a considered and planful approach with an inclusive lens, harnessing ambition and talent wherever it resides .As a necessary vital step managers will be educated and developed to fully embrace this aspect of their role, whist they also help plan with their teams clear development plans based on the S4G model. This is a National pilot located in the SSOT ICS with NSCHCT as full partners. | | | |
| SPAR | Learning and development options reflect the demands of our sector and the | 1 | Develop a suite of learning and development options | DPO DI | | Q4 | Development of organisation and personal development; including clinical, service improvement and leadership skills. | | | |

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| | investment in Mental Health through the 10 year Plan. | | that reflect the demands of our sector. | | | | Development and Leadership programme for support staff in development (Joint with Nursing)<br><br>A Leadership and Quality Improvement Virtual Development Programme was developed with a further 2 cohorts to be delivered 22/23. | | | |
| SPAR | **Equality Delivery System (EDS)**<br><br>The care that services users and carers receive respects (reflects) the diverse requirements of our local population | 2 | The workforce more accurately represents the community it serves through themes identified within the:<br><br>• Staff Survey<br>• WRES<br>• WDES<br>• Annual D&I report | DPOD I | | Q4 | Significant improvements have been made in relation to workforce representation /reporting of diverse protected characteristics (namely diverse ethnic heritage, disability and sexual orientation<br><br>Work streams supporting improvements:<br><br>• WRES, WDES, Staff Survey<br>• Inclusive recruitment programme ongoing with focus on recruiting for greater diversity and inclusion (including flexible working)<br>• Inclusion School<br>• Comfortable Being Uncomfortable programme<br>• New Futures / Stepping Up<br>• Staff Networks embedding<br>• EDS - the Trust EDS for 2021 in development and due for | | | |

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| | | | | | | | publication. Learning Disabilities services being reviewed as part of this.<br>• Differently Abled Buddy Scheme (workforce) | | | |
| SPAR | Deliver Talent Management Strategy linking Trust People & OD strategy and the Regional Talent Review | | | | | | | | | |
| | | 1 | Launch Talent Management Steering Group. | DPO DI | | Q3 | Existing Development Group & engagement events utilised to shape priorities for the Trust with plans to launch Talent Management Steering Group in Q1 22/23 | | | |
| SPAR | Enhance our staff and wellbeing activities and initiatives to ensure that our working environment is supportive and encourages self-care. | 1 | Refresh workforce Health and Wellbeing Strategy | DPO DI | | Ongoing | H & W group now has local representatives from directorate teams to enhance engagement.<br><br>Continuing to report on attendance / sickness absence performance and health and wellbeing interventions in Clinical Operations Directorate reports and meetings, including Occupational Health data regarding time to refer and DNAs.<br>Regroup-Reflect-Recharge campaign launched in April 2021 and themes shared for incorporation into staff survey plans.<br><br>Developed COVID-19 risk assessments for our staff using LMS and specific | | | |

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| | | | | | | | support for staff with increased risk factors linked to COVID-19, including our BAME, shielding / clinically extremely vulnerable and clinically vulnerable staff members<br><br>Health & Wellbeing event planned and due to be delivered 25th April 2022 Mindset modules embedded in the LMS for delivery to all people in the Trust.<br><br>Agile working risk assessments launched launched as part of Lawton House Management of Change. | | | |
| SPAR | Deliver OD interventions to support staff engagement aligned to staff survey trends | 2 | Ensure the Staff Survey results (2022) are promoted and celebrated<br><br>Continuation of an annual cycle of activity using a cross sectional approach and regular engagement, ensuring action plans reflect Directorate ownership | DPO<br>DI | | Q2 | Staff survey results shared through Trust Board, various committees and sub-committees of the board.<br><br>Two themes – staff engagement and morale, with the remaining 3 promise elements above average and just shy of the best scores.<br><br>Themes for Trust wide action have been identified in 5 main categories and are due to be presented at Trust Board for sign off.<br><br>Strong interest in our scores have been shown from NHS employers with initial meetings planned to discuss. | | | |

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| | | | | | | | Results have been broken down to Directorate level and meetings to share results.<br>Results used Trust wide to identify bespoke areas for improvement. | | | |
| SPAR | Encouraging an open, fair, inclusive, transparent and just culture. | 1 | Widen the focus of the Inclusion Council to include other protected characteristics. | DPO<br>DI | | Q3 | The Trust's Inclusion Council has continued to meet (online) bi-monthly throughout the COVID-19 pandemic.<br><br>New FTSU Guardian in place<br><br>Trust Staff networks continue to develop role and impact<br><br>Our Inclusion School and Comfortable Being<br>Uncomfortable programme journeys continue. | | | |

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| SPAR | Embed Values and Behaviour framework. | 2 | Evidenced in all development programmes e.g. In Place Systems Leadership Programme | DPO DI | | Ongoing | Our 'Comfortable Being Uncomfortable' programme continues to be rolled out across the Trust and system. Approx. 50 Trust leaders/colleagues have participated in this programme so far. Additionally 6 sessions have been purchased and commenced specifically for clinical staff to attend. | | | |
| SPAR | Promote and extend our reach into all communities within our localities. | 1 | Stakeholder Engagement Map and Listening Landscape in MOOD.<br><br>Develop Stakeholder Engagement Programme.<br><br>Increase number of engaged groups, with emphasis on Seldom Heard Groups. | DSPD | | Q3 | Stakeholder Map and Listening Landscape under construction.<br><br>Participation of stakeholders in 'Ask the Board'<br><br>Community engagement in transformation work on health inequalities underway | | | |

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| SA | Workforce Planning regarding Vacancies | 1 | | DPO DI | | Ongoing | Vacancy challenges recognised and receive Senior Leadership team and committee oversight | | | |
| P | Training Passports | 2 | | DPO DI | | Q3 | Under Development | | | |

| Objective 3: Partnerships | We will actively promote partnership and integrated models of working | | | | | | | | | |
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| **SPAR PRIORITY** |   | | | | | | | | | |
| **Exec owner:** | Director of Partnerships, Strategy and Digital | | | | | | | | | |
| **Assurance Committee:** | Finance and Resource Committee | | | | | | | | | |
| **Risk appetite** | Financial | | Quality (Innovation) | | Regulation | | Reputation | | | |
| ***RISK:*** *The Trust fails to lead in partnership working resulting in an absence of system and clinical integration.* | **Gross Risk (no mitigation)** | | | **Residual Risk (with mitigation)** | | | **Target Risk (31/03/23)** | | | |
| | **LIKELIHOOD** | **IMPACT** | **SCORE** | **LIKELIHOOD** | **IMPACT** | **SCORE** | **LIKELIHOOD** | **IMPACT** | **SCORE** | |
| *Risk Trend Arrow* | 4 | 4 | 16 | 4 | 4 | 16 | 2 | 4 | 8 | |
| *COVID-19 Risk - There is a risk that the Trust cannot maintain business critical functions due to the impact of COVID-19* | 4 | 5 | 20 | 3 | 5 | 15 | 2 | 5 | 10 | |
| **Links to 12+ Trust Risks** | **Description of linked 12+ Trust Risks**<br>• 1010- Scale and scope of ICB plans.<br>• 1103 – Primary care integration.<br>• 1113 - Community pathway for Personality Disorder<br>• 1139 – GP prescribing. | | | | | | | | | |

| Internal Assurance Examples | | External Assurance Examples |
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| **Level 1** | **Level 2** | **Level 3** |
| • Corporate Performance Report/ Dashboard<br>• Internal Performance<br>• Reportable Issues Alert<br>• Quality Account<br>• Practice Improvement & Lessons Learnt Report<br>• Complaints and Concerns Report<br>• Incident Reports<br>• SI Reports | • Strategy implemented<br>• Plan realised<br>• Clinical Audit<br>• Unannounced Assurance Visits<br>• Performance Scrutiny | • Internal Audit (linked to annual plan)<br>• National Patient Satisfaction Surveys (F & F Test)<br>• Healthwatch Reports<br>• Independent Reviews (e.g. Ombudsman Reports)<br>• External Visits / Inspection Reports<br>• CQC<br>• EY External Audit (e.g. Annual Governance Statement / Statement of Financial Control)<br>• NHS Benchmarking Club<br>• Quality Account<br>• Annual Governance Statement<br>• INSIGHT<br>• NHSI Oversight<br>• AQUA |
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| SPAR Reference | CONTROLS to Mitigate Strategic Risk | Level of Assurance | Description of Assurance | Exec Owner | Year Start RAG | Qtr Due | Forward Plan/Progress | Q1 RAG | On Target RAG | Year End RAG |
|---|---|---|---|---|---|---|---|---|---|---|
| ARP | Ongoing cannel development channel development to ensure the Trust is at the forefront of digitalisation that will enhance service user engagement. | 2 | Implementation and further development of Combined TV | DSPD | | Q2 | Combined Podcast well established<br><br>CTV established and launched and will be further promoted | | | |

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| S | Zero Suicide Ambition – 2019/20 is the third year of this collaborative journey with partners to reduce deaths by suicide as part of the county wide strategy. | 1 | Work with partners to deliver new 2022/2025 strategy – work with partners and the system to reach others who are not in contact with the system. | MD | | Q4 | Following the cancellation of several speakers, it was collectively agreed that the conference for 2020 would be poICBoned and a refocus on the new strategy alongside partners | | | |
| SPAR | Strengthen relationships with HEI beyond Keele | 2 | Continue to strengthen Keele & Staffordshire University Partnership.<br>• Meet criteria to become a University Trust. | MD | | Q3 | The research team continue to explore University opportunities and enhance partnership working with Keele University A NED has been appointed from Keele University which strengthens board oversight and engagement.<br><br>A series of meetings have been scheduled with Staffordshire University to enhance partnership working for the clinical psychology professional doctorate programme, and to explore effective joint research governance arrangements. | | | |
| SPAR | Commitment to the ICS as a willing partner in deploying the skills | 3 | CEO is the lead for the Mental Health work stream. | CEO | | Ongoing | Continues – transition for Executive lead (following resignation of DO) in train. | | | |

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| | and expertise of our workforce outside of our immediate organisational boundaries. | 3 | Trust is the lead for the OD work stream. | CEO (DPO DI) | | Ongoing | Achieved and Ongoing | | | |
| | | 3 | Trust is Programme Director lead for the Mental Health work stream. | CEO (DON) | | Ongoing | Achieved and Ongoing | | | |
| SPAR | Continue to identify and develop further primary care service offerings. | 2 | Continued dialogue with GP Practices who have shown an interest in NSCHT service menu. | DPSD | | Ongoing | Further practice integrated and due diligence work underway to explore further practices | | | |

| Objective 4: Sustainability | We will increase our efficiency and effectiveness through sustainable development | | | | | | | | |
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| **SPAR PRIORITY** |  | | | | | | | | |
| **Exec owner:** | Director of Partnerships, Strategy and Digital and Director of Finance, Performance and Estates | | | | | | | | |
| **Assurance Committee:** | Finance and Resource | | | | | | | | |
| **Risk appetite** | Financial | | Quality (Innovation) | | Regulation | | Reputation | | |
| ***RISK:*** *The Trust fails to optimise its resources resulting in an inability to be sustainable.*<br><br>*Risk Trend Arrow* | **Gross Risk (no mitigation)** | | | **Residual Risk (with mitigation)** | | | **Target Risk (31/03/23)** | | |
| | **LIKELIHOOD** | **IMPACT** | **SCORE** | **LIKELIHOOD** | **IMPACT** | **SCORE** | **LIKELIHOOD** | **IMPACT** | **SCORE** |
| | 4 | 5 | 20 | 4 | 4 | 16 | 3 | 4 | 12 |
| *COVID-19 Risk - There is a risk that as a result of COVID-19 business as usual and financial arrangements are not in place for 20/21 and there is insufficient monies to ensure continued abilities to pay staff and suppliers and so ensure business continuity* | 4 | 5 | 20 | 3 | 5 | 15 | 2 | 5 | 10 |
| **Links to 12+ Trust Risks** | **Description of linked 12+ Trust Risks**<br>• 12 – Staffing | | | | | | | | |

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| | • 868 – Agency spend |

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| A | Services are responsive to the needs of service users. | 1 | Deliver substantial compliance against EPRR core standards in annual declaration. | DO | | Q2 | The Trust achieved full compliance against the EPRR core standards, one of only a small number of Trusts within England to achieve this. | | | |
| A | Utilise national profile re digital to enhance accessibility for service users, carers and staff. | 1 | Optimising digitalisation of clinical processes – evaluation of and enhancement of digital systems | MD | | Q3 | Review use of video consultations from patient and staff perspective<br><br>Evaluate formatting/tools available to support ease of access of patients clinical information | | | |
| A | Increase Digital profile as national exemplar improving access to services within CYP through the use of digital technology. | 2 | Delivery of the Lorenzo digital exemplar pilot within the CYP Directorate. | DPSD | | Ongoing | Digital Aspirant programme confirmed with £4m of national funding, DXC support in place with purchase orders approved. DA programme content has been shared and approved via SLT and individual 'spotlight' sessions with key internal stakeholders. | | | |
| - | Delivery of CIP targets. | 1 | CIP target for 2022/23 is achieved recurrently. | DO | | Q4 | CIP plans and delivery programmes discussed at the CIP Management Group and subject to QIA process. There remains a CIP gap at the present time. | | | |

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| | | 2 | Granular CIP plans are developed for 23/24. | DO | | Q4 | Plans developed and actioned, QIAs within approval process or approved. There remains a CIP gap at the present time. | | | |
| SPAR | Five year financial model aligned to organisational and ICB strategy (year 1 of 5). | 2 | Five year plan is developed which describes plans for sustainability. | DOF | | Q1 | Plans developed and actioned, QIAs within approval process or approved. There remains a CIP gap at the present time. | | | |
| | | 2 | Delivery of the control total. | DOF | | Q4 | | | | |
| | | 3 | Use of resources level 1. | DOF | | Q4 | Agency caps are not included in UoR metrics which have been announced but the scoring is yet to be clarified, there is a focus on systems managing within their financial envelope. The system is in balance in 21/22 but maintains an underlying deficit. Use of Resources level 1 is dependent on the guidance requirements issues nationally | Awaiting confirmation | | |
| | | | Agency spend contained within the agency cap throughout the year. | DO | | Q4 | Agency spend remains a challenge | | | |

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| SPAR | Delivery of ICB Financial Plan. | 3 | Work with the ICB long-term financial plan for system solutions to resolve the deficit. | DOF | | Q4 | Agreed plan is in place with regular discussions with NHSE/I who provide scrutiny and oversight. Savings plans in place to support the eradication of the underlying deficit. | | | |
| SPAR | Rationalisation of the Trust Estate ensuring value for money. | 2 | Development of a five year Estates Strategy aligning the estate to operational delivery, locality working and strategic direction. | DOF | | Q3 | Preliminary work has taken place focused on working arrangements after COVID. Inpatient reconfiguration is underway with the Dormitory scheme. An external company has been commissioned to help support the development of a 5-year Estates Strategy. This has been delayed but should be ready by summer 2022. | | | |
| SPAR | Capital Plan | 2 | Implement 22/23 capital plan: | DOF | | Q4 | Capital plan implementation overseen by Capital Investment Group. Schemes identified | | | |
| SPAR | Enhance approach to Sustainability Development Goals. | 2 | Implement Green Plan | DPSD | | Q4 | NSCHT has published Trust level Green Plan in January 2022 and will be coordinating delivery through the Trust Sustainability Group | | | |
| SPAR | Deliver of transformational programmes of work to | 2 | • Projects TCP and 86 | DO | | Q4 | Project 86/TCP is delivering a net benefit in terms of run rate | | | |

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| | enhance service user experience and quality of care | | | | | | reduction and has a decreasing financial trajectory between M1 and M<br><br>Board Development session planned for August 2022 | | | |
| | | | Project Chrysalis | DO | | Q4 | The trust is in regular dialogue with NHSE/I regarding the shortfall in funding this year and expects to a solution by the end of the year | | | |