Towards Outstanding
Our quality journey continues

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Keele
UNIVERSITY
TEACHING TRUST

Quality Account 2017/18

Contents

Message from the Chair and the Chief Executive

We are delighted to introduce this year's Quality Account, to look back with pride on another year of significant success and achievement, to look forward with excitement to the developments we are leading within the Trust, and to celebrate our crucial partnerships with health and care colleagues across Staffordshire and Stoke-on-Trent.

Care Quality Commission

In February, we were really pleased that the Care Quality Commission rated every Combined Service as "Good" or "Outstanding". The results mean that at the time of publication, Combined Healthcare was the highest rated mental health trust across the Midlands and East of England, and third highest in the country.

The CQC results also confirm that the Trust's journey of improvement has continued – we were described last year by the CQC as the fastest improving mental health trust in the country.

To be able to continue to improve upon last year's fantastic results is something quite remarkable. It is a tribute to the continuing sheer determination, talent, dedication and ability of our fantastic staff. Particularly impressive was the improvement of our Community CAMHS services who in our first CQC inspection were rated Inadequate and now have had all five domains rated as Good. Our Adult Rehab services joined our Older Peoples Community services who are now rated as Outstanding.

But we are not complacent and our journey of improvement is continuing supported by our Towards Outstanding Engagement programme. We will be continuing our quality strategy to deliver Safe, Personalised, Accessible and Recovery focused services based on integrated locality working across North Staffordshire and Stoke-on-Trent. We are also proud that we have been chosen by the CQC as a mental health exemplar and have been asked to share our journey of improvement with other organisations.

Our key achievements

This Report sets out some of our key achievements in improving the quality of our services. These include:

- 91% of staff in NHS staff survey believe the organisation provides equal opportunities for career progression or promotion
- Finalist in no less than four 2018 HSJ Value Awards - including 2 out of only five finalists in mental health category
- Significant improvement in CAMHS waiting times - Two thirds of children and young people are seen for a first assessment within four weeks - no child waits more than 18 weeks, 97% of children and young people start their course of treatment within 18 weeks
- Among the very best performers in the country in Patient Led Assessment of the Care Environment (PLACE) results. Each of the six Trust sites inspected achieved 100% perfect scores in one or more areas.
- First mental health Trust in the country to host NHS Chief Executive Simon Stevens and the national NHS Executive Team for their Regional Meeting
- 19 consecutive years of financial balance
- Working closely with Keele University, achieving the highest conversion rates to psychiatry training of any medical school in England
- Average length of stay for new learning disability admissions cut by 60%.
- Proud to be able to be called a Keele University Teaching Trust
- Meir Partnership Care Hub winner of National Positive Practice in Mental Health Collaboration - a user led multi agency collaborative of 75 organisations, including NHS trusts, clinical commissioning groups, the police, third sector providers, frontline charities and service user groups.

Our key priorities

We continue to be committed to providing high quality care for our service users and carers. We feel this is only achievable by maintaining our partnerships across the communities we serve.

During the year we have set out our plans to continue our journey of improvement towards outstanding by moving to more integrated services based on locality working across North Staffordshire and Stoke on Trent. We are proud to be a key part of the North Staffordshire and Stoke on Trent Alliance – bringing together health and care providers including mental health, primary care, community services, acute services, social care and the voluntary sector.

We are also proud to play a leading role in the Together We're Better Sustainability and Transformation Partnership.

Our clinical services will deliver collaborative models of care and will reflect the needs of our service users and their experience of care. We will achieve this by having an on-going conversation with our service users and carers through a variety of both formal and informal feedback mechanisms. Our Open Space Event brought together over 50 of our service users and carers to give us their views on how we prioritise the specific approaches we take under our core quality SPAR priorities and how we can expand the ways in which service users and carers can get involved with the Trust, building on the excellent work to date of the Service User and Carer Council.

We hope you enjoy reading our Quality Account.

Caroline Donovan
Chief Executive

David Rogers
Chair

Welcome to our Trust

Our team of 1,277 whole time equivalent (WTE) staff are committed to providing high standards of quality and safe services

North Staffordshire, Combined Health Care, NHS trust was established in 1994 and provides mental health and learning disability care to people predominantly living in the city of Stoke-On-Trent and in North Staffordshire. We provide services to people of all ages with a wide range of mental health and learning disability needs. Sometimes our service users need to spend time in hospital, but much more often, we are able to provide care in outpatients, community resource settings and in people's own homes.

We also provide specialist mental health services such as Child and Adolescent Mental Health Services (CAMHS), substance misuse services and psychological therapies, plus a range of clinical and non-clinical services to support University Hospital of North Midlands NHS Trust (UHNM).

We currently work from both hospital and community based premises, operating from approximately 30 sites. Our main site is Harplands Hospital, which opened in 2001 and provides the setting for most of our inpatient units.

Our team of 1277 whole time equivalent (WTE) staff are committed to providing high standards of quality and safe services. We service a population of approximately 464,000 people from a variety of diverse communities across Northern Staffordshire.

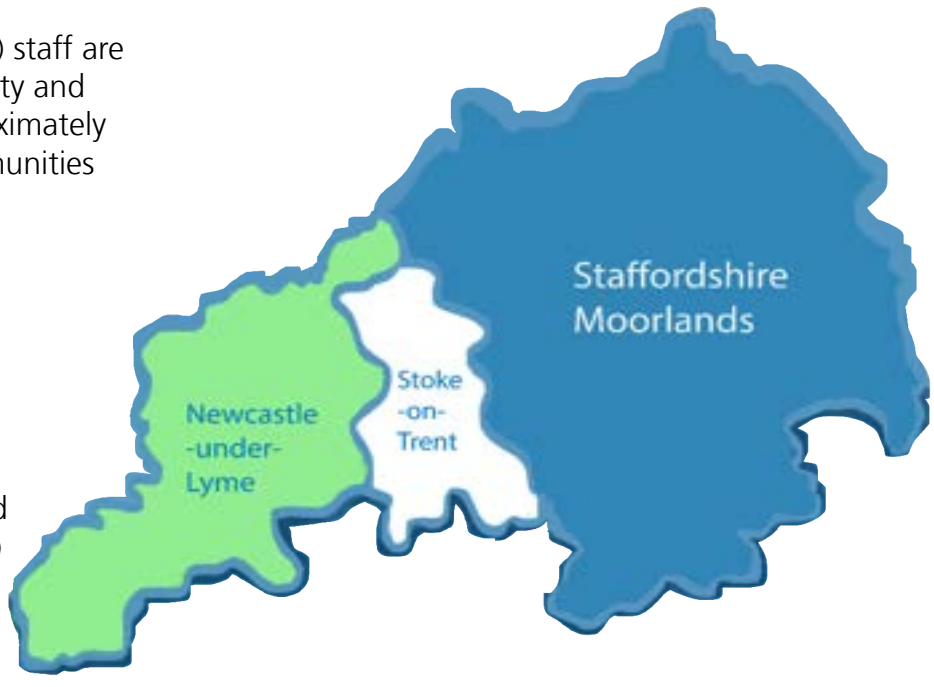
In 2017/18 the Trust achieved an adjusted retained surplus (control total) of £3.68m against an income of £85.1m. This is the 19th consecutive year the Trust has achieved financial surplus.

For 2017/18, our main commissioners remained the two Clinical Commissioning Groups (CCGs) – North Staffordshire CCG and Stoke-on-Trent CCG. We also work very closely with the local authorities in these areas in addition to our other NHS partners.

We have close partnerships with agencies that support people with mental health and learning disability problems, such as Approach, ASIST, Brighter Futures, Changes, EngAGE, North Staffordshire Huntington's Disease Association, Mind, North Staffs Carers Association, Reach and the Beth Johnson Association.

The Trust Board, comprising the Chairman and five non-executive directors, the Chief Executive and six executive directors, leads our organisation. A General Practitioner, Staff Side Representative and the chair of our Service User and Carer Council supplement the Board.

Further information regarding our purpose, vision and values is contained in the Trust's Annual Report, which provides an overarching summary of the Trust's services and can be found on our website at www.combined.nhs.uk



Welcome to our Quality Account

Welcome to our latest Quality Account, which covers the financial year 2017/18 – 1 April 2017 to 31 March 2018.

We produce a Quality Account each year, which is a report to the public about the quality of services we provide and demonstrates that we have processes in place to regularly scrutinise all of our services. Patients, carers, key partners and the general public use our Quality Account to understand:

- ✓ What our organisation is doing well
- ✓ Where improvements in the quality of services we provide are required
- ✓ What our priorities for improvement are for the coming year
- ✓ How we have involved service users, staff and others with an interest in our organisation in determining these priorities for improvement.

We hope that you find this Quality Account helpful in informing you about our work to date and our priorities to improve services over the coming year.

We also look forward to your feedback, which will assist us in improving the content and format of future Quality Accounts. This can be given through the Trust's website www.combined.nhs.uk or by email to qualityaccount@northstaffs.nhs.uk.

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Services covered by this Quality Account

This Quality Account covers all six clinical directorates provided by the Trust. During the period from 1 April 2017 to 31 March 2018, the Trust provided or sub-contracted eight relevant health services - the trust sub-contracts out to two non-NHS bodies in respect of improving access to psychological therapies (IAPT). The services we provide are shown below under our clinical structure.

Adult Mental Health Inpatient Directorate	Adult Mental Health Community Directorate	Neuro and Old Age Psychiatry Directorate	Substance Misuse Directorate	Learning Disability Directorate	Children and Young People's Directorate
Clinical Director & Head of Directorate	Clinical Director & Head of Directorate	Clinical Director & Head of Directorate	Clinical Director & Head of Directorate	Clinical Director & Head of Directorate	Clinical Director & Head of Directorate
Acute In-patient (Wards 1, 2, & 3)	Access and Home Treatment	Ward 4	Edward Myers Inpatient Unit	Assessment & Treatment	CAMHS North Stoke
Place of Safety	AMPHs & DOLs	Complex Needs (Ward 6)	One Recovery North Staffs	Community LD Team, City	CAMHS South Stoke
ECT Suite	ASD Service	Mental Health and Vascular Well Being	One Recovery South-East Staffs	Community LD Team, North Staffs	CAMHS North Staffs
Florence House	Carers Team	Neuropsychiatry Community and Day Hospital	One Recovery South-West Staffs	Specialist Short Break Services	Darwin Inpatient Unit
Summers View	Community Day Services	Neuropsychiatry Inpatient Services (Ward 5)	Stoke Heath Substance Misuse Team	Intensive Support Team (IST)	Specialised Services
	Criminal Justice Mental Health Team	Neuropsychology, Physical Health & Older Adults Psychology	Stoke Community Services	Children LD Services	CAMHS Referral Hub
	Early Intervention	Old Age Outreach Team			
	Hillcrest Recovery and Resettlement	Older Persons Ward (Ward 7)			
	Healthy Minds Stoke-on-Trent	Rapid Assessment Interface and Discharge Service (RAID)			
	Wellbeing Services Staffordshire	Staffordshire CMHT			
	ICMHT City	Stoke CMHT			
	ICMHT County				
	Resettlement and Review Team				

1.0 Statement on Quality

1.1 Our vision, values and objectives

Our core purpose is to improve the mental health and wellbeing of our local communities - some 464,000 people living across Stoke-on-Trent and North Staffordshire.

Our strategy is to deliver an evidence-based model of care, which is appropriate to our service user needs and focuses on wellbeing and ongoing recovery. We aim to be recognised as a centre of excellence, bringing innovative solutions to the services we deliver and embedding a culture of continuous learning across our organisation. This is reflected in our vision, values and objectives, as well as our focus on quality and safety.

Our Vision: "To be outstanding"

This will be achieved through **seven key objectives**:

1. Enhance service user and carer involvement
2. Provide the highest quality services
3. Create a learning culture to continually improve
4. Encourage, inspire and implement research and innovation at all levels
5. Attract and inspire the best people to work here
6. Maximise and use our resources intelligently and efficiently
7. Continually improve our partnership working

Our values are:

Proud to **CARE** – Compassionate, Approachable, Responsible and Excellent.

These values are well-embedded and were developed by our staff and partners and will underpin everything we do

Quality Priorities

Our Quality priorities are aligned to the four strands of quality known as SPAR:

- Our services will be consistently Safe.
- Our care will be Personalised to the individual needs of our service users.
- Our processes and structures will guarantee Access for service users and their carers.
- Our focus will be on the Recovery needs of those with mental illness.

1.2 Trust Care Quality Commission Comprehensive Inspection

In February 2018 the CQC published their findings from their unannounced and well led inspections which took place within the Trust throughout October and November 2017. We are delighted to have received an improved rating from the CQC with every one of our services rated as 'good' or 'outstanding. '

Our Community CAMHS team made a significant improvement with every CQC domain now rated as 'good.'

Our Inpatient Rehabilitation services have also obtained a significant achievement with both Florence House and Summers View obtaining an overall rating of 'outstanding.' They joined the Older Peoples' Community Services who also have an 'outstanding' rating.

The CQC results confirmed that the Trust's journey of improvement - labelled last year by the CQC as the fastest improving mental health trust in the country has continued. Amongst many compliments, the CQC found:

- "The overall culture of the trust was very patient-centred. Staff treated patients with dignity, respect and compassion and most experienced high morale and motivation for their work."
- "There had been significant improvement in the reduction of waiting lists in the child and adolescent mental health services and the adult community mental health services since the last CQC inspection. All teams were meeting the national waiting time standards."
- "We found staff to be dedicated, kind, caring and patient focused. The local management and leadership of services were both knowledgeable and visible. Staff we talked to during inspection spoke highly of their managers and told us that a more positive and open culture had continued to develop since our last inspection."
- "We were particularly impressed by the level of care offered to patients in the long stay and rehabilitation wards and the community based mental health services for older people, both of which were rated Outstanding overall."

To be able to continue to improve upon last year's results is something quite remarkable and the Trust recognises that this is due to the determination, talent, dedication and ability of all our staff.

CQC highlighted several areas of 'Outstanding' practice including:

- **Acute Inpatient wards** cohesive and knowledgeable multidisciplinary team and the instigation of the acute care pathway ensured that a wide range of activities, therapies and interventions were available to actively engage patients and carers, which reduced the amount of time patients needed to stay in hospital.
- **Rehabilitation Inpatient units** introduction of a support time and recovery worker who normally worked within a community team to the units has enhanced the community programme offered to patients.
- **Adult Community Mental Health Services** - The early intervention team had worked with service users to develop a specific dual diagnosis pathway for people who used drugs and alcohol and experienced psychosis. They had developed a set of 'change cards' to assess where people were in the cycle of change so that they could assess the most suitable interventions for patients.
- **Specialist CAMHS Community Services** - the service recently launched a new mental health and wellbeing strategy in schools across Stoke-on-Trent.
- **Inpatient Wards for Older People** - The service manager had led on a project to identify causes of delayed transfers of care from the service alongside commissioners, local authority and NHS partners. An action plan had been in put in place that had reduced the numbers of patients delayed in their discharge. They had also linked local actions into a broader local health and social care effort to improve the care experience of older adults throughout Stoke and North Staffordshire.

The journey of improvement is set to continue and is aligned with the quality strategy to deliver Safe, Personalised, Accessible and Recovery focused services based on integrated locality working across North Staffordshire and Stoke-on-Trent.

One of the areas of improvement that we have focused our intention on is the approach to medicines management. The CQC identified some issues with management of topical medicines and fridge temperature monitoring under the Safe domain.

In addition to the Inspection results the Community CAMHS Team have been spotlighted in the latest edition of the CQC regional publication highlighting great practice and innovation.

The Trust is also proud to have been chosen by the CQC as a national mental health exemplar and is delighted to have the opportunity to share our journey of improvement with other organisations.
All core services have comprehensive improvement plans in place to address the areas noted in the CQC reports and to date significant progress has been made with many of the 'must' and 'should' do requirements being addressed and rated as 'complete' following a robust assurance process through our performance management arrangements.

Summary CQC Rating Table:

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

Detailed CQC Rating Table:

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Substance misuse services	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good

1.3 Quality of Services - Key achievements at a glance

Quality of Care

We are committed to providing safe mental health services that are of the highest quality. Safety and quality drive our improvement agenda and each year we set out quality priorities that are agreed with service users and carers. Improvements during 2017/18 include:

Under 'Safe' we have:

- ✓ In the 2017 CQC inspection all core services were rated as 'good' or 'outstanding'. Furthermore all 'must do' and 'should do' requirements from CQC from 2016 have been addressed. Additionally all core services have comprehensive improvement plans in place to address the areas identified in the 2017 CQC inspection and to date significant progress has been made with many of the 'must do' and 'should do' requirements being addressed and rated as complete. We will continue this robust assurance process through our performance management arrangements.

- ✓ In terms of improved physical health monitoring, clinical staff received physical health training including recognition of the deteriorating patient in relation to the onset of sepsis as part of mandatory training. The National Early Warning Scoring (NEWS) tool has also been implemented within inpatient areas. Following these initiatives there has been a reduction in our inpatients being transferred to the local acute hospital.

- ✓ Commenced our journey towards being a smoke free organisation with in-patient areas going smoke-free from April 2018.

- ✓ For the second year running the flu vaccination campaign achieved the national target of at least 70% frontline staff receiving the vaccination.

- ✓ Compliance with physical health monitoring and recording post rapid tranquilisation is monitored through monthly review of incidents and subsequent completion of physical health monitoring; the Inpatient Safety Matrix demonstrated 100% compliance in Q4

- ✓ The Trust Suicide Prevention Strategy was implemented during 2017/18. As part of this strategy we have worked in collaboration with Public Health with the aim of reducing suicides in the local area.

- ✓ Continued to facilitate the 'living well with risk group' to embed the Suicide Prevention strategy and ensure collaboration with people with lived experience.

- ✓ Embedded unannounced assurance visits to in-patient wards with quarterly reporting to the Quality Committee and Trust Board.

- ✓ Agreed a plan for further investment in environmental ligature improvements in accordance with 2016/19 plan. Introduced an acute care pathway on adult inpatient wards the impact of which has seen a reduction in the length of stay

- ✓ Implementation of an assurance framework and strategy for Infection Prevention & Control (IPC). This forms part of the governance around IPC with quarterly and annual IPC report to the Board of Directors.

Under 'Personalised' we have:

- ✓ Where possible we have continued to involve family/carers to ensure that their views are incorporated into risk management plans, highlighting any protective factors that these relationships provide.
- ✓ The Service User and Carer Council (SUCC) have engaged with the development of the Person Centeredness Framework.
- ✓ We have representation from service user and carer's across a range of trust business and activity; including interviewing new recruits, co-facilitating a wide range of events, attending various committees including People, Culture and Development, Quality, Finance, Performance and Digital and Business Development.
- ✓ Worked with our service users, carers and staff to develop a Person Centeredness Framework; the overarching principles have been agreed and the framework will be implemented in 2018/19.

Under 'Accessible' we have:

- ✓ Across Staffordshire,commenced the process to procure a single integrated care record; a project led by the Chief Executive on behalf of the STP.
- ✓ The chair of the SUCC is a full member of the Trust Board The service user and engagement strategy has been refreshed in partnership with the SUCC.
- ✓ We have ensured that there is a service user and carer representative at the mental health sustainability and transformation plans (STP) board.
- ✓ When preparing for the 2016/17 AGM, the finance team developed an animated video to present the accounts in a way that was easy to understand, which fully supported staff and service users to understand how we spend our money to deliver the best patient care. Many viewers said it was the first year they genuinely understood the numbers.
- ✓ A psychiatric intensive care unit (PICU) has been built and we are currently recruiting the staff team.
- ✓ Achieved 92% compliance with national waiting times targets and 18 week waits for definitive treatment for all services.
- ✓ Worked in collaboration with primary care and the University Hospital of North Midlands (UHNM) to become improve accessibility to patients through the use of video consultation in the Neuropsychiatry and Older Persons directorate. This will be carried forward in 2018/19 with pilots in 2 further directorates.

Under 'Recovery Focussed' we have:

- ✓ Developed a prototype for an app that promotes recovery from depression, encourage hope and help seeking behaviour at the point of personal crisis.
- ✓ Work has commenced in developing a network of peer support workers and peer support worker strategy is being developed.
- ✓ To support recovery we have progressed the development of a well-being academy (recovery college) establishing a collaboration with the voluntary sector with plans in place for a virtual and physical resource.
- ✓ Agreed a contract for the extension of the FLO and autographer innovation to develop a self-managed integrated care pathway for dementia patients.
- ✓ Ensured care plans are completed with individuals and are recovery focussed.
- ✓ Strengthened to develop evidence based psychological interventions in adult acute wards.

1.4 Building Capacity and Capability

During the year the Board membership has been refreshed and further enhanced with the appointment of a new Director of Workforce, Organisational Development and Communications, Director of Operations and new Non-Executive Director. A GP Associate Board member continues to give strength and support to the Board from a primary care perspective. The Chair of the Service User and Carer Council is also a full member of the Board to strengthen decisions made and which are service user focussed.

The Board has a wide range of experience and skills to provide effective leadership. As part of the Board Development Programme we have undertaken a Board skills assessment.

A core component of the development programme is to ensure that all board members have a focus on their own and collective leadership style and also to have a focus on continuous improvement in order to deliver the highest quality, safe services for our community, within resources available. During 2017/18, the Trust strengthened its approach to Board Development, participating in the Advancing Quality Alliance programme (AQuA) and linking this through to leadership and service development across the wider Trust through the Leadership Academy.

As part of a review of its effectiveness, the Board undertook a full evaluation of its effectiveness with the support of AQUA against the NHSI well-led framework and CQC Key Lines of Enquiry (KLOEs) in preparation for a full well-led review undertaken by the CQC in November 2017.

1.5 Workforce

We employ 1,286 (WTE) substantive staff, with the majority providing professional healthcare directly to service users. We also have an active staff bank which supports our substantive workforce. We have recently strengthened our Temporary Staffing service to allow a greater provision and flexible staffing model which is more adaptive to service needs and removes wherever possible the need for agency provision. This has resulted in our use of agency staff to fulfil 'core' operations as being one of the lowest rates of any NHS Trust in the country.

We recognise that our workforce are our greatest asset and we continue to develop our staff and the culture within which they work, to enhance service users' experience, improve performance and increase staff engagement.

Our People and Culture Development Committee meets six times a year and has a transformational approach to the workforce agenda.

We focus on:

Cultural Development
Towards Outstanding Engagement:

We have been on a journey of staff engagement for 4 years, starting with the introduction of Listening into Action (LiA) which was a Trust wide approach to engagement, creating excellent demonstrable results. LiA was really successful at creating change through the engagement and involvement of staff, service users and carers and helping to influence staff engagement culture at an organisational level. This saw the Trust improve its staff survey engagement scores from being one of the lowest scoring Mental Health Trusts, to being in the top quartile in 2016/17and also recording average or above average in over 80% of the findings.

The introduction of Towards Outstanding Engagement in April 2017 has enabled the Trust to take our next step in our engagement journey. The approach is evidence-based, and won multiple awards for its implementation and success in numerous NHS organisations. It provides us with the ability within the organisation to measure and use diagnostics to gauge trends, hotspots, carry out appreciative enquiry and target engagement activity where it is going to have most impact. It helps to influence and change engagement culture at a team level.

By developing both organisational and team engagement cultures through LiA and the recent introduction of the Towards Outstanding Engagement Programme, we are priming the organisation for the next stage in our journey, which will see the development and introduction of a Trust approach to service improvement.

Improving team engagement, results in better performing teams, which ultimately improves the quality of care we provide to our service users. The delivery of Cohort 1 has been a major success in helping to improve staff engagement with 12 of the 16 teams who took part increasing their engagement scores. We have already seen changes to ways of working and the start of culture change within teams, with most teams seeing significant change at a time when the Trust average engagement score and seen a slight dip.

For those teams that have seen a slight decrease, despite effort to improve their team engagement, we will continue to provide close support during this transition to seeing a positive impact on team engagement. Cohort 2 of Towards Outstanding Engagement will commence later in the year.

Health and Wellbeing:

Fostering a positive culture that supports the health and wellbeing of our workforce is of great importance. Significant progress has been made this year by focusing on a variety of Health and Wellbeing initiatives for our staff including the initiation of a Health and Wellbeing Steering Group which has led to the development of a number of health and wellbeing initiatives including healthy eating education, our winter flu fighter campaign, the introduction of a Physio fast track service and Pilates sessions which staff are invited to attend.

Our Wellbeing Wednesday and Feel Good Friday initiative has continued to be a great success and encompassed a wide variety of Health and Wellbeing topics including Staff Counselling services, Occupational Health surveillance checks, Staff Side advice and HR workshops. This initiative has been extremely well received with many staff reporting taking positive actions to improve their health and wellbeing. Such initiatives demonstrate our continued commitment to supporting a healthy workforce and proactive stress management and resilience.

Diversity & Inclusion:

2017/18 has been an extremely important year for the Trust in terms of advancing equality, diversity and inclusion within the organisation and beyond with lots more work planned for the coming year with a specific focus on improving the experience of working here for our BAME staff and embedding the EQIA process.

Some of our key achievements for 2017- 2018 are listed below:

- April 2017: Trust appointed as an NHS Employers Diversity and Inclusion Partners Programme Diversity Champion
- May 2017: We held our first Trust LGBT (Lesbian, Gay, Bi and Trans) Focus Groups for service users and staff facilitated by Abby Crawford from Stonewall and were also presented with an award from Deafvibe for the work of the Trust's Deaf Awareness Group in raising awareness, and developing access and experience for service users who are deaf or hearing impaired.
- May 2017: the Trust established links with the local Stoke Sikh Gurdwara and was presented with an award at the Vaisakhi celebrations; this has led to continued collaboration and partnership working throughout the year
- June 2017: We held our highly acclaimed Staffordshire Symphony of Hidden Voices inclusion conference that aimed to 'show not tell' people what inclusion is through the power of personal stories
- July 2017: The Trust's Diversity and Inclusion Group were runners up in the Trust REACH Awards for the Team of the Year Award
- September 2017: Trust spirituality garden opened with daily access for service users, carers, other visitors and staff – thanks to a generous grant of £12,000 from the Tesco Bags of Help fund.
- October 2017: We launched our Trust BAME Staff Network, led by Cherelle Laryea, Trainee Clinical Psychologist and held 'Afternoon Tea with the Director of Nursing' sessions held for BAME staff
- December 2017: Trust awarded £50,000 funding to deliver a Staffordshire NHS BAME Leadership Programme (programme will be delivered in 2018-19)
- February 2018: Trust established links with Stoke Central Mosque and agreement to work in collaboration going forwards and praised by the local Commissioning Support Unit (CSU) for the work the Trust has done in developing diversity and inclusion

Proactive stress management and resilience approach:

Through our Staff Counselling and Support service, we provide a vast range of services including preventative and responsive mechanisms of support. In supporting increased resilience, the service works to identify stress flash points and provide debrief sessions for staff following incidents.

Leadership and management development:

Our People Management Programme is a modular scheme that develops our managers and aspiring managers in multiple aspects of their management competency. This programme has been extended to include new subject areas to support our managers and aspiring managers.
We have continued to work with our leaders through our Leadership Academy with the programme of events focussing on key strategic topics that are aligned to our Board Development Programme.

Leading with Compassion:

This is a scheme whereby there is a central point (electronic and paper version) where staff, patients and carers are able to recognise someone who they believe has demonstrated leading with compassion.

Every nominated person will receive a Trust designed personalised badge and card. We will gather nominations and theme into the different ways in which compassion was shown. We have created an NHS compassion website www.nhscompassion.org incorporating a video which gives an overview of the scheme and some of the evidence behind why it is important.

Staff and patients have nominated staff across all clinical and non-clinical areas resulting in 774 nominations from across the Trust.

Recruitment and Retention:

Recruitment and retention continues to be a major focus for the Trust. Along with many NHS Trusts due to a national workforce shortage, Nursing and Medical recruitment remains a challenge. A number of strategies have been adopted to support attracting potential candidates including Apprenticeships, the development of new roles, enhanced media campaigns and one stop shop recruitment campaigns.

To further support the timely recruitment of our workforce the Trust recently introduced an enhanced electronic appointment system called TRAC. Although in its early stages significant progress continues to made to reduce the time taken to recruit new staff.

Learning Management:

We have recently launched our new Learning Management System (LMS) where every staff member has their own account. This enables our staff to easily access and complete e learning and to book onto classes. The LMS reminds people when they are due to complete regular education sessions and advertises new opportunities directly to staff and delivers real time reporting to all managers across the Trust. This has proved to be an efficient and responsive system, driving up standards whilst allowing us to launch a raft of education opportunities enhancing our preventative and proactive capabilities. As a consequence we have seen month on month improvements in mandatory education and staff accessing e learning development opportunites.

Apprenticeships and New Roles:

We offer a range of apprenticeships and apprentice qualifications at different levels to enhance skills with the Trust, support talent management and draw maximum benefit from the funding available. We understand our current staff qualification levels to further enhance the skills of the workforce through apprentice qualifications and are developing new roles and pathways to enable staff to progress their career examples include the development of Assistant Practitioner, Nurse Associate Roles and Apprentice Nurses. We are doing this by working with partner organisations to maximise our buying potential with Approved Training Providers.

Staff Awards:

We acknowledge and reward staff through our annual Recognising Excellence and Achievement in Combined Healthcare (REACH) Awards and 'spotlight' the efforts of an individual and a team at our public Trust Board meetings.

Listening to Staff:

Our CEO's blog is read widely and strengthens openness and honesty as part of our drive for authentic leadership. We have well-established means of listening and responding to staff, including the appointment of our Freedom to Speak up Guardian, and the Dear Caroline initiative which provides all staff with access to our Chief Executive to anonymously raise any issues, concerns, service suggestions and compliments.

The National NHS Staff Survey provides us with an annual opportunity both to monitor changes in what it feels like to work for the Trust over time and to benchmark against other mental health trusts.

Members of the Board also visit teams on a monthly basis for informal Q&A sessions, giving staff an opportunity to share in successes in their services as well as discussing challenges with a Board member. This has proven to be a great way of developing two-way conversations and empowering staff to raise issues of concern.

Research shows that trusts with stronger staff recommendation scores are also found to have stronger outcomes in terms of quality of patient care and experience.

1.6 Quality of Services - Key Priorities 2017/18

Looking forward, we continue to be committed to providing high quality care for our service users and carers. We feel this is only achievable by maintaining our partnership across the communities we serve. Our clinical services will deliver models of care and will reflect the needs of our service users and their experience of care. We will achieve this by having an on-going conversation with our service users and carers through a variety of both formal and informal feedback mechanisms.

We will commit to building on our quality systems and learning from CQC inspections to ensure a continuous programme of improvement. Following October 2017's CQC inspection we have continued to review areas for improvement through the on-going development of comprehensive improvement plans and will work in partnership with service users, the CCQ, carers and other key stakeholders to implement and sustain improvements.

We are committed and ambitious in our endeavour to provide the highest quality mental health services. Our board's business is driven by the quality plan as defined by our four on-going priorities, known as SPAR:

- Our services will be consistently SAFE
- Our care will be PERSONALISED to the individual needs of our service users
- Our processes and structures will guarantee ACCESS for service users and their carers
- Our focus will be on the RECOVERY needs of those with mental health illnesses.

In summary our quality priorities for 2018/19 include:

Safe:

- Dual Diagnosis pathway
- Zero Suicide ambition
- Improve physical health by being a Smoke-Free Trust
- 100% achievement of CQUIN schemes
- Transition between services
- SPAR wards accreditation framework
- Continued investment in environmental ligature improvements
- Auditing Sepsis compliance
- Falls prevention
- Flu vaccination campaign
- Improved medicines management
- Community Safety Matrix
- PLACE programme
- Audit prone restraint and benchmark nationally

Personalised:

- Implement Person Centredness Framework
- Implement restraint reduction strategy
- Patient control to access their own electronic patient record
- Mental Health Law
- Roll out therapeutic observation Quality Improvement project

Accessible:

- Improve access to services
- Reduce out of area placements and reduce delays in transfers of care
- CAMHS digital exemplar
- Achieve 100% compliance with 3 hour assessment target for service users entering the Place of Safety
- Use of video consultation

Recovery Focussed:

- Wellbeing Academy
- Peer mentor, volunteers and employment opportunities for people with lived experience
- Towards Outstanding service user environments
- Unannounced assurance visits to Community Teams

Further details are within Section 2.2

1.7 Trust Statement

We are pleased to publish this quality account for the financial year 2017/18 (1 April 2017 to 31 March 2018). It re-confirms our commitment to continually drive improvements in services and to remain transparent and accountable to the general public, patients, commissioners, key stake holders and those that regulate our services.

To ensure our quality account covers the priority areas important to local people we have consulted with our key stakeholders in the voluntary and statutory sectors, with local authorities and with our staff. Their valuable comments have been listened to and, where appropriate, have been incorporated into this document to help strengthen involvement in our services going forwards.

In line with the recommendation of the Francis inquiry, this Quality Account is signed by all trust board members to provide assurance that this is a true and accurate account of the quality of services provided by North Staffordshire Combined Healthcare NHS trust.

We can confirm that we have seen the quality account, that we are happy with the accuracy of the data reported, are aware of the quality of the NHS services provided and understand where the trust needs to improve the services it delivers.

Name and Position	Signature	Date
David Rogers, Chair		21st June 2018
Tony Gadsby, Non-Executive		21st June 2018
Patrick Sullivan, Non-Executive		21st June 2018
Lorien Barber, Non-Executive		21st June 2018
Joan Walley, Non-Executive		21st June 2018
Gan Mahadea, Non-Executive		21st June 2018
Caroline Donovan, Chief Executive		21st June 2018
Dr Buki Adeyemo, Executive Medical Director		21st June 2018
Suzanne Robinson, Executive Director of Finance, Performance and Digital		21st June 2018
Maria Nelligan, Executive Director of Nursing & Quality		21st June 2018
Alex Brett, Director of Workforce, Organisational Development and Communications		21st June 2018
Jonathan O'Brien, Executive Director of Operations		21st June 2018
Andrew Hughes, Director of Strategy and Development		21st June 2018
Keith Tattum, GP Associate		21st June 2018
Wendy Dutton, Chair of Service User and Carer Council		21st June 2018

Statement of director's responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The department of health has issued guidance on the form and content of the annual Quality Account (which incorporates the legal requirements in the health act 2009 and the National Health Service (Quality Account) regulations 2010 (as amended by the National Health Service (Quality Account) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfying themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and this subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance
- The directors confirm that, to the best of their knowledge and belief, they have complied with the above requirements in preparing the Quality Account

David Rogers
Chair

Caroline Donovan
Chief Executive

2.0 PRIORITIES FOR IMPROVEMENT (LOOKING FORWARD) AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 Plans for Improvement:

Engaging our partners and stakeholders

In any year, trusts have a number of competing priorities in terms of improving service delivery, providing value for money and good quality service provision. We are committed to working collaboratively with a range of partners and as such have included partners in the development and publication of this Quality Account.

Performance Quality Monitoring Framework.

This Quality Account is underpinned by a comprehensive performance monitoring framework (PQMF), which monitors the quality of services we provide. It also provides detailed information on other key performance indicators concerned with access and outcomes.

Where performance or quality metrics are not on target, clinical directorates provide rectification plans, including action planning, for performance review by the trust executives. The PQMF enables granular reporting of weekly and monthly dashboard reports to clinical teams and trust committees, with an overview maintained by the Trust Board.

Monthly clinical dashboards have been enhanced to provide better visualisation of the most important performance measures and quality indicators, thereby enabling trends to be more easily identified. Key priorities are reviewed to ensure that the pressing indicators of quality are in focus. The review of individual clinical teams' compliance with CQC and Mental Health Act standards continued during the year, with results being used to drive improvements in the services provided to patients.

The Trust uses local and national benchmarking information to add intelligence and insight to our performance management processes. Benchmarking enables the performance of the directorates to be analysed and they are supported in identifying how improvement in quality, productivity and efficiency can be achieved. Benchmarking with others will also help to determine how the trust will become outstanding in areas. The Trust remains a key member of the NHS mental health benchmarking reference group.

The Trust's quality committee continued to actively monitor the quality of services. Robust assurance is provided to Trust Board, service users and commissioners on performance measures.

2.2 Priorities for improvement and goals agreed with Commissioners

Key priorities for improvement

As previously described, in determining our priorities we have engaged with our service users to ensure the priorities meet the needs of our local population.

We are committed and ambitious in our endeavour to provide the highest quality mental health services. Our board's business is driven by the quality plan as defined by our four on-going priorities, known as SPAR:

- Our services will be consistently SAFE
- Our care will be PERSONALISED to the individual needs of our service users
- Our processes and structures will guarantee ACCESS for service users and their carers
- Our focus will be on the RECOVERY needs of those with mental health illnesses.

Progress monitoring:

Progress to achieve these quality priorities will be monitored and measured through individual area milestones, with regular reports to the senior leadership team and quality committee on progress made, risks identified and mitigation plans developed. Progress will also be reported through the commissioner-led Clinical Quality Review group.

Key quality priorities for 2018/19:

Safe:

- Develop and implement a Trustwide clinical pathway implemented by a standard operating procedure that reflects the needs of service users with Dual Diagnosis
- Collaborate with partners to reduce death by suicide within the Trust as part of our Zero Suicide ambition and as part of a countywide strategy
- Improve physical health by being a smoke-free Trust (year 2 of 2)
- Improve physical health monitoring for service users
- achievement of CQUIN schemes
- Transition pathway between services are strengthened
- Implement SPAR wards accreditation framework to enhance the quality of care on in-patient wards
- Continue investment in environmental ligature improvements
- Continue to audit sepsis compliance against national standards
- Audit of falls to evidence reduction in avoidable falls following quality improvement programme
- Increase compliance with IPC audits from 85% to 90%
- Implement a Flu vaccination campaign achieving a target of 75%
- Improve medicines management including achieving 100% compliance with daily fridge temperature monitoring and correct labelling of topical medications
- Implement a standardised approach to safety through the Community Safety Matrix
- Maintain safer staffing in line with NQB and continue with review of the 24/7 teams and introduce to community teams
- Continue to implement PLACE programme and develop a strategy to be in the top performing quartile of trusts nationally
- Audit prone restraint and benchmark nationally

Personalised:

- Implement Person Centredness Framework co-produced with service users, carers and staff
- Implement restraint reduction strategy through co-production and embedding person centred care
- Use Service User feedback and FFT themes to influence Quality Improvement agenda in collaboration with the Service User & Carer Council (SUCC)
- Develop the protocol to give the patient control to access their own electronic patient record (year 1 of 3)
- Ensure compliance with Mental Health Law for every patient
- Roll out the NHSI Therapeutic observation Quality Improvement project across all acute wards

Accessible:

- Improve access to services by continuously achieving
  - 100% compliance for referral to assessment (1st contact) in 18 weeks in general and 4 weeks in CAMHS
  - 92% compliance for referral to treatment (2nd contact) in 18 weeks
- Continue to work with health and social care commissioners to ensure that every effort is made to ensure that service users are treated in the most appropriate environment and reduce delays in transfers of care
- Use technology to improve access to CAMHS services for young people and be more responsive through the digital exemplar
- Achieve 100% compliance with 3 hour assessment target for service users entering the Place of Safety
- Work in collaboration with Primary Care and the University Hospital of North Midlands (UHNM) to become more accessible to patients through the use of video consultation

Recovery Focussed:

- Implement both a virtual and physical wellbeing academy to complement traditional rehabilitation approaches by providing people with education and learning experiences as a means of supporting recovery
- Develop and implement a Trustwide strategy to embed peer mentor, volunteers and employment opportunities for people with lived experience (develop at least 10 peer mentors)
- Identify quality priorities for 2019/20 in partnership with the SUCC who will conitnue to collaborate in improvement initiatives
- Develop and implement a Towards Outstanding service user environments programme in collaboration with SUCC
- Implement unannounced assurance visits to Community Teams

2.3 Statement of assurance from the Board

How progress will be measured and monitored

This section is provided to offer assurance that the trust is performing well as assessed internally via the trusts own processes; externally (therefore providing independent assurance); through processes to measure clinical outcomes; through audit and research and development; and through participation in national projects and initiatives.

The majority (82%) of clinical services provided by North Staffordshire Combined Healthcare NHS Trust in 2017/18 were commissioned by the two local clinical commissioning groups- North Staffordshire CCG (33%) and Stoke-On-Trent CCG (49%).

Quality was monitored by the NHS Staffordshire and Lancashire commissioning support unit (CSU) on behalf of North Staffordshire and Stoke-on-Trent CCGs.

There is a contract in place to ensure clarity regarding the services commissioned for local people, the expectations of the service provider and expectations for the quality of services.

The Trust signed the standard national two year contract covering service delivery in 2017/18 and 2018/19 on 21st December 2016. The contract is largely block in nature with the two local CCGs, although the associate element of the contract is cost and volume with thresholds. The contract contains specific targets on a range of performance measures.

All elements of this contract are monitored through a CSU-led series of monthly meetings, with relevant associated data sent to the CSU as the co-ordinating body on a monthly basis.

Compliance with the Health and Social Care Act 2008 and the essential standards of quality and safety:

North Staffordshire Combined Healthcare NHS Trust has self- assessed against the outcomes defined by the regulations and declared compliance with all of the outcomes. The Trust registered with the Care Quality Commission in 2010, without conditions to provide a range of regulated activities.

Payment by Results:

The trust is not subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.

Measuring clinical performance

Clinical audit, clinical excellence and research and development all contribute to measuring effectiveness (including both clinical outcomes and patient-reported outcomes) safety and patient experience through quantitative information. This includes reporting data regarding the impact of services on patients.

The clinical audit programme is developed to reflect the needs and the national priorities. Further information is contained below.

National Projects and Initiatives

This section includes reference to the national projects and initiatives that we are applying to improve the quality of our services.

Quality governance assurance framework

Our NHSI oversight segmentation is band 2; the highest segmentation being band 1 which gives trusts maximum authority.

Litigation cases for 2017/18

The numbers of cases against the Trust have remained static for non-clinical claims received for 2017/18 with only two being registered for employee liability. The expenditure on non-clinical claims has seen a 52% reduction from the previous year. The Trust has been able to successfully defend claims where we have been able to provide evidence that policies and procedures have been followed. We continue to work closely with NHS Resolution to use the intelligence learnt from these cases thereby ensuring quality improvements.

National quality improvement projects (service accreditation programmes): Managed by the Royal College of Psychiatrists' centre of quality improvement

The Trust has one ECT clinic which is accredited. Three wards (1, 2 and 3 at the Harplands hospital) for working age adults are also accredited. Two rehabilitation units: (Florence House and Summers View) are accredited. Our Memory Clinic services are accredited. Our learning disability wards and older persons wards have commenced the accreditation process this year.

Learning lessons

The Trust's Learning Lessons framework has continued to be extremely well received by staff over the past year. Staff feedback from participants in the monthly Learning Lessons session has continued to be 100% positive with staff generating ideas for future sessions. We have welcomed service users and partner agencies to speak at the sessions which has given us opportunities to share learning across the health and public sector economy.

2.4 Review of services

This section is provided to offer assurance that we have included all of the services mandated for inclusion.

During the period from 1st April 2017 to the 31st of March 2018 North Staffordshire Combined Healthcare NHS trust provided eight NHS services. The trust has reviewed all the data available on the quality of care in all of the NHS services provided by the trust. The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of the NHS services by North Staffordshire Combined Healthcare NHS Trusts for 2017/18.

The Trust's six main services, as referred to above are listed in the introductory section of this Quality Account- see 'services covered by this Quality Account'.

2.5 Participation in clinical audit

'Clinical audit is a quality improvement process that seeks to improve patient care and outcomes against specific criteria and the implementation of change.
Where indicated, changes are implemented at an individual team, or service level and further monitoring is used to confirm improvement in healthcare delivery. As such, clinical audit is an essential part of the quality assessment framework and a key element of clinical governance.'

During 2017/18, there were three national audits, two national confidential inquiries and one national review programme related to NHS services the trust provides.

During that period the trust participated in all (100%) of these national clinical audits and both the national confidential inquiries, as follows:

- Prescribing Observatory for Mental Health (POMH) – 100%
- Early Intervention in Psychosis – 100%
- Learning Disabilities Mortality Review – 100%
- National Clinical Audit of Psychosis – 100%
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH) – 100%
- Young People's Mental Health (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – 100%

The national clinical audits and national confidential inquiries that the trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

TITLE	% of cases submitted	% of cases required to be submitted
Early Intervention in Psychosis	100%	100%
Learning Disabilities Mortality Review*	100%	100%
National Clinical Audit of Psychosis	100% of required sample	100% of required sample
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)*	100%	100%
Prescribing Observatory for Mental Health topics:		
• Prescribing valproate for bipolar disorder (Topic 15b)	100%	100%
• Use of depot / long-acting injections for relapse prevention (Topic 17a)	12%	100%[1]
• Rapid tranquilisation (Topic 16b)	Data collection ongoing at April 2018	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	100%	100%
Young People's Mental Health (National Confidential Enquiry into Patient Outcome and Death)	100%	100%

**This data is collected centrally on a rolling basis.*

[1]Please note that for POMH audits there is no minimum requirement of cases to be submitted. For Topic 17a an adequate sample size was obtained without the need to submit 100% of cases relevant to the sample population, therefore the Trust still met the 100% requirement for POMH.

The reports of 2/2 national audits (as specified above) were reviewed by the provider in 2017/18 and actions agreed for implementation are detailed below. In one case the report is currently under review. In one case the audit data is still being analysed by the Royal College of Psychiatrists and the report will be reviewed by the provider on their release.

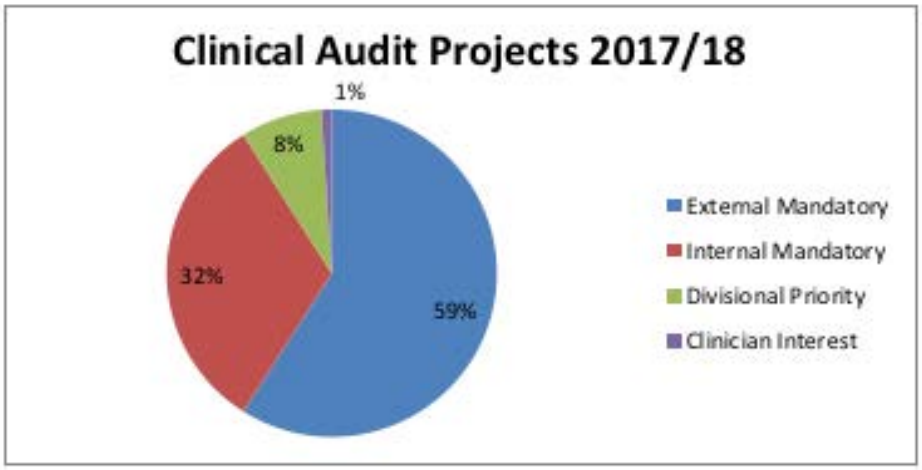
POMH 1g: Prescribing high dose and combined antipsychotics	Action completed
• Clinicians working on Wards 1, 2 and 3 at Harplands Hospital will be asked to investigate patients on the wards who are prescribed high dose or combination antipsychotics to determine reasons for prescription and feed back via the Trust Clinical Effectiveness Group.	Ongoing
• Positive findings will be shared with the Clinical Effectiveness Group and through Directorate meetings.	Ongoing
• The results of the audit will be presented at one of the Trust's educational sessions.	Ongoing

POMH 16a: Rapid tranquillisation	Action completed
• It was noted that due to ward round timings and weekends it may not be feasible for debrief to take place within 24 hours. To review with the Medical Director to agree whether 72 hours is an appropriate timeframe for debrief to take place.	✓
• Results to be fed back to Ward Managers for cascade to staff.	✓
• To discuss the possibility of providing injectable drugs training as part of the in-depth physical health training programme via the Physical Health meeting	✓
• Pharmacists will continue to highlight at-risk patients via prescription charts and to support the use of the HDAT monitoring form.	Ongoing
• To highlight areas where the HDAT monitoring form is not completed on a systematic basis via the Clinical Effectiveness Group for further action.	Ongoing
• To present the results as part of one of the trust's educational sessions, including: - The difference between maximum doses of IM and oral haloperidol - The importance of completing the HDAT monitoring tool - That intramuscular haloperidol should not be used as part of rapid tranquilisation in the absence of a recent ECG. - Recording of physical observations and cases where patients decline physical observations via the NEWS chart.	✓

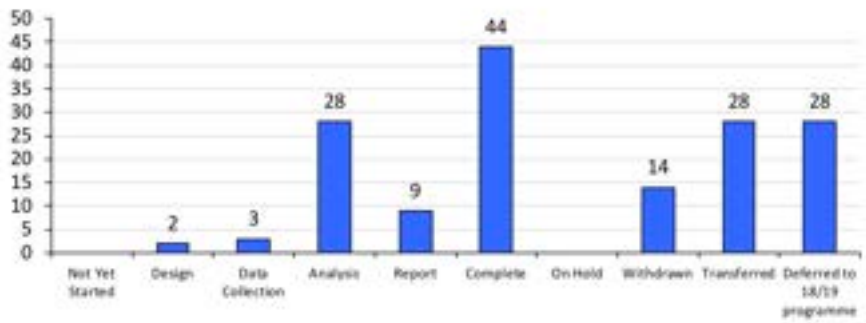
The results of POMH audits are disseminated to and action plans agreed at the Trust's Clinical Effectiveness Group.

Local clinical audit programme 2017/18

All projects on the clinical audit programme were facilitated by the Clinical Audit department. The programme is split into four priority levels in line with national requirements/ standards, including National Institute for Health and Clinical Excellence (NICE) guidance, POMH and standards produced by the Royal Colleges. The following chart reflects the total number of projects identified for 2017/18 split by the four priority areas:



Of the 86 active projects undertaken by the Clinical Audit Department during 2017/18, 44 (51%) were completed and all 44 reviewed by the provider in the reporting period. All completed audits contained a comprehensive action plan agreed by the Trust and all stages of the audit cycle undergo a robust validation exercise to ensure the reliability and quality of data reported. The graph below outlines project status for the 146 projects registered on the clinical audit programme for 2017/18:



Clinical Audit Programme 2017/18

For all clinical audits on the formal programme of work, an action plan to improve the quality of healthcare was developed in conjunction with the project steering group. The process included reviewing the findings and devising appropriate actions to reduce any shortfalls identified. The action plans were agreed with the audit lead and then submitted to the Clinical Effectiveness Group for ratification. Once this process was complete, the reports were published and disseminated accordingly. Individual action plans were then entered onto the action plan - monitoring database and regular updates requested from the action 'owners' to ensure progress is being made.

Once actions have been implemented, a re-audit is undertaken to determine if the actions made have resulted in improvements to the quality of healthcare. Further information on completed clinical audits and the clinical audit programme can be obtained from the Trust's Clinical Audit Department.

2.6 Participation in Research

During 2017/18 the Research and Development (R&D) team has continued to contribute to NHS national research through the delivery of high quality portfolio and commercial research.

During 2017/18 the Trust faced a significant challenge with regards to recruitment to NIHR portfolio studies; our initial recruitment target was revised in month 5 and increased by over 200%.

This challenge inspired staff to consider innovative ways to respond to meet the target. An incentive for the highest number of referrals received, weekly communications to wider staff about research referrals. Our final recruitment figure of participants in research approved by an ethics committee is 110 and is in excess of our original target.

During the year we have developed and reviewed our research recruitment strategies and agreed a work plan for 2018/19 which will impact significantly upon our performance during 2018/19.

We recognise that for many individuals research offers an opportunity to take a more active role in care and make an active contribution to the development of new knowledge while at the same time experiencing an enhanced quality of care. We firmly believe that service user involvement is crucial to high quality research, not just at the point of implementing a protocol but all through the study design process.

During 2017/18 we have engaged directly with groups of service users and carers both within the trust and the local community. We have received positive feedback from service users regarding their experiences of being involved in research and are committed to increasing the opportunities that our service users and carers have for helping to shape the future of research within the trust.

The development of our research profile continues to be a Trust ambition we are demonstrating a clear commitment to our aspiration to encourage, inspire and implement research and innovation at all levels, our strategy for how this will be taken forward over the next five years has been well received and approved at board level.

Research engagement

Research offers many opportunities for clinical staff in terms of personal and professional development and the enhancement of skills and knowledge which leads to a higher standard of care delivery, enhanced job satisfaction and, ultimately, to improved outcomes for our service users. Within the Trust we have sought to extend the level of engagement across the organisation.

The research forum continues to take place on a bi-monthly basis, we have had a range of presentations on a variety of different subjects and have a number of regular attendees.

We continue to utilise various approaches to keep staff informed of our research activities including regular updates via Newsround and a physical presences at various trust events. We have agreed a re-branding and are in the process of developing a variety of promotional materials and reviewing both our intranet page and our external facing internet page in line with the communications development across the trust as a whole.

The R&D Steering group is the forum through which we progress our strategy and business, chaired by the medical director we meet on a bi-monthly basis with membership including directorate representatives, our service user representative as well representation from the Clinical Research Network West Midlands. We have reviewed the membership of the R&D Steering group and have initiated work to look at the roles and expectations of the directorate representatives.

Student Research

During 2017/18, the R&D team continued to support staff at Combined who were undertaking research as part of a higher educational qualification e.g. professional doctorate, masters etc. Twenty three students received support, with 13 completing the research approvals process. Of the 23, twenty were undertaking professional doctorates, and 3 were undertaking a masters qualification.

See Table 1 below for a breakdown by directorate, and Table 2 for a breakdown by participant type.

Table 1 – Student Research / Directorates

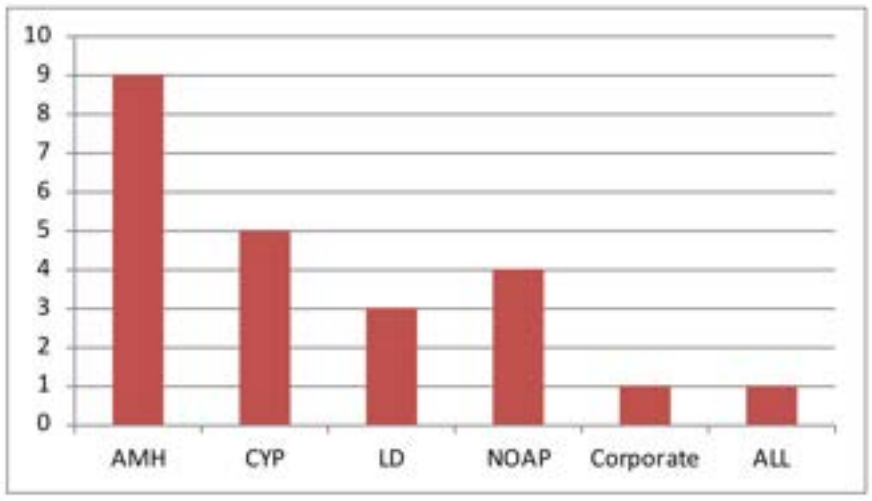
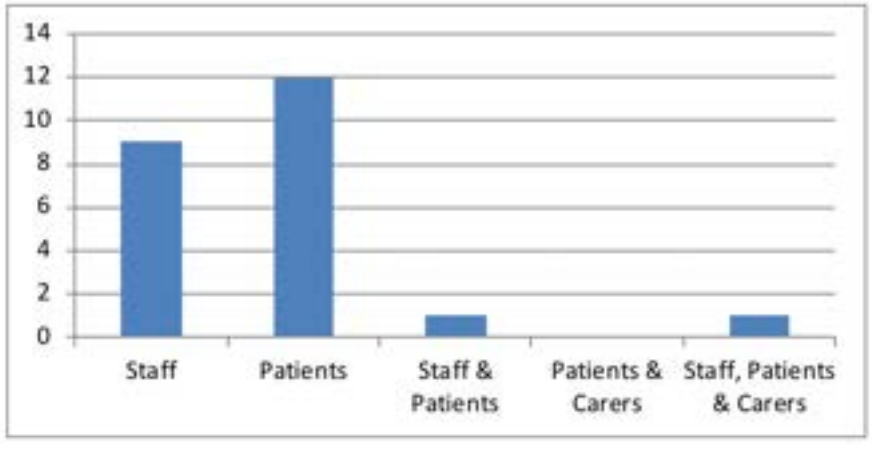


Table 2 – Student Research / Participant Type



The trend for support has doubled (from 13 to 23); this surge is primarily to do with students who deferred, and the complete cohort (professional doctorate in clinical psychology at Staffordshire and Keele Universities) wishing to conduct their research at the Trust.

Delivery of Clinical Trials of Medicinal Products (CTIMPS)

Developing our capacity and capability to deliver CTIMP studies is an important aspect of our research development. Frequently complex and resource intensive they require sites to consistently deliver research of the highest standards. CTIMPS provide opportunities for our staff to be at the forefront of the development of new treatments and also provide service users increased choice and opportunities that might not otherwise be available to them. Many CTIMPs are commercially sponsored trials through which the trust is not only able to recover the costs of implementing the study but also generate additional income which can be re-invested to develop our own research capacity and capability. For 2017/18 the trust set a target to increase the income generated through commercial research by 10%, we exceeded this target achieving a total increase of 152%.

External Engagement

Our research endeavours should reflect the clinical landscape and, just as the value of delivering clinical care in partnership across the community is recognised as an essential requirement for service development so too are our research partnerships. During 2017/18 we worked to widen our engagement with our local community, other NHS organisations, academic institutes, voluntary agencies, commercial companies, local authorities and even schools. During 2017/18 we have sought to build upon these links into formal agreements most notably establishing a memorandum of understanding with Staffordshire University.

Key achievements during 2017/18

BeAble App Developments

Moving forward in 2017/18, the Vascular Wellbeing Team and BitJam Ltd began prototype development for the BeAble App, working with the R&D team, clinicians and patients. The BeAble App prototype development and evaluation continues to progress into 2018/19, with the BeAble project team currently scoping out how to progress this to the next stage.

Neurodegenerative Active Partnership (NOGAP) developments

The NOGAP team were successful in securing a further one year's NIHR CRN Strategic funding for 2017/18 for the Joint Dementia Research Coordinator post, shared across both University Hospitals of North Midlands and the Trust. During 2017/18 the NOGAP began to look as to how the partnership can be extended into Primary Care and have been working with Primary Care and the Clinical Research Network to scope this further.

2.7 Goals agreed with Commissioners

Commissioning for Quality and Innovation (CQUIN) Framework.

A proportion (2.5%) of the total potential income from CCGs in 2017/18 was conditional on achieving quality improvement and innovation goals agreed with commissioners through the CQUIN framework. As an incentive 1.5% of the trust's total, potential income from CCG's for 2017/18 was linked to delivery of CQUIN targets and the trust agreed five CQUIN indicators with commissioners. Further details can be seen in section 3.

2.8 Statement from the Care Quality Commission

Registration:

North Staffordshire Combined Healthcare NHS Trust is required to register with the Care Quality Commission (registration number CRT1-1467551366). The trust is registered to carry out the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act

At the following locations:

- Lawton House (Trust Headquarters)
- Harplands Hospital
- Darwin Centre
- Dragon Square Community Unit
- Summers View
- Florence House

Further information regarding the registration and compliance process can be found in the papers to the Trust board and on the Care Quality Commission's (CQC) website at: www.cqc.org.uk

CQC inspection:

Following the inspection in October and November 2017 the CQC rated the Trust as 'good'. There have been no enforcement actions required by the Trust during 2017/18.

CQC special reviews and investigations:

The CQC has not required the Trust to participate in any special reviews or investigations during 2017/18.

2.9 Statement on Data Quality

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number, was:

- 99.7% for admitted patient care; and
- 100% for outpatient care.

N.B. The Trust does not provide accident and emergency care.

The percentage of records in the published data, which included the patient's valid General Medical Practice Code, was:

- 100% for admitted patient care; and
- 100% for outpatient care.

N.B. The Trust does not provide accident and emergency care.

Information Governance Toolkit attainment levels

The Trust's score for 2017/18 for Information Governance assessed using the national NHS Information Governance Toolkit was 75% (the same as 2016/17), and was graded green as all requirements achieved a minimum score of Level 2 resulting in a 'Satisfactory' result (the only results achievable are 'Satisfactory' or 'Not Satisfactory').

External Clinical Coding Audit

The Trust was subject to the annual external clinical coding audit during 2017/18 by NHS Digital approved auditors. The audit results reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) are:

- 100% Primary diagnosis correctly recorded (94% in 2016/17)
- 93% for Secondary diagnosis correctly recorded (93% in 2016/17)
- 100% primary procedures correctly coded (100% in 2016/17)
- 100% Secondary procedures correctly coded (100% in 2016/17)

The services reviewed in the sample were adult and older adult mental health, child & adolescent mental health and substance misuse.
The audit was undertaken by D&A Clinical Coding Consultancy Ltd, who are NHS Classifications Service approved auditors.The Trust was commended for its excellent level of coding accuracy and commended on the strong commitment to coding. It was further noted that there is a strong clinical engagement across all specialties.

Relevance of data quality

The availability of complete, comprehensive, accurate and timely data is an essential component in the provision of high quality mental health services and risk management. It is also required to ensure compliance with external regulatory requirements and with national and local targets, standards and contractual requirements.

Good data quality is essential to ensuring that, at all times, reliable information is available throughout the Trust to support clinical and/or managerial decisions. Poor data quality can create clinical risk, compromise effective decision making and impact on the Trust's ability to monitor standards of care and secure income for its services.

Safe and efficient patient care relies on high quality data. By taking responsibility for their clinical data, clinicians can improve its quality and help drive up standards of care.

Data Quality Metrics

To make the governance process manageable and monitoring proportionate, appropriate key data quality metrics have been developed and are kept under review to support the governance arrangements. This is discharged through the review of business processes; identification of critical data flows; analysing (potential and actual) data quality issues; defining key data quality performance measures; and agreeing tolerance thresholds (beyond which issue are escalated).

Action to improve data quality

There is an imperative to create a culture and understanding in staff of the value of capturing high quality data in real time to improve patient care. All members of staff are required to continually record accurate data to ensure high quality care to all patients and stakeholders.

Other actions include:

- On the job training and induction programmes to ensure that data is entered correctly onto systems and system champions to support clinicians
- Regular audits to check the quality of data items to ensure that data is recorded accurately, completely and kept as up to-date as possible.

Following a review of the "Model Hospital" dashboards, the Trust identified that data quality could be improved in the accuracy and regularity of patient demographics data, in particular their accommodation and employment status. Updated guidance has been issued to clinical staff and reports are reviewed each month to help improve performance.

Data Quality Forum - Data issue management

The Trust has a clear management structure that clarifies the responsibilities and accountabilities in regard to those individuals who enter in data. This ensures that there is accountability for low levels of data quality and accuracy.

The Data Quality Forum comprises of representatives from corporate services and clinical directorates (data champions who take a leadership role in resolving data integrity issues). The Forum is responsible for data issue management and the process of reducing and removing the barriers that limit the effective use of data within the Trust.

This includes identifying data quality issues, approving definitions, establishing quantification of issues, prioritizing data quality problems, tracking progress, and ultimately resolving the DQ issues.

The Forum also ensures a high standard of data quality within the clinical systems across the Trust and changes that need to be made to systems or processes to deliver improvements in data quality.

The Data Quality Forum is concerned with policy development and compliance at the right level of granularity to make a difference.

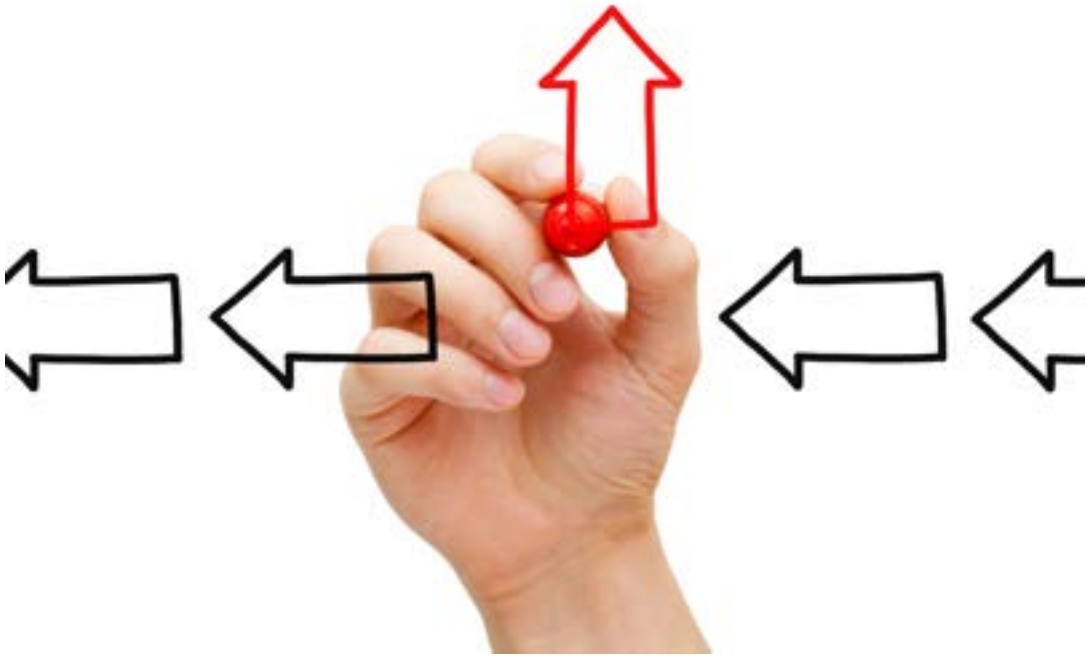
Reporting and monitoring are key components of data quality management. The Forum also ensures that staff are aware of their responsibilities surrounding excellent standards of data quality through continuous communication and promotion.

The Forum is supported by performance management meetings within each directorate that provide an opportunity to address data governance and data quality from end to end.

National Tools to support Data Quality

Data Quality Maturity Index (DQMI)

The DQMI is a quarterly publication intended to raise the profile and significance of data quality in the NHS by providing data submitters with timely and transparent information about their data quality. The Trust's DQMI was 97.4% in the latest published national data (September 2017).



3.0 REVIEW OF QUALITY PERFORMANCE FOR 2017/18 (LOOKING BACK) AND STATEMENTS FROM PARTNERS

3.1 Performance against 2017/18 Key Priorities

This section is in three parts:

Section 3.1: reviews performance and progress against the key priorities defined in the 2016/17 Quality Account.

Section 3.2: Adds to the information provided in section 3.1 and provides a summary of our performance against a range or quality indicators/metrics, which are of interest to people who use our services. Each quality indicator/metric is linked to one or more of the following three headings: patient safety, clinical effectiveness and patient experience.

Section 3.3: includes reference to those involved in the development of this account and statements from key partners.

3.1.1 Performance against 2017/18 key priorities

The CQUIN payment framework is a national framework for agreeing local quality improvement schemes and makes a proportion of our total potential income from CCG's (2.5%) conditional on the achievement of ambitious quality improvement goals and innovations agreed between commissioner and provider with active clinical engagement. The CQUIN framework is intended to reward genuine ambition and stretch trusts, encouraging a culture of continuous quality improvement in all providers.

The following table identifies the CQUIN areas as identified:

Priority	CQUIN area	Patient safety	Clinical Effectiveness	Patient Experience	Innovation	Achievement (%)	Financial value (£)
	Staff Health and Well-being: (Initiatives 1a, b & c) Improvement of health and wellbeing of NHS staff, healthy food and drink for NHS staff, visitors and patients, and improving the uptake of flu vaccinations for frontline clinical staff.	✓			✓	100%	£181,021
	Physical health 3a & b: Cardiometabolic assessment and treatment for patients with psychoses / Collaboration with primary care clinicians	✓	✓		✓	95%	£181,021
	Improving Services for People who Present at A&E: Supporting people with a mental health need to reduce A&E attendances	✓	✓		✓	100%	£181,021
	Transitions from CYPMHS to AMHS: Supporting young service users as they move from children's to adult services, or back into primary care	✓	✓	✓	✓	98.5%	£181,021
	Preventing Ill Health by Risky behaviours: (Initiatives 9a, 9b, 9c, 9d and 9e)Improving the identification of inpatients who smoke or who drink above safe levels and ensuring that they receive appropriate interventions		✓			87%	£181,021

Staff Health and Wellbeing: Improvement of health and wellbeing

SPAR priority
Safe

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
We aimed to improve the staff culture of health and wellbeing across the Trust, as demonstrated through the annual Staff Survey.

How did we monitor and report on progress?
An action plan was developed by the working group to monitor progress in implementing initiatives across the Trust. Final compliance with CQUIN requirements was determined through the annual Staff Survey, which is coordinated, analysed and reported on nationally.

What did we achieve?
As a result of this CQUIN the Trust has consolidated and improved its health and wellbeing offer to staff and the Working Group will continue to take this work forward into 2018-19.

Staff Health and Wellbeing: Healthy food for NHS staff, visitors and patients

SPAR priority
Safe

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
The Trust was tasked with ensuring that where food and drink is sold on Trust premises, healthy food options are available, that foods high in fat, salt and sugar are not advertised or promoted on Trust premises or offered for sale at checkouts, and that percentage targets are met around the proportion of sugar sweetened beverages and food high in fat sugar and salt offered for sale.

How did we monitor and report on progress?
An action plan was developed by the working group to monitor progress in implementing initiatives across the Trust. Local commissioners were provided with a quarterly report detailing progress.

What did we achieve?
As a result of this CQUIN the Trust has ensured that healthy food and drink options continue to be offered wherever sold on Trust premises, including to staff working out of hours.

Staff Health and Wellbeing: Improving the uptake of flu vaccinations by frontline clinical staff

SPAR priority
Safe

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
We aimed to ensure that frontline clinical staff were encouraged and supported to receive the flu vaccination.

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress in implementing processes across the Trust. Once the flu vaccination season was underway, regular updates were provided via the Senior Leadership Team and reported nationally onto UNIFY.

What did we achieve?
In 2017-18, 72.1% of frontline clinical staff across the Trust were vaccinated against flu, contributing to patient safety.

Physical Health: Cardiometabolic assessment and treatment for people with psychoses

SPAR priority
Safe

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
The Trust was tasked with implementing appropriate processes for assessing, documenting and acting on six cardiometabolic risk factors in 90% of a sample of inpatients, 90% of Early Intervention Team service users and 65% of a sample of community service users, who fell into the following categories (based on ICD10 codes)

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Drug induced psychosis

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress by implementing clinical processes across the Trust. Data relating to inpatients and community service users was submitted as part of the National Clinical Audit of Psychosis for central analysis. Data relating to EI service users was submitted as part of the EIPN Audit for central analysis.

What did we achieve?
As a result of this CQUIN , the Trust has continued to build on progress made in previous years in assessing the physical health of service users and ensuring that they are offered the right interventions.

Physical Health: Collaboration with Primary Care Clinicians

SPAR priorities
Safe, Personalised

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
In accordance with the CQUIN, we aimed to ensure that key information relating to service user's mental and physical well-being was communicated from the Trust to the service user's GP in a timely fashion. We also aimed to work with GP colleagues to reduce discrepancies between their patient registers and those held by the Trust, and to develop a protocol to outline physical health monitoring responsibilities across primary health care and secondary mental health services.

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress. Quarterly reports detailing progress were shared with Commissioners, which included the results of a casenote audit.

What did we achieve?
As a result of this CQUIN the Trust has strengthened links with CCG and primary care colleagues and has begun the process of aligning Trust and primary care databases. The Trust has worked with the CCGs and primary care representatives to develop a clear protocol outlining responsibilities for assessing and treating physical health in mental health service users.

Improving Services for People with Mental Health Needs who Present to A&E

SPAR priorities
Accessible, Personalised

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
We aimed to work with colleagues at the University Hospital of North Staffordshire to reduce attendances at A&E by people identified as frequently attending A&E who would benefit from mental health and psychological interventions.

How did we monitor and report on progress?
A Working Group was set up which was attended by representatives from the Trust, UHNM and other interested parties on a two-weekly basis. Progress against the CQUIN requirements was monitored by this group, which was also attended by the Commissioner Quality Lead for this CQUIN.

What did we achieve?
Working together, the Trust and UHNM have been able to demonstrate a reduction in avoidable attendances by 40%. This is an excellent achievement and significantly exceeded the CQUIN requirement for a 20% reduction.

Transitions out of Children and Young People's Mental Health Services

SPAR priorities
Accessible, Personalised

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
We aimed to improve the transition process for young people moving out of our children's services into adult services and to ensure that young people who were discharged back to primary care at the age of 18 were adequately supported during the discharge process.

How did we monitor and report on progress?
An audit of casenotes was undertaken which reviewed all service users who transitioned or were discharged at transition age between January and March 2018. Surveys were produced to determine how prepared service users felt at the point of discharge / transition and whether they felt their goals had been achieved following transition.

What did we achieve?
As a result of this CQUIN the Trust has improved its processes in relation to transitions from children's services. This will mean that service users are better supported when moving from children's to adult services, or when stepping down into primary care at transition age.

Preventing Ill Health by Risky Behaviour: Alcohol and tobacco

SPAR priorities
Safe, Personalised

Why was this selected as a priority?
This was a national CQUIN priority as determined by NHS England.

Our goal
We aimed to ensure that people who access our services are asked about their smoking status and alcohol intake and that where necessary they are provided with relevant advice and interventions and that this is recorded.

How did we monitor and report on progress?
A casenote audit was undertaken on a quarterly basis to determine what proportion of inpatients had been assessed for smoking status and alcohol intake, and of those who indicated that they smoked or consumed alcohol to an unsafe level, how many had been given appropriate interventions.

What did we achieve?
As a result of this CQUIN the Trust has rolled out training to nursing staff so that they are aware of their responsibilities and have the skills in relation to smoking cessation and alcohol interventions. Processes have been streamlined to ensure that patients are offered the support they need with smoking and alcohol consumption. This is supported by the Trust's move towards Smoke Free environments, which was launched on 3 April 2018.

The Trust uses local and national benchmarking information to add intelligence and insight to our performance management processes. Benchmarking enables the performance of the directorates to be analysed and they are supported in identifying how improvement in quality, productivity and efficiency can be achieved. Benchmarking with others will also help to determine how the Trust will become outstanding in all areas.

The Trust remains a key member of the NHS Mental Health Benchmarking Reference Group.

The Trust's Quality Committee continued to actively monitor the quality of services. Robust assurance is provided to Trust Board, service users and commissioners on performance measures.

3.1.2 Key Quality Priorities Achievements 2017/18

Priority: Every CQC core service rating is 'good' or 'outstanding'

Outcome: In the 2017 CQC inspection all core services were rated as 'good' or 'outstanding'

Furthermore all 'must do' and 'should do' requirements from CQC from 2016 have been addressed. Additionally all core services have comprehensive improvement plans in place to address the areas identified in the 2017 CQC inspection and to date significant progress has been made with many of the 'must do' and 'should do' requirements being addressed and rated as complete. We will continue this robust assurance process through our performance management arrangements.

Priority: Improved physical health monitoring

Outcome: Clinical staff (63%) received physical health training including recognition of the deteriorating patient in relation to the onset of sepsis. The National Early Warning Scoring (NEWS) tool was also implemented. Following these initiatives there has been a reduction in avoidable transfers to the local acute hospital

.

Additionally we have achieved the following:

- Commenced our journey towards being a smoke free organisation with in-patient areas going smoke-free from April 2018
- For the second year running the flu vaccination campaign achieved the national target of at least 70% frontline staff receiving the vaccination
- A rapid falls reduction programme was implemented and the policy, practice and training were all reviewed and updated to minimise avoidable falls. Avoidable falls have decreased as has harm from avoidable and unavoidable falls.
- 100% compliance with physical health assessment
- Compliance with physical health monitoring and recording post rapid tranquilisation is monitored through monthly review of incidents and subsequent completion of physical health monitoring; additionally the Inpatient Safety Matrix with 100% compliance achieved in Q4.

Priority: Implement our Suicide Prevention Strategy

Outcome: The Trust Suicide Prevention Strategy was finalised and implemented during 2017/18. As part of this strategy we have worked in collaboration with Public Health with the aim of reducing suicides in the local area.

Additionally we have:

- Continued to facilitate the 'living well with risk group' to embed the strategy and ensure involvement of people with lived experience.
- Developed a prototype for an app that promotes recovery from depression, encourage hope and help seeking behaviour at the point of personal crisis.
- Received patient stories of hope in different media formats to share the recovery messages at both our Quality Committee and Board.
- Across Staffordshire we commenced the process to procure a single integrated care record
- Where appropriate we have involved family/carers to ensure that their views are incorporated into risk management plans, highlighting any protective factors that these relationships provide.
- We have increased staff training in relation to suicide awareness with 88% (target 85% of all staff completing level 1 training and 80 people completing level 2 training

Priority: Increase service users' carers and staff feedback to improve service development.

Outcome: The Service User and Carer Council (SUCC) have engaged with the development of the Person Centredness Framework and we have representation from service user and carer's across a range of trust business and activity; including interviewing new recruits, co-facilitating a wide range of events, attending various committees including People, Culture and Development, Quality, Finance, Performance and Digital and Business Development.

Additionally:

- The service user and carer strategy has been refreshed in partnership with the SUCC.
- We have ensured that there is a service user and carer representative at the mental health sustainability and transformation plans (STP) board.
- There is service user and carer representation on our trust committees facilitated through the SUCC.
- Work has commenced in developing a network of peer support workers and peer support worker strategy is being developed.
- To support recovery we have progressed the development of a well-being academy (recovery college) with plans in place for a virtual and physical resource.

Priority: Review of models of care and care pathways.

Outcome: Following the work on productivity undertaken in 2016 Value-maker Workshops have been held with teams and opportunities for improved efficiency and productivity have been identified.

Additionally:

- We have introduced an acute care pathway on adult inpatient wards
- A psychiatric intensive care unit (PICU) has been built and we are currently recruiting the staff team.

Outcomes from additional objectives for 2017/18:

Under Safe we have:

- Embedded unannounced assurance visits to in-patient wards with quarterly reporting to the Quality Committee and Trust Board.
- Agreed a plan for further investment in environmental ligature improvements in accordance with 2017/18 plan.

Under Personalised we have:

- Agreed a contract for the extension of the FLO and autographed innovation to develop a self-managed integrated care pathway for dementia patients. This work is now being taken forward.
- Implemented the diversity and inclusion plan and Workforce Race Equality Standard (WRES) awareness sessions have been delivered with staff, Board and Leadership Academy involvement. This work will continue during 2018/19.
- Worked with Helen Sanderson Associates, our service users, carers and staff to develop a Person Centredness Framework; the overarching principles have been agreed and the framework will be implemented in 2018/19.

Under Accessible we have:

- Achieved 92% compliance with national waiting times targets and 18 week waits for treatment for all services.
- Worked in collaboration with primary care and the University Hospital of North Midlands (UHNM) to become more accessible to patients through the use of video consultation in the Neuropsychiatry and Older Persons directorate. This will be carried forward in 2018/19 with pilots in 2 further directorates.
- Progresses work through collaboration with the Service User and Carer Council and R&I Steering Group with a view to re-launching Dragons Den; this will be linked to the value-makers scheme. This will be carried forward in 2018/19.
- Developed an allied health professional strategy which is proceeding through internal governance processes prior to implementation.
- Worked with partners to develop an estates (building and land) optimisation strategy for North Staffordshire.

Under Recovery focussed we have:

- Ensured recovery principles underpin our strategic priorities, policies, procedures, risk assessments and care plans (audited monthly).
- Ensured care plans are completed with individuals which are wellbeing and recovery focussed.
- Introduced and strengthened to develop evidence based psychological interventions in our adult acute wards.

3.2 Performance in 2017/18 as measured against a range of quality indicators

This section of the Quality Account provides a summary of our performance as measured against a range of quality indicators / metrics, which are of interest to people who use our services; most were selected for inclusion by key stakeholders.

The information is presented under the three main headings of:

- patient safety
- clinical effectiveness
- patient experience.

Each section describes the area being reviewed, the metric used to measure performance and the overall Trust performance.

Patient safety

We are proud of our excellent cleanliness standards. Each PLACE inspection team included 50% patient representation and there was an independent validator on each assessment.

Environments and cleanliness – Patient Led Assessment Care Environment (PLACE)

Area of performance	Environments and cleanliness
Metric – method of calculating performance:	Trust Key Performance Indicator (KPI) – The cleanliness of 6 environments as assessed by the PLACE team
Performance:	The Trust's overall score for cleanliness was 99.61%.

Cleanliness as assessed by the PLACE team 2017/18

PLACE 2017	Cleanliness	Food & hydration	Privacy, dignity & wellbeing	Condition, appearance & maintenance	Dementia
Harplands Hospital overall site score	99.52%	97.67%	96.39%	98.46%	93.63%
Dragon Square	100%	-	96.55%	99.41%	-
A&T and Telford Unit	98.94 %	92.64%	100%	99.40%	-
Darwin Centre	100%	96.96 %	93.75%	100%	-
Florence House	100%	94.86 %	97.22%	99.45%	-
Summers View	100%	95.32%	96.30%	100%	-
Trust overall score	**99.61%**	**97.18 %**	**96.33%**	**98.78%**	**93.63%**

Disability arrangements have been included as part of PLACE. As with the Trust's other PLACE scores, the Trust has scored exceptionally well in this area, well above the national average.

2017 PLACE scores for Disability	
Harplands Hospital	96.44%
Dragon Square	100%
A&T and Telford Unit	100%
Darwin Centre (under refurbishment)	100%
Florence House	98.30%
Summers View	100%
Trust Overall Score	97.24%
National Average Score	82.60%

Incidents

Ulysses incident reporting system supports the Trust for Incident reporting and management. The incidents are categorised in to clinical and non-clinical, accidents and near misses. The system allows all Trust staff to report incidents in a timely manner and provides the Trust with the data for the monitoring of incident themes or trends.

The definitions of incidents used by the trust are listed below

Incident

An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public

Serious Incident

The Serious Incident (SI) framework (NHS England. 2015) definition for reportable incidents is as follows:

"Acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services".

Patient Safety Incident

The National Reporting and Learning System's (NRLS) definition for reportable incidents is as follows; "A Patient Safety Incident (PSI) is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care".

Investigation

The act or process of investigating i.e. a detailed enquiry or systematic examination.

Area of performance	Incidents (clinical and non-clinical)
Metric – method of calculating performance:	Trust Metric: QI PS
Performance:	Please refer to the table below for performance during 2017/18

	2015/16	2016/17	2017/18
No harm, low harm and near miss	4,037	4,563	4330
Moderate	79	75	80
Major	6	3	9
Catastrophic	128	76	65
Total	4,250	4,750	4484
Moderate, major & catastrophic incidents as a % of total	5.0%	3.2%	3.4%

Ulysses, the Trust electronic reporting system generates weekly and monthly scheduled incident reports for directorates and individual teams which allows them to explore and interrogate incidents in order to further understand and improve patient and staff safety within each area.

The table above illustrates a small decrease in the number of incidents reported across the Trust for 2017/18. The rationale for this decrease has been analysed and is in relation to a small number of people with complex needs in 2016/17 therefore this decrease has not raised concerns regarding the reporting culture. In the last 3 years there has been increased staff understanding of the need for incidents to be reported and an indication of a learning and improving culture. All incidents are subject to weekly review and analysis, in order to ensure that issues / trends are quickly identified and actions implemented enabling improved delivery of care services.

Safety Improvement Initiatives

Throughout 2017/18, the Trust has continued to build on the work commenced in 2016/17 to improve our safety culture. This year the Trust has maintained our focus on improving the quality of the care that the staff deliver and we have participated in a number of safety improvement initiatives.

Staff from across the Trust joined with the Advancing Quality Alliance (AQuA) to complete a course in Patient Safety Leadership. This programme, co-ordinated by the Director of Nursing and Quality, provided staff with the ability to use Quality Improvement (QI) tools in order to lead and complete their own QI projects. In addition, two senior nurses were supported to complete the Advanced Improvement Practitioner Programme which provided them with increased QI knowledge and skills, which will be used to support clinical teams in learning quality improvement methodology and to take forward QI projects.

The QI projects chosen included those with a patient safety focus: the initiatives included a falls reduction project across the NOAP wards and a restraint reduction project across ward 1, Assessment and Treatment and the Darwin Centre.

The Trust continues to learn from its incidents, with staff reporting an average of 80-100 incidents per week. The learning from incidents, including Serious Incidents, is shared across the trust through our Learning Lessons framework. There is a bi-monthly bulletin and a monthly Learning Lessons workshop where staff listen to the learning outcomes of investigations and share their stories. These events are always well supported by staff and receive positive feedback, demonstrating the staff commitment to 'being open' and a willingness to learn in order to improve the safety of the care delivered to our service users.

Incidents reported to the National Reporting and Learning System (NRLS)

The Trust is required to report patient safety incidents to the national incident database known as the National Learning and Reporting System (NRLS). This is the only data collection agency nationally and the data submitted is analysed by subject experts to provide trusts with six monthly organisational reports, based on data submission

Area of performance	Incidents reported to the National Reporting and Learning System (NRLS)
Metric – method of calculating performance:	KPI Number of incidents reported to the National Patient Safety Agency
Performance:	There were 2,096 NRLS incidents reported during 2017/18 which is a slight reduction in the number of incidents reported from the previous year. As previously stated this was due to a small number of people with complex needs being responsible for a large number of incidents in 2016/17. Of these, the number of incidents reported under the categories severe harm or death (30) was 1.4% of the total. 3

Our culture of incident reporting has been maintained during 2017/18 as demonstrated through benchmarked data from the NRLS. The latest data illustrates our higher reporting rate per 1000 beds than the national reporting median for mental health trusts. We have also improved our report rating at the national level. Improved reporting of incidents helps to better identify risks and provides better opportunities to improve patient safety. 74% of all patient safety incidents reported were no harm incidents; this reflects the national average of 73% and is indicative of a positive reporting culture for reporting both harm and no harm incidents.

Never events

Area of performance	'Never events'
Metric – method of calculating performance:	Trust Metric: QI PS 8 never events A never event is a serious, largely preventable, patient safety incident that should not occur if the available preventable measures have been implemented. An example would be an inpatient suicide using curtain or shower rails.
Performance:	Nil – No 'never events' in the Trust during 2017/18.

Serious incidents

In 2017/18 we have maintained a strong performance in respect of the timely investigation and quality of completed investigations and the approaches taken to learning from serious incident investigation.

We have maintained our performance of 100% of investigations undertaken within the required timescales by staff trained in Root Cause Analysis methodology. The Trust was subject to an audit by RSM, the internal auditors in 2017/18. This audit aimed to assess the Trust process in terms of the management of unexpected deaths. The auditors were able to determine that the Board should take 'substantial assurance' that the process was robust, thorough and met the key standards in line with 'National Guidance on Learning from Deaths' published in March 2017.

Area of performance	Serious incidents (SIs) (clinical and non-clinical)
Metric – method of calculating performance:	Trust Metric: KPI 17.17 Investigating and reporting of serious incidents
Performance:	During 2017/16 there have been 73 serious incidents reported by the Trust. During 2017/18 no investigation breached the 60 working day deadline, as any extensions required were agreed with commissioners.

The Patient and Organisational Safety Team work in partnership with directorates to ensure that learning or trends arising from incidents are discussed at directorate and team level meetings and reported to the Trust's Quality Committee and Trust Board oversight through the Medical Director as Executive Director Lead for Serious Incidents and Mortality Surveillance. Quarterly Serious Incidents reports help to identify emerging themes and trends and where required thematic reviews will be undertaken to facilitate learning and improvement.

We are committed to learning when things go wrong and taking action to improve. Furthermore, we take responsibility to ensure that we share learning in an open transparent and compassionate manner with families and carers through our Being Open and Statutory Duty of Candour Policy Framework.

In order to support the implementation of this policy, a series of initiatives have been delivered to raise staff awareness and embed the statutory requirements into practice. These initiatives form part of an on-going programme of education for all employees and are facilitated by the Patient and Organisational Safety Team.

These include.

- Inclusion of Duty of Candour awareness within the Trust mandatory training curriculum.
- A series of workshops, using the "Learning Lessons" forum to discuss the duty and to set out responsibilities.
- Awareness sessions in individual clinical teams.
- Inclusion in the Trust Preceptorship programme.
- Inclusion in the Student Nurse learning programme.
- Training sessions facilitated for Governance Leads to support their quality and safety role within clinical directorates.
-

The Trust`s responsibility for ensuring compliance with this statutory duty is monitored through a series of reporting mechanisms. In addition to the weekly Incident Review Group minutes reflecting the decision making for Duty of Candour threshold, additional assurance is given to the Board by means of reporting to the Clinical Safety Improvement Group, Quality Committee and Trust Board.

Reports are shared with the Clinical Quality Review Group. c

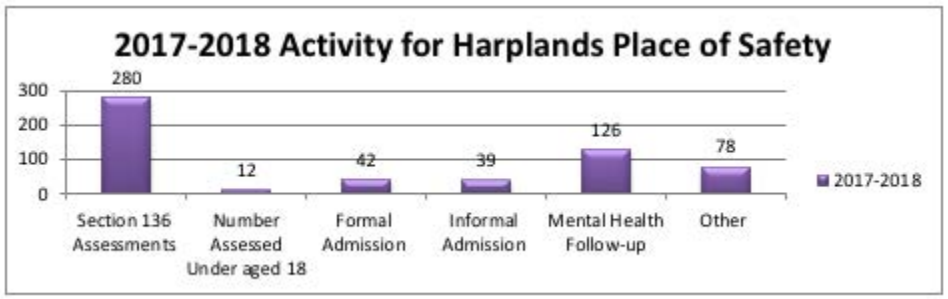
Infection Prevention and Control

There have been no MRSA blood stream infections and no Methicillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections reported in 2017/18. MRSA screening compliance remains at 100% for all those admissions who fulfil the criteria for screening. The Trust's target of zero avoidable HCAIs was therefore maintained.

Clinical effectiveness

Area of performance	Mental health activity
Metric – method of calculating performance:	**Mental health activity**
Performance:	280 assessments under Section 136 of the Mental Health Act 1983 took place at Harplands Hospital Place of Safety. Of the 280 assessments completed, 12 were under the age of 18 years. The outcomes of all of the assessments are as follows: • 15% - Formal admission to hospital under the Mental Health Act • 13% - Informally admitted to hospital • 45% - To be followed-up by mental health / social care services • 27% - Other / care of family / own GP 72% of those people assessed under Section 136 of the Mental Health Act were not admitted to hospital, with 45% being followed-up by secondary mental health services.

Number of Place of Safety assessments carried out under Section 136 of the Mental Health Act 2017/18

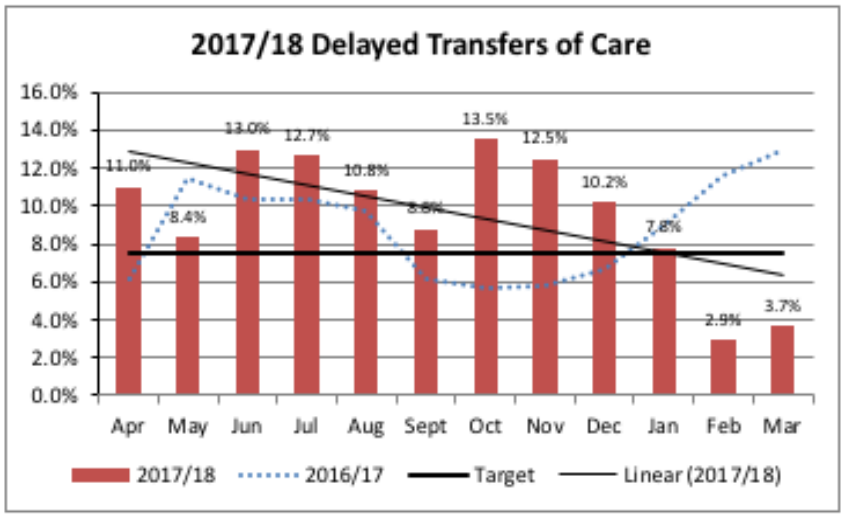


On occasions when the Harplands Place of Safety Suite is occupied, the Trust will seek to support the police to locate a vacant alternative health-based place of safety within Staffordshire to enable the completion of the assessment. The Police and Crime Act 2017 came into force on 11th December 2017 and where appropriate, Accident and Emergency Departments can be used as a health-based Place of Safety for completion of the assessment. No assessments have taken place in police custody since December 2017

Place of Safety: assessments carried out under Section 136 of the Mental Health Act 2013/14 – 2017/18

Delayed Transfers of Care

Area of performance	Delayed Transfers of Care
Metric – method of calculating performance:	Delayed Transfers of Care
Performance:	Overall, for 2017/18 the Trust's rate for delayed transfers of care is 9.6% for the year, against a target of less than 7.5%. This reflects an increase from 5.76% reported for 2016/17 and is in line with the national position where there is an increase in whole system delays associated with high rates of bed occupancy and reduction in funding of social care that are resulting in extra pressures on the health economy. The Trust is in discussion with health and social care commissioners to ensure that every effort is made to ensure that service users are located in the most appropriate environment. The Trust has been an early adopter of the RED and GREEN approach in mental Health. Developed by the Emergency Care Programme (ECIP), it focuses on eliminating patient time wasted in the pathway (Red days) and focussing on days which are of value to the patient (Green days. The Trust also worked with the A&E Delivery Board and has received support from partner agencies to improve processes, such as timely assessment and rapid approval to funding and progression on the Choice Protocol. The Trust will continue to focus on this as a quality priority for 2017/18.

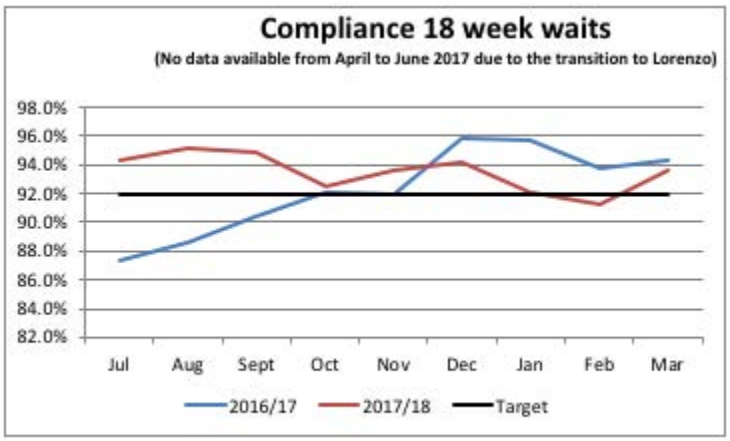


Physical Health

Area of Performance	Physical Health Check
Metric – method of calculating performance: Performance:	Physical health checks 100% of physical assessments completed included all of the components listed: • A baseline physical examination • Abaseline lifestyle assessment • A baseline haematological screening • A history of past physical, psychotropic and non- prescribed medications • Current use of physical, psychotropic and non-prescribed medications • MRSA screening

Waiting Times

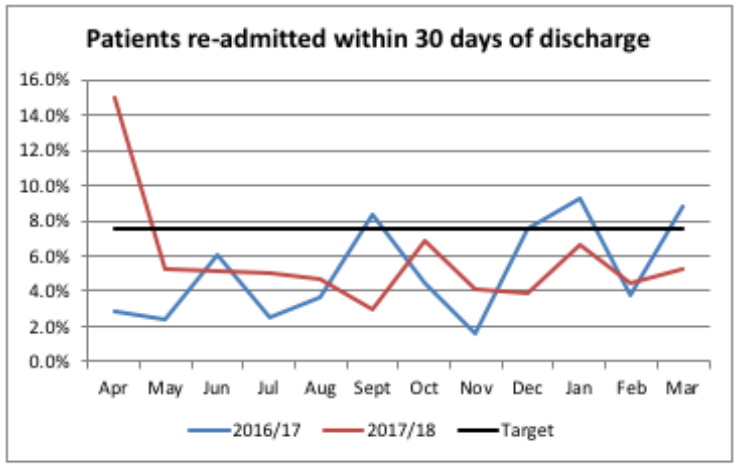
Area of Performance	Compliance 18 week waits
Metric – method of calculating performance:	18 week waiting time (Referral to Treatment)Target 92%
Performance:	Performance for 2017/18 is 92.5% at year end. The Trust monitors the waiting time from referral for all service users who have been waiting to ensure that treatment is received within 18 weeks. The metric reports on the wait from when the patient is referred into the Trust to the time they are seen by a Trust member of staff.



We are unable to report our position in April to June 2017 due to the transition to the Trust's new Electronic Patient Record, Lorenzo.

Readmissions

Area of performance	Patients re-admitted within 30 days of discharge
Metric – method of calculating performance:	The rate of unplanned readmissions for patients (adults and older adults) within 30 days is a key performance indicator for the Trust. The target for this metric is 7.5%
Performance:	For 2017/18 there were a total of 1762 admissions, of which 418 were readmissions.



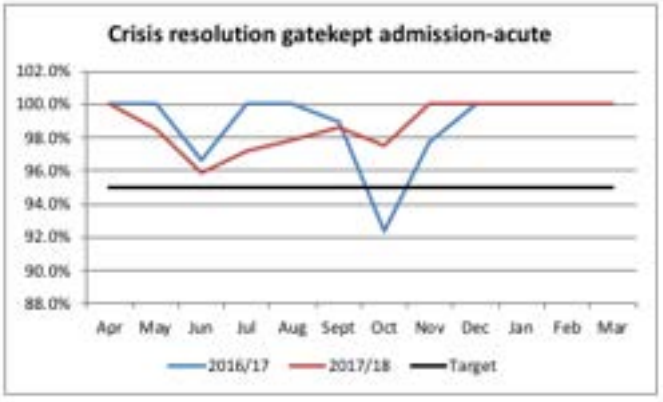
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	97.5%	96.8%	96.9%	97.9%	96.2%	97.9%	100%	92.3%	97.5%	95.8%	92.5%	91.0%
2017/18	100.0%	96.9%	94.1%	93.1%	86.7%	97.4%	92.9%	97.4%	90.9%	95.7%	93.9%	96.1%

Most recent published benchmarking data:	Q4 2014/15 (%)	Q4 2015/16 (%)	Q4 2016/17 (%)	Q3 2017/18 (%)
Trust	100	97.5	93.1	93.9
National average	97.2	97.2	96.4	95.9
Highest	100	100	98.6	98.3
Lowest	93.1	80	95.0	95.5

Gatekeeping

Area of performance	Crisis resolution gate kept admissions – acute
Metric – method of calculating performance:	Acute admissions gate kept by Crisis Resolution teams National target: 95%
Performance:	100% of patients admitted to acute inpatient wards were gate kept by the CRHTs at the end of 2017/18.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	100%	100%	96.6%	100%	100%	98.9%	92.3%	97.7%	100%	100%	100%	100%
2017/18	100%	98.5%	95.9%	97.2%	97.8%	98.6%	97.5%	100%	100%	100%	100%	100%



Most recent published benchmarking data:	Q4 2014/15 (%)	Q4 2015/16 (%)	Q4 2016/17 (%)	Q3 2017/18 (%)
Trust	99.0	99.5	100.0	100
National average	99.1	98.2	98.8	98.5
Highest	100	100	100	100
Lowest	59.5	84.3	90.0	90.0

Source: NHS England

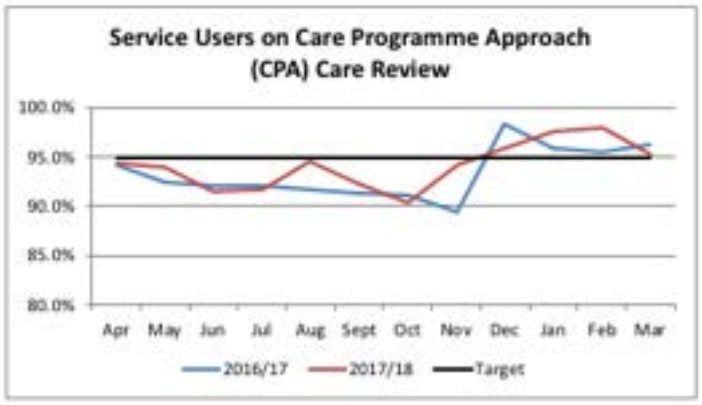
Seven-day follow-up

Area of performance	7 day follow up of Care Programme Approach (CPA) patients
Metric – method of calculating performance:	Follow up of CPA patients within seven days of discharge Target 95%
Performance:	There is strong national evidence that the period following discharge has shown to be a high risk period for service users at risk of suicide and self-harm. To mitigate these risks and provide appropriate support to service users, the Trust aims to ensure that every adult is followed up within 7 days of discharge. Our average level of performance for the year was 94.6% This are is a key focus for the trust and a new standard operating procedure has been put in place ensure that the standard is consistently achieved in 2018/19. Reports are provided for every patient who was not followed up within 7 days to provide assurance that there were no clinical issues arising from the delays.

CPA Review

Area of performance	Service users on Care Programme Approach (CPA) care review
Metric – method of calculating performance:	Number of patients on CPA who have received a review of care in the past 12 months National target: 95%
Performance:	This is a national indicator to monitor compliance with CPA. The Trust continues to ensure service users receive timely reviews of care to ensure that their care and support needs are met. More focussed monitoring and a review of business processes has resulted in significant improvement in year and the trust has exceeded the target each month from December 2017.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	94.1%	92.4%	92.1%	92.0%	91.8%	91.4%	91.2%	89.4%	98.3%	95.8%	95.5%	96.2%
2017/18	94.3%	93.9%	91.5%	91.8%	94.5%	92.2%	90.3%	94.1%	95.9%	97.5%	98.0%	95.3%



Settled Accommodation and Employment

The core aim of the employment and settled accommodation outcome measure is to increase the proportion of the most socially excluded adults in settled accommodation and employment. This underpins a long-term vision of ensuring that vulnerable adults have the foundations they need to get their lives back on track.

The reporting of the measure has changed in line with the requirements of the Single Oversight Framework to require an annual review of the accommodation and employment status for all service users. The trust is working with clinicians to ensure compliance with the new standard.

Area of performance	Patients in settled accommodation
Metric – method of calculating performance:	Percentage of patients who are in settled accommodation
Performance:	The Trust has maintained the percentage of patients in settled accommodation, with over 16.6% for 2017/18.

Area of performance	Patients in employment
Metric – method of calculating performance:	Percentage of patients who are in employment
Performance:	The Trust continues to provide vocational support to our service users to increase the proportion of the most socially excluded adults in employment.

Staff Satisfaction

Towards Outstanding Engagement

The Trust introduced 'Go Engage' in April 2017, branded as our 'Towards Outstanding Engagement' programme. Our first cohort successfully supported 16 teams through an intensive 6 month programme.

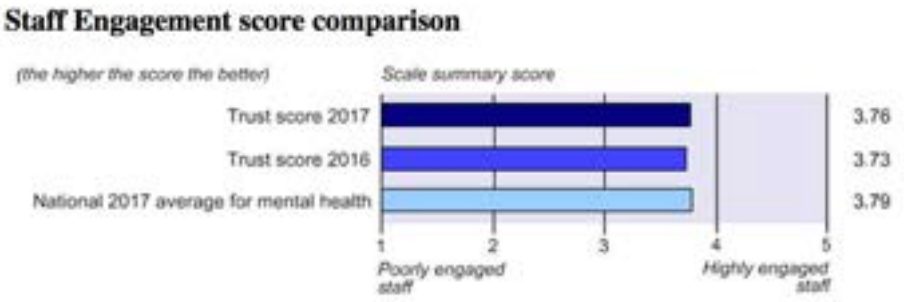
A diagnostic is used to assess 9 enablers, 3 feelings and 4 behaviours crucial to engagement. Three staff from each team are trained and supported to interpret their teams report and select what tools, techniques and approach they feel will have most impact on improving engagement.

Our first cohort has been a success and we are already yielding positive results;

- 12 of the 16 teams in this cohort initially scored below our Trust's average engagement score, which shows they were ideal teams for the programme
- Out of these 12 teams, 9 improved their engagement scores, with 6 improving to above the Trust average

Staff Survey Results

Our 2017 staff survey results show an improvement in our staff engagement from 3.73 to 3.76, sitting just below the national average on 3.79. Whilst there has been little significant variation in our scores compared to 2016, when we compare our scores to the national mental health average, we see a comparative improvement.



The below table show the number of average and above average scores in 2017 vs 2016:

Benchmarked data

2017 (32 key findings)			2016 (27 key findings)		
Above average	10	31%	Above average	9	33%
Average	15	47%	Average	10	44%

Patient Experience

In 2017/18 we have seen the embedding of our Service User and Carer Experience and Engagement Group to oversee the implementation of the Service User and Carer Strategy and work plan.

Additionally the campaign to improve the response rate to the Family and Friends Test (FFT) continues to be successful with NSCHT having the 5th highest rate of returns nationally in Nov 2017 at 21.6%.

Friends and Family Test (FFT)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. We are pleased to report a significant increase in FFT returns across the Trust following the campaign. In 2015 we were averaging 50 FFT returns per month. Our latest return, in March 2018 rate, was 436 returns. This is a result of the positive impact of the campaign and importantly, a sense check of the service user experiences of our services. The Q4 FFT report reflects that 91% of people using our services would recommend us as a place to receive care.

Service User and Carer Council

The Council continues to meet on a monthly basis, with an active and forward looking agenda. These meetings alternate between business meeting and an educational workshop. The educational workshops are new with the aim of increasing representation from other service users, carers and volunteers. These have been positively received with the Council identifying the educational topics, therefore meeting the development needs of the members.

We have and will continue to seek wider involvement to support the Council, on increasing service user and carer involvement across a range of trust business and activities. Most recently we have developed a BAME strategy to increase inclusivity and representation across diverse communities.

We are pleased to have received many expressions of interest and willingness to be a part of the engagement agenda of the trust.

The Annual Mental Health Community Survey 2017

The 2017 survey of people who use community mental health services involved 56 providers of NHS mental health services in England. We welcome the feedback from this Survey as it provides an additional feedback opportunity on service user experience and perceptions of our service.

While aspects of people's experiences have remained relatively stable, there is more work to do as part of our journey of improvement. Our response rate of 31% was above the national average of 26% and is comparable with our response rate for 2016 of 33%. However, we would like to improve this position. As a result, an action plan has been drawn up by our Adult and NOAP Community Directorates to address this and also respond to the points raised and further improve those areas. This will be monitored closely by the Service User and Carer Experience and Involvement Group and the Trust's Quality Committee. It will be reviewed and discussed by our Service User and Carer Council on an annual basis.

Area of performance	Patient experience
Metric – method of calculating performance:	Patient experience as measured by the annual national patient survey in relation to community based care – the most recent survey results were published in November 2017.
Performance:	We are pleased with our most recent survey results.

Questions relating to	Score out of 10	How this score compares with other trusts		
Health and social care workers	7.6	Worse	About the same	Better

"My care is very good. I feel I can put my trust in my nurse and she understands me fully. She gives me all the support I need."

Questions relating to	Score out of 10	How this score compares with other trusts		
Organising care	8.5	Worse	About the same	Better
Planning care	7.1	Worse	About the same	Better
Reviewing care	7.5	Worse	About the same	Better

Questions relating to	Score out of 10	How this score compares with other trusts		
Organising care	8.5	Worse	About the same	Better
Planning care	7.1	Worse	About the same	Better
Reviewing care	7.5	Worse	About the same	Better

"Care co-ordinator was excellent very friendly, there when needed, understanding. Therapist/Psychology were phenomenal."

Questions relating to	Score out of 10	How this score compares with other trusts		
Changes in who you see	5.9	Worse	About the same	Better
Treatments	7.6	Worse	About the same	Better
Support and Wellbeing	4.7	Worse	About the same	Better
Crisis care	6.4	Worse	About the same	Better

"Whilst in a crisis the care I received was outstanding."

Questions relating to	Score out of 10	How this score compares with other trusts		
Overall views of care and services	7.4	Worse	About the same	Better
Overall experience	7.1	Worse	About the same	Better

"I was looked after very well and I received all the treatment and care that I needed."

Complaints Received

Area of performance	Complaints
Metric – method of calculating performance:	Complaint acknowledgments, response and trends
Performance:	Detail below

	2016/17	2017/18
Number of complaints	43	33
Number acknowledged within three working days	100%	100%

The Trust is committed to providing service users, families or members of the public with the opportunity to make a compliment, seek advice, raise concerns or make a complaint about any of the services it provides. We view all feedback, as valuable information about how trust services and facilities are received and perceived. We will continue to develop a culture that sees feedback and the learning from complaints as opportunities to improve and develop services.

Overall, the Trust receives a very low number of complaints when compared to NHS benchmarking data. This is because the Trust focuses on attempting to resolve concerns at a local informal level to enable prompt resolution. We have continued to implement a number of initiatives to encourage and strengthen feedback. We have refreshed our Listening Responding and Complaints materials, maintained attendance at Service User and Carer Forums and provided bespoke training on the importance of feedback to ensure continuous improvement within our clinical teams.

We will continue to signpost individuals to the Parliamentary Health Services Ombudsman (PHSO) when all attempts at local resolution have been exhausted. During 2017/18, two complaints were referred to the PHSO who are undertaking their careful review and consideration of the evidence before informing the Trust of their recommendations.

Themes, Trends and Learning

Looking back in 2017/18, complaints received generally fell within the categories of care planning, attitude of staff and communication issues. In response, we have undertaken a programme of customer care training with our clinical teams utilising service user and carer feedback as a means to provide a reflective learning environment in which to develop understanding of the service user perspective of our own behaviours. We emphasise the importance of local resolution and timely signposting where local resolution has been unsuccessful.

Patient Advice and Liaison Service (PALS) contacts

Area of performance	Patient Advice and Liaison Service (PALS) & compliments
Metric – method of calculating performance:	Numbers and types of contacts via PALS and compliments
Performance:	344 PALS contacts and 2,063 compliments received during 2017/18.

We recognise the importance of our PALS service in being a key source of information and feedback for the Trust and an early warning system for emerging issues and concerns. We are pleased to report the further strengthening of our approach to patient experience with the appointment of a whole time PALS officer.

During 2017/18 there have been 344 contacts compared with the previous year, when a total of 400 contacts were received. Themes identified on analysis relate to access and waiting times, concerns about customer care and signposting to other services. To ensure that concerns raised are addressed and actioned by the right person in a timely way, the Head of Directorate and Team Manager initially respond to outline the action taken and to the satisfaction of the individual concerned.

Compliments

Each year our staff receive compliments, thank you's and much praise from people they have cared for. Many patients want to write to thank staff personally or to praise the service that they have received. It gives staff a great boost when people take the trouble to pass on their positive feedback We are pleased to report that compliments received directly by the PALS service and via FFT have increased from 244 in 2016/17 to 2,063 in 2017/18.

3.3 Engagement and statement from key partners

Engaging our partners and stakeholders

North Staffordshire Combined Healthcare NHS Trust remains committed to working collaboratively with a range of partners and as such has engaged partners in the development and publication of this Quality Account.

We would like to take this opportunity to thank everyone who has worked with us and provided assurance that your views and comments have helped to shape this Quality Account.

Development Stage

We have sought the views of key partners, service user representative groups, local authorities and staff about what they liked and disliked about our previous Quality Account and what should be changed. All feedback received was responded to and reviewed as part of the engagement and design process for this Quality Account.

Agreeing priorities

We asked our service user and carer council what priorities they would like to see reported in this quality account. In addition we have held a number of engagement meetings including dedicated 'drop in' sessions, attended events and communications from our partners to agree our key quality priorities

Sharing the draft Quality Account

In line with a Department of Health Guidance, we also produced a draft Quality Account and shared this with key partners as follows: Local commissioners, Local Health watch organisations, Local Authority Overview and Scrutiny Committees.

We invite each partner to provide a statement for inclusion in the Trusts Quality Account. These statements are shown in the section below.

Comments from key partners

North Staffordshire Clinical Commissioning Group (CCG) and Stoke-on-Trent CCG.

North Staffordshire CCG and Stoke-on-Trent CCG are making this joint statement as the nominated commissioners for North Staffordshire Combined Healthcare NHS Trust.

The contract and service specifications with the Trust detail the level and standards of care expected and how these will be measured, monitored, reviewed and performance managed. As part of the contract monitoring process, North Staffordshire CCG and Stoke-on-Trent CCG meet with the Trust on a bimonthly basis to monitor and seek assurance on the quality of services provided. In addition the CCGs work closely with the Trust and undertake continuous dialogue as issues arise to seek assurance, obtained through quality visits and attendance at Trust internal meetings.

The Quality Account covers many of the areas that are discussed at these meetings, which seek to ensure that patients receive safe, high quality care.

Review of 2017/18

- It is pleasing to note the Trust's commitment to improving quality as demonstrated by the following achievements:
- The CCGs recognise the considerable amount of work undertaken by NSCHT staff to achieve a "Good" or "Outstanding" rating in every Service and a 'Good' rating following the CQC inspection during October and November 2017 and acknowledge the significant achievement of been chosen as a mental health exemplar by CQC.
- It is pleasing to note during 2017/18, the Trust strengthened its approach to quality by participating in the Advancing Quality Alliance programme (AQuA) and linking this through their leadership development and the innovative approach to developing their falls reduction programme.
- Throughout 2017/18 the CCGs in partnership with the Trust's Governance Team, Staffordshire and Stoke-on-Trent Healthwatchs' have undertaken 14 announced quality visits which have provided 'real time' assurance on the quality of services provided by the Trust to the local community. The CCG would like to thank staff for their continued support and open approach to these visits. The 2018/19 quality visits programme has been agreed with the Trust.

- We are pleased to see the Trust's continued focus on Service User and Carer Experience and Engagement and notable improvements to the Family and Friends Test (FFT) response with NSCHT achieving the 5th highest rate of returns nationally in November 2017.
- The Trust has continued to participate in the delivery of the five national CQUIN schemes throughout the year and have provided reports detailing the successes and the substantial improvements made for service users as a result of these schemes.
- During 2017-18 the Trust attended the CCG's Joint Quality Committee in common and presented the improvements made to the Child and Adolescent Mental Health Services [CAMHS]. The CCG are pleased to see significant improvements in waiting times to access Services
- It is pleasing to note that the Trust is the best performing trust in England for IAPT recovery rates.

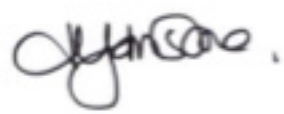
However, 2017/18 has not been without its challenges and these will remain key areas of focus in 2018/19:

- Although improvements have been made to the Trust workforce, in light of the current national shortage of registered nurses and the increasing dependency and acuity of service users the challenge for the Trust will be to maintain safe staffing levels.
- The CCG actively support the collaboration between the Trust and other stakeholders to reduce death by suicide as part of the Zero Suicide ambition and as part of the Suicide Awareness Strategy for Pan Staffordshire.

Priorities for 2018/19

The Commissioners have worked closely with the Trust to agree quality improvements and priorities for 2018/19 which will drive real improvements in quality and safety as the Trust continue to implement their quality strategy to deliver Safe, Personalised, Accessible and Recovery focused services based on integrated locality working across North Staffordshire and Stoke-on-Trent. We look forward to continuing to work with the Trust as part of Together We're Better Sustainability and Transformation Partnership

To the best of the commissioner's knowledge, the information contained within this report is accurate.



Heather Johnstone
Director of Nursing & Quality

Health Watch Staffordshire

Healthwatch Staffordshire was pleased to have been invited to comment on the Quality Accounts of the Trust.

It is reassuring to review an account of such an improved Trust and we recognise the commitment of the Trust and its staff in achieving the outcomes from the latest CQC inspection.

We are pleased to see that the Trust is taking steps to engage with service users and their local community including schools, members of the LGBT community and BAME communities. However, we would note that the detailed engagement has been located in Stoke-on-Trent and would welcome this being extended to the rest of North Staffordshire, particularly the more rural areas in the Staffordshire Moorlands.

We would comment that some of the presentation of performance in charts and diagrams are not always clear to the lay reader of the account. Likewise, it where the results of the Annual Mental Health Community Survey were discussed it may be helpful to understand the scores of the Trust against the national average rather than being described as being 'about the same' as other Trusts. This enables the reader to make their own judgement of where the Trust is in relation to the national picture.

We recognise the low number of complaints received by the Trust and applaud the approach of encouraging early resolution to prevent escalation of complaints. However, it would be helpful to understand how early intervention can provide lessons learned as well as formal complaints and how they are recorded and learning embedded. It would also be helpful to have information on how long it takes the Trust to respond to complaints with a full response as opposed to the time taken to simply acknowledge a complaint.

On the evidence presented in the account and stated priorities for the next 12 months we believe that the Trust shows a commitment to continuous improvement and look forward to being asked to review the Quality Account in 2018/19.

Health Watch Stoke-On-Trent

We would like to congratulate the Trust in achieving good and outstanding for your services during your recent CQC inspection.

We want to say that we have enjoyed working with the Trust over the last 12 months in particular with our 'While We Were Waiting' project around CAMHS services and Access to services. We agree with the Trust's priorities for the coming 12 months. We understand that transition between services is within those priorities but ask that this is made clearer within these priorities as we feel that this area does need improving. We are also pleased that improving community services is one of the priorities and we look forward to working with you over the coming 12 months in this work and on your journey towards outstanding in all services through our Mental Health Group at Healthwatch Stoke- on Trent.

Stoke-on-Trent City Council Adults and Neighbourhoods Overview and Scrutiny Committee

The committee welcomed the opportunity to comment on the North Staffordshire Combined Healthcare Trust's draft Quality Account 2017/18 and would like to thank Laurie Wrench and Dr Buki Adeyemo for their attendance at the committee meeting on 11 May 2018, where they gave a detailed presentation and answered committee members' questions.

General Comments

The Quality Account is a very well presented, comprehensive document. It contains all the required elements and explains clearly how the Trust has performed against the 2017/18 priorities and the priorities for 2018/19.

Statement on Quality

The committee were pleased to note the Trust's improved rating following the recent Care Quality Commission (CQC) inspections during October 2017; especially within the CAMHS team, with every domain now rated as 'good'. The committee congratulated the Trust on its achievements and the Trust's employees for their hard work and commitment to improving the quality of the Trust's services.
Priorities for improvement 2018/19

The priorities for 2018/19 are supported by the committee and clearly demonstrate the Trust's continued commitment to quality improvement. The committee acknowledges the consultation undertaken by the Trust with key stakeholders to develop these priorities.

The committee felt that the 'Zero Suicide' ambition was admirable and the proposed work with partners to achieve this was welcomed. However, committee members questioned how such an ambitious objective would be achieved.

The committee were pleased to note the Trust's continued focus on waiting times for both referral to assessment and referral to treatment times for adult mental health services and CAMHS. However, they had previously been made aware of the concerns held by some partners about the quality of some assessments and also about the process for transition from children and young people's services to adult services, and sought assurances in this respect. The committee were interested in the proposals for a 'Wellbeing Academy' and the work being undertaken with partners in this area and stated that this might be something that the committee might want it explore further at the appropriate time.

This section of the report contains a thorough account of the Trust's participation in the national and local clinical audit programme and of the research projects undertaken by the Trust.

Review of Priorities 2017/18

The committee were pleased to note the 100% achievement of four of five CQUIN schemes for 2017/18 and were made aware that the partially achieved scheme is to be queried. The committee noted that the headings for the table were on a different page than the table and requested that this be amended to make the table easier to understand for the reader.

The committee noted a discrepancy in the Delayed Transfers of Care (DToC) figures reported for 2016/17 and were advised that these would be checked prior to the publication of the final Quality Account.

3.4 Statement of changes

The statements above include a small number of additional suggestions for changes to the format / content of the Quality Account. The section below describes whether the suggestions have been responded to in the final draft:

You said:

Where the results of the Annual Mental Health Community Survey were discussed it may be helpful to understand the scores of the Trust against the national average rather than being described as being 'about the same' as other Trusts. This enables the reader to make their own judgement of where the Trust is in relation to the national picture.

Our response:

Unfortunately the national survey does not report a national average score. The terminology used in the Quality Account is the terminology used in the national report for the Community Mental Health Survey

You said:

It would be helpful to understand how early intervention can provide lessons learned as well as formal complaints and how they are recorded and learning embedded. It would also be helpful to have information on how long it takes the Trust to respond to complaints with a full response as opposed to the time taken to simply acknowledge a complaint.

Our response:

Themes and trends for both PALS and complaints are monitored by the Patient Experience Team and if concerns are identified a 'deep dive' into specific issues is commissioned. We also share any learning from PALS/complaints in the following ways:

- to the wider Trust via the Learning Lessons programme which consists of bi-monthly bulletins and face to face sessions
- through discussion at the Directorate Quality Forums
- through the Listening and Responding training provided by the Patient Experience Team to individual Teams and on Trust Induction, Preceptorship Programme as well as to student clinicians

Additionally there is an action plan produced for each complaint; implementation and monitoring of these actions is overseen by the directorate. Complaints are also monitored regularly through SLT Performance and Quality Committee; additionally an annual report is provided to QC to provide further assurance.

During 2017/18 the average response time for complaints was 55 days. This is longer than the 40 days the Trust aspires to however the Trust aims to ensure that all complaints are thoroughly investigated to the satisfaction of the complainant. We are continuing to work on improving out response times with the aim of achieving 100% compliance with the target.

You said:

We understand that transition between services is within those priorities but ask that this is made clearer within these priorities as we feel that this area does need improving

Our response:

We have made transitions an explicit priority as detailed in the Quality Account and Board Assurance Framework as part of an ongoing CQUIN priority

You said:

The committee noted that the headings for the table were on a different page than the table and requested that this be amended to make the table easier to understand for the reader.

Our response:

Revised formatting completed

You said:

The committee noted a discrepancy in the Delayed Transfers of Care (DToC) figures reported for 2016/17 and were advised that these would be checked prior to the publication of the final Quality Account.

Our response:

The original data reported is the correct data as confirmed by the Trust Performance Team. The Trust wide average for last year; months 11 & 12 was lower after taking out detained patients out of the reporting

3.5 Auditor Statement of Assurance

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of North Staffordshire Combined Healthcare NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Crisis resolution gate kept admissions
- Patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations). In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS Choices website in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from North Staffordshire and Stoke on Trent CCG dated June 2018;
- feedback from Healthwatch Staffordshire dated June 2018;
- feedback from Healthwatch Stoke on Trent dated June 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 dated April 2018;
- feedback from the Stoke Adults and Neighbourhoods Overview and Scrutiny Committee dated May 2018;
- the latest Care Quality Commission inspection report dated February 2018;
- the 2017 National Staff Survey;
- the 2016 Survey of people who use community mental health services
- The Head of Internal Audit's Annual Opinion over the trust's control environment, dated April 2018
- The Annual Governance Statement for the year ended 31 March 2018
- North Staffs Voice for Mental Health comments, June 2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of North Staffordshire Combined Healthcare NHS Trust.
We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and North Staffordshire Combined Healthcare NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by North Staffordshire Combined Healthcare NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Ernst & Young LLP

Ernst & Young
2 St Peter's Square, Manchester
27 June 2018

The maintenance and integrity of the North Staffordshire Combined Healthcare NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the Quality Accounts since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of the Quality Accounts may differ from legislation in other jurisdictions.

3.6 Glossary

AAIMS- Accreditation for inpatient rehabilitation units.
ASD- Autistic spectrum disorder
ADHD- Attention deficit hyperactivity disorder
ASIST- Advocacy services in Staffordshire
CAMHS- Child & Adolescent mental health services
CCG- Clinical commissioning group (made up of local GPs, these groups replaced primary care trusts (PCTs) as commissioners of NHS services from 2013/14)
CLRN- Comprehensive local research network
CPA- Care programme approach
CPD- Continuing professional development
CPN- Community Psychiatric nurse
CQC- Care quality commission
DOH- Department of health
ECT- Electroconvulsive therapy
EngAGE- Stoke-on-Trent forum for people over 50 to give their views
Health watch- Local independent consumer champions, represents the views of the public.
HRG4- Health resource group (standard groupings of clinically similar treatments)
IAPT- Improving access to psychological therapies team
IM&T- information management and technology
IT- information technology
KPI- key performance indicator
Metric- method of calculating performance
Mind- Mental health charity network
MRSA- Methicillin-resistant staphylococcus Aureus
NDTI- National Development team for inclusion
NHSLA- NHS Litigation Authority
NICE- National Institute for health and clinical excellence
NIHR-National institute for health research
NPSA- National patient safety agency
NSCHT- North Staffordshire Combined Health Care NHS Trust
PALS- Patient advice and liaison service
PBR- Payments by results
PIP- Productivity improvement pathway programme.
POMH- Prescribing Observatory for mental health
QIPPP- Quality, innovation, productivity, partnership and prevention.
RAID- Rapid assessment interface and discharge
R&D- Research and development
REACH- Local advocacy project supporting people with learning disabilities
RETHINK- Mental health membership charity
SPA- Single point of access (to mental health services)
SUS-Secondary user's service
TDA- Trust development Authority
UHNM- University Hospital of North Midlands NHS Trust

The Trust is committed to providing communication and foreign language support for service users and carers who may need it for any reason. This Annual Report and Accounts can be made available in different languages and formats, including Easy Read. If you would like to receive this document in a different format, please contact the Communications Team on 0300 123 1535 ext 2676 (Freephone 0800 0328 728) or write to the FREEPOST address below:-

Freepost RTCT-YEHA-UTUU
Communications and Membership Team
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Stoke-on-Trent
ST4 8HH