North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 7th September 2017, 10:00AM,
BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS,
BELLRINGER ROAD, TRENTHAM LAKES SOUTH,
STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 13th July 2017** *To APPROVE the minutes of the meeting held on 13th July 2017*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
8	*To RECEIVE questions from members of the public*	Verbal
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
9.	**REACH RECOGNITION AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Individual Award* To be introduced by the Chief Executive and presented by the Chair	Verbal

10	**STUARTS PATIENT STORY – WARD 1** *To RECEIVE Stuarts Patient Story from Ward 1 to be introduced by the Executive Director of Nursing, Maria Nelligan*	Verbal
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
11	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
12.	**NURSE STAFFING MONTHLY REPORT - June & July 2017** *To RECEIVE the assurance report on the planned versus actual staff variances from Ms M Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 5/6
13	**INFECTION, PREVENTION AND CONTROL ANNUAL REPORT** *To RECEIVE the Infection, Prevention and Control Annual report for assurance from Ms Nelligan, Executive Director of Nursing and Quality*	Assurance Enclosure 7
14	**SAFEGUARDING CHILDREN AND ADULTS REPORT** *To RECEIVE the Safeguarding Children and Adults report for assurance from Ms Nelligan, Executive Director of Nursing and Quality*	Assurance Enclosure 8
15	**QUALITY STRATEGY AND ACTION PLAN** *To RECEIVE the Quality Strategy and Action Plan report for assurance from Ms Nelligan, Executive Director of Nursing and Quality*	Assurance Enclosure 9
16.	**SERIOUS INCIDENTS QUARTER 1 REPORT** *To RECEIVE the Serious Incidents Quarter 1 Report for assurance from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 10
17.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 4** *To RECEIVE the Month 4 Performance Report from Miss Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 11
18.	**WINTER PLANNING** *To RECEIVE the Winter Planning report for assurance from Dr Fazal-Short, Acting Director of Operations*	Assurance Enclosure 12
19.	**FIRE ANNUAL REPORT / SAFETY UPDATE** *To RECEIVE the Fire Annual report and Safety Update for assurance from Dr Fazal-Short, Acting Director of Operations*	Assurance Enclosure 13
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
20. .	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Ms Tess Tainton, Vice Chair of the Service User and Carer Council*	Assurance Enclosure 14

	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
21.	**FINANCE REPORT – MONTH 4 (2017/18)** *To RECEIVE for discussion the Month 4 financial position from Miss S Robinson, Director of Finance, Performance and Digital*	Assurance Enclosure 15
22.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 31st August 2017 from Mr Patrick Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 16
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
23	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** *To RECEIVE the People and Culture Development Committee Assurance report from the meeting held 4th September 2017 from Mr P Sullivan, Chair/Non-Executive Director*	Assurance Tabled
24	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 31st August 2017 from Mr P Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 17
25.	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from the meeting held 30th August 2017 from Mr T Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 18
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
26.	*To RECEIVE a verbal update on progress from Mr A Hughes, Joint Director Strategy and Development (NSCHT/GP Federation)*	Verbal
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 5th October 2017 at 10:00am.	
	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	

THE REMAINDER OF THE MEETING WILL BE IN PRIVATE

	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note
	SERIOUS INCIDENTS	Assurance
	BUSINESS PLAN UPDATE	Approve
	LEADERSHIP & WORKFORCE REPORT AND SERVICE REVIEW	Assurance
	ANY OTHER BUSINESS	

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 13th July 2017 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr D Rogers
Chairman

Directors:

Mrs C Donovan
Chief Executive

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Dr Nasreen Fazal-Short
Acting Director of Operations

Mr T Gadsby
Non-Executive Director

Mr P Draycott
Executive Director of Leadership &Workforce

Mrs B Johnson
Non-Executive Director

Ms J Walley
Non-Executive Director

Ms M Nelligan
Executive Director of Nursing and Quality

Dr K Tattum [part]
GP Associate Director

Miss S Robinson
Director of Finance, Performance and Digital

Ms L Barber
Non-Executive Director

Mrs W Dutton
Interim Chair of Service User Carer Council

In attendance:

Mr J McCrea
Associate Director of Communications

Mrs L Wilkinson
Acting Corporate Governance Manager

Members of the public:
Hilda Johnson [part]
Phil Copestake

Staff Retirements
Steven Proffitt
Maureen Proffitt
Jane Blagg

REACH Individual Recognition Award -
Ward 3 Adult Mental Health Inpatient Services

The meeting commenced at 10:00am.

763/2017	**Apologies for Absence** Apologies were received from: Mrs Laurie Wrench, Associate Director of	**Action**

	Governance and Mr Andrew Hughes, Joint Director of Strategy and Development	
764/2017	**Declaration of Interest relating to agenda items** Dr Tattum, GP Associate Director - Local GP Federation and Local Medical Committee Maria Nelligan, Director of Nursing and Quality – Honorary Lecturer at Chester University	
765/2017	**Declarations of interest relating to any other business** There were no declarations of interest relating to any other business.	
766/2017	**Minutes of the Open Agenda – 8th June 2017** The minutes of the open session of the meeting held on 8th June 2017 were approved.	
767/2017	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***700/17 – Questions from the public – Agenda item for today's Open Trust Board meeting*** ***705/17 Serious Incident Q4 Report –Agenda item for today's Open Trust Board meeting.*** ***708/17 Board Assurance Framework 2017/18 - Agenda item for today's Open Trust Board meeting.*** ***754/17 Feedback from Service User and Carer Council Open Space / Quality Priorities – Key Questions Cards –*** *Currently being developed by Communications Team following which will be sighted at Service User Carer Council.*	
768/2017	**Chair's Report** Mr Rogers explained that the Capped Expenditure Process is focussing on improving the financial position of those areas of the country with the worst financial deficit. This stems from conversations from the Treasury / Social Care and the Health Service. Mr Rogers talked about clinically led better care for our communities advising that progress can be made. The Board will be looking at this today during the Closed Trust Board Session. Mr Rogers acknowledged that staff members within the Trust are working	

	long hours and working tirelessly to meet the requirements of the CQC data requests and CEP. Mr Rogers thanked Mrs Donovan for leading the process. The Chairman advised he was happy to answer questions. ***Received***	
769/2017	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in June 2017 and draws the Board's attention to any other issues of significance or interest. **CEP** The Staffordshire health economy is one of 13 areas across the country undergoing a process introduced in April 2017 by NHS England and NHS Improvement called the Capped Expenditure Process (CEP). As the NHS entered the new financial year, Commissioners and Providers within the Staffordshire economy had not, in aggregate, been able to agree a set of affordable 2017/18 Operating Plans, or, in some cases, confirm delivery of financial Control Totals. The objective of the CEP therefore was for NHSE and NHSi to support Providers and Commissioners to work together to prioritise the financial resources they have on behalf of the populations they serve and ensure they live within their budgets. According to NHSI, "the health economies selected to participate in the process are those with the greatest gap between their planned expenditure for 2017/18 and their budget allocation for the year. The Trust will work with NHS England and the Department of Health in the next few weeks to understand the impact of implementing these plans'. To facilitate the process, the Trust Board will be considering the following actions which we believe are critical to the assurance and acceptance of any CEP plans, a process endorsed by NHSi: • Board assurance, on a self-assessment basis, must take place so that the consequences of proposed trust CEP proposals are fully considered and will safeguard patient safety and quality. • Ensure that CEP plans are consistent with constitutional rights for waiting times (referral to treatment RTT) and patient choice. • Where service reconfiguration proposals trigger the NHS' public consultation duties, this is followed. In addition, the Trust shall ensure that service users, carers and staff are engaged throughout the planning and implementation stages of agreed CEP proposals that impact on the services they receive/provide. • The Trust will work collaboratively with commissioners in agreeing plans, engagement, undertaking impact assessments and taking forward delivery.	

Whilst the Trust will continue to play an active role to help shape the future of a sustainable Staffordshire, we will remain committed to our journey towards outstanding mental health, learning disability and substance misuse services via our SPAR quality priorities and the exciting development of population based integrated care through the Multi-Specialty Community Provider (MCP).

The next stage of the scrutiny process takes place tomorrow (14th July 2017) outcomes of discussions from CEP meetings will be brought back to a future Trust Board meeting.

AWARDS AND SUCCESSES

Congratulations to NSCHT staff and teams, who have won a string of awards. The Finance team won the Great Place to Work Award at the Healthcare Finance Management Association (HFMA) West Midlands Branch Awards on 23 June. This follows on from their success at the national 2017 HFMA Awards where they won the Costing Award.

The Trust enjoyed further success at the Healthcare People Management Association (HPMA) 2017 Awards. The Leading with Compassion scheme, where staff, patients and carers can nominate someone who they believe has demonstrated compassion won the Academic Wales Award for Excellence in Organisational Development.

In addition, our Feel Good Friday health and wellbeing initiative was a runner-up in the HPMA Social Partnership Forum Award for partnership working between employers and trade unions.

CQC

When the Trust published its fantastic CQC results in February this year, where 10 out of 11 of our core services received 'Good' or 'Outstanding' ratings, we asked the CQC to return to inspect our Community CAMHS services.

The CQC has introduced a new inspection regime and has informed the Trust they will be revisiting the Trust to do core service unannounced inspections and a well-led review. Alongside this, the CQC has asked for a series of data requests from our various services.

The Trust will be working with the teams involved and their clinical directors and heads of service to ensure they receive the fullest support possible and, of course, thank them in advance for their efforts and dedication.

The new CQC regime will now include annual reviews and this is our opportunity to demonstrate how the improvement programme we embarked upon years ago is continuing to bear fruit and that we are really delivering on our vision 'to be outstanding'.

NEW CLINICAL DIRECTOR

Following discussion with clinical directors and in light of Dr Jo Barton

stepping down as our Clinical Director for Children and Young People (CYP), the decision was made for the Learning Disabilities (LD) and CYP directorates to come together – with the leadership arrangements therefore changing. Thank you to Jo for her leadership over the past two years; we wish her the very best success in the future.

Dr Matt Johnson, our Clinical Director for Learning Disabilities, is offering Clinical Director Interim support for the two directorates in order to continue to support CYP and also to enable support for all clinical and other matters. The Board have been delighted with the leadership achievement to date of Matt in his LD role.

SUCCESSFUL CONFERENCES

The Psychological Services Open Day on 9 June 2017 featured talks throughout the day from psychologists and therapists about the services offered throughout the Trust to support people with their psychological care.

On 27th June 2017, the Trust hosted the latest in our nationally recognised Neuropsychiatry conferences. This was the sixth Neuropsychiatry conference we have hosted and the focus of this year's event was Huntington's disease (HD). This year marks the 30th anniversary of providing HD services in North Staffordshire, one of only a few NHS-based services in the country for this condition. A very big thank-you to Dr George El-Nimr for organising the event.

28th June 2017 saw the first in what we hope will be a long running series of Primary Care and Combined Integrated Psychiatry conferences - with the theme of this one being psychopharmacology. We welcomed dozens of GPs, psychiatrists and students to the event, which featured a keynote presentation from Professor Ian Anderson, Professor of Psychiatry at the University of Manchester. A further talk was given by our Medical Director Dr Buki Adeyemo, while there was a focus on MCPs by Andrew Hughes, Joint Director of Strategy and Development for Combined and North Staffordshire GP Federation, and Dr Mark Williams, Clinical Director for Primary Care.

The final event of June saw service users, carers, partners and staff attend the Trusts first Inclusion Conference - called **Symphony for Hidden Voices**. The event celebrated diversity and shared stories from a number of different individuals whose lives have been shaped in different ways by their experiences of both inclusion and exclusion. Among those who gave a talk was Jenny Harvey, Unison Staff Side representative, who spoke about her transgender story.

Other talks included those given by Joy Heal, who spoke eloquently about the impact of her son Jonathan's suicide; Wahida Mohammed, Human Resources Administrator, and Sophia Hussain, Senior Pharmacist, who both spoke about their lives as Muslim women; Kirsty Booth and Jaymee Smith from the Child and Young Peoples' North Staffordshire IAPT Youth Council, who gave a young persons' perspective of mental health; Abby Crawford from LGBT campaign organisation Stonewall UK; and

	representatives from Sanctus, who spoke about the work they are ding to support asylum seekers. **MCP WORK** There has been an enormous amount of effort and energy put in by Combined to develop a model of multispecialty community providers (MCPs) across North Staffordshire and Stoke-on-Trent. A significant step forward was taken at the most recent meeting of the North Staffordshire Alliance Board, which unanimously agreed that Newcastle-under-Lyme would be the first locality that will begin to bring forward the new ways of working. The Trust is planning to go live with the new locality from September. A palpable sense of momentum is growing around our plans and the Trust is delighted that as part of the preparations for the MCP, we will be supported by the NHS Chief Transformation Officer, Helen Bevan and her Horizons team – working with the Sustainability and Transformation Plan (STP) system leadership organisations development team – to design and deliver an Accelerated Design event. **CAMHS** Thanks to a concerted effort by our Children and Young People's services, I am delighted to announce that **no child is now waiting over 18 weeks for an assessment**, with 75 per cent of children and young people assessed within four weeks. This is a fantastic achievement and is testament to the hard work of all of our Community CAMHS teams who have been working to improve services for children and young people. **OUTSTANDING ENGAGEMENT** Our first 15 pioneering Trust teams are embarking on their six-month Towards Outstanding Engagement journeys. These teams cover the whole organisation and the programme will encompass a wide range of staff engagement tools, including listening events, team building and back to the floor. Staff will be able to highlight issues within their team and make choices about how they can improve or sustain staff engagement. **REACH** Nominations are open now for the Trusts annual REACH Awards. REACH takes place on Thursday 5 October at the Moat House, Stoke-on-Trent and celebrates staff and teams who have made a truly outstanding contribution and have gone above and beyond as part of their work. A new award this year will be the Proud to Care Award – this exciting addition will involve anonymised voting in advance solely by our own staff. ***Received***	
770/2017	**Questions from the public** **Symphony for Hidden Voices Event**	

	Jenny Harvey wished to acknowledge Lesley Faux's hard work in organising the event. Feedback was very positive. Mr Draycott advised he was delighted with the positive impact of the event. A number of staff also attended the PRIDE event supported in Stoke who felt it was really important to engage with the community. The Trust are looking to participate in other events in the wider community over the course of the next year. **CEP** Jenny Harvey acknowledged that CEP has been very difficult for staff members. There is a shared concern if we are going to organise our NHS around short term under-funded projects.	
771/2017	**Staff Retirements** Mrs Donovan recognised staff who are retiring this month as follows: **Steven Proffitt - Support Time and Recovery (STR) Worker** Steve joined the Trust on 9th February 1998 as a health care support worker on the Fernwood Unit at St Edwards Hospital. In July 1999 he moved to work in the Grange and soon progressed and become a senior support worker in the community at the Ashcombe Centre in October 2001. Steve joined the Early Intervention team on 14th June 2010 as a Support, Time and Recovery Worker. Steve was described as kind, caring with a deep respect for all people and an awareness of the potential in the service users he worked alongside. He is calm, reliable and trustworthy with a great sense of humour gaining respect from peers and service users/families alike. Steve believes in social justice and the rights of all people to fulfil their potential; he worked in this way providing recovery opportunities and giving hope and confidence when people have been in a vulnerable and difficult place. Steve has given great service to the trust and teams he has worked with and we wish him every happiness in his retirement. **Maureen Proffitt – Healthcare Support Worker** Staff at the Darwin Centre were sad when Maureen announced her plans to retire. She was a valuable member of the team and will be sorely missed. Maureen would always be willing to help and was excellent with the young people in her care able to make them laugh and smile when they were feeling at some of the lowest points in their lives. Maureen demonstrated empathy to the young people and support to staff when they needed it. Working with Maureen has been a pleasure and we hope she has a long and happy retirement. **Jane Blagg – Community Learning Disabilities Nurse** Jane commenced her career in learning Disability's as a Care Assistant in 1980. Jane came to Stallington alongside her dad who, at the time was the	

	headmaster at the on-site school. It was not long before Jane enrolled on the 3 year nurse training program, qualifying in 1983. Jane was then promoted to Senior Staff Nurse in 1986 and then onto Acting Charge Nurse in 1991. In 2001 Jane undertook a change in her career from 24 hour residential nursing care to have a new experience within the community learning disabilities team. In 2014 Jane was successful in securing the post of Deputy Team Leader to both city and county community teams, and whilst undertaking this post Jane also ran a busy and very complex caseload. Jane has been an excellent Deputy in the way she has supported the whole team and in particular the Team Leader. Janes calm and measured leadership style in recent busy and challenging years has certainly helped these teams to flourish and develop the strong reputation they have. Jane has been constantly committed to the development of many student nurses and to the mentorship of many newly qualified team members and she has led several development programmes and initiatives, valuing every CPD opportunity. Jane has had a career of 37 years, one to be hugely proud of. Jane herself often said that she felt hugely privileged to have experienced and been involved with so many positive changes in the lives of people with learning disabilities. ***Received***	
772/2017	**REACH Recognition Award** **Team Award July 2017** **Acute Inpatient Ward 3** Ward 3 is a 22 bedded, acute inpatient, female only unit based at Harplands Hospital. The values of the Trust underpin all the work undertaken by the team. They deliver person centred care which supports the needs of each individual in a compassionate and caring manner. Each individual has a thorough assessment of their needs in the first 72 hours of their admission which determines the most effective care pathway. For some this may lead to a discharge back to the community with support from the Home Treatment Team or their care co-ordinator; for others, this may need a longer stay with a range of therapeutic interventions to help support their journey to recovery. There have been a number of key staffing changes over the past year with the appointment of Laura Jones as Ward Manager, and a new consultant Dr Chris Link has strengthened the ward leadership. A number of vacancies have also been filled which has strengthened the skills mix on the ward. The embedding of psychological services has additionally made a huge difference to the way in which individuals with a diagnosis of personality disorder are supported whilst on the ward.	

	The value that best represents the team is 'Compassionate'. They are a caring team who work together to support service users and each other in a respectful manner, providing safe, effective care while promoting recovery in a meaningful way. Ward 3 staff provided a presentation entitled 'The Purposeful Admission Pathway', which described their achievements, admission process, and Laura Jones, Ward Manager shared a service users story. It was suggested that the Communications team undertake an interview with the service user who is unwell today and was therefore unable to attend. Mr Rogers suggested this for future board meetings part of the ongoing programme of patient stories to the Board. Hilda Johnson shared that she had seen changes since Laura Jones become ward Manager and commented that Laura 'is doing 'a great job with the patients'. Mr Sullivan thanked the team for the presentation and asked the team if they felt 22 beds was excessive. Laura advised it is very challenging when full, but of course it depends on the presentation of the service users. The unpredictable nature of acute care makes it hard but we do work above national guidance for acute wards. Mr Sullivan asked if there was anything staff on Ward 3 felt the Trust Board could do to help support the ward. Laura Jones suggested more focus on workloads in community teams explaining that very often the ward make demands of them and it does pose challenges. Ms Walley asked how the Board are looking at strategically the size of the ward and the level of need to ensure consequently we do not put undue pressure on those that require access to the bed. Mrs Donovan advised that discussion have been had with Commissioners and ideally we want to expand investment in the community to reduce admissions to beds. Hilda Johnson highlighted that community services are the key to preventing admissions and ensuring discharge but there is not the resource available, therefore North staffs Voice for Mental Health are happy to support the Boards conversations with Commissioners to ensure we are resourced properly. We need to focus on changing the culture and thinking of patients who have been admitted for years. Mrs Dutton advised having a really good care co-ordinator is key the Service User & Carer Council are looking at this. The group will be refreshing policies and undertaking promotional work the in coming weeks around the process of care co-ordination.	**JMc**
773/2017	**Nursing Staffing Monthly Report – May 2017** Ms M Nelligan, Executive Director of Nursing & Quality presented the report	

	and highlighted the following: This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during May 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual number of staff deployed vs numbers planned) during May 2017 was 84% for registered staff and 102% for care staff on day shifts and 84% and 106% respectively on night shifts. Overall a 95% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Managers supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. Ms Nelligan advised she met with Keele University recently to look at the best way to maximise training of mental health nurses as one area had 15 places available for Learning Disabilities and only one applicant. There are also issues with Occupational Therapy Training. Ms Nelligan advised work is underway to look at shift preferences i.e. short and long days, changes to which the Trust are looking to implement in August 2017. Jenny Harvey highlighted this as being a difficult issue having only just moved away from long days due to quality reasons. Although Unison would welcome and support a mixed approach. Mr Gadsby asked if the Board could receive within future reports updates with regards to relationships with Staffordshire University. Ms Nelligan advised she is meeting with Staffordshire; there are plans to have conversations with Chester University. Mr Rogers advised there is a workshop planned for Thursday 20th July 2017 to look at better and more comprehensive relations with the Trust and Keele. Ms Nelligan has launched flexible retirement options within the nursing fraternity and Mr Draycott's team are working hard to take this forward. The Trust is looking at how this offer can be broadened in an attempt to retain experienced staff. Hilda Johnson wished to raise concerns regarding community staffing levels. North Staffs Voice for Mental Health are being alerted to issues from Greenfield's and Sutherland Centre and an overall picture is required. Ms Nelligan advised there is a plan to look at services across the Board during which staffing reviews will be undertaken in the community, work has commenced with Meridian with regards to productivity. Mr Sullivan suggested time is taken at Quality Committee to seek assurance. Ms Nelligan agreed to take forward to Quality Committee. ***Received***	**MN**
774/2017	**Serious Incidents Annual Report** Dr Buki Adeyemo, Executive Medical Director, presented the report	

	highlighting key points. - During 2016/17 the trust reported and investigated 57 serious incidents. This is a 10% reduction when compared to the 62 SIs reported and investigated during 2015/16 - During this reporting period, April 2016 to March 2017, we had no Never Events. - The highest number of SIs (47) relate to unexpected/potentially avoidable deaths. - Adult Community Directorate had the highest number of incidents during 2016/17, the highest number of unexpected deaths (6) occurred within the locality of the Greenfield's Centre. A thematic review was commissioned in order to determine any possible linking factors. The thematic review focused on 11 unexpected deaths within the locality of Greenfield's over a 9 month period (April – December 2016). The themes from a multidisciplinary review of the incidents showed some inconsistencies in care and process but as with the SI investigations there were no causative factors in cases reviewed. - Lessons learnt are highlighted within the report - In the NOAP Directorate there was an increase in sustained fractures and falls in response to this increase due to falls due to ward 4 - All investigations were completed in a timely manner according to national policy - CQC commended our proactive approach to how we manage our SI's The Trust Suicide Prevention strategy mirrors the Health Select Committee Suicide Strategy. Improvement plans are sighted at the Quality Committee on a quarterly basis. Ms Johnson stated that the biggest killer of 17 year olds is reported to be suicide and asked if this was a problem for this area. Dr Adeyemo advised it is a national problem as this age group are hard to reach there needs to be more focus on engagement. Our CYP directorate are innovative in the way they are trying to engage with people, visiting schools, raising awareness of mental health. There is also a correlation of substance misuse in this age group and on the whole it is about being aware it is a group we need to proactively engage with. Ms Walley highlighted that NUS students are particularly interested in pursuing this theme which again highlighted the importance of relationships with Staffordshire University to ensure our expertise can be used. Dr Adeyemo highlighted as part of the Local Health Economy Suicide Prevention Group we are actively in conversation with Staffordshire University to develop this. ***Received***	

775/2017	**Quality Account 2016/17** Dr Buki Adeyemo, Executive Medical Director, presented the report and highlighted the following. The Quality Committee has delegated authority on behalf of the Trust Board to approve the Quality Account. The Quality Account 2016/17 was approved by the Quality Committee at its meeting on the 22 June 2017. The report identifies the quality achievements for 2016/17 and quality priorities for 2017/18. The report was endorsed by key stakeholders including commissioners for Stoke and commissioners for Staffordshire, Healthwatch Stoke and Healthwatch Staffordshire, Stoke Overview and Scrutiny Committee and external auditors Ernest & Young LLP, as a true and accurate reflection of the Trust's performance and for its presentation. The Trust was particularly commended for the progress made and achievement of its quality priorities. The Quality Account was uploaded to NHS Choices meeting the publication deadline of the 30 June 2017 which also fulfilled the statutory duty of sending a copy of the Quality Account to the Secretary of State. ***Received***	
776/2017	**Performance and Quality Management Framework Report (PQMF) Month 2** Miss Robinson, Director of Finance, Performance and Digital, presented this report. The report provides the Board with a more detailed level of summary of performance to the end of Month 2. The following performance highlights should be noted; • 68.5% of IAPT patients are moving to recovery (50% target) • The nursing agency spend (as a % of nursing paybill) has significantly reduced compared the same period last year • The use of locums to (non NHS medical as a % of medical actual pay) is reducing • 98.2% of all service users have a care plan in line with their needs In Month 2 there is 1 related metric rated as Red and 3 as Amber; all other indicators are within expected tolerances. White KPIs are those where measures where the requirement is to report absolute numbers rather than % performance. **<u>Exceptions</u>** **CPA** - 93.9% at M2 from 94.3% at M1 **Agency** - At month 2, the year to date overspend against the agency ceiling was 6%. At month 1, the year to date overspend compared to the agency ceiling was 11%. Ward 4 was a key driver of Agency expenditure in M1 & M2, accounting for 9% in M1 and 11% in M2 of overspend against the	

	ceiling. For core agency at month 2, there was a year to date underspend against the agency ceiling of 5%. At month 1, the year to date overspend compared to the agency ceiling was 2%. **Delayed Transfers of Care** - 16.6% at M2 from 14.8% at M1. A deep dive analysis has identified patient/family choice as being the most significant contributing factor to delays, particularly on older people's wards. Other factors include home care placements, onward funding and housing. **RAID** - 94.0% at M2 the same as at M1 ***Received***	
777/2017	**Service User Carer Council** Ms Dutton, Vice Chair of the Service User Carer Council updated the Board in respect of the Service User Carer Council on meeting activity and achievements to-date. The first workshop took place in June 2017 around care planning. Mr Boyd Associate Director of Transformation gave an overview of Lorenzo. Agreed reasonable baseline on discharge to include; • Prescribing, how much supplied and subsequent prescribing responsibility • Printed care plan for Service User/ Carer • Contact name and telephone number Following expressions of interest from Phil Leese and Wendy Dutton, the Council unanimously voted Wendy Dutton as a new Chair and arrangements will be put in place for the Vice Chair to be elected. The New Chair welcomed and thanked the SUCC for their support. There is now a vacancy for a Vice Chair position which will be discussed at the next SUCC meeting. Advocacy concerns were raised that services and funding is currently under debate and the need to ensure access for service user's/carer's is maintained. Sue Carson (Healthwatch Staffordshire) offered to do an update for the SUCC at the next meeting. ***Received***	
778/2017	**Place of Safety Capacity and Performance** Dr Fazal-Short, Director of Operations presented the report highlighting the following: Under section 136 of the Mental Health Act (MHA) 1983, someone who appears to be experiencing a mental health crisis in a public place can be picked up by the police and taken to a place of safety for an assessment of their needs. Currently in North Staffordshire we have access to one place of safety at the Harplands Hospital. Also within Staffordshire, there are an additional two places of safety at St George's Hospital, Stafford, which are	

	utilized when needed. The Trust has been working hard to enable those service users who need a place of safety to access this at the Harplands or St George's Hospital, Stafford and reduce those who end up in police custody. Significantly there is a new Policing and Crime Act which is clear about defining what is meant by "exceptional circumstances", it will remove police custody as a place of safety for people aged 17 and younger, and it will reduce the amount of time a person can be detained under section 136 (from 72 hours to 24 hours). These, and other proposals contained within the Act will likely have the effect of further reducing the use of police custody. The Crisis Care Concordat which includes the Police commissioner's office, has been meeting regularly and focusing on the number of citizens detained both in police custody, the availability of the places of safety and plans going forwards. These discussions and local data have indicated that we do not have enough provision to meet the needs of all our citizens. In May 2017, 4 out of 17 citizens were taken to alternative health based places of safety outside of Staffordshire due to the capacity being full. Locally we have started a dialogue with commissioners about supporting the revenue costs for a second place of safety in Stoke. The business case for this is currently being discussed with commissioners. There has been considerable local success to reduce the number of people being detained on Section 136 in Police custody with 85% reduction between 2013-14 and 2015-16, following the introduction of the Community Triage team in November 2014. However, some concerns about the use of police cells as places of safety remain, given that the number of people needing to be assessed in a place of safety appears to be increasing. Overall the data also indicates that use of Section 136 is increasing. In 2015-16 there was a 14% increase, and so far in 2016-17 there has been an 11% increase (compared to same months last year). The Trust recognises that there is currently not enough capacity for the place of safety provision in the North of the County and we are working with commissioners to support an additional place so that we can support citizens with this assessment when needed in our local vicinity. Mr Sullivan questioned if we are looking at the problem in the right way highlighting the need to understand we are an outlier. Is there an issue about whether our community and crisis services are supplying that need or are police picking up people that should not be on a 136. Mrs Donovan highlighted we need to have a look at benchmarking information and have an understanding of this. Dr Adeyemo added that Stoke is the highest in 136 detention. However there was a lot of training that was undertaken and the community triage team was introduced which did reduce numbers previously.	

	Received	
779/2017	**Learning from Deaths – Provider Responsibilities** Dr Buki Adeyemo, Executive Medical Director presented the report. Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals". This was reinforced by the recent findings of the Care Quality Commission (CQC) report Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning. Mrs Donovan requested the report go back through Quality Committee so we can understand what the gaps are and identify actions. Mr Draycott highlighted that learning from what we are doing is incredibly important and to enhance this further we need to look at the equality and diversity information behind this to ensure we are not missing anything in this regard. ***Noted***	**BA**
780/2017	**Finance Report Month 2 (2017/18)** Miss Robinson, Director of Finance, Performance and Digital, presented this report which contains the financial position at Month 1 The Trust Board was asked to note: The reported deficit of £63k against a planned deficit of £101k. This is a favourable variance to plan of £38k. The M2 CIP achievement: o YTD achievement of £45k (16%); an adverse variance of £234k; o 2017/18 forecast CIP delivery of £2,161k (68%) based on schemes identified so far; an adverse variance of £1,036k to plan; o The recurrent forecast delivery at month 2 of £2,434 representing a recurrent variance to plan of £763k. The cash position of the Trust as at 31st May 2017 with a balance of £6,059k; £905k worse than plan. We are undertaking a significant amount of work within the Finance Department to address this. Year to date Capital expenditure for 2017/18 is £51k compared to a plan of £728k;	

	Use of resource rating of 3. The negative aspects of the rating being driven by the deficit position at Month 2. The Trust Finance Strategy deep dive report will be available for September Trust Board. ***Received***	**SR**
781/2017	**Assurance Report from People and Culture Development Committee** Miss Barber, Chair of the People and Culture Development Committee/Non-Executive Director, presented the assurance report to the Trust Board from the People and Culture Development Committee held on 3rd July 2017. The following policies were approved by the Committee and the Trust Board are requested to approve the following: • Pay Progression Policy • On Call Policy • Expenses Policy • Acting Down Policy • Producing Clinical Information for Service Users • Media Policy The following policy was agreed an extension until October 31st 2017 and the Board are asked to support that extension: • Remediation Policy Two related staff stories were presented to the Committee. The Trust has a proactive policy of recruiting service users, and at the point of recruitment their mental health history was made known. Due to the complex nature of mental health their health fluctuated several times which triggered their sickness management. The staff members were redeployed into administration positions in the hope that the adjustments would support them to stay in employment at the Trust. In hindsight the move has exacerbated their conditions and has been less easy on their anxieties than anticipated. The learning outcomes highlight the need for a greater degree of honesty in work care plans; the real understanding the impact of offering alternative employment; future pay progression opportunities and the fact that there may be others within the Trust experiencing similar issues that have not yet triggered active management and the need to use expertise in house more effectively such as Step On. The staff members concerned are now healthy but have experienced a long and often complex journey to reach this point. These concerns also need to be considered as part of the sickness policy review. Go Engage - The main headline is that the Trust currently experiences a reasonably positive level of engagement with an overall score of 3.96 out of	

	5. This overall figure will now form the benchmark in which we can then track staff engagement levels going forward. The results will also be presented to the Board to update the Board on progress. Diversity and inclusion report - The suite of documents summarised the progress made in developing and embedding the Trust's culture of diversity and inclusion through 2016-17 and sets out our plans to further this in 2017-18 and beyond. There are also planned Board Development and Leadership Academy sessions for end of July and beginning of August that will further inform our planning. ***Received***	
782/2017	**Fit and Proper Persons** Mr David Rogers, Chairman presented the report to the Trust Board. The Board were asked to note that all Board members meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that all individuals holding the role of Executive Director (or equivalent) and Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5). ***Received***	
783/2017	**The Trusts Approach to Partnerships** Mr Hughes, Joint Director of Strategy and Development, presented the report to the Trust Board. The report describes the reasons why the Trust has and needs to continue to focus on partnerships, identifies the different types of and reasons for partnership, highlights the resource and effort required to establish and maintain partnerships, schedules the partners with which the Trust currently works and identifies what other partnerships the Trust may need to develop. The Board were asked to: • Receive the paper and to debate the issues that it raises. • Understand where partnership activity is currently focused. • Approve next steps to develop a Partnership Plan. Ms Johnson asked how the Trust assesses the level of risk going into a partnership and what proportion of risk lies with us and / or our partners? Miss Robinson confirmed that the Trust are proactive regarding due diligence and that we expect our partners to do the same before entering into an agreement. Mr Gadsby suggested it might be useful prior to developing plans if the Board were given the opportunity to scan areas that form the partnership	

	plan. Ms Walley highlighted this is very much a work in progress the Trust has lots of partnerships in progress but we need to be more strategic. ***Approved***	
	Consent Agenda Items	
784/2017	**Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Report and Statement of Compliance (AOA)** Dr Adeyemo, Executive Medical Director presented the report and highlighted the following: This is the fifth annual board report since the introduction of medical appraisal and revalidation in 2012. The Trust has, in 2016/17, achieved a 100% appraisal and revalidation rate. ***Received***	
785/2017	**Assurance Report from Finance and Performance Committee** Mr Gadsby, Chair of the Finance and Performance Committee/Non-Executive Director, presented the assurance report to the Trust Board from the Finance and Performance Committee held on 6th July 2017. Cash - Cash balances show an improvement compared to the M1 position, falling short of the Cash Target by £0.9m. The committee noted that the timing difference between cash spent on EPR and funding received from NHS Digital was a significant factor. There are issues with historical contracting arrangements where commissioning organisations pay quarterly in arrears, creating short term cash pressures. The committee acknowledges the progress made around cash control but could not give assurance that the trust will be able to deliver against its cash plan until affordability has been reviewed and the capital plan recast in line with the BAF objective CYP waiting times - The Head of Directorate for CAMHS attended F&P to update on waiting times performance for CAMH's and ASD. For ASD, it was reported that no Children are waiting over 18 weeks for an ASD assessment. Since the last F&P, performance has improved around both the 4 week and 18 weeks target. Further improvements are expected through transformational changes within the CAMHS hub that will see quicker decision making and signposting to the right service. The committee can give assurance that there are solid plans to deliver the improvements required and can be assured that performance has improved	

	on waiting times in month 2, however will need evidence of sustained performance before full assurance can be given. Deep dive analysis into readmissions and DTOC – Particular issues were noted in NOAP due to patient choice and agreement of funding. The trust patient choice policy is being revisited and is anticipated to improve performance in the area. A comprehensive report on readmissions was received providing a thorough analysis of performance, key metrics and trends. There is a notable issue around Personality Disorder Patients who are consistently readmitting, raising questions around a potential service development opportunity. The quality of both reports was acknowledged by the committee which provided significant insight into the drivers of performance. The depth of information provoked further questions which require more investigation. Findings will be shared with the committee members. It was highlighted that the challenge we have is how we manage personal choice and delayed transfer at the same time. ***Received***	
786/2017	**Assurance Report from the Quality Committee** Mr Sullivan, Chair of the Quality Committee/Non-Executive Director, presented the assurance report to the Trust Board from the Quality Committee held on 22nd June 2017. Quality Account - The Committee received the final draft of the Quality Account for sign off on behalf of the Trust Board. Members were assured that the project plan remains on target to ensure completion and publication by the deadline of 30 June 2017. The committee noted the positive feedback from key stakeholders such as the Stoke Overview and Scrutiny Committee, Stoke Healthwatch, Staffordshire Healthwatch and local commissioners. The external audit of the Quality Account was also positive and no comments or learning points were identified. Risks - Committee members considered the report for quality risks, particularly those scoring 12, which have been reported to the Committee previously and how they interrelate to Directorate risks. Members discussed the risk treatment plans in place and assurance about the actions being taken. It was agreed that safer staffing and place of safety would be added to the risk register to ensure on-going review and close monitoring. Mr Sullivan advised that he had asked the Directorates to select a highlight they thought the Board should be aware of, after detailing these Mr Sullivan advised he felt the themes paralleled discussions we have at Board regularly i.e. IT systems, capital and clinical challenges. Ms Walley asked with regards to Substance Misuse Services is there any way we can influence reinstating the money from Commissioners from	

	Staffordshire County Council. The Staffordshire cutbacks have caused them to be a prescribing service. Mrs Donovan advised she has asked for QIA assessment of Staffordshire County Council decisions as discussions can be had if a decline in service user experience is noted. **Received**	
787/2017	**Any Other Business** **Trust Communications** Mr Rogers suggested if the Trust has a good story to share this should be shared at Open Trust Board meetings it was therefore agreed there will be an item around Trust Communications for future Trust Boards via the People and Culture Development Committee Report.	**JMc**
788/2017	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 7th September 2017 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
789/2017	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 1.03pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
13-07-17	772/2017	Acute Inpatient Ward 3 - The Communications team to undertake an interview with the service user as part of programme of patient stories to Board.	Mr McCrea	07-09-17	Agenda item
13-07-17	773/2017	Nursing Safer Staffing - May 2017 - Community Staffing Levels - Mr Sullivan suggested time is taken at Quality Committee to seek assurance. Ms Nelligan agreed to take forward to Quality Committee.	Ms Nelligan	07-09-17	Qualty Committee agenda item - 30th August 2017
13-07-17	779/2017	Learning from Deaths - Mrs Donovan requested the report go back through Quality Committee so we can understand what the gaps are and identify actions.	Dr Adeyemo	07-09-17	Discussed at Quality Committee 31st August 2017
13-07-17	780/2017	Finance Report Month 2 - The Trust Finance Strategy deep dive report will be available for September Trust Board.	Suzanne Robinson	07-09-17	Agenda item closed Trust Board
13-07-17	787/2017	Trust communications - Good news to be shared at open board as part of CEO report	Mr McCrea	07-09-17	It was agreed to strengthen PCD comms and therefore reporting into the Board.

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REPORT TO: Trust Board ENCLOSURE 4

Date of Meeting:	7th September 2017		
Title of Report:	Chief Executives Report to the Trust Board		
Presented by:	Caroline Donovan, Chief Executive		
Author:	Caroline Donovan, Chief Executive		
Executive Lead Name:	Caroline Donovan, Chief Executive	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐
Seen at:	SLT ☐ Execs ☐	Document Version No.	
Committee Approval / Review			
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	For information		

Chief Executive's Report to the Trust Board
7 September 2017

PURPOSE OF THE REPORT

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

LOCAL UPDATE

1. CARE QUALITY COMMISSION (CQC) TO RETURN TO TRUST

We are anticipating that the CQC will be returning to the Trust soon as part of their new inspection process.

Rather than being a comprehensive inspection as in 2015 and 2016, this time two types of visits will take place – one will be an announced well-led inspection and there will also be unannounced inspections of our core services.

Alongside this, we have already responded to more than 200 separate data requests from the CQC asking us for information relating to our various services.

We have been holding a number of CQC refresher courses for our clinical and corporate staff and team leaders providing them with more information on the new regime. We continue to work with teams and their clinical directors and heads of service to ensure they receive the fullest support possible.

We have also produced updated versions of our Vison and Values poster and our Board poster and these have been distributed around the Trust.

2. TRUST SHORTLISTED IN NATIONAL AWARDS

Our ongoing awards success has continued after we were chosen as a finalist in the national Positive Practice in Mental Health Awards 2017. We have been shortlisted in the Mental Health and Social Care Award in recognition of the excellent partnership working between Combined Healthcare and Stoke-on-Trent City Council in developing the Meir Partnership Care Hub. The Hub has brought together and co-located health, social care and community practitioners to provide support to the patients of five GP practices in Meir. Both the Trust and local authority have brought in existing partners to develop and focus third sector provision around the locality, which is already making a difference to peoples' lives. The awards will be announced on 12 October.

In other awards news, the Leading with Compassion scheme has been selected as a finalist in the national Kate Granger Awards for Compassionate Care. The scheme, which recognises acts of compassion by NHS staff, has been chosen as one of three finalists. It was launched at Combined Healthcare and has been rolled out across 11 NHS organisations in the region. To date, more than 500 of our staff have been recognised for their compassion under the scheme. The awards will be presented on 12 September as part of the national event.

3. PATIENT-LED ASSESSMENT OF INPATIENT AREAS ONCE AGAIN RATES COMBINED HEALTHCARE AMONG THE TOP PERFORMERS

Combined Healthcare is once again among the very best performers in the country, according to an independent report of inpatient environments. This year's Patient Led Assessment of the Care Environment (PLACE) results have revealed the Trust is well above the national average in each of the areas assessed by the inspection team, at least half of which is made up of patients and service users. Furthermore, each of the six five Trust sites inspected achieved 100% perfect scores in one or more areas.

PLACE focuses on the cleanliness on inpatient areas, as well as food and hydration, privacy and dignity, how well premises are equipped for people with dementia and how well they meet the needs of people with disabilities.

Inspections took place at inpatient areas at Harplands Hospital, Dragon Square, Summers View, Florence House, Darwin Centre and Assessment and Treatment Unit. The Trust achieved the following results:

- Cleanliness – 99.6% (compared to the national average of 98.4%)
- Food and hydration – 97.2% (compared to the national average of 89.7%)
- Privacy, dignity and wellbeing – 96.3% (compared to the national average of 83.7%)
- Condition, appearance and maintenance – 98.8% (compared to the national average of 94%)
- Dementia – 93.6% (compared to the national average of 76.7%)
- Disability – 97.2% (new for 2016, compared to the national average of 82.6%)

Perfect 100% scores were achieved by the following Trust sites in one or more areas:

- Harplands Hospital – 100% in food and hydration on its inpatient wards
- Dragon Square – 100% in cleanliness and disability
- Assessment and Treatment Unit – 100% in privacy, dignity and wellbeing, and disability
- Darwin Centre – 100% in cleanliness, food and hydration on its inpatient areas, condition, appearance and maintenance, and disability
- Florence House – 100% in cleanliness
- Summers View – 100% in cleanliness, food and hydration on inpatient areas, condition, appearance and maintenance, and disability

4. AGM A GREAT SUCCESS

Partners, service users, carers and staff were welcomed to our Annual General Meeting (AGM) on 10 August at The Bridge Centre in Stoke-on-Trent. It was an excellent event and a great opportunity to celebrate everything the Trust has achieved over the past year. As part of the AGM we also unveiled our 2016/17 Annual Report and 2016/17 Quality Account, both of which are available to view via our website at www.combined.nhs.uk. We made a big effort this year to use videos as a different way to engage our audience, including a Review of the Year film showcasing our achievements and, for the first time, a short animated film explaining how we have achieved an 18th consecutive year of financial surplus. Both of these

videos can be viewed via our YouTube channel at www.youtube.com/user/NSCombinedHealthcare.

5. STAFFORDSHIRE TOP PERFORMING STP IN THE COUNTRY FOR IAPT RECOVERY RATES

Staffordshire and Stoke-on-Trent are leading the way nationally when it comes to supporting people with common mental health difficulties into recovery. The county has the highest recovery rate of any Sustainability and Transformation Plan (STP) in England for those accessing improving access to psychological therapies (IAPT) services. The IAPT recovery rate in Staffordshire and Stoke-on-Trent is 61.2% - the only STP in England to have achieved over 60%. The figures form part of the first progress dashboards published by NHS England and NHS Improvement for the country's 44 STPs.

6. FUNDING BID FOR 24/7 RAID SERVICE A SUCCESS

A bid to secure new transformation funding for our mental health liaison services has been successful. The funding will enable the Trust's Rapid Assessment, Interface and Discharge (RAID) team to provide a 24/7 service to meet mental health needs at Royal Stoke University Hospital. RAID provides a psychiatric service to patients aged 16 and over at Royal Stoke and also offers teaching, support and advice to acute staff. Nationally there is a commitment to deliver a 'core 24' standard of mental health liaison services in at least 50% of acute hospitals by 2020-21. As there will be a delay in receiving the funding until April 2018, we are working with commissioners to look at whether they can bridge the funding gap between October and April in order to support the local health economy over the winter period.

7. DISCOVER YOUR FUTURE RECRUITMENT CAMPAIGN

Our Discover Your Future recruitment campaign has continued with further one-stop events at Harplands Hospital for registered nurses mental health (RNMHs), registered nurses learning disability (RNLDs) and registered nurses adults (RNAs). We have been running a promotional campaign on Signal Radio to promote the events and wider campaign and the next one-stop sessions take place on Friday 29 and Saturday 30 September. Those applying have the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer. We are thankful to staff, who continue to support the act as ambassadors for the campaign by promoting the events and www.discoveryourfuture.co.uk recruitment website via social media.

We have also produced a new poster and leaflet aimed at nurses who have newly moved in to the area and are looking for a great new job in the NHS. We are in discussion with Stoke-on-Trent City Council about using their locations and channels to get the leaflet and posters displayed in areas outside the NHS; for example, libraries or leisure centres. We will also be looking to work with supermarkets and estate agents to see if we can harness their channels.

8. PRAISE FROM NHS ENGLAND FOR COMBINED'S WORK ON WORKFORCE RACE EQUALITY

We were delighted to welcome Yvonne Coghill OBE, Director of Workforce Race Equality Standard (WRES) Implementation for NHS England, to the Trust to lead our recent Board Development session on diversity and inclusion. WRES holds trusts to account for the action they take to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It was great to hear from Yvonne that our Trust Board and Executive team is among the leading organisations in the NHS in terms of its diversity.

Yvonne also led our first Black, Asian and Minority Ethnic Focus Group. The purpose of the session was to enable us to review the experience we offer to this group, identify where improvements can be made and highlight any good practice. We are going to establish a BME network across the Trust and we are committed to pursuing the potential for a BME leadership programme across the Staffordshire Sustainability and Transformation Plan (STP) providing the opportunity for our BME staff to be provided with greater opportunity.

9. PAUL DRAYCOTT TO LEAVE COMBINED TO TAKE UP EXCITING NEW OPPORTUNITY AT SOUTHERN HEALTH NHS FOUDATION TRUST

Paul Draycott, our Director of Leadership and Workforce, is leaving Combined to take up an exciting new opportunity as Director of Workforce and Organisational Development at Southern Health NHS Foundation Trust, one of the largest mental health, learning disability and community health providers in the country.

Paul has been a highly valued member of the Trust Board and Executive team since March 2014. He is well respected and very popular with colleagues at all levels of the organisation, as well as with our staff side representatives and stakeholders. He has made a significant contribution to our journey of improvement and will be greatly missed. Paul will be part of a completely new management team at Southern Health and is very much looking forward to the challenge.
We have just put out a national advert for Paul's replacement and have altered the title of the post to reflect the full portfolio - Director of Workforce, Organisational Development and Communications.

10. RECOGNISING EXCELLENCE AND ACHIEVEMENT IN COMBINED HEALTHCARE (REACH) AWARDS

Thank you to everyone who has made a nomination for our annual REACH Awards, which this year take place on Thursday 5 October at the Moat House, Stoke-on-Trent. The awards celebrate staff, teams, volunteers and service user representatives who have gone above and beyond as part of their work. We are in the process of deciding the winners from over 230 nominations received across the categories and look forward to welcoming hundreds of nominees, service users, carers, partner organisations and sponsors for what is one of the highlights of Combined Healthcare's year.

11. NEW SYSTEM LAUNCHED TO SUPPORT STAFF TRAINING

We are delighted to have launched our Learning Management System (LMS), a new staff training site that enables people to do most of their e-learning from anywhere – be it at work, away from work and at home. It also allows staff to view their current training requirements and compliance status. The LMS is already proving a success, with hundreds of lessons and assessments having been completed and passed.

12. STAFFORDSHIRE AND STOKE-ON-TRENT SUSTAINABILITY AND TRANSFORMATION PLAN (STP) AND NORTH STAFFS AND STOKE-ON-TRENT ALLIANCE

We have been working with the Staffordshire clinical leads group helping them to create a simple narrative to describe the STP through the eyes of staff and patients/service users. We also spent some time focusing on what clinical impact they wanted to have and how they could refocus the clinical leads group to achieve their purpose.

On the digital workstream, we are looking to build our agreements on data sharing, common standards and interoperability and are working with our STP partners to do this. As part of this we are planning a supplier event to bring all our respective suppliers together across Staffordshire to see how we can collaborate in delivering our priorities. The excellent work led by Dr Ruth Chambers on the Technology Enabled Care Systems (TECS) group is really delivering innovation, with trials progressing on GP video consultation and online GP consultations. We are also developing further the role and impact of a Staffordshire Digital Design Authority and an Information Professionals Network, which would be a major boost to the hundreds of our staff who work in IT and information management.All in all, it's a challenging and busy agenda.

A meeting of Chairs, CEOs and GP leaders across North Staffordshire confirmed a unanimous commitment to wrapping our teams around primary care. In respect of recent rumours of Combined Healthcare merging with Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) and South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT), we all discussed and agreed that this would not be happening as Combined are absolutely committed to the integration of services across North Staffordshire. The next steps for us will be building on the conversations we have had across the Trust about strengthening geographical working.

At my regular 1 to 1 with Marcus Warnes, Accountable Officer for our 2 CCGs, we discussed the positive progress with the North Staffordshire Alliance Board and the importance of Commissioners supporting the direction of travel. The CCGs have now joined the Board which will help commissioning decisions enabling our direction of travel to develop integrated teams around primary care and move resources to keeping people well.

NATIONAL UPDATE

The national debate in the past month for the NHS surrounds the announcement of Health Secretary's Mental Health Five Year Forward View and the creation of 20,000 jobs.

13. GOVERNMENT PROMISES 20,000 NEW MENTAL HEALTH POSTS
Health Secretary Jeremy Hunt has announced a workforce strategy for implementation of the Mental Health Five Year Forward View.

It follows NHS England's Five Year Forward View for Mental Health implementation plan which pledged nearly £4bn extra for the sector by 2020-21. The new staff will be funded using part of this increased funding and the strategy sets out plans to create 21,000 new posts across all major specialities sector, including:

- 2,000 additional nurse, consultant and therapist posts in child and adolescent mental health services.
- 2,900 additional therapists and other allied health professionals in adult talking therapies.
- 4,800 additional posts for nurses and therapists working in crisis care settings, with 4,600 of these being nursing positions.
- Perinatal mental health support, liaison and diversion teams and early intervention teams working with people at risk of psychosis should also see significant increases.

The strategy also includes plans to:

- Improve the retention of staff beginning with "targeted support" for 20 trusts with the highest rates of clinical leavers.
- A major "return to practice" campaign to encourage psychiatrists and mental health nurses not substantively employed by the NHS to return to the service.
- Encouraging more junior doctors to experience psychiatry as part of their foundation training – either through a new two-week taster programme, or through increased availability of rotation placements in psychiatry.
- Developing and expanding new professional roles in mental health to help create more flexible teams and boost capacity.

This is a key issue for me, as I am the lead CEO across Midlands and East for Workforce and passionate about developing and training our future and current workforce.

14. NHS PROVIDERS FLAGSHIP REPORT HIGHLIGHTS MENTAL HEALTH

NHS Providers is publishing what it calls a “flagship series” of Reports - *The state of the NHS provider sector*. The series provides what NHS Providers calls” a valuable update on how the provider sector is performing, identifying the challenges its members are facing and the support they need over the course of this parliament.”

The centrepiece of the latest Report is mental health. NHS Providers describes it as “a critical area of care for the NHS, working in collaboration with a range of other public services, as well as now being a growing concern for wider society. Our report notes the welcome commitment at the very top of government and among NHS system leaders to address longstanding inequalities in care for people with mental health needs. However, the key finding – that core mental health services on the ground are under increasing pressure and at risk of deteriorating – should make compelling reading for politicians, system leaders and all those engaged in improving outcomes for people with mental health needs.”

The Report can be downloaded from http://nhsproviders.org/state-of-the-provider-sector-07-17

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REPORT TO: TRUST BOARD

Enclosure No: 5

Date of Meeting:	7 September 2017		
Title of Report:	June 2017 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:	Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during June 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during June 2017 was 84% for registered staff and 102% for care staff on day shifts and 81% and 108% respectively on night shifts. Overall a 95% fill-rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties. The data reflects that Ward Manages are staffing their wards to meet increasing patient needs as necessary.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☒ 6. Attract and inspire the best people to work here. ☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	To receive the report for assurance and information		

1 Introduction

This report details the ward daily staffing levels during the month of June 2017 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to Unify. Appendix 1 also details the establishment hours in comparison to planned and actual hours.

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. The last 6 month review covering the period July 2016 – December 2016 was reported to SLT and Board of Directors in May 2017. The next 6 monthly review will concentrate on workforce planning and is currently being undertaken.

3 Trust performance

During June 2017 the Trust achieved staffing levels of 84% for registered staff and 102% for care staff on day shifts and 81% and 108% respectively on night shifts. Overall a 95% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, ward managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

4 Issues impacting on fill rates

WMs report the impact of unfilled shifts on a shift by shift basis. Staffing issues contributing to fill rates are summarised in appendix 2.

4.1 Impact on patient safety

There were 11 incident forms completed by in-patient wards during June 2017 relating to nurse staffing issues. No harm arose from these incidents. Breakdown by ward is summarised as follows:

Ward	Incident
A&T	6 incidents of staffing impacting on the ability to maintain enhanced support levels
Edward Myers	1 incident where baseline staffing was not met
Ward 2	2 incidents - 1 of staffing impacting on the ability to maintain clinical observation levels and 1 where the Access Team had to provide RN cover
Ward 4	1 incident where baseline staffing was not met

Ward 6	1 incident where baseline staffing was not met

The 6 incidents on A&T were reported due to enhanced support levels not being met. Three incidents affected the waking night shift and contingencies were put in place including support from Ward 1 staff and the Duty Senior Nurse. The remaining 3 incidents were during the daytime. All service users had the allocated 1:1 observations maintained as per trust policy and the Intensive Support Team also supported the ward to maintain safe staffing. Alongside this the emergency response procedure was strengthened in liaison with the Harplands Duty Senior Nursing staff. These incidents arose due to either being unable to backfill vacant shifts caused by vacancies, maternity leave and sickness or additional shifts required due to enhanced support levels.

4.2 Impact on patient experience

Staff prioritise patient experience and direct patient care. During June 2017 it was reported that 4 activities were cancelled or shortened due to nurse staffing levels.

4.3 Impact on staff experience

In order to maintain safe staffing the following actions were taken by the Ward Manager during June 2017:

- 74 staff breaks were cancelled (equivalent to approximately 1.6% of breaks)
- 3 staff breaks were shortened (equivalent to approximately 0.06% of breaks)
- 178 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas

4.4 Mitigating actions

Ward managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 232 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 24 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened (time is given in lieu) or not taken and wards have cross covered to support safe staffing levels.

5. Summary

Safe staffing level reporting indicated challenges in staffing wards during June 2017. Vacancies across acute AMH wards in particular and the opening of ward 4 have contributed to this. The allocation of RNs from wards 5, 6 and 7 to ward 4 has reduced RN staffing on those wards. Additionally the use of temporary staffing to support ward 4 has reduced the availability of temporary staff to backfill other wards. Recruitment to RN vacancies has had limited success therefore alternate strategies are being investigated with the support of the HR and communication teams.

Appendix 1 June 2017 Safer Staffing

Jun-17	DAY						NIGHT						DAY		NIGHT					
Ward name	Registered nurses			Care staff			Registered nurses			Care staff			Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Overall fill rate	Safe staffing was maintained by:	Vacancies	Bed occupancy Movement	Provisional sickness data
	Establishment Hours	Clinically required Hours	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual staff hours									
Ward 1	1515	1515	1032	1350	1626	1942	643	643	332	965	1030	1309	68%	119%	52%	127%	96%	Nurses working additional hours and altering skill mix. Cross cover was also provided to other wards.	2 B5 3 B3	awaiting ↓	3.65%
Ward 2	1481	1481	1052	1350	1350	1572	643	643	332	643	654	922	71%	116%	52%	141%	94%	Altering skill mix. Cross cover was also provided to other wards.	4 B5 1 B3 2 B2	awaiting	3.58%
Ward 3	1515	1515	1203	1350	1350	1431	643	643	354	643	643	922	79%	106%	55%	143%	94%	Altering skill mix. Cross cover was also provided to other wards.	2.8 B5 0.6 B3 1.6 B2	awaiting	0.00%
Ward 4	1515	1515	1200	1350	1350	1376	281	281	281	675	675	667	79%	102%	100%	99%	92%	Nurses working additional unplanned hours.	6 B5 3B3	awaiting	0.00%
Ward 5	1095	1568	1138	930	1395	1653	290	290	298	871	871	834	73%	118%	103%	96%	95%	Altering skill mix. Cross cover was also provided to other wards.	2 B5	awaiting	0.00%
Ward 6	1065	1070	759	1800	1800	1875	281	281	301	835	844	845	71%	104%	107%	100%	95%	Altering skill mix.	3 B5	awaiting	3.05%
Ward 7	1065	1058	1050	1350	1350	1235	281	281	275	563	563	563	99%	91%	98%	100%	96%	Nurses working additional unplanned hours and altering skill mix.	1 B5	awaiting	0.00%
A&T	1542	1347	1324	1350	1800	1510	323	323	323	968	1613	1591	98%	84%	100%	99%	93%	Nurses working additional unplanned hours and altering skill mix. Rearranging non-direct care activity.	3.1 B5	awaiting	3.40%
Edward Myers	1073	1125	1104	900	923	864	281	281	292	563	572	554	98%	94%	104%	97%	97%	Nurses working additional unplanned hours. Cross cover was also provided to other wards.	0.8 B3	awaiting	5.56%
Darwin Centre	1054	1054	1054	1232	1232	1106	333	333	333	667	667	667	100%	90%	100%	100%	96%	Nurses working additional unplanned hours.	3.2 B5 2.4 B3	awaiting	0.00%
Summers View	983	978	896	900	805	699	322	322	322	643	643	643	92%	87%	100%	100%	93%	The multi-disciplinary team supporting the nursing team	1 B4 1B3	awaiting	4.69%
Florence House	533	533	523	885	575	572	322	322	322	321	322	322	98%	100%	100%	100%	99%	*	1 B3	awaiting	5.71%
Trust total	**14434**	**14757**	**12334**	**14747**	**15556**	**15835**	**4644**	**4644**	**3764**	**8356**	**9096**	**9838**	**84%**	**102%**	**81%**	**108%**	**95%**	*** over 95% in all areas**			

Appendix 2 Staffing Issues

- Ward 4 opened at short notice to support the local health economy and was initially commissioned as a nursing assessment unit from November 2016 until the end of May 2017. This resulted in an adverse impact on staffing levels across the site as registered nurses and health care support workers were seconded into Ward 4 supplemented by bank and agency. The ward has recently been commissioned to open permanently as a shared care ward and whilst recruitment to the ward manager, deputy ward manager, clinical lead and HCSW posts have been successful there has been limited success in recruiting band 5 RNs. This is notably the Adult Registered Nurses who are needed to offer 'shared care'. Therefore there will be a transition period whilst staffing, equipment, processes and procedures etc are put in place to safely open the ward as shared care.

- There has also been staff turnover across wards and further vacancies have arisen since October 2016. These have been difficult to fill and despite several adverts there are currently 27 WTE RN vacancies reported within in-patient wards. This is in line with the national picture where nursing shortages are being experienced across sectors. To proactively attract new nurses to the trust University of Keele student nurses, due to qualify in Oct 2017, have been offered posts. Sixteen have accepted offers of employment. Monthly one-stop shops are also taking place alongside a rolling recruitment campaign. From a long term perspective the DoN and Head of Nursing have met with UHNM with regards to pre-registration nursing and nursing associate apprenticeships. A joint proposal is being drafted to take this forward in partnership. This will help us to 'grow our own' nursing associates and registered nurses over coming years.

- The highest RN vacancies are across the Acute AMH wards with wards 1, 2 and 3 currently having B5 vacancies of 2, 4 and 2.8 WTE respectively; these posts have been advertised externally with limited success. Further recruitment events have been held during June 2017 with limited success.

- The ward 5 RN fill rate on days was 73% during June 2017. The previous 2 six monthly safe staffing reviews have recommended that ward 5 require an additional 4.26 RNs, additionally Ward 5 have 1 RN seconded to Ward 4 and 1 RN seconded to RAID. These factors are impacting on the RN fill rate. In terms of day shifts the ward are attempting to staff to the uplift in staffing recommended in the safer staffing, that is 3 RNs on the early shift and 3 on the late shift. Currently the ward establishment will only allow for staffing of 2 RNs on the early and late shifts therefore, as a maximum, they can only achieve 72% fill rate within their current establishment. This situation has been reviewed by the Modern Matron (MM) and Head of Directorate and agency RN cover has been agreed to backfill the RN seconded to ward 4.

- The ward 1 RN fill rate on days was 68% during and the ward had 2 RN vacancies and one RN redeployment. The ward 2 RN fill rate on days was 71% during June and the ward had 4 RN vacancies. Skill mix was altered on both wards to increase HCSW numbers during June bringing the overall fill rate to 96% and 94% respectively. The MM continues to oversee roster practices to ensure that resources are used effectively.

- The ward 6 RN fill rate was 71% during June and the ward had 3 RN vacancies. Skill mix was altered to achieve an overall fill rate of 95%. The MM continues to oversee roster practices to ensure that resources are used effectively.

- Ward teams are supported by Modern Matrons and a Duty Senior Nurse who are further supported by an on-call manager out of hours. These staff are not included in the safer staffing returns.

- In June 2016 the planned RN night shift cover was increased from 1 to 2 RNs on the acute wards (1, 2 and 3); this has led to a temporary decreased RN nightshift fill rate on these wards. It was expected that once the Oct 2016 newly qualified nurses had completed preceptorship the WMs have been directed to prioritise 2 RNs being rostered on nights. The number of vacancies have made this challenging however given that more registered nurse support is available on the day, through WMs, MMs and NPs, night shifts are the time when RN support needs to be strengthened. Therefore the WMs have been directed to ensure that 2 RNs are rostered onto nights although this continues to be difficult to achieve. This will be considered as part of the next 6 monthly review which will concentrate on workforce planning.

- High occupancy, increased acuity have also contributed to shortfalls, in the fill rate.

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REPORT TO: TRUST BOARD

Enclosure No: 6

Date of Meeting:	7 September 2017		
Title of Report:	July 2017 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:	Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during July 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during July 2017 was 83% for registered staff and 99% for care staff on day shifts and 82% and 106% respectively on night shifts. Overall a 93% fill-rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties. The data reflects that Ward Manages are staffing their wards to meet increasing patient needs as necessary.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	To receive the report for assurance and information		

1 Introduction

This report details the ward daily staffing levels during the month of July 2017 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to Unify. Appendix 1 also details the establishment hours in comparison to planned and actual hours.

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. The next 6 monthly review covering January to June 2017 is currently underway and is concentrating on workforce planning.

3 Trust Performance

During July 2017 the Trust achieved staffing levels of 83% for registered staff and 99% for care staff on day shifts and 82% and 106% respectively on night shifts. Taking skill mix adjustments into account an overall a 93% fill-rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, ward managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

4 Issues impacting on fill rates

WMs report the impact of unfilled shifts on a shift by shift basis. Staffing issues contributing to fill rates are summarised in appendix 2.

4.1 Impact on Patient Safety

There were 6 incident forms completed by in-patient wards during July 2017 relating to nurse staffing issues. No harm arose from these incidents. Breakdown by ward is summarised as follows:

Ward	Incident
A&T	2 incidents where staffing impacted on the ability to maintain enhanced support levels; clinical observation levels were maintained
Edward Myers	One incident where the IOU staff moved to Darwin for part of the shift
Access	Two incidents of Access having to provide cover due to no RN being on a number of wards (Ward 1 and Ward 4/7)
Ward 2	One incident where staff had to escort a service user to UHNM

4.2 Impact on patient experience

Staff prioritise patient experience and direct patient care. During July 2017 it was reported that no activities were cancelled or shortened due to nurse staffing levels.

4.3 Impact on staff experience

In order to maintain safe staffing the following actions were taken by the Ward Manager during July 2017:

- 91 staff breaks were cancelled (equivalent to approximately 1.8% of breaks)
- 55.5 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas

4.4 Mitigating actions

Ward managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 287 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 19 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened (time is given in lieu) or not taken and wards have cross covered to support safe staffing levels.

5. Summary

Safe staffing level reporting indicated challenges in staffing wards during July 2017. Vacancies across acute AMH wards and ward 4 have contributed to this. Additionally the use of temporary staffing to support ward 4 has reduced the availability of temporary staff to backfill other wards. A significant number of RN vacancies will be filled by October 2017 due to newly qualified registered nurses graduating. The trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

Appendix 1 July 2017 Safer Staffing

July	DAY						NIGHT						DAY		NIGHT						
	Registered nurses			Care staff			Registered nurses			Care staff											
Ward name	Establishment Hours	Clinically required Hours	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Overall fill rate	Safe staffing was maintained by:	Vacancies	Bed occupancy	Movement	Provisional sickness data
Ward 1	1553	1553	1122	1395	1665	1863	665	665	332	997	997	1297	72%	112%	50%	130%	95%	Altering skill mix, the ward also provided cross cover to other wards	1 B6 2.2 B5 1.8 B3	89%	↓	Not yet received
Ward 2	1515	1515	1027	1395	1395	1649	665	665	397	665	665	922	68%	118%	60%	139%	94%	Altering skill mix, the ward also provided cross cover to other wards	1 B6 over 4.2 B5 2.2 B3 2 B2	98%	↓	Not yet received
Ward 3	1553	1553	1213	1395	1395	1630	665	665	375	665	665	943	78%	117%	56%	142%	97%	Altering skill mix, the ward also provided cross cover to other wards	2.8 B5 1.6 B3 1.6 B2	92%	↑	Not yet received
Ward 4	1575	1575	1162	1395	1395	1466	290	290	290	698	698	695	74%	105%	100%	100%	91%	Altering skill mix and nurses working additional unplanned hours	8.2 B5 10 B3	76%	↑	Not yet received
Ward 5	1088	1553	1015	930	1395	1605	290	290	301	871	871	880	65%	115%	104%	101%	92%	Altering skill mix	1 B6 over 1.8 B5 0.4 B3 over	114%	↑	Not yet received
Ward 6	1088	1088	1157	1860	1860	1628	291	291	291	863	872	881	106%	88%	100%	101%	96%	Altering skill mix	1 B6 over 3.1 B5 2.4 B3	100%	—	Not yet received
Ward 7	1088	1080	1052	1395	1407	1292	290	290	284	581	609	609	97%	92%	98%	100%	96%	Altering skill mix and nurses working additional unplanned hours	2.4 B5	100%	—	Not yet received
A&T	1545	1344	1231	1395	1860	1662	333	333	333	1000	1699	1666	92%	89%	100%	98%	93%	Altering skill mix and cancelling non direct care activities	3.2 B5 4.5 B3	70%	↑	Not yet received
Edward Myers	1088	1088	979	930	930	862	281	291	303	581	591	576	90%	93%	104%	97%	94%	The ability to use IOU bed would have been affected if needed.	1 B3	85%	↓	Not yet received
Darwin Centre	1088	1112	997	1395	1334	1275	333	333	333	667	1128	892	90%	96%	100%	79%	89%	Altering skill mix, nurses working additional unplanned hours and cancelling non direct care activities	2.4 B5 2.2 B3	94%	↓	Not yet received
Summers View	1009	963	880	930	897	792	332	332	332	665	632	622	91%	88%	100%	98%	93%	The MDT supported the nursing team	0.2 B2 0.8 B3 0.2 B5 over	96%	↓	Not yet received
Florence House	544	571	555	930	900	602	332	332	332	332	332	332	97%	67%	100%	100%	85%	The MDT supported the nursing team	0.1 B3	86%	↑	Not yet received
Trust total	**14730**	**14993**	**12389**	**15345**	**16433**	**16324**	**4769**	**4778**	**3905**	**8583**	**9759**	**10316**	**83%**	**99%**	**82%**	**106%**	**93%**					

Appendix 2 Staffing Issues

- There has been limited success in recruiting band 5 adult RNs to ward 4 therefore the team are seeking to recruit RNs from other fields who have physical health experience, this will be supported by an education programme.

- There are currently 28.1 WTE RN vacancies reported within in-patient wards. Of these, 18.2 WTE have been recruited to, partly by proactively attracting newly qualified nurses to the trust.

- The highest RN vacancies are across the Acute AMH wards with wards 1, 2 and 3 currently having B5 vacancies of 2.2, 4.2 and 2.8 WTE respectively; 7 WTE newly qualified nurses have been recruited. The remaining posts have been advertised externally and included within the recruitment events with limited success.

- The ward 5 RN fill rate on days was 65% during July 2017. Ward 5 establishment does not meet the safe staffing levels recommended in the 6 month reviews and this is impacting on the RN fill rate. Currently the ward establishment will only allow for staffing of 2 RNs on the early and late shifts therefore, as a maximum, they can only achieve 72% fill rate within their current establishment.

- The ward 2 RN fill rate on days was 68% during and the ward had 4.2 WTE RN vacancies and one RN redeployment. Skill mix was altered on the ward to increase HCSW numbers during July bringing the overall fill rate to 94%. The MM continues to oversee roster practices to ensure that resources are used effectively.

- Ward teams are supported by Modern Matrons and a Duty Senior Nurse who are further supported by an on-call manager out of hours. These staff are not included in the safer staffing returns.

- RN night shift cover remains challenging. This is a result of increasing night cover to 2 RNs on the acute wards (1, 2 and 3). The number of vacancies on these wards has made this challenging to achieve consistently.

- High occupancy and increased acuity have also contributed to shortfalls, in the fill rate.

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REPORT TO Trust Board

Enclosure No: 7

Date of Meeting:	7th September 2017		
Title of Report:	Director of Infection Prevention and Control (DIPC) Report Quarter One, April – June 2017 which includes the 2016/2017 Annual Report		
Presented by:	Ms M Nelligan, Executive Director of Nursing and Quality & DIPC		
Author:	Amanda Miskell, Consultant Nurse for Physical Health and Deputy DIPC		
Executive Lead Name:	Maria Nelligan	Approved by Exec	☒

Executive Summary:		Purpose of report	
Director of infection Prevention and Control (DIPC Report Q1 April -June 2017 including 2016/2017 Annual Report. Approved by Quality Committee 31st August 2017.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date: 22nd August 2017	Document Version No.	1
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	The Board receive the reports for information and assurance		

North Staffordshire Combined Healthcare NHS
NHS Trust

DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) QUARTERLY REPORT TO THE BOARD OF DIRECTORS

Quarter One (April – June 2017) inclusive of the 2016/2017 Annual Report

8/10/2017

1 Purpose of the report

This report will provide inform the Board of the assurances for quarter one (Q1) on IPC arrangements, and includes the annual report from 2016-2017. The Board will also be apprised of our position in relation to Health Care Acquired Infections and other relevant issues. This report and those included within it, will provide assurances in relation to the national agenda and the requirements for identification and reduction of gram negative Multi Resistant Organisms (MROs) and Blood Stream Infections (BSI's).

2 Health Care Acquired Infections (HCAI)

There were no HCAIs to report, including incidents of MRSA Bacteraemia or C-difficile in the Q1 period. MRSA screening continues to result in a zero return in terms of positive results, and from Q1 2017/2018, NSCHT will report to commissioners by exception only.

3 Incidents & Outbreaks

There has been no incidence of cross infection risks, or outbreaks of infection in Q1.

4 Infection Prevention & Control Team

The team consists of a consultant nurse, and two nurses who commenced employment in May/June 2017. The remit of these two staff will be to deliver IPC work programme and includes the facilitation of training in identifying the deteriorating patient and the care of invasive devices, a contributing factor in BSIs.

5 Infection Prevention & Control Group

The Infection Prevention and Control Group (IPCG) met in June 2017. The Chair`s summary comprises:

- All high risk antimicrobials have alert labels on for consideration prior to dispensing or using.
- The IPCT carry out daily (Monday - Friday) surveillance on all invasive devices, infections, antimicrobial prescribing and microbiology results.
- The team are working closely with Estates and the clinical teams on the refurbishments for PICU, Ward 1, Place of Safety and Dragons Square.
- The "Outbreak" Standard Operating Procedure (SOP) has been communicated trust wide following discussion at IPCG.
- Preparation for the 2017 Flu campaign has commenced.
- Both the Water Safety and Waste Services Level Agreements are under review for efficiency and quality.
- The Alcohol Hand Gel expansion instillation begins mid' July 2017. This allows easier access to products in communal areas for patients, visitors and staff.

6 Gram Negative Blood Stream Infections

Through infection prevention and control, and antimicrobial prescribing surveillance we have recognised that patients are experiencing infections caused by MROs, in particular gram negative strains. The MROs we have identified in NSCHT through surveillance have been *E. coli, P. aeruginosa and Klebsiella spp.*

These are usually identified by culture & sensitivity diagnostics which are sent from our services, as part of our Service Level Agreement with the pathology services, or screening at UHNM. These are most prevalent in rectal swabs, and Urinary Tract Infections (UTIs).

From April 2017, there is an NHS ambition to halve the numbers of healthcare associated Gram-negative BSIs by 2021 (NHS Improvement June 2017). We can only achieve the reductions by working together across the health and social care sector. The majority of BSIs (72%) across hospitals and community are caused by *E. coli, P. aeruginosa and Klebsiella spp.* similar to what we have seen in our patient population. There are key healthcare-associated risk factors in relation to BSIs, and the following should be used as a basis to classify Gram-negative (GN) BSIs (GNBSIs) as healthcare associated infections (HCAIs) in our inpatient units:

- indwelling vascular access devices (insertion, in situ, or removal)
- urinary catheterisation (insertion, in situ with or without manipulation, or removal)
- other devices (insertion, in situ with or without manipulation, or removal)
- neutropenia (<500/ □L at time of bacteraemia)
- antimicrobial therapy within the previous 28 days
- hospital admission within the previous 28 days.

Because of the risks associated with BSIs, the IPC team are vigilant of any admissions or inpatients considered as a potential risk associated with any of the above. To this end each patient is assessed on an individual basis with the multi-disciplinary team before the decision is made to consider any of the above.

Although we do not input any data onto the national Data Capture System for BSIs, we may be identified as the originating health care provider. Maria Nelligan, Director of Infection Prevention & Control (DIPC) is the Trust`s identified executive level lead who will act as our main point of contact in relation to the health economy work in reducing healthcare associated GNBSIs. This was communicated to NHS improvement on 14th July before the deadline of the 21st.

7 IPC Annual Report for 2016/2017

The annual report is included in Appendix One.

8 Recommendations

The Board is asked to note the DIPC Quarter One Report for 2017/18.
The Board is asked to approve the Annual Report for 2016/2017.

9 Appendix One

IPC Annual Report 2016-17 v1 AM (1).dc

North Staffordshire Combined Healthcare NHS
NHS Trust

Infection Prevention and Control Annual Report 2016 - 2017

Working together, developing together.

Trust Strategic Goals

Our Vision - the way we want our organisation to be seen

To be an outstanding organisation providing safe, personalised, accessible and recovery-focused support/services every time.

Proud to CARE - our Values for the way we want our staff to behave

- **C**ompassionate
- **A**pproachable
- **R**esponsible
- **E**xcellent

SPAR - our Quality Priorities - the four key areas which evidence that we are delivering high quality care and treatment to those using our services in a way that is person-centered

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

Objectives - measurable metrics against which we will deliver our goals

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

Contents

Introduction

The Health and Social Care Act 2008 (updated July 2015) Code of Practice on the prevention and control of infections and related guidance requires the Trust to produce an annual report and release it publicly.

This report produced on behalf of the Director of Infection Prevention and Control (DIPC) for North Staffordshire Combined Healthcare NHS Trust details the actions taken by the organisation to prevent and minimise the risk and consequence of infection for the period April 2016 to March 2017. It will also assure our Trust Board members of our current position, and demonstrate that infection prevention and control is an integral part of the Trust's assurance framework.

The report outlines progress measured against the stated objectives detailed in the Trust's Annual Programme of Work including responsibilities, timescales and priorities for action.

The focus of this report is the work associated with prevention and the provision of a safe environment for patients, visitors and staff.

Individual sections outline compliance with key documents such as the Health and Social Care Act 2008 Code of Practice, Sepsis Care and Care Quality Commission regulations, particularly Regulation 12 and 15.

- Surveillance
- MRSA admission screening
- Outbreak prevention and management
- Quality improvement and audit
- Cleanliness
- Policy development and review
- Specialist advice
- Training and education
- Antimicrobial stewardship

Trust Arrangements for Infection Prevention & Control

The Chief Executive Officer (CEO) has corporate responsibility for Infection Prevention and Control and ensures that effective arrangements are in place throughout the Trust.

Caroline Donovan
Chief Executive

Maria Nelligan
Executive Director of Nursing and Quality, Director of Infection Prevention and Control (DIPC).

The role of the Director of Infection Prevention & Control (DIPC) is to be directly accountable to members of the Trust Board and have the executive authority and responsibility for ensuring the implementation of strategies to prevent avoidable infection at all levels within the organisation.

The Trust continued a Service Level Agreement with the University Hospitals of North Midlands until October 2016 to provide an Infection Prevention and Control Service. The Infection Prevention Lead Nurse was Emyr Phillips, who was the point of contact for NHSLA, CQC, performance requirements and the Trust's assurance framework.

In December 2016, the Infection Prevention & Control service was brought in house with the appointment of Amanda Miskell, as Consultant Nurse for Physical Health & Deputy DIPC.

The Trust has a zero tolerance to avoidable infections and a collective responsibility which places a duty on all staff to minimise the risk of infection at all times.

The Trust aims to care for patients in a safe environment protecting them from avoidable harm.

Compliance with the Health and Social Care Act 2008 (updated July 2015) Code of Practice on the prevention and control of infections and related guidance

The Care Quality Commission (CQC) is the independent regulator established to ensure that providers of health and social care meet the required standards of quality and safety.

The table below outlines the ten criteria against which a provider is assessed. The Trust is registered with the CQC and has declared full compliance with the criteria detailed below.

Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs of staff in relation to infection.

Assurance Framework

Infection Prevention and Control Group (IPCG)

The Terms of Reference have been reviewed and approved at Quality Committee. The IPCG has responsibility for Summary reports, briefing papers, policy and guidance documents, surveillance data, outbreaks, incidents and root cause analysis reports. These are presented to members of the Group for discussion, agreement and approval prior to submission to the Quality Committee.

The IPCG meets six times a year and is chaired by the DIPC or deputy DIPC.

IPCG Membership	
Title	**Name**
Director of Infection Prevention & Control (DIPC) - Chair	Maria Nelligan
Deputy Director of Infection Prevention & Control (Deputy DIPC/Chair)	Carol Sylvester till November 2016 then Amanda Miskell
Infection Prevention & Control Nurse (IPN)	Josie Sage till March 2017
Matrons	Jackie Clowes/Josey Povey/ Melanie Hart/Tina Mottram/ Susanne Laird /Jacqui Shenton
Support Services Advisor	Anne Melville
Head of Estates	Ian Ball
Senior Occupational Health Advisor	Dan Hooper
Medical Director	Dr Olubukola Adeyemo
Head of Pharmacy/Antimicrobial Pharmacist	Louise Jackson/Rachel Tarbuck
Admin Support	Fay Smallman
Head of Infection Prevention and Control, Staffordshire Cluster Clinical Commissioning Group	Jackie Derby

Annual Programme of Work

The Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to have an Infection Prevention and Control Annual Programme of Work which should:

- Set clear objectives which meet the needs of the organisation and ensure the safety of service users
- Identify priorities for action
- Provide evidence that policies have been implemented to reduce infections
- Report progress against the objectives in the DIPC's annual report.

The programme ensures that national objectives are met, assists operational performance and protects against variations in standards within and across the organisation.

Members of the Infection Prevention and Control Group receive reports on progress of the Annual Programme, at each meeting, six times a year.

The plan of work for 2017/18 is detailed in Appendix 1for approval by the Board.

Legislative and Regulatory Framework

Department of Health - The Health and Social Care Act 2008 (updated July 2015) Code of Practice on the prevention and control of infections and related guidance. www.dh.gov.uk
Department of Health - The NHS Outcomes Framework 2015/16. www.dh.gov.uk

NHS Litigation Authority - NHSLA Risk Management Standards for NHS Trusts providing Acute, Community or Mental Health and Learning Disability Services and Non- NHS Providers of NHS Care (2013/14) www.nhsla.com/RiskManagement mailto:safetyandlearningenquiries@nhsla.com

The Information Centre for Health and Social Care - Mental Health Information (Monthly Updates 2015/16). www.ic.nhs.uk

Department of Health - Implementation of modified admission MRSA screening guidance for NHS (2014). www.dh.gov.uk

Public Health England - Health Protection Report volume 10 (2016). www.phe.gov.uk

The Role of the IPN

Criterion 1 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to ensure that the Infection Prevention and Control infrastructure has an infection control nurse (IPN).

The Trust employed one whole time IPCN, supported by an IPC Clinical specialist and Microbiologist based at the Harplands Hospital via a Service Level Agreement with University Hospitals of North Midlands until late 2016. Since then we have used community services and employed our own lead to develop and enhance the IPC service. The role of the IPCN is to undertake the core work associated with infection prevention and control including -

- Surveillance
- MRSA admission screening
- Outbreak prevention and management – including weekend and public holiday cover
- Quality improvement and audit
- Cleanliness
- Policy development and review
- Training and education
- Preparation of the Annual Programme
- Preparation of the Annual Report
- Support to the DIPC, Senior Managers, Service Leads and clinical teams
- Seasonal influenza campaign support (lead by Occupational Health provider)

Specialist advice is provided to all staff within the Trust with a focus on clinical teams providing inpatient and community care. This may relate to -

- The management of individual patients with a known or suspected infection
- Infection risks to staff
- Refurbishment, redevelopment and upgrade projects
- Quality and performance reports.

Surveillance and Mandatory Reporting

Criterion 4, Criterion 5 and Criterion 8 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion; to ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people; and have secure adequate access to laboratory support as appropriate. The laboratory has CPA accreditation and there is a SLA in place for advice regarding complex microbiology results, particularly in reference to multi resistant organisms as outlined in the Code of Practice and the National Antimicrobial Strategy 2013-2018.

Clinical specimens generated by the Trust are managed by the University Hospitals of North Midlands Pathology Laboratory. Reports are uploaded onto ICNet, a web based software system specific to the work of infection prevention and control teams provided for by UHNM until October 2017. Since then our in-house IPC team monitor through surveillance all microbiology results and treatments.

The purpose of surveillance

Surveillance of laboratory reports allows the effective monitoring of specific and potentially pathogenic organisms. The subsequent review supports the analysis of trends and variances, the production of comparative data and the identification of emerging risks.

The Consultant Microbiologists and the Trust Infection Prevention & Control Nurse undertake daily alert organism surveillance during periods of duty. Clinical teams are subsequently informed of the necessary actions required to minimise the risk of infection to the individual or other patients on the ward or unit.

Mandatory Reporting

The Department of Health requires UHNM to report *Clostridium difficile* infections (CDIs) Meticillin resistant *Staphylococcus aureus* (MRSA), Meticillin sensitive *Staphylococcus aureus* and *Escherichia coli* blood stream infections BSI (2011). This is co-ordinated by the laboratory and national reporting system (Data Capture System). However any Trust apportioned MRSA BSI or CDI would be reported to the patients CCG by exception. The responsibility for this lies with our Trust.

Meticillin-resistant *Staphylococcus aureus* (MRSA)

The Trust is pleased to announce that there have been no MRSA bacteraemia reported within our Trust.

MRSA Admission Screening

Department of Health guidance (2014) requires NHS provider Trusts to undertake MRSA screening of patients admitted to emergency and elective hospital inpatient beds. However this guidance did not include Mental Health secondary care.

In Mental Health Trusts, swabs are taken from the nose, any wounds and indwelling devices if the individual meets the criteria detailed below:-

- Admitted following surgical procedures
- Transferred from an Acute Trust
- Intravenous drug user
- Self-harm
- Affected by chronic wounds such as leg ulcers and pressure sores
- Living with long term indwelling devices such as enteral feeding tubes and catheters

However, consent must be gained, and or consideration of the risks if the patient is unable to be screened on admission.

Individuals with MRSA positive screening on admission (colonised with MRSA), are offered a five days decolonisation regime in accordance with National guidance and the Trust MRSA Policy.

The Trust IPCN monitors implementation through weekly MRSA admission screening returns received from all hospital in-patient areas.

The Performance Department receive monthly data summary reports, while members of the Trust Infection Prevention and Control Group receive updates at each meeting.

MRSA admission screening and the subsequent decolonisation of individuals who are carriers of MRSA forms part of the Trust's strategy to minimise the risk of infection.

Clostridium difficile Infection (CDI)

No incidents to report.

Serious Incidents

During April 2016 two wards were affected by an increase in the number of patients acquiring chest infections and or pneumonia whilst in patients on wards at the Harplands Hospital. Initially infection prevention and control were notified about the situation on ward 4 and subsequently were notified about similar cases on ward 6. A total of 8 patients became unwell on ward 4 between the dates 23/3/2016 and 8/4/2016. On ward 6 a further 8 patients were identified as having respiratory infection between the dates of 22/3/2016 and 14/4/2016. In addition to the patient cases on ward 6 there were also 5 staff members reporting that they had developed respiratory infections in this time period. Ward 4 was at this time a shared care older person's ward and ward 6 a complex needs older person's ward.

Investigations into individual patients and their symptoms on ward 4 established that 8 patients had been affected. 1 Patient had been transferred to UHNM with sepsis and had since died. This patient was subject to DOLS authorisation and the death was reported to the coroner.

The microbiologist conducted a review and extended viral testing was performed on respiratory swabs. Coronavirus (Common cold) was isolated from 3 samples, all different types (NL63, OC43, and HK41). A subsequent viral swab submitted for a patient on 8/4/2016 was positive for Influenza B. All previous samples sent on several of the patients had been negative for Flu. The patient with Flu B had been transferred from ward 6 on 23/3/2016. At this point Tamiflu was prescribed to all contacts as prophylaxis.

The patients on ward 4 had been treated with IV antibiotics and IV fluids when they initially became unwell on the ward. This is due to the fact that these patients were under the care of UHNM medical staff and advanced practitioners between the hours of 9-5pm Monday to Friday. The affected patients had been inpatients on ward 4 ranging from 14/1/2016 and 23/3/2016 (average length of stay 38 days).

Although tis could not be defined as an outbreak due to the fact that the same virus was not implicated in two or more cases, it is considered that "traffic" from an acute environment to Harplands repetitively may be a source of exposure.

Ward 4 was restricted until the affected patient with influenza B was isolated. This was accomplished and the ward reopened to admissions and transfers.

Both wards underwent barrier cleans and a full terminal clean when usual activity resumed.

All outbreaks of infection are managed in accordance with national guidance (Public Health England, 2016); all are reported as serious incidents (SIs) and subject to a Root Cause Analysis (RCA) investigation. The aim is to determine the index case, the possible source of the outbreak and any contributory factors, while the subsequent action plan addresses the issues identified and lessons learned.

Most patients are cared for in single rooms with hand washing facilities and this assists in implementing control measures during an outbreak of infection. The decision to isolate, however, is based on a balance of risk approach with consideration of any safety issues, particularly where the patient is confused, disorientated or in the acute phase of a mental illness. Patients with infections are therefore assessed individually and an appropriate care plan implemented.

Preventative measures implemented by the Trust to detect and minimise the impact of outbreaks of infection	
Policy	Section 12 of the Infection Prevention and Control Policy Manual is the Trust Policy and Procedure for the prevention and management of outbreaks of infection including viral gastroenteritis.
Training	The correct hand hygiene procedure, the signs, symptoms and incubation period for norovirus and exclusion period following diarrhoea and vomiting due to an infectious cause are included in Trust Corporate Induction and Mandatory Training Programme.
Information for staff	The Trust Toolkit for the detection and management of outbreaks of infection provides information and guidance for clinical teams.
Information for members of the public	The Trust leaflet "Spread the Word not the germs" provides information on how members of the public can help the Trust in preventing infections.
Isolation Rooms	Most patients within the Trust are cared for in single rooms with hand washing or en-suite facilities. During an outbreak of infection and following a risk assessment, these rooms may be used as isolation rooms.
Hand washing facilities	Newly refurbished areas have been equipped with electronic no touch Health Technical Memorandum 64 compliant hand washing facilities
Specialist advice	The Trust Infection Prevention Nurse provides advice on the prevention and management of outbreaks of infection
Cleaning	Support services staff respond immediately to requests for additional cleaning from the Trust IPN. Colour coded cloths and equipment are used specifically for isolation rooms and cleaning schedules are increased.
Surveillance	Electronic access to laboratory reports through ICNet/other alerts the Trust IPCN of emerging risks.
Communication and Partnership working	Infection Prevention and Control teams across Staffordshire share information on locations affected by outbreaks of infection to minimise the risk of spread through transfers into and from affected areas.

Escherichia coli (*E.coli*)

1 National data indicates that the NHS has been successful in bringing about reductions in MRSA and *Clostridium difficile* infections. With controls in place this may be the time to move away from this limited focus to address the emerging risks associated with *E.coli* blood stream infections and highly resistant organisms.

2 *E. coli* accounts for approximately 40% of bacteraemias in England. Almost half of all antibiotics prescribed within the Trust relate to urinary tract infections (UTIs) (Trust Antimicrobial Pharmacist Reports) particularly in those locations caring for older people. We have continued to focus on prevention of urinary tract infections, particularly in older people.

Antimicrobial prescribing

Criterion 3 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice require the Trust to ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk adverse events and antimicrobial resistance.

The Chief Medical Officer, Sally Davies, has warned that "we use antibiotics inappropriately; we are increasing the opportunities for the bugs to develop resistance – the biggest threat to human health" (2016).

Antimicrobial Pharmacist

The Trust has a Senior Pharmacist to promote appropriate use, audit, monitor, review and report on antimicrobial prescribing. The role includes supporting prescribers and other members of the clinical team and monitoring practice to ensure that the most appropriate antibiotic is prescribed at the correct dose for the correct period of time.

Their role is to also promote antimicrobial stewardship with other members of pharmacy to monitor antibiotic use, to advise clinicians, educate all grades of healthcare workers and help to develop policy. Summary reports for antibiotic prescribing are presented to members of the Infection Prevention and Control Group for discussion at each meeting. Recently, the Pharmacist has promoted the antimicrobial pledge 2014 as part of stewardship and developed links with UHNM infection prevention team. The antimicrobial audit reports are standardised with UHNM using a 'Red Amber Green' 'RAG' rating point prevalence audit to identify areas for improvement in antimicrobial prescribing.

Almost half of all antibiotics prescribed within the Trust relate to urinary tract infections (UTIs) (Trust Antimicrobial Pharmacist Reports) particularly in those locations caring for older people. We have continued to focus on prevention of urinary tract infections, particularly in older people.

Strategies to monitor and optimise antimicrobial prescribing includes implementing antibiotic guidelines, supporting professional development on appropriate prescribing and reducing inappropriate prescribing.

Antibiotic Prescribing Guidelines

The Trust follows the primary care antibiotic prescribing guidelines for North Staffordshire. These are reviewed every two years and republished and circulated to prescribers and ward staff to assist and standardise prescribing practice. The guidelines are amended as per resistance patterns and other relevant updated information. The Pharmacists largely effect change by constantly questioning the prescription of antibiotics outside the local guidelines. Antimicrobial issues are therefore regularly detected and discussed and the appropriate action suggested to the clinical team. The opportunistic education given during these discussions helps to promote the understanding and use of guidelines in the future, resulting in long-term behavioural change.

Hand Hygiene

Criterion 2 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to ensure that there is adequate provision of suitable hand washing facilities and antimicrobial hand rubs.

Actions taken by the Trust to promote good hand hygiene practice	
Hand Hygiene Training	Hand hygiene training is included at Corporate Induction and all mandatory updates additionally ward based teaching sessions provided by UHNM Nursing Assistant.
Hand Hygiene Equipment	In Trust premises, all staff have access to a hand wash basin, liquid soap and disposable paper towels in wall mounted dispensers. Additionally are provided with and encouraged to carry personal hand gel dispensing bottles.
Refurbishment and Upgrade Projects	Clinical specification hand washing facilities are provided for staff in all refurbishment and upgrade projects.
Alcohol Hand Rub	Clinical teams and staff supporting clinical teams all have personal dispensers of alcohol hand rub. This complements hand washing.
Quality Improvement and Audit	Compliance with national guidance and Trust policies are regularly audited.
Cleanliness Audits	The cleanliness of hand washing facilities is monitored during monthly cleanliness audits.

Actions taken by the Trust to promote good hand hygiene practice	
Information	Posters and leaflets are available for staff and members of the public, the Infection Prevention and Control site on the intranet added a link direct to Infection Prevention Dashboard at RSUH.
Trust Policy	The Trust has a Hand Hygiene Policy detailing the correct hand hygiene technique, the critical points for hand hygiene and the World Health Organisation Five Moments for Hand Hygiene.

Cleanliness

Criterion 2 of the Health and Social Care Act 2008 Code of Practice (updated July 2015) requires the Trust to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

From 1st October to 31st December 2016, the Support Services Management teams in partnership with Modern Matrons and Infection Control Prevention (IPC) have measured standards against the National Standards of Cleanliness using our professional performance monitoring package, "Support Services Solutions Ltd".

Each area has been audited against the category of risk in compliance with the National Specification for Cleanliness in the NHS (NSPA 2009). During this quarter period the Trust's achieved an overall performance of 96.54% for all areas and risk categories with an average performance of 95.90 %.

In-patient areas

During this quarter period, the Trust achieved an overall performance of 95.19 % in all inpatient areas with an average performance of 96.23%; these scores include the cleanliness of the clinical environment including estates and nursing equipment.

Site	**Average performance**		
	Q 1	Q 2	Q3
Harplands Site	97.34%	95.85%	97.03%
Florence House	97.72%	98.52%	97.66%
Darwin Centre	93.21%	93.32%	91.51%
Summers View	90.65%	93.23%	91.59%
Assessment and Treatment	98.15 %	99.33%	98.67%
Dragon Square Bungalow 4 and 5.	96.56%	91.74%	96.87%

During this quarter period, the scores ranged between 91.43% at Summers View to 98.64% been achieved at L/D Assessment and Treatment unit. Clinical Leads and Support Services are actively working together to ensure we achieve a score of 95% or above.

Summers View - During this quarter period we have continued to see fluctuating audit scores. However the cleanliness scores are now heading in the right direction and when the vacant post has been recruited to, we should see cleanliness standards increase in the next quarter. Clinical teams continue to work together with the Support Services management team to strive to achieve the required standards.

Darwin- Building work continues to be a challenge for the support services staff in this centre. The staff are working extremely hard to maintain standards. Support services staff

continue to focus on the patient/clinical areas as their priority to maintain standards. Any actions from the audits are addressed and completed. The last cleanliness audit completed in December 2016 achieved a score of 94.94%

Harplands – All areas achieved 95% or above.

During the same quarter period, our Private Finance Initiative (PFI) partners, Carillion who provide the support services provision at the Harplands site, achieved an average of 95% or above each month, for cleanliness as agreed in their service line specification. Carillion average cleanliness scores are discussed and monitored at Trust's Monthly Contract Performance Monitoring group meeting.

Carillion Housekeeping Cleanliness Scores %					
Apr -16	97.1	July -16	97.8	Oct -16	97.6
May-16	97.6	Aug -16	97.8	Nov -16	97.8
Jun-16	97.0	Sept -16	97.6	Dec -16	97.6

The above scores represent cleanliness of the environment in line with the PFI Contract measured by Carillion excluding the clinical equipment and estate defects.

Community Premises

Site	**Average performance %**		
	Q 1	Q 2	Q3
Hope Centre	92.77	94.74	94.50
Greenfields	91.45	92.40	96.03
Broom Street	93.12	96.18	96.24
Bennett Day Centre	95.87	93.23	98.84
Sutherland Centre	96.35	95.73	99.09
Roundwell Place	96.62	95.28	97.57
CAMHS Dragon 2/3	96.62	95.70	94.31
Dragon Day Centre	96.26	95.58	96.66
Eaves/Marrow House	97.67	98.32	98.86
Parent and Baby Unit	98.86	96.74	98.69
Ashcombe Centre	100	99.27	98.67
Trust HQ	93.23	95.58	97.60

During this quarter period, the scores ranged between 93.99% at Hope Centre to 99.09 % been achieved at the Sutherland Centre. All community premises achieved their target of 92% or above.

Service Level Agreements - with Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP)

At Lymebrook, Maple House and the Brandon Centre where we have a service level agreement with SSOTP who provide a support services provision to these areas, all three areas have achieved audits scores of 92% or above during the period.

Cleaning Strategy Objectives

All cleaning frequencies publicly displayed have been reviewed and updated during August and September 2016.

DIPC visits in partnership with Support Services Advisor have been undertaken at Broom Street Darwin Centre and Furlong Court (Substance Misuse Centre).

Environmental maintenance by our Cleanliness Technician:

Our Cleanliness Technician has continued to play a key role in maintaining and actioning any environmental defects from our audits in all our NSCHT premises, to support our Support Services/clinical staff to maintain standards.

Support Services bespoke refresher domestic task training.

During this quarter period support service staff have completed their practical domestic task refresher training.

Duty of Care site Visit to our linen hire provider Synergy at Derby

On 7th December 2016 a Duty of Care Audit was completed by Anne Melville and Josie Sage, IPC.

At the time of the audit, NSCHT were satisfied that Synergy Laundry demonstrated compliance with CFPP-0104 legislation.

The duty of care audit identified the following points in their soiled linen area for Synergy to address:

1) To remove notices from the wall protector behind the hand wash station in the soiled linen area to ensure that the panel can be cleaned daily.
2) Provide a notice board for the posters.
3) Replace the waste bin with one that is foot operated and has a lid on.
4) Replace missing tap heads.

Confirmation received from Synergy on 10th January 2017 advising that all actions had been completed.

The Healthcare Environment

Criterion 2.2 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

The Trust renewed its Legionella policy to ensure that appropriate systems and procedures are in place to minimise the risk of legionella within the Trust's hot and cold water systems. The policy describes the responsibility of the Trust to provide adequate resources to enable full implementation of the Codes of Practice as defined in the Health and Safety Executives document L8, The Control of Legionella Bacteria in Water Systems and for specific technical guidance, the NHS Estates Code of Practice HTM 04-01 and 'safe' water guidance notes, in order that they can properly control their water supply system.

The Water Safety Group, chaired by the Head of Estates continued to meet on a quarterly basis. The reports from the group were fed back to the Infection Prevention and Control Group.

Regular sampling and testing for Pseudomonas aeruginosa continued on a quarterly basis and the results were reported back to the IPCG via the Water Safety Group.

A documented twice weekly flushing regime was introduced for all outlets. This is supported by the Trust's Support Services Manager and random samples of the signed flushing documents are reviewed by the Water Safety Group.

Refurbishment Projects

Research has confirmed that the healthcare environment can be a reservoir for pathogenic micro-organisms; it is therefore important that good infection prevention and control practice is integrated into the planning, design and build process (Department of Health 2013). Infection prevention and control is now included at all stages of refurbishment and new build schemes.

The Trust continues to balance the anti-ligature requirements for sanitary ware in patient areas by reviewing the inclusion of sensor no touch taps, whilst considering flow rates as the reduced flow from these outlets have caused concerns. There are new systems on the market that operate behind the sanitary ware, linking to computer systems that will operate regular automated flushing regimes and provide electronic reports of when these were completed.

Refurbishment projects completed this year include:

- Refurbishment of Bungalows 2 & 3 Dragon Square, from LD in-patient accommodation to office and clinical environments.

- Refurbishment of former inpatient area at Bennett Centre to clinical and office accommodation for CAMHS.

- Creation of two IOU bedrooms on the ground floor of Edward Myers Unit at Harplands Hospital.

- Creation of Seclusion Unit at Ward 1 Harplands Hospital, with the en-suite sanitary ware being replaced with anti-ligature sanitary ware.

- Refurbishment of Place of Safety toilet facility to anti-ligature sanitary ware.

Patient Led Assessment Care Environment 2016 - PLACE
The Patient Led Assessment Care Environment (PLACE) for NSCHT has been completed in line with the target dates set by HSCIC in the following areas:

- Harplands Hospital
- Darwin Centre
- Florence House
- A&T Summer View
- Dragon Square

All assessments have been completed in accordance with the PLACE guidelines and with a team of at least 50% patient representation from New Beginning's, NSUG, Health Watch, a Non-Executive Director or Patient representatives on each team.

This year we had a total of 11 patient assessors engaged in the PLACE assessments. We have also been fortunate to use the same independent validator on all of our assessments; this has proved to be invaluable and clearly demonstrates our commitment to ensure consistency across our organisation.

This year there has been a new category introduced to the audit process, this being a section on Disability.

The PLACE questions require a YES/NO, Pass, Qualified Pass or Fail in categories relating to Cleanliness; Food and Hydration; Organisation Food; Ward Food; Privacy, Dignity and Wellbeing; Condition, Appearance and Maintenance and Dementia. There was no disability assessment but questions were asked with in the other elements.

Trust's overall score for 2016:
Cleanliness - 99.60%
Food and Hydration - 97.20%
Organisation Food - 92.97%
Ward Food – 99.88%
Privacy, Dignity and Well-Being - 97.54 %
Condition, Appearance and Maintenance. - 98.44%
Dementia - 96.26%
Disability - 96.48%

- The overall cleanliness scores which included hand hygiene and equipment cleanliness were excellent. Darwin Centre and Summers View each scored 100%.

- The Food and Hydration scores were excellent with an organisation score for food and hydration of 97.20%. There is a slight increase on last year's score.

- Privacy, Dignity and Dignity scores range between 94.12% and 98.05%. These scores vary dependant on the responses submitted in relation to observation panels and integrated blinds in patient bedroom doors. Again, there is a slight increase on last year's score.

- The overall condition, appearance and maintenance scores were excellent and demonstrate our commitment to maintain the areas with scores ranging between 97.59% and 100%. Darwin Centre and Florence House both scored 100%. This is a real credit to the Estates Team, PFI partners and our Hospital Cleanliness Technician.

- Dementia – this section was scored on WD 4, WD 5, WD 6, WD 7, ECT and the communal areas on the Harplands site, with an overall Trust Score of 96.26% being achieved.

The actions taken during the year to improve the environment for dementia at the Harplands has enabled us to see an increase in this year's results.

- Disability – As an organisation we have achieved a score of 96.48%. This is 17.64% above the national average.

Many favourable comments were received throughout the PLACE Assessments:

- ***Florence House*** *- A light, well maintained modern building which is clean and offers clients dignity and respect.*
- ***B4/5 Dragon Square*** *– It is a well maintained building, very clean and tidy. Clients are treated with dignity and respect and their individual needs are well cared for .This unit is a credit to the team.*
- ***A & T Unit*** *– Clean and well maintained environment both inside and outside. Clients well looked after. Excellent activity room facility- a credit to the unit. Beautiful food at meal service time.*
- ***Summer View*** *–. All food prepared freshly by staff on premises. A well maintained modern building where the staff treat the clients with respect and dignity. Staff very dedicated and looked after the client's individual needs.*
- ***Darwin*** *– An exceptionally well organised, well maintained building both inside and outside. Provides a tranquil and happy experience for service users. The staff and teachers are a credit to the service.*
- ***Harplands Hospital****– Excellent décor well maintained to a high standard. Food was serviced very hot. Excellent standard of patient care especially observed at meal time service.*

PLACE 2016	**Cleanliness** **%**	**Food and Hydration**			**Privacy, Dignity and Well Being** **%**	**Condition, Appearance and Maintenance** **%**	**Dementia** **%**	**Disability (new for 2016)**
		Food	**Organisation Food**	**Ward Food**				
Harplands Hospital	99.58	97.64	93.15	100	98.05	98.15	96.26	95.60
Dragon Square	99.63	N/A	N/A	N/A	97.54	98.44	N/A	96.48
A&T Unit	98.89	94.08	90.63	98.78	100	97.59	N/A	98.25
Darwin Centre	100	96.66	94.46	99.03	94.12	100	N/A	98.30

Florence House	99.26	94.28	89.30	100	94.17	100	N/A	100
Summers View	100	96.16	92.47	100	97.32	98.85	N/A	100
Organisation Average score	**99.60**	**97.20**	**92.97**	**99.88**	**97.54**	**98.44**	**96.26**	**96.48**
% Above National Average	**+ 1.54**	**+8.96**	**+5.96**	**+10.92**	**+9.38**	**+5.07**	**+20.98**	**+17.64**
National Average score	**98.06**	**88.24**	**87.01**	**88.96**	**88.16**	**93.37**	**75.28**	**78.84**

Summary of action points for consideration:

The following actions points need to be considered to address the areas which have not be able to achieve the maximum score. However each year there is always a slight change in the questions asked, these can sometimes be to our advantage. The format of the forms this year made the process easier to complete.

A&T – the unavailability of wash hand basin in the clinical room will be addressed in the refurbishment plan.
Darwin Centre – The bedroom doors do not have the means for observation. This will be addressed as part of the refurbishment programme.
Dragon Square – The bedroom doors have the means for observation but do not have an integral blind.
Florence House – There are no outdoor facilities dedicated for physical activities. This has impacted on the privacy, dignity and well-being score. Clients do not have personal access to TV's in their bedrooms, clients supply their own.
Summers View - The bedroom doors have the means for observation but do not have an integral blind. The recreation room used for woman only is managed on a needs basis and therefore does not score the maximum point which has an impact on the privacy, dignity and well-being score. This has since been resolved.
Harplands –To continue to replace the carpets as part of Life Cycle programme with our PFI partners.

Cleanliness/ environmental issues – Any cleanliness unsatisfactory elements were actioned at the time of the assessment and minor works requests raised.

Food and Hydration – the score that we have achieved reflect the style and menus choices that we offer to our clients.

Dementia –To continue to strengthen this element with Modern Matron for NOAP and Clinical Leads.

Conclusion
This year we have achieved an improvement on our PLACE scores and received very positive feedback from our patient assessors who have actively been engaged in the process.

In all elements we have achieved in excessive of the National Average Scores.
This year's scores are a credit to the all staff within the organisation.
Clinical Leads, Support Services, Infection Control and Prevention Team and on- going audits will continue to monitor, our internal performance to enable us to maintain the environmental standards.

Seasonal Influenza Vaccine Campaign

Criterion 10 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust has a system in place to manage the occupational health needs of staff in relation to infection.

Vaccination and immunisation is the most important way of protecting individuals from vaccine preventable infectious disease. Providing the seasonal influenza vaccine to healthcare workers benefits the individual and their families and helps to reduce the risk of transmitting the virus to vulnerable patients.

Vaccinating staff is therefore part of the Trust's strategy to prevent infections and is an integral part of winter planning and resilience.

The Department of Health challenged NHS provider organisations with achieving a target of 75% uptake of the seasonal influenza vaccine by frontline staff.

Uptake of the seasonal influenza vaccine in the Trust

Healthcare worker vaccination is an essential part of the overall infection prevention and control arrangements in any health and social care setting. Frontline health and social care workers also have a duty of care to protect their patients and service users from infection.

The 2016/17 campaign saw the implementation of NHS England incentivising the uptake of flu vaccinations for frontline clinical staff through the CQUIN scheme.
Planning for the campaign in partnership with Team Prevent, the trust occupational health provider utilised national resources to commence the campaign.
There were no incidences of an influenza outbreak within our clinical services during this reporting period.

The CQUIN campaign target to vaccinate 75% of eligible front line staff provided a challenge and motivation to review, refresh and build on our previous campaigns. In 2016/17 our overall uptake of the vaccine was 45.6 % of which 44.8% were frontline staff. In 2016/17, our target was to vaccinate 804 staff of our eligible frontline workforce of 1059.

Working in partnership with Team Prevent, our occupational health provider and utilising the NHS Employers Flu Fighter resources we mobilised an active peer vaccinator team and an in reach service in addition to planned clinics. We achieved and improved on the CQUIN target of 75% reaching a 75.9% uptake by December 31st, the CQUIN submission cut-off date.

Continued peer worker activity saw the final frontline staff vaccination uptake of 79.7% at February 2017.

We were delighted to be recognised as the highest achieving mental health trust nationally and to receive recognition of the campaign success by the NHS Employers annual awards ceremony. Shortlisted in the Team of the Year award, the trust received a highly commended award. The occasion enabled the trust team to hear the different and innovative approaches from other trusts of which we will build in to the forthcoming annual programme.

Education & Training

Criterion 6 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

The principles and practice of the prevention and control of infection must be included in induction and training programmes for new staff and there must be appropriate on-going education for existing staff.

The Trust includes infection prevention and control in their Corporate Induction Programme which runs every month. Infection prevention and control is part of the Trust's Market Place, at the Induction day, where new employees gain key information and staff have an opportunity to introduce themselves to new employees.

Face to face infection prevention and control training is delivered to all staff as part of the Trust's Mandatory Training programme. This is delivered by the IPN. It provides an interactive session, which aims to develop a positive relationship with staff, whilst promoting best practice. Content of the session includes:

- An introduction to The Health and Social Care Act 2008 (2015) Code of Practice
- Lines of accountability including the role of the Director of Infection Prevention and Control
- Sharps awareness
- Hand Hygiene
- Minimising the risks of outbreaks and exclusion periods for diarrhoea and vomiting
- Topical issues such as seasonal influenza
- Who to contact for advice and support.

In addition to face to face training, E-learning is available to staff as an alternative learning option. This will be promoted widely later in 2016 by the Trust's training team.

All staff complete Infection Control and Prevention training every 3 years and staff training compliance in this subject area in March 2016 was 94%. The Trust's target is 90%.

Below shows a trend report showing staff compliance up until the end of April 2016:

Infection Control Training– March 2017

Infection prevention & Control compliance has increased from 94% up to 95% and is above the target of 90%.

To support clinical staff in obtaining full mandatory training compliance, the Training and Education Development Advisor worked closely with the Modern Matrons, to set up block weeks of training. Clinical staff are now released from all clinical duties and are provided

with a week's protected time to allow them to attend and complete their training. This is working really well and the aim is that by March 2018, all clinical staff will be fully compliant in all mandatory training subjects.

Policy Development and Review

Criterion 9 of the Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

The following Trust policies reflect the requirements of the above Act:

No	Policy Title
1	Sources of Advice
2	Infection Prevention & Control Operational Policy
3	Policy for minimising the risk of infection through standard precautions
4a	Hand Hygiene Policy
4b	Policy for the use of Personal Protective Equipment (PPE) for staff working within and supporting clinical teams
5	Isolation Policy
6	Notifiable Diseases
7	Policy for the prevention of occupational exposure to blood borne viruses and the management of inoculation or splash injuries
8	Cleaning and Disinfection Policy
9	Food Safety Policy
10	Management of Pulmonary Tuberculosis Policy
11	Meticillin resistant *Staphylococcus aureus* (MRSA) policy
12	Policy for The Prevention and Management of Outbreaks of Infection including viral gastroenteritis
13	Management of Linen and Laundry Policy
14	Specimen Management Policy
15	Policy for the prevention and management of *Clostridium difficile* infections (CDI)

All policies are available electronically on the Staff Information Desk (SID) in the Infection Prevention and Control folder.

Each document is subject to a planned programme of review every three years or prior to this date in response to changes in national guidance and published evidence based practice.

During the coming year these policies and standard operating procedures will be encompassed into a portfolio resource for staff which is user friendly.

Quality Improvement

Criterion 2 of The Health and Social Care Act 2008 (updated July 2015) Code of Practice requires the Trust to ensure that a programme of audit is in place to ensure that key policies and practices are being implemented appropriately.

Infection Prevention and Control standards are monitored through a structured programme of regular audit using nationally approved quality improvement tools endorsed by the Department of Health and the Infection Prevention Society (IPS 2012).

Random unannounced visits and assessments are made by the IPCN.

A subsequent audit report details the standard required, the issue identified and the necessary action. The ward or unit manager is required to complete the report detailing the actions taken, the individual responsible and the timescale.

Ambitions for 2017/18

The year-end analysis and review provides an opportunity to celebrate positive outcomes and to agree the Trust's ambitions for the forthcoming year.

The Trust have reviewed the 2016/17 ambitions and believe that the ambitions detailed below should remain our focus in to 2017/18 in addition to the new innovatives currently planned.

- **Prevent avoidable urinary tract infections.**
- **Promote prudent antibiotic prescribing.**
- **Increase compliance with mandatory training to 95%.**
- **Maintain or improve uptake of the seasonal influenza vaccine by frontline staff.**
- **Monitor and minimise the risk from emerging resistant micro-organisms.**

In addition, we have identified five further aims to focus on additional further success in the following areas:

- **To improve ward based hand hygiene standards.**
- **To identify IPC champions in all in-patient areas.**
- **Develop a standard operating procedure for naso-gastric and Invasive devices.**
- **Develop the role of the Infection Prevention Link Practitioner (IPLP).**

Although the Department of Health does not have an Action Plan in place for non-acute Trusts for Carbapenamase Producing Enterobacteriaceae (CPE) other than to advise making staff aware of the increasing prevalence of multidrug resistant organisms, we have taken the step of incorporating this into the Mandatory training presentation.

Summary & Recommendations

People with a diagnosis of severe and enduring mental illness (SMI) such as schizophrenia and bipolar disorder are at increased risk of physical illness including infections. The Trust, therefore, has a duty to protect vulnerable patients from avoidable infections through robust systems and procedures, particularly in in-patient locations.

NSCHT have provided high standards of cleanliness/hygiene with well-maintained environments that are aesthetically pleasing and safe for patients, staff visitors and the general public in all areas.

The information provided in this report summarises the planned and responsive actions taken to minimise the risk of infection. This document serves to inform and provide assurance to members of the Board that the actions support the Trust's aim to care for patients in a safe environment, protecting them from avoidable harm.

The Board is asked to approve the IPC annual report.

Appendix I
Infection Prevention and Control Annual Programme of Work 2017/18


IPC Work programme.doc

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NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: Trust Board

Enclosure No: 8

Date of Meeting:	7th September 2017		
Title of Report:	Safeguarding Annual Report 2016-2017		
Presented by:	Julie Anne Murray, Acting Deputy Director of Nursing, AHP & Quality		
Author:	Vicki Baxendale, Head of Safeguarding		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
The Safeguarding Annual Report 2016-2017 provides assurance on safeguarding activity including referral rates, training, audit and case reviews. The scope of the report is the portfolio of the Safeguarding Team and includes Safeguarding Children, Safeguarding Adults, Prevent and Domestic Abuse. The report was approved by the Quality Committee 31st August 2017.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ Execs ☐ Date: 08.08.2017	Document Version No.	1
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Safeguarding annual report addresses the needs of vulnerable adults and children who will have protected characteristics.		
Recommendations:	The Board receive the annual report for information and assurance		

North Staffordshire Combined Healthcare NHS Trust

Safeguarding Annual Report 2016 - 2017

Contents

1 INTRODUCTION

1.1 North Staffordshire Combined Healthcare NHS Trust provide mental health and learning disability care to people predominantly living in the city of Stoke-on-Trent and in North Staffordshire.

We also provide specialist mental health services such as Child and Adolescent Mental Health Services, including a regional inpatients unit, learning disabilities and substance misuse services.

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

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 outpatient settings, community resource settings and in people's own homes.

The purpose of this report is to outline the safeguarding work within the Trust for the period of April 2016 to March 2017, evidencing how we are making a difference and providing assurance of compliance to the Trust Board and partners.

1.2 Safeguarding Adults

North Staffordshire Combined Healthcare NHS Trust (NSCHT) is committed to ensuring that all adults who come into contact with our services are protected and safeguarded from abuse. We work within the legal framework of The Care Act (2014) which came into force April 2015 and enshrined the safeguarding of adults at risk of abuse/neglect in law.

All staff have a duty of care in relation to safeguarding adults and to ensure that any concerns are appropriately responded to.

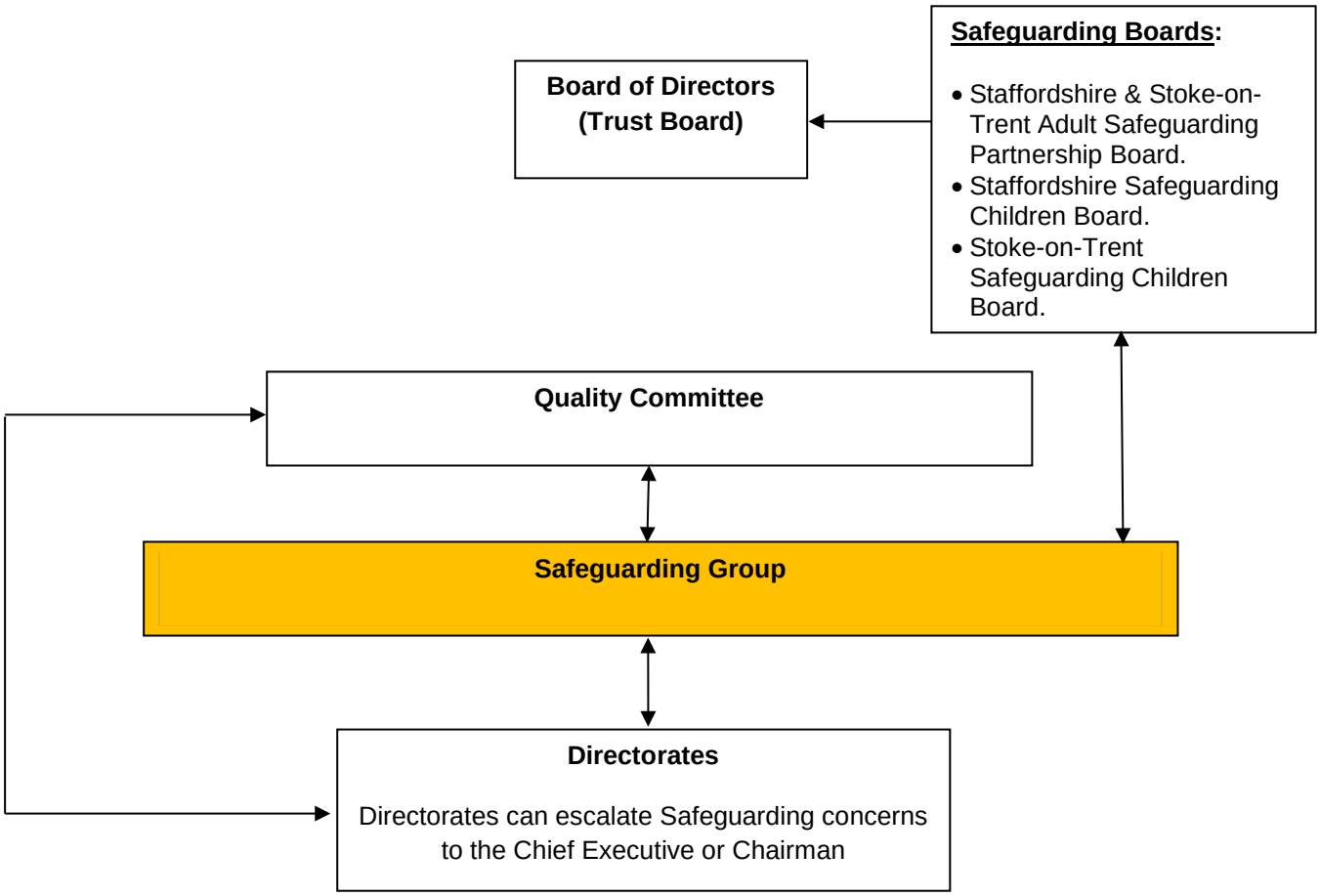
1.3 Safeguarding Children

Most parents manage their problems well and care for their children well, however, some need extra help and support, particularly at times when a parent's difficulties may become harder to manage, or at times of transition in children's lives.

We have a duty to make sure that children are safe and well cared for, either when the child is a service user or where their parent/carer or another person in the child's family or network is a service user.

North Staffordshire Combined Healthcare NHS Trust (NSCHT) is committed to ensuring the safety of all children who come in to contact with our services, either directly or through parents/guardians.

2 ACCOUNTABILITY FRAMEWORK



2.1 Quality Committee

The Trust's Assurance Framework includes reports from the Executive Safeguarding Lead to the Quality Committee. Guidance documents and new or updated policies receive agreement and approval via this committee prior to submission to the Trust Board. Policies reviewed include Safeguarding Children Policy Statement, Safeguarding Adults Policy Statement, Preventing Harm, Children Visiting Mental Health Hospitals, Managing Visits to Trust Premises by Celebrities and VIPs, PREVENT and Domestic Abuse.

2.2 NSCHT Safeguarding Group

The Trust Safeguarding Group meets quarterly and provides an opportunity for representatives from key services to discuss issues, and report progress against documented action plans and audit. Attendance includes: Executive Director of Nursing & Quality, Non-Executive Director/Safeguarding Champion, Safeguarding Team, Directorate Governance Leads and Representatives from North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups.

2.3 Executive Lead: Executive Director of Nursing and Quality

The Executive Director of Nursing and Quality is the Executive Nominated Lead for Safeguarding. The Executive Safeguarding Lead reports directly to the Chief Executive and the Trust Board and represents the Trust on Stoke-on-Trent Safeguarding Children Board, Staffordshire Safeguarding Children Board and Staffordshire & Stoke on Trent Adult Safeguarding Partnership Board.

2.4 Safeguarding Team

The Safeguarding Team develops and monitors safeguarding policies, processes and procedures to provide assurance to the Trust Board that effective safeguarding arrangements are in place. The Safeguarding Team is responsible for safeguarding surveillance across the organisation to identify trends, themes and any areas of concern. This function is carried out by supporting staff in clinical practice and through the delivery of mandatory training and supervision. A key role of the team is to engage with partner agencies via the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and both of the local Safeguarding Children Boards to improve safeguarding across Staffordshire.

The Safeguarding Team includes a Named Nurse for Safeguarding, Named Doctor, Safeguarding Practitioner, Safeguarding Team Coordinator and Safeguarding Administration Assistant.

2.5 All NSCHT Staff

The Trust recognises that "Safeguarding is Everyone's Responsibility" and depends upon the collective contribution of all staff, patients, relatives and carers. Policies and procedures are easily accessible on the Trust intranet. Staff attend training and access supervision as applicable.

3 PARTNERSHIP WORKING

3.1 Safeguarding Adults

NSCHT are active members of Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB). SSASPB co-ordinates its work via the following groups of which NSCHT participate:

- Partnership Board with an Independent Chair and Board level representation from statutory agencies.
- Executive Sub-Group.
- Sub Groups: Policy & Procedures, Performance Monitoring and Evaluation, Safeguarding Adult Review, Learning & Development, Mental Capacity Act.

The SSASPB brings together lead officers from all agencies concerned with the wellbeing and protection of adults. Working together, they develop policies and procedures to protect adults from abuse, deliver training and seek assurance from partner agencies regarding the quality of safeguarding activity.

The SSASPB also lead on Safeguarding Adult Reviews and engage the appropriate partners to complete this important work.

The statutory partners involved are Staffordshire County Council, Stoke-on-Trent City Council, Clinical Commissioning Groups, Staffordshire Police and Staffordshire Fire & Rescue Service.

3.2 SSASPB Approved Strategic Priorities for 2016/2018:

i) Transition from children to adult services
ii) Leadership in the Independent Care Sector
iii) Engagement

3.3 Safeguarding Children

NSCHT are active members of Staffordshire and Stoke-on-Trent Safeguarding Children's Boards. The Executive Director of Nursing & Quality represents NSCHT at board level. These partnerships were developed to co-ordinate multi-agency working to safeguard and protect children in Staffordshire and Stoke-on-Trent.

The Safeguarding Children Boards co-ordinate their work via the following sub groups of which NSCHT participates:

- Policies and Procedures
- Training
- Audit and Performance
- Practice (Stoke-on-Trent only)
- Serious Case Review

The Safeguarding Children Boards bring together representatives from various agencies and organisations in Stoke-on-Trent and Staffordshire to work in partnership to protect children and young people. Both Stoke-on-Trent and Staffordshire Safeguarding Children Boards involve key partner agencies and organisations.

The Safeguarding Children Boards' priorities for 2015/2018 are:

1. Child Sexual Abuse (including child sexual exploitation, child trafficking, missing children, female genital mutilation, forced marriage, honour based violence, youth violence and intra-familial abuse.
2. Neglect including the Toxic Trio (Domestic Violence, Substance Misuse, Parental Mental Health difficulties).

4 INSPECTIONS

4.1 External Inspections

During 2016/17 there was one external safeguarding inspection. This took place In April 2016 when the Care Quality Commission undertook a Staffordshire wide inspection on the theme of Children Looked After and Safeguarding (CLAS Review).

The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

The CQC looked at:

- The role of healthcare providers and commissioners.
- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

They also reviewed whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.

Within NSCHT the review team visited CAMHS services, Adult Mental Health services and Substance Misuse services spoke with managers at these services, the Named Nurse for Safeguarding and reviewed notes.

There were areas of good practice highlighted including:

- Engagement with CAMHS and Adult Mental Health practitioners is good which enables a smooth transition to adult services.
- High priority is given to multi-agency safeguarding work including Child Protection, Child In Need and Multi Agency Risk Assessment Conference.
- Adult mental health practitioners have a good understanding of their professional accountabilities for safeguarding children including the early identification of risk. This denotes required improvements in practice have been embedded following learning from a serious case review.

Some areas for improvement were identified including:

- Team managers ensuring they are aware of all safeguarding cases on the team's caseload. This has been addressed by introducing risk markers on records if either adult or child safeguarding processes are on-going and the development of the caseload management tool which now identifies all safeguarding cases.

- Ensuring a consistent approach was utilised when raising safeguarding concerns. This was addressed immediately with a step by step guide sent out to all teams and assurance received from team managers that it had been shared with staff. An audit has since been completed that provided assurance that teams are now utilising the correct process.
- Ensuring that robust supervision arrangements are in place for teams. An increasing number of teams are now accessing supervision; this is being monitored and reported quarterly to the internal safeguarding scrutiny group.

There is a multi-agency action plan that has oversight from the local Clinical Commissioning Groups to address all areas of improvement identified within the review.

Within NSCHT it is subject to ongoing review at CQRM. The majority of the actions were completed by end of March 2017, with only 2 actions remaining namely implementing electronic notes and an audit of MARAC recording in notes outstanding. The electronic records were implemented in May 2017.

5 AUDIT

The Trust's Safeguarding Team undertake/contribute to the following internal and external audits:

5.1 External Audits

i) Adult Safeguarding Self-Assessment Audit

This self-assessment is completed on an annual basis to provide Board level assurance of safeguarding practices within the organisation.

This year the audit identified that staff may not have up to date knowledge of adult safeguarding since the introduction of the Care Act (2014). This was addressed by training sessions delivered to each Adult Community Mental Health Team, adult safeguarding training sessions aimed at in-patient staff which were accessible to all, specific training sessions delivered to Parent & Baby services and Community Learning Disability Teams.

ii) Adult Safeguarding Case File Audit

The SSASPB Performance Sub-Group meet bi-monthly and review case files for people that have required safeguarding support in their lives. This is a multi-agency approach and all partners involved in the care contribute, NSCHT is committed to this quality assurance process.

iii) Section 11 Audit

This is a joint audit completed every two years for both Staffordshire Safeguarding Children Board and Stoke-on-Trent Safeguarding Children Board).

This year there was a full Section 11 audit which reviewed leadership and processes within the organisation to provide assurance around child safeguarding. The organisation met all standards set out within the audit with minor recommendations to distribute reminders to staff on how to raise concerns and improve training compliance.

5.2 Internal Audits

i) Adult Safeguarding

The focus of the internal adult audit this year has been the quality of concerns raised and do they meet the standards expected from the SSASPB adult safeguarding procedures.

The majority of concerns raised contained the appropriate demographic information and capacity was well documented. However, there was a lack of evidence of engagement of the service user in the process particularly from specific clinical areas. The Safeguarding Team will work with those clinical areas to improve this and re audit November.

ii) Children

The focus of the internal audit for children has been a baseline audit of Think Family approach.

Think Family is a whole family approach, regardless of whether a service is working predominantly with an adult or a child. In practical terms this means that adult services need to recognise service users as parents and children's services need to be aware of parents' needs and how they can be supported.

Although Think Family was not highlighted as an area for improvement by the CQC CLAS inspection, it was felt during the inspection that this approach could be strengthened within the Trust.

To strengthen and further embed this approach it has been a focus of the Level Three training that has been developed and delivered this year since the inspection. The audit was to ascertain how well embedded Think Family already is and also provide a baseline to support understanding the impact of the training in the future.

The audit identified that in the majority of notes basic information of any children the adult had contact with was recorded in the appropriate box on the assessment form; on occasions was sometimes recorded in the narrative of the initial assessment instead.

The majority of care plans identify parenting needs however few staying well plans acknowledge parenting needs or have contingency plans for childcare if the parent becomes unwell.

There was evidence of good practice within the notes that were reviewed in the audit including a care plan that acknowledged a grandparent who had recently gained Parental Responsibility for his grandson and what support they would both require including which agencies would be providing this.

There were also a number of cases where children were acknowledged and discussed where the service user does not have contact with their children and what support they would like for this.

This demonstrates that staff are recognising parenting as part of their service user's lives and the need to support this. They are Thinking Family.

The Think Family approach will continue to be a focus of training for registered professional staff.

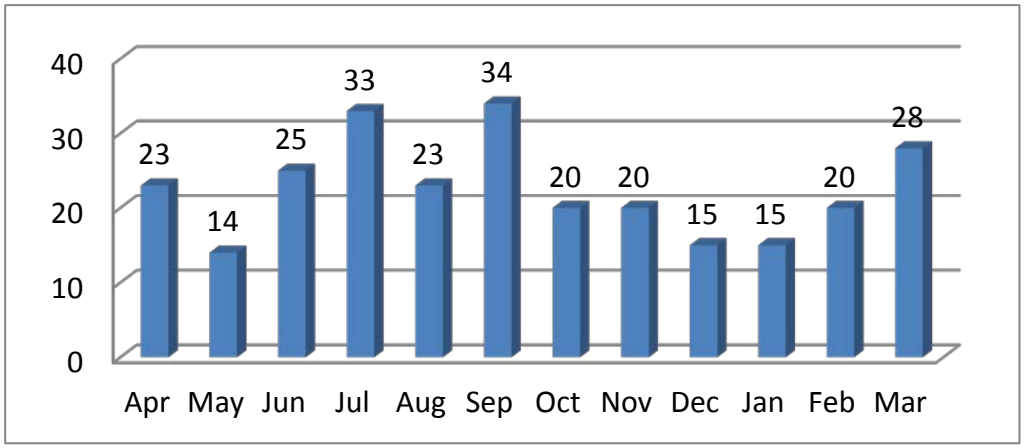
6 PERFORMANCE

6.1 NSCHT Incident Reporting and Safeguarding

i) Safeguarding Adults

The table below shows the total number of adult safeguarding referrals which have been raised by NSCHT staff over the previous 12 months. Not all safeguarding incidents require an adult safeguarding referral, for example if a similar incident is already undergoing enquiry or if it is an ongoing risk that would require the safeguarding plan to be reviewed rather than a full referral to be made. NSCHT monitor all safeguarding incidents and referrals in order to identify any trends and themes.

Total Number of Adult Referrals during 2016-2017: 270



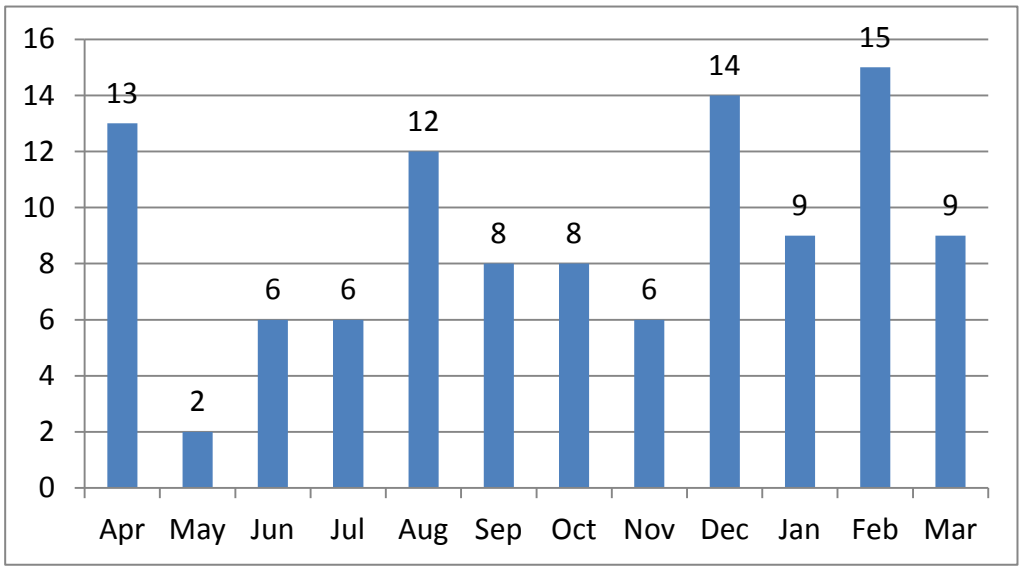
All referrals are reviewed on a weekly basis by the Incident Review Group, this provides cross-Directorate oversight of all incidents allowing incidents not previously identified under Safeguarding to be identified and acted upon appropriately.

The number of referrals (270) represents a slight decrease from 205/16 (296). With the introduction of the Care Act (2014) it would be expected to see a small drop in referral rates as Safeguarding risks that are on-going are required to be managed under a safeguarding plan rather than make repeated referrals for the same risk.

ii) Safeguarding Children

The table below shows the total of number of Child Safeguarding referrals which have been made by NSCHT staff over the last 12 months:

Number of Child Protection Referrals 2016 - 2017: 108



As anticipated the Adult Directorate and Children & Young People's Directorate generate the majority of child protection referrals for NSCHT, this demonstrates both the children's and adults' workforce recognise and act upon child safeguarding concerns.

Child safeguarding concerns are identified and raised by all Directorates including the adult and older adult workforce. This indicates a good understanding from staff of their responsibilities to child safeguarding whether they work directly with children or their parents/carers.

The number of referrals this year (108) does not represent any change in rate from last year. The internal process of making referrals in a way that is visible to the organisation was streamlined to be aligned with the referral process for adult safeguarding in October 2016. This does not appear to have had any impact of the overall referral trend.

7 TRAINING

7.1 Mandatory Safeguarding Training

Safeguarding training is mandatory for all NSCHT staff to ensure that they are equipped with the essential knowledge and skills to recognise and report abuse. Training provided is in accordance with the Intercollegiate Document that clarifies levels of training required by role within health services.

A significant number of training sessions have been delivered by the Safeguarding Team to ensure that all staff have access to Safeguarding Training. Level 1 & 2 training sessions are held twice per month.

A training strategy is in place and has been refreshed; this identifies which staff groups are required to participate in each level of training. This is in keeping with local and national guidelines to ensure that NSCHT staff receive appropriate training to meet their needs.

This year we are introduced Health Intercollegiate Document Level 3 training face to face for the appropriate level of staff. This has been well received and has had a high level of uptake in the first year.

The table below outlines the training figures for Mandatory Safeguarding Training by Directorate as at year end 2016 – 2017. Each directorate is responsible for supporting their staff to attend mandatory training, each Directorate reports monthly on mandatory training to the Senior Leadership Team. The Safeguarding Team are responsible for ensuring there are enough training places made available to achieve compliance. During 2016-2017 level 1/2 sessions were delivered twice a month which provides enough spaces for staff requiring that level. In 2017 e-learning will be introduced for level 1/2 and this will release time to provide monthly sessions for level 3 so staff will have more opportunity to attend.

Directorate	L1/2 Children % Compliance	L1/2 Adults % Compliance	L3 Safeguarding % Compliance
Adult Mental Health Community	86%	82%	71%
Adult Mental Health Inpatient	81%	74%	73%
Substance Misuse	92%	85%	71%
Children & Adolescent Mental Health	88%	84%	89%
Neuro and Old Age Psychiatry	89%	83%	67%
Learning Disabilities	90%	86%	79%
Trust Overall Compliance	85%	81%	72%
Trust Compliance Target	90%	90%	90%

Although level three is some way off the expected 90% target it is the first year that level 3 has been delivered and this must be acknowledged when considering compliance rates.

7.2 Local Safeguarding Children Board Level 2 & 3 Safeguarding Training

The Safeguarding Lead has worked with the Safeguarding Children Boards to deliver LSCB level 2 & 3 multi-agency training as part of the Safeguarding Children Board training team. We aim to continue this contribution.

NSCHT has developed and provided multi-agency training sessions for Stoke-on-Trent and Staffordshire Safeguarding Children Boards. This is LSCB level 3 training for parental mental health and the impact this will have on child safeguarding. This training has been received during 2016/2017 and is continuing to be received by both Boards for 2017/2018.

8 PREVENT

8.1 Introduction

Prevent is one of the four strands of the Governments Counter Terrorism strategy called Contest. NSCHT are active partners within the Prevent programme. Prevent gained a statutory footing in July 2015 giving staff a legal duty to report any concerns. The Safeguarding Team are active members of Channel, the West Midlands Regional Prevent Forum, for both Staffordshire and Stoke-on-Trent and in 2017 has been invited to attend the Stoke-on-Trent Prevent Board.

Channel is an early intervention multi-agency process designed to safeguard vulnerable people from being drawn into violent extremist or terrorist behaviour. Channel works in a similar way to existing safeguarding partnerships aimed at protecting vulnerable people.

8.2 PREVENT/WRAP Training

The training aims to give professional members of our community the skills to identify individuals who show signs of vulnerability, identify what they are vulnerable to, and support those individuals so that they do not become exploited and drawn into terrorism by persons or groups supporting Violent Extremism or acts of Terrorism.

The training looks at the background of crime, social processes, the history of terrorism, susceptibility, narratives used by radical groups or individuals and recognising, understanding and referring vulnerable people.

Training has been delivered twice a month throughout 2016-2017 by the Safeguarding Team and Training Team with support from the Health and Safety Officer. The training is a one off requirement with annual updates provided by the Safeguarding Team in written format sent to all staff.

Breakdown of Directorate PREVENT Training Compliance (as at 31 March 2017):

Directorate	% Compliance
Adult Mental Health Community	95%
Adult Mental Health Inpatient	83%
Substance Misuse	95%
Children & Adolescent Mental Health	95%
Neuro and Old Age Psychiatry	93%
Learning Disabilities	97%
Trust Overall Compliance	93%
Trust Compliance Target	90%

9 DOMESTIC ABUSE

Domestic abuse is now a category of abuse under the Care Act (2014).

9.1 Domestic Abuse Policy

All NHS Trusts are required to have a Domestic Abuse Policy. This is clearly defined within the Government's Domestic Violence Strategy (Home Office 2005) and supported by the Department of Health (2005). This can be found on our policy page.

9.2 Domestic Abuse Training

During 2016/17 the Safeguarding Team commissioned the local charity Women's' Aid to deliver Domestic Abuse training to frontline staff.

9.3 Domestic Abuse Partnership

The Safeguarding Team are active partners within the Stoke-on-Trent Domestic Abuse Partnership whose purpose it is to implement and further develop the Partnership Strategy and to advance its main aims that are based on the national vision from the Government's Violence Against Women and Girls (VAWG) Strategy. This includes preventative measures to ensure a reduction in violence by providing adequate support through partnership working to achieve the best outcomes for victims and their families.

In 2016 the Safeguarding Team began to contribute to lateral checks within the Multi-Agency Safeguarding Hub for domestic abuse incidents. This has supported a more cohesive multi-agency response to domestic abuse incidents across North Staffordshire.

9.4 MARAC Engagement

Multi -gency Risk Assessment Conferences are held every fortnight and are a multi-agency response to individuals and their families experiencing domestic abuse. The Safeguarding Team ensures that when a service user is being discussed at MARAC the appropriate frontline practitioner is aware of this so that they can attend, a good practice guide of what to expect and what is expected of them has been developed for practitioners and is included with every invite.

The Domestic Abuse partnership and local agencies including Local Authorities, Police and Health partners are currently reviewing the MARAC process during 2017.

10 CASE REVIEWS

10.1 Safeguarding Adult Reviews

Safeguarding Adult Reviews (SAR) are undertaken when an adult dies or experiences significant harm and it is felt that agencies could have worked together more effectively to support the adult.

There has been one on-going Safeguarding Adult Review from 2013; it is not yet completed due to some delays whilst waiting the completion of legal processes. There has also been a new SAR initiated 2016-17 which was also delayed due to legal processes. Both of the above SARs are now progressing as planned.

10.2 Domestic Homicide Reviews

Domestic Homicide Reviews (DHR) are undertaken when a person over 16 dies as a result of suspected violence or abuse, the alleged perpetrator was part of their household or was in an intimate relationship with them.

The Trust has participated in one new Domestic Homicide Review in the last year, recommendations have included ensuring that when staying well plans are developed they are developed with the service user and their family and contain sufficient detail. Training has been delivered to the team concerned and a recent audit demonstrated that this has improved.

10.3 Serious Case Reviews

Serious Case Reviews (SCR) are undertaken when a child dies or experiences significant harm and abuse or neglect are suspected.

The organisation has not been required to participate in any Serious Case Reviews in the last year.

10.4 Multi-Agency Learning Reviews

Multi-Agency Learning Reviews (MALR) do not have a statutory duty to publish reports however do offer the opportunity for agencies to learn together.

There have been two MALRs initiated by Safeguarding Children Boards that the Trust is participating in however they have not yet been completed.

11 SAFEGUARDING SUPERVISION

11.1 Supervision Strategy

A Trust wide supervision strategy is in place which identifies four levels of safeguarding supervision available to any staff working with adults or children:

Level 1
Staff can access safeguarding support and advice from their peers and line managers.

Level 2
Safeguarding support and advice is available from the Named Professionals (Named Nurse for Safeguarding or Named Doctor for Safeguarding) via telephone or face to face contact. This is one off advice regarding a specific safeguarding concern.

Level 3
Staff can access planned face to face individual supervision from the Named Professionals.

Level 4
Teams can access planned face to face group supervision from the Named Professionals.

Level 5
Supervision for the Named Professional is accessed from the Local Authority Lead for Adult Safeguarding and Designated Nurse for Safeguarding Children.

Staff are made aware of the opportunity to seek safeguarding supervision via in-house training, supervision policy and information provided for staff on the intranet. Practitioners are also offered supervision when invited to a child protection conference.

11.2 Supervision Sessions

During 2016/17 eleven teams received regular supervision from the Safeguarding Team.

The Safeguarding Team also offer case specific supervision with teams; this has included the opportunity to have multi agency safeguarding supervision/discussion of specific cases.

The Safeguarding Lead and Adult Safeguarding Nurse regularly provide safeguarding advice on an individual basis either via telephone or e-mail.

The Safeguarding Lead also received monthly supervision from Local Authority lead for adult safeguarding and Designated Nurse for safeguarding children throughout 2016/17.

12 LADO (Local Authority Designated Officer)

12.1 Referrals

A referral is made to LADO when someone in the course of their work has harmed a child or behaved in a way which may deem them inappropriate to work with children. The referral would be received by the Local Authority who would investigate concerns under Section 47 of the Children's Act 1989. The Safeguarding Lead and Named Doctor are the named officers for Trust LADO referrals.

During 2016-2017, there have been four LADO referrals all have been reviewed within the internal policy and through Local Authority LADO processes, all have been found to be unsubstantiated.

13 EXAMPLES OF GOOD PRACTICE

During 2016/17 there were a number of examples of good practice identified.

13.1 Children

A Community Mental Health Nurse (CMHN) was working with a service user who lived with his partner and two children. The relationship between both parents was volatile and characterised by arguments and physical violence. The children were frequently witness to the arguments and violence. The Community Mental Health Nurse worked in partnership with other agencies particularly Children's' Social Care and was persistent in raising her concerns regarding the children both with the parents and agencies supporting the children. The Nurse worked pro-actively with parents around how to manage their emotions so they would impact less on the children. During review of the case it was evident that there was good communication between the Community Mental Health Nurse, School and Children's social Care.

This demonstrates that the Community Mental Health Nurse was aware of her responsibilities to protect children, recognised the risk to children and worked pro-actively to support parents and other agencies around the children to improve their lives.

13.2 Adults

A service user disclosed to her Community Mental Health Team that she had been having frequent arguments with her husband and they had escalated into physical violence on occasions and her husband had assaulted her. They had been married for many years and were both in their 70s. An adult safeguarding concern was raised and the enquiry completed by the care team. The case was also discussed at MARAC.

Initially the service user wanted to stay at home with her husband. The care team discussed the incident with the husband, he admitted he had assaulted her and reported he was struggling to manage caring for her. The care team explored options available with the service user, her husband and their adult children. The service user eventually chose to leave the marital home, a placement was found and the service user was safe.

This work demonstrated not only an appropriate response to a safeguarding concern but that the care team clearly worked with the service user, her husband and their family. At all times the service user was kept informed and her wishes and feelings were at the forefront of the enquiry.

14 ACHIEVEMENTS & PRIORITIES

14.1 Key Achievements 2016/2017

- Internal audit process strengthened to include focussed audits around both adult and child safeguarding including quality of referrals and Think Family approach.
- Staff aware of the implications of the Care Act (2014) for safeguarding through a variety of training and awareness raising processes, including accessible training aimed at in-patient staff.
- Completion of annual Adult Safeguarding Self-Assessment Audit and Section 11 audit.
- Developed Good practice Guide for staff attending MARAC.
- Increased teams accessing supervision either on a regular basis or on a case specific basis including multi-agency.
- Trust wide alert system on Electronic records to identify safeguarding cases to any team that is working with a service user.
- Development of caseload management tool that identifies all safeguarding cases allowing frontline practitioners and line managers to be aware of all on-going cases.
- Increased contribution to MASH processes with Safeguarding Team contributing daily to the Information Sharing Log to ensure agencies obtain the correct information in a timely way.
- Developing and delivering Level 3 Safeguarding Children Training and achieving 72% compliance in the first year.

14.2 Key Priorities 2017/2018

- Ensure all safeguarding activity is captured and reported on open safeguarding cases on the new electronic records system. This is so we are able to demonstrate not just level of referrals but also amount of partnership working within safeguarding.
- Develop internal training to strengthen practitioners' ability to complete Adult Safeguarding enquiries.
- Further embed Think Family approach to safeguarding.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No: 9

Date of Meeting:	7th September 2017		
Title of Report:	Quality Strategy and Action Plan		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Interim Deputy Director of Nursing & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
The Quality Strategy and action plan has been refreshed and was approved at Quality Committee 31st August 2017		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date: 22nd August 2017	Document Version No.	1
Committee Approval / Review	• Quality Committee ☒		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒ This report relates to all strategic objectives		
Risk / legal implications: Risk Register Ref	The Trust develops and implements policies and procedural documents to provide a common framework for safe, effective and acceptable practice To ensure kept abreast of any legal developments and implications for the Trust		
Resource Implications: Funding Source:	None Known		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The quality strategy and action plan support the delivery of inclusive services		
Recommendations:	The Board receive the strategy for information and assurance		

North Staffordshire Combined Healthcare NHS Trust

Quality Strategy 2017-2020

Towards Outstanding

June 2017

safe • personalised • accessible • recovery focused

Version control

Version 1	Quality Strategy 2017-20	JA Murray	
Version 2		JA Murray and M Nelligan	

Foreword by Caroline Donovan, Chief Executive

I am delighted to introduce our Quality Strategy for 2017-20. Ensuring the delivery of high quality clinical care and ensuring excellence in mental health and learning disability services is the Trust's overriding priority. We recognise that quality and good governance is a hallmark of high performing organisations and we are committed to continuous improvement in these areas on our journey 'Towards Outstanding'.

The Five Year Forward View for Mental Health (May 2016) report highlights important changes needed in mental health, including developing new models of care and ways of working, integration of mental and physical health, 24/7 mental health support and supporting a 'data revolution' to improve transparency, drive improvement and inform decision making. Therefore, over the next three years our governance arrangements will evolve as we develop as an organisation to meet these changes and as our organisational boundaries change.

Throughout this time we will continue to ensure that we have the right systems and skills in place to empower our staff to continue our pursuit of excellence and to ensure that Trust Board is driven by the quality agenda. We aspire to be an outstanding organisation and everything we are doing is laying the foundations for this. We will know if we have been successful in delivering this strategy by our measurement and performance monitoring framework which is regularly reviewed to ensure that it remains robust and it fit for purpose.

We recognise that strong clinical leadership is critical to the successful completion of our quality objectives through influencing and leading desired changes in our quality and safety culture. Therefore our clinical structure is founded upon the evidence-based principle of distributed leadership, team working, stretch objectives and role clarity which empowers our staff to take personal responsibility for their actions.

By seeking to deliver high quality care for all, we are striving to reduce inequalities in access to health services and in the outcomes from care. We aim to achieve our quality vision through the completion of our objectives outlined in this strategy, aiming to further develop and improve our culture and performance by focussing on our SPAR quality priorities.

1. Introduction

At North Staffordshire Combined Healthcare NHS Trust (Combined NHS) our vision is *'to be an outstanding organisation providing safe, personalised, recovery focussed support/services every time'*. At the heart of achieving this vision is quality and this strategy sets out our quality objectives for the next 3 years so that we deliver care that is safe, personalised, accessible and recovery-focussed. We are committed to working with our service users, carers and partners to continually develop our priorities and we have engaged in a variety of ways to progress this.

We also recognise the need to get the right balance between quality assurance, improvement and control. Our framework for quality assurance needs to evolve as we move forward towards outstanding. The quality strategy will support our organisational objectives and provide a framework for the delivery of our quality vision through measurable quality goals and metrics.

To ensure that quality improvements are sustainable quality improvement needs to be integrated into our everyday work. We inevitably have targets to meet however if we focus on what is important to our service users, carers and staff then we can provide the highest quality care. We are committed to providing the highest quality services possible for the patients we serve. It is essential we continually improve the quality of our services by engaging with and listening to our patients, staff and key stakeholders in order to meet and exceed their expectations. This quality strategy is a vehicle to drive this engagement and partnership working to improve services and the care that matters most to our patients, staff and stakeholders.

Additionally we recognise that each individual member of our staff makes a contribution to the experiences of our service users and carers; we will continue to invest in our staff development and well-being and ensure, through on-going engagement, that they have the resources and are suitably empowered to drive up standards within their own area of practice.

2. What is the strategic context?

Our journey towards outstanding is underpinned by our vision, values, quality priorities and strategic objectives. These have been developed through engagement and consultation with staff and key stakeholders.

Our Vision - the way we want our organisation to be seen

To be an outstanding organisation providing safe, personalised, accessible and recovery-focussed support/services every time.

Our Values - Proud to CARE - the way we want our staff to behave

- ***C**ompassionate*
- ***A**pproachable*
- ***R**esponsible*
- ***E**xcellent*

Strategic Objectives - measurable metrics against which we will deliver our goals

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

Our Quality Priorities - SPAR - the four key areas which evidence that we are delivering high quality care and treatment to those using our services in a way that is person-centred

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

Other key strategies linked to our Quality Strategy

- Service User and Carer Engagement Strategy
- Workforce Strategy
- Diversity & Inclusion Strategy

3. What is quality?

In 2008 Lord Darzi developed a single definition of quality for the NHS as part of his 'High Quality Care for All' review. Darzi identified that, within healthcare, quality relates to:

- Care that is safe
- Care that is clinically effective
- Care that provides the best possible experience for service users

Therefore quality relates to the following 3 domains:

1) **Patient safety:**
   This refers to providing care, environments and services which protect our services users, carers and staff from suffering harm as a result of the care and treatment that they are receiving or providing.

2) **Effective care:**
   Effective care is treatment that has a positive impact upon people's lives, enabling them to achieve their individual potential and work towards recovery. This involves ensuring that people accessing our services receive the right treatment at the right time. To achieve this our staff need to be informed about best practice and we need to constantly measure and review our outcome data to ensure that we know which interventions are effective and which are not.

3) **Patient experience:**
   To measure patient experience we need to ascertain the impact that our care and treatment has had on the person's wellbeing; the degree to which the person feels that they were treated with compassion, respect and dignity, how responsive the service is to their individual needs, whether their care is personalised and the degree to which we have supported their progress towards recovery.

The Trust recognises that to provide high quality care all 3 quality domains must be at the heart of everything we do. Furthermore we need to consider these domains within the context of how we govern, measure and improve the quality of care we provide.

4. How will we govern, measure and improve the Quality of Care we provide?

4.1 Governance - quality assurance processes

Our Quality Assurance Programme Board is chaired by the Chief Executive and oversees the delivery of service improvement. The function of this Board is embedded into the senior leadership team (SLT) meeting who meet on a monthly basis. The governance meeting structure is in appendix 3.

Additionally we remain a key member of the national NHS Mental Health Benchmarking Reference Group enabling us to benchmark the trusts performance with other trusts.

Following the CQC inspection of the trust in September 2016 we received a rating of 'Good'. This was announced in February 2017 and at the announcement we launched 'Toward Outstanding' as part of our on-going journey of improvement.

We have implemented an internal unannounced inspection programme that mirrors the CQC inspection regime. The majority of in-patient wards have had an internal inspection and we will extend these to community teams during 2017-18.

We have developed an internal ward accreditation scheme; this will examine 13 standards across 3 domains (environment, care and leadership). This will be implemented during 2017-18.

We recognise that over the next 3 years our quality assurance processes will need to evolve. As the boundaries of our organisation change and we become an integrated care organisation we will require more complex governance arrangements to meet our responsibilities.

5.2 Measuring quality - quality control activities

To demonstrate success a series of quality and safety metrics are being used to monitor and measure our continuous improvement. Through 'towards outstanding' we are challenging ourselves to be amongst the very best service providers. This is managed through close scrutiny and monitoring via the Trust's comprehensive Performance and Quality Monitoring Framework (PQMF), benchmarking and subsequent discussion at Committee and Board.

Our PQMF monitors the quality of services we provide. Where performance or quality metrics are not on target, clinical directorates provide rectification plans, including action planning, for performance review by the Trust Executive. The PQMF enables granular reporting of weekly and monthly dashboard reports to clinical teams and Trust committees, with an overview maintained by the Trust's 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 most pressing indicators of quality are in focus. The review of individual clinical teams' compliance with CQC and Mental Health Act standards is used to drive improvements in the quality of the services provided to patients.

Key to achieving our objectives is development of our infrastructure and most significantly our IT systems through 'Digital by Choice' and the commitment and investment to developing our staff. As detailed in our Digital Strategy, the 'Digital by Choice' programme will be key to supporting the quality agenda ensuring staff have access to the appropriate technology and data at team level in real time, enabling a responsive approach to monitoring, identifying fluctuations in performance and

enabling the prompt escalation of risks. To support this record, went live in May 2017.

In addition, our Board Assurance Framework (BAF) and Trust Risk Register enable the Board to be fully engaged in risk management. The annual independent audit of the BAF ensures that controls are in place and that risks are effectively monitored and addressed.

Whilst there are robust processes in place to monitor risk and to address performance additionally we celebrate and share best practice through a number of initiatives such as conferences, the Trust research forum and REACH awards.

5.3 Quality improvement

The Trust continues to demonstrate its commitment to quality improvement through the on-going development of its organisational culture, to improve the effectiveness, efficacy and safety of the services provided. A good working culture ensures that staff are engaged with the development of the Trust services, are open to learning and change and are committed to providing the best mental health and learning disability care that they can for our service users. The Trust recognises that support for our clinical leaders, through education and training focuses staff on our key clinical priorities of providing safe, personalised, accessible care to service users and their families/carers. Team leaders and clinical teams have been supported through a number of leadership programmes to develop leadership at all levels of the organisation.

Listening to feedback and engaging with service users, carers, staff and other key stakeholders is also a key element of our quality improvement process. We gain feedback from service users and carers through the annual national community mental health survey, directorate discharge surveys, trust carer survey, NHS Choices and the Friends and Family Test. Service users and carers also feedback compliments and raise concerns or complaints through the Patient Experience Team. Additionally the Service User and Carer Council (SUCC) has an active and forward looking agenda. Furthermore the Chair of the SUCC is a member of our Trust Board. We also hold events such as the Recovery Conference , Open Space Event and Diversity and Inclusion Conference to engage with service users and carers.

We recognise that to achieve successful and sustainable quality improvement changes staff have to be engaged in the processes. There have been a number of initiatives used to facilitate greater staff engagement from the use of weekly news letters, the Listening into Action programme, the Go Engage project and the use of ‘Dear Caroline’ which provides an extra forum for raising and learning from concerns. The Trust recognises that it is only by working collaboratively with service users and staff, with a shared vision that better performance and better patient outcomes are achieved.

We are also committed to working collaboratively with a range of partners including Healthwatch and local Clinical Commissioning Groups. These partners are involved in key activities such as our internal unannounced inspections and determining our annual priorities.

We use improvement methodologies to assess our current position and to move forward. Methodologies we use include the following:

- LEAN working
- PRODUCTIVE series
- PDSA cycles (Plan, Do, Study, Act)
- SBARD communication (Situation, Background, Assessment, Recommendation and Decision)
- MaPSaF (Manchester Patient Safety Assessment Framework)

Therefore we utilise a variety of quality improvement tools, in addition to listening to and engaging with service users, carers, staff and key stakeholders and continually improve the leadership skills of our workforce. Through these actions the Trust is committed to developing the skills and knowledge of the staff in order to ensure continuous and sustainable improvement in delivering high quality care.

5.4 Quality improvement work plan

This Quality Strategy will be implemented through an annual quality improvement work plan. To strengthen our quality improvement culture, during 2017-18, we will implement a Quality Improvement Development Program. Working with the support of AQuA (Advancing Quality Alliance) we will further develop staff's knowledge and skills in relation to quality improvement. This will support the implementation of the annual work plan. Quality priorities identified within the BAF, Commissioning for Quality and Innovation **(**CQUIN) schemes and CQC feedback will be our key drivers. Key vehicles for delivery of the plan include the SUCC, the clinical audit programme, the learning lessons programme and the leadership academy.

5.4.1 Key drivers

Business Assurance Framework (BAF): In order to effectively deliver a quality service there is a need to ensure that there is an effective and comprehensive process in place to identify, monitor, understand and address current and future risks. We have a Board Assurance Framework (BAF) and Trust Risk Register to enable the Board to be fully engaged in and sighted on risk management. The annual independent audit of the BAF ensures that controls are in place and that risks are effectively monitored.

Commissioning for Quality and Innovation (CQUIN): NHS England set out the CQUIN scheme; key CQUINS for mental health and learning disability providers include improving the physical health of people with severe and enduring mental ill health and people with a learning disability, improving services for people with mental health needs presenting at A&E and transitions out of children and young people's mental health services.

Within the trust each CQUIN has a lead identified and a working group to support and drive implementation. CQUIN progress is monitored through monthly directorate

meetings and the Clinical Effectiveness Group. We ha
100% of CQUINs, demonstrating year on year improvements in the quality of care.

CQC feedback: Each time we have a CQC inspection the trust directorates develop comprehensive improvement plans to address the areas noted in the CQC reports and these are monitored through the Senior Leadership Team. Significant progress has been made with many of the requirements being addressed and rated as complete following a robust assurance process through our performance management arrangements.

5.4.2 Key delivery vehicles

Key delivery vehicles will include, but are not limited to, the following -

Service user and carer council (SUCC): The SUCC continues to develop to expand the ways in which service users and carers get involved in the Trust**.** The council will lead on developing engagement with service users and carers and in ensuring their feedback and views are integral in influencing the Trusts priorities. They will also play a key role in helping us set our quality priorities annually and will be integral to our quality improvement programme.

Clinical audit programme: Clinical audit is an important means of ensuring continuous improvement in the quality and effectiveness of care. We produce an annual audit programme driven by national, local and internal priorities. Each Trust directorate has an agreed audit programme and is required to report on progress which is monitored by the senior leadership team and the Quality Committee.

Learning lessons: The learning lessons programme is well embedded within the trust whereby workshops and bulletins highlighting and sharing learning are delivered through a rolling programme. The programme encourages ownership of incidents at team level and aims to promote and develop a positive sharing culture. The continued development of the programme will strengthen quality improvement within the Trust.

Leadership academy: We recently launched our leadership academy to continue to develop our staff enabling them to deliver high quality services. The academy is open to all team and senior leaders, both clinical and managerial. The aim of the academy is to ensure that our strategy and operational priorities align, that there is individual and organisational development and that our leaders have ongoing support.

6. Conclusion

This Quality Strategy articulates a vision through which the quality of the services we offer can be improved. We have taken time to listen to our patients, public and staff about the things that really matter to them. To continue to strengthen and service users and stakeholders feedback and collaboration about our service improvement priorities we held our first open space event in March 2017. This will be an annual event, led by the SUCC and will focus on hearing how well we are doing and identifying with our stakeholders our quality priorities from 2018-20. The experience

of service users and carers is at the heart of our pla
continue to meet the needs of our local population and support wellbeing and recovery through practice which is based upon the best available evidence. By utilising quality improvement methodology, engaging with service users, carers, staff and key stakeholders we will continuously improve the quality of care we provide. Through continuous improvement we aim to be recognised as a centre of excellence, with a culture of continuous learning, in which we are able to work in partnership with service users and carers to develop effective care pathways and innovative high quality care.

Quality strategy workplan 2017-18

Quality priority	Quality objective	Outcome measure
 **Safe**	S1) A quality improvement programme is established	• Implementation of our CQC improvement program to ensure all core services are rated good or outstanding • Implementation of a community safety matrix • Unannounced assurance visits continue to be embedded with quarterly reports to the Quality Committee and Trust Board • Implementation of Productive Wards to release time to care for patients • Implementation of an inpatient assessment accreditation framework • Strengthened approach to governance, professional and clinical leadership within Directorates to support operational management • Implement the Trust Suicide Strategy • Continued investment in environmental ligature improvements
	S2) Improve physical health of people with mental health needs and people with a learning disability	• Meet CQUINs on nutrition (1b), flu (1c), cardiometabolic monitoring (3a), communication with GPs (3b), tobacco screening, brief advice and referral & medication offer (9a, b and c), alcohol screening and brief advice / referral (9 d and e) • Go smoke free by March 2018 • Increased staff recognition of the 'deteriorating patient' in relation to the onset of sepsis • A falls reduction programme is developed and implemented resulting in a 30% decrease in the number of falls
	S3) Contribute to improved services for people with mental health and psychosocial needs who present to Accident & Emergency Departments (A&E)	• Meet CQUIN on improving services for people with mental health needs who present to A&E (4)

 **Safe**	S4) Implement our suicide prevention strategy	• Continue to facilitate the 'Living Well with Risk Group' to embed this strategy and facilitate participation from people with lived experience • Support the development of patient held "apps" or applications that promote recovery from depression, encourage hope and help seeking behaviour at the point of personal crisis • Use stories of hope from patients in different media formats to share the recovery messages • Family/carers views incorporated into risk management plans, and highlight any protective factors that these relationships provide. • Increase staff training in supporting patients with suicidal ideation. • Audit Trust investigations of suicides annually to give a clear picture of the patients' lives, their presentations and our service responses prior to the incident • Strengthen training for dual diagnosis care pathways with a focus on higher risk patients
	S5) Review of Models of Care and Care Pathways	• Review our care pathways underpinned by work on productivity that took place during 2016 • Plan to deliver directorate specific and cross directorate benefits of productivity improvements linked to a review of the 2 year plan • To complete an acute care pathway with a Psychiatric Intensive Care Unit (PICU) with an enhanced Place of Safety
 **Personalised**	P1) Embed service user involvement across the Trust	• There is service user and carer representation at the mental health STP board and on all trust committees • Implement the service user and carer strategy
	P2) Ensure person-centred care is experienced by all service users	• A person-centred framework will be implemented to increase service user, carer and staff knowledge and skills in relation to person centred care • All care plans will be person-centred • The FLO and autographer innovation will be extended to develop a self-managed integrated care pathway for dementia patients.
	P3) Improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services	• Meet CQUIN on transitions out of children and young people's mental health services (5)

Accessible	A1) Ensure services are responsive to the needs of service users	• Achieve 92% compliance for all national waiting time targets and 18 week waits for first definitive treatment for all services • 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 • Continue to work 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 and reduce delays in transfers of care
	A2) Diversity and inclusion is strengthened	• The diversity and inclusion plan is implemented • A diversity and inclusion conference is hosted
	A3) Ensure accessible information is available	• We will have accessible information leaflets, effective sign-posting and a well-informed external website
Recovery focussed	R1) Develop a network of peer support workers	• Ten peer support workers will be in place by March 2018
	R2) Develop a Recovery College (Well-being Academy)	• A Well-being Academy will be opened with partners to complement traditional rehabilitation approaches by providing people with education and learning experiences as a means of supporting personal and social recovery
	R3) Ensure that recovery principles underpin our strategic priorities, policies and procedures, risk assessments and care plans	• Patient reported outcome measures (PROMS) will demonstrate improved recovery for our service users • Continue to develop evidence based psychological interventions in our adult acute wards • To improve the effectiveness of our discharge planning process and enhance recovery, implement a programme of " Red to Green" days for all inpatient stays

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REPORT TO Trust Board

Enclosure No: 10

Date of Meeting:	7th September 2017		
Title of Report:	Q1 Serious Incident report		
Presented by:	Dr Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw, Head of Patient & Organisational Safety		
Executive Lead Name:	Dr Adeyemo, Executive Medical Director	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
This report provides an overview of the Serious Incidents reported during Q1 2017/18		**Approval**	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date: 08/08/2017	Document Version No.	1
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	None known		
Resource Implications: Funding Source:	None known		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None known		
Recommendations:	For assurance/information		

1. Purpose of the report

This report provides assurance to the Quality committee of the Trust processes relating serious incidents, duty of candour and mortality surveillance. The report covers the period from 1st April 2017 to 30th June 2017 (Quarter 1 2017/18) and details the following:

- the status of SIs currently open and trend data for Q4 2016/17 and Q1 2017/18
- serious incidents by category reported by quarter
- themes, learning and change arising from serious incidents.
- the quarterly Duty of Candour report
- the quarterly Mortality Surveillance report

2. Serious Incidents Q1

Serious incident investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. This does not include those service users whose deaths are determined by HM Coroner to be as a result of natural causes. The table below illustrates the total number of SIs reported by quarter for the period April 2016 to June 2017

Incident category	Q1	Q2	Q3	Q4	**Total 2016/17**	Q1	Q2	Q3	Q4	**Total 2017/18 YTD**
Slip, trip, fall	2	0	1	2	**5**	2				**2**
Pending review- unexpected/potentially avoidable death	0	10	7	6	**23**	6				**6**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (non-fatal)	0	1	1	1	**3**	1				**1**
Disruptive, aggressive behaviour meeting SI criteria	1	0	0	0	**1**	0				**03**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (suspected suicide)	7	11	4	2	**24**	3				**3**
Unexpected/potentially avoidable injury causing harm	0	1	0	0	**1**	0				**0**
Total	10	23	13	11	**57**	12				**12**

During Q1, 14 incidents were initially reported onto StEIS but after consideration with the CCG Quality Lead, 2 incidents were downgraded. Therefore 12 incidents are undergoing investigation.

The main points to note are;

- There were 2 unexpected deaths in the Substance Misuse Directorate in Q1. This is a reduction on the number of deaths reported in previous quarters in 2016/17.
- There were 7 unexpected deaths reported in the Adult Community Directorate. These included a serious incident of self-harm and the death of a person with a dual-diagnosis, who was in receipt of mental health and substance misuse services.
- There were 2 incidents involving 'Slips, trip and falls' in the NOAP directorate; these incidents occurred on ward 4 and resulted in 2 people suffering fractures requiring surgery.
  There is 1 death within the Adult In-Patient directorate figures; the incident occurred post discharge however the community team did not have the opportunity to visit the person. as the death occurred a short period after discharge.

From the initial review of the incidents, no care or service delivery problems (creating a causal link to the incidents) were identified. Investigations into Q1 SIs are ongoing and any learning identified will be actioned as appropriate and reported in subsequent quarterly reports .

3. Themes and Trends

There are no themes or trends specifically identified in Q1

In Q1 there were 3 unexpected deaths where suicide was suspected. This is an increase from Q4 2016/17 when there were 2 suspected suicides. In comparison there were 7 suspected suicides in Q1 of 2016/17, with an average of 6 unexpected deaths by suicide each quarter.

4. Learning from Serious Incidents

Recommendations and learning from investigations are disseminated on completion of the SI investigation. The learning that was found from the previous quarter and early quarter 1 investigations is outlined below:

- A practice note was issued, reminding clinical teams of the need to ensure information is communicated effectively between teams i.e. telephone conversations directly to care coordinators/team leaders supported by emails, rather than one-off emails.
- Staff were reminded through the risk assessment training of the need to review and consider historical risk information when assessing a person's current presentation and risk potential.
- A review of the processes used by the RAID team led to a change in practice; RAID practitioners were previously unable to make direct referrals to the IAPT teams and were reliant on people taking responsibility for making self-referrals. However as a

result of the learning from an investigation the team are now able to send referrals directly to IAPT services.

- RAID also reviewed their use of the triage assessment process, to include the DUDIT tool for those people where alcohol or substance misuse issues are identified.
- The Learning Lessons bulletin and workshop was used to remind staff of the need to ensure timely and meaningful communication with our external partners when supporting people who may be using several agencies.
- Within AMH a home leave 'checklist' was produced in order to ensure that plans were in place to support all care needs whilst the person is on leave. This includes arrangements relating to the delivery of/support with medication.
- A Learning Lessons workshop will be delivered to support staff in the management of vulnerable adults: Safeguarding and self-neglect. This session will explore the limitations of the Mental Health Act and the potential to use the Mental Capacity Act. This session will be delivered across beyond the LL process and will include delivery at the Doctor's training sessions and has also been added to the AMHP CPD programme. This investigation was downgraded from a formal SI however the Trust recognised that there was learning to be achieved from investigating this particular incident and is an example of the using the spirit of the SI Framework for learning.

5. Duty of Candour (Quarterly report)

The aim of the Duty of Candour (DoC) regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. The Patient and Organisational Safety Team continue to provide a secondary safeguard for identifying and monitoring possible DoC incidents and alerting clinical teams. All incidents are also discussed at the weekly Incident Review Group to ensure that all Patient Safety Incidents are correctly categorised and each moderate and above level incident is reviewed regarding the potential DoC requirement.

In the cases of the SI investigations, it is not always immediately possible to determine which, if any of the deaths under current SI investigation meet the Duty of Candour requirements, however should any incident investigation identify causal links between harm and service delivery, Duty of Candour requirements would be initiated and a letter sent.

Any Serious Incidents that meet the criteria for a contractual Duty of Candour (DoC) would be managed via the Serious Incident investigation process (the local investigation process is used for incidents that are not identified as SIs). At the time of writing there are 9* incidents which are being investigated and consideration of the DoC requirements will be made.

The next-of-kin of people whose deaths meet the SI criteria receive a condolence letter and the offer of a face to face meeting from the relevant Head of Directorate (HoD) or Clinical Director (CD). The SI Policy has been strengthened to reflect the actions of the HoD/CD to support bereaved families.

The Duty of Candour Incidents for Q1 are set out in the table below:

Directorate	Cause	DoC Process	Potential DoC incidents, (managed via SI process)
Adult Community			4
Substance Misuse			1
Adult Inpatient			1
NOAP	Patient Fall. Local Investigation completed. DoC letter sent	1	3
Total		**1**	**9***

6. Mortality Surveillance (Quarterly report)

The table below denotes the total number of deaths reported through the Trust performance team and reviewed by the P+OS Team.

2017	Total number of deaths	Total number of deaths – out of service	Reported as SI	Open to services at time of death- natural causes
Jan	148	142	3	3
Feb	43	38	2 *2	3
Mar	116	114	0	2
Apr	68	63	2	3
May	32	29	3 *2	0
June				

The figures for June 2017 are not yet available

*Denotes deaths reported as SIs from either One Recovery East or One Recovery West that would not be included in the numbers of deaths from North Staffordshire

Following the publication of Learning, candour and accountability (CQC, December 2016), from April 2016 the Trust is required to collect and publish a quarterly account of specified information on deaths. This report will include information on those deaths that are assessed as being 'more likely as not due to problems in care' and the learning and actions taken as a result of this information.

The quarterly report is required to cover all in-patient deaths, however this will largely be not applicable to mental health trusts; therefore following discussion with our commissioners, the trust has agreed to look at a small number of unexpected deaths that have not met the criteria for investigation under the SI Framework i.e. those unexpected deaths that are later determined by HM Coroner as being due to natural causes.

At the time of this report, the investigations completed have not revealed any deaths to have occurred as being ‘due to problems in care’.

All unnatural deaths where the person is in receipt of services were investigated through the Serious Incident process. There is robust governance around this process and areas for action are monitored by the directorate responsible. In addition, the learning from these deaths is disseminated throughout the Trust as part of the Learning Lessons framework, with support from other trust departments, such as HR, as necessary.

Natural cause deaths (open to services at the time of death), as identified by HM Coroner, are not subject to SI investigation, however local investigations are undertaken in order to ensure that there are no gaps/omissions in service delivery.

The Coroner’s Office informs the Trust in cases where the deaths have a drug or alcohol component; they also report deaths where there are suspicious circumstance in order to check if the person is known to mental health services.

The vast majority of deaths are reported are from the Neuro and Old Age Psychiatry Directorate and relate to elderly people who have had some contact with the memory service; in the main these deaths relate to people who have been out of service for over 12 months and deaths that do not meet the criteria for SI investigation.

7. Conclusion

The trust continues to monitor all incidents on a weekly and monthly basis. This report demonstrates compliance with trust policy and processes. There were no trends identified in relation to Serious Incidents however learning was identified during investigations and this has been disseminated to staff. Duty of Candour requirements continue to be met, this is supported by the patient and organisational safety team through the incident monitoring process. Nationally, the process of mortality surveillance is in development however the trust has demonstrated early understanding and compliance with the requirements. These will continue to be strengthened during the next quarter.

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REPORT TO Public Trust Board

Enclosure No:11

Date of Meeting:	7th September 2017		
Title of Report:	Performance & Quality Management Framework Month 4		
Presented by:	Director of Finance, Performance & Digital		
Author:	Performance & Information Team		
Executive Lead Name:	Suzanne Robinson	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
The report provides an overview of performance for July 2017 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.		**Approval**	☒
		Information	☒
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee X☐ • Finance & Performance Committee X ☐ • Audit Committee ☐ • People & Culture Development Committee X ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services X☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	The Trust Board is asked to; • Receive the Trust performance as at Month 4 • Note the rectification plans received through Board sub-committees		

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK MONTH 4
REPORT TO PUBLIC TRUST BOARD

Date of meeting:	7th September 2017
Report title:	**Performance & Quality Management Framework Performance Report – Month 4 2017/18**
Executive Lead:	Director of Finance, Performance & Digital
Prepared by:	Performance & Information Team
Presented by:	Director of Finance, Performance & Digital

1 Introduction

The report provides an overview of performance for July 2017 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.

In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

Data Quality (DQ) work is ongoing to validate and refine metrics reported in this paper, in relation to the transition to the Lorenzo EPR, which went live in May 2017.

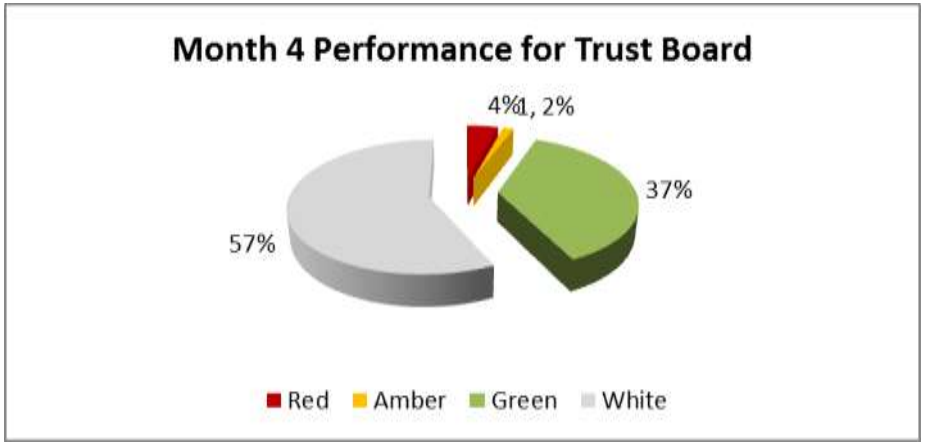
2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- **97.2%** patient have been gate kept by the crisis resolution/home treatment team
- **98.9%** of patients on a care programme approach for at least 12 months have received a HONOS assessment
- **100%** of IAPT service users are treated within 6 weeks of referral
- Readmissions has significantly reduced from 15% in April to **5%** in July
- Agency spend is underspent compared to the ceiling in Month 4

In Month 4 there are 3 related metrics rated as Red and 1 related metric as Amber; all other indicators are within expected tolerances. White KPIs are those where the requirement is to report absolute numbers rather than % performance or there is no defined target.

Contracted (National/Local CCG) & NHSI KPIs					
Metric	Red	Amber	Green	White	TOTAL
Exceptions – Month 2	1	3	33	57	94
Exceptions – Month 3	3	2	27	40	72
Exceptions – Month 4	3	1	26	40	70



3 Rectification Plans

Rectification plans are produced for any KPI classed as RED/AMBER, or where an individual directorate is classed as RED/AMBER, for a consecutive 2 month period. These offer a more detailed recovery position, focused actions and improvement trajectory and are scrutinised by Board Sub-Committees.

4 Updated Metrics and Targets

The following measures and targets have been updated in Month 4

- **Bed Occupancy (Including Home Leave)**
  The contractual bed occupancy targets agreed with local commissioners have been added to the PQMF in month 4

5 Exceptions - Month 4

KPI Classification	Metric	Exec/Op Lead	Target	M3	M4	Trend	Commentary
NHSI	**CPA:** The proportion of those on Care Programme Approach (CPA) for at least 12 months having a formal review within 12 months (NHSI)	Dir of Ops	**95%**	**AMBER 91.5%**	**AMBER 91.8%**	↗	**91.8% at M4 from 91.5% at M3** CPA review compliance overall was 91.8% with 117 patients with no recorded review (1,442/1,325). Trust compliance is impacted by the Adult Community Directorate as the majority of service users on CPA are located within community services. From audit data it is clear that more reviews are being undertaken than reported and not all cases are being recorded correctly in line with data entry guidance. This is a result of the change process associated with the new EPR. CPA compliance reports have been provided to Directorates to enable them to monitor performance by team and care co-ordinator ensuring that reviews are booked in within 12 months of the last care plan review. Teams are receiving focused training on data entry guidance to ensure accurate reporting going forward and weekly validation processes will continue in month 5. **Rectification Plan : Quality Committee**
NHSI	**Delayed Transfers of Care:** DTOC	Dir of Ops	**7.5%**	**RED 14.6%**	**RED 15.9%**	↗	**15.9% at M4 from 14.6% at M3** Reason for Delay / Total Pts / Total Days / Days as a % of Total D) Care Home placement 7 189 33.5% G) Patient or family choice 16 179 31.7% B) Public Funding 9 106 18.8% A) Completion of assessment 5 44 7.8% E) Care package in own home 2 25 4.4% F) Equipment 1 18 3.2% H) Disputes 1 4 0.7% C) Further non acute NHD care (including intermediate care, rehabilitation etc) 0 0 0.0% I) Housing-patients not covered by NHS and Community Care Act 0 0 0.0% Total 41 565 100.0%

KPI Classification	Metric	Exec/Op Lead	Target	M3	M4	Trend	Commentary

NOAP
19.2% at M4 from 17.8% at M3

Within NOAP, the RED to GREEN programme continues to embed. Delays are associated with access to NHS or residential funding or placements and family choice (80% of all delays). The Directorate is working to a rectification plan to address the delays associated with choice. Weekly DTOC meetings take place to manage the processes and issues are escalated to health and social care commissioners for resolution.

Reason for Delay	Total Pts	Total Day	Days as a % of Total
D) Care Home placement	5	127	30.0%
G) Patient or family choice	11	107	25.2%
B) Public Funding	9	106	25.0%
A) Completion of assessment	5	44	10.4%
E) Care package in own home	1	18	4.2%
F) Equipment	1	18	4.2%
H) Disputes	1	4	0.9%
C) Further non acute NHD care (including intermediate care, rehabilitation etc)	0	0	0.0%
I) Housing-patients not covered by NHS and Community Care Act	0		0.0%
Total	**33**	**424**	100.0%

Adult Inpatient
The decrease in Adult Inpatient DTOCs has been achieved through strengthening the liaison between the Adult Inpatient and Adult Community Directorates to address any issues delaying patients moving out of the inpatient setting. This includes patients not yet recorded as a delay who may become a delay without interaction.

A report will be presented to the A&E Delivery Board in August which outlines the internal pressures around DTOCs and the associated

KPI Classification	Metric	Exec/Op Lead	Target	M3	M4	Trend	Commentary
							action plan. It also seeks support from partner agencies to improve processes, such as timely assessment and rapid approval to funding and progression on the Choice Protocol. **Rectification Plan : Finance & Performance Committee**
National Operational	**CPA:** The proportion of those on Care Programme Approach (CPA) receiving follow up contact within 7 days of discharge	Dir of Ops	**95%**	**AMBER 91.2%**	**RED 90.0%**	↘	**90.0% at M4 from 91.2% at M3** AMH Community – 88.5% at M4 26 people were eligible for follow up 23 people were followed up within 7 days of discharge 3 people were not followed up within 7 days of discharge There were 3 breaches in month 4, all of which were attributable to the Adult Community. Plans are in place to rectify performance for M5 **Rectification Plans : Quality Committee**
Trust Measure	**Bed Occupancy:** Bed Occupancy (Including Home Leave)	Dir of Ops	**85%** (90% AMH IP only)	**RED 92.9%**	**RED 92.6%**	↘	**92.6% at M4 from 92.9% at M3** **NOAP – 113.7% at M4 from 107.7% at M3** The pressure on older adult inpatient beds is impacted by high levels of delayed transfers of care (19.2% in July) and associated length of stay. Actions to address are aligned to those for DTOCs. **Rectification Plan: to be received Finance & Performance Committee**

6 Recommendations

The Trust Board is asked to;

- Receive the Trust performance as at Month 4
- Note the rectification plans received through Board sub-committees

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REPORT TO (Trust Board)

Enclosure No:12

Date of Meeting:	7th September 2017		
Title of Report:	NSCHT Winter Plan		
Presented by:	Dr Nasreen Fazal-Short		
Author:	Jane Munton-Davies		
Executive Lead Name:	Dr Nasreen Fazal-Short	Approved by Exec	☐

Executive Summary:	Purpose of report	
In response to the NHSI letter of 14th July where expectations where outlined for CCG's to build resilience for the coming winter, NSCHT has considered the themes identified and produced the attached winter plan. This addresses both internal and external actions and will feed into the comprehensive winter plan that is being developed by the A&E delivery board. The Trust has an active role in the system wide Winter Planning group and will support the submission of a strong and credible plan for the coming months.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	✓ To enhance service user and carer involvement.☐ ✓ To provide the highest quality services x☐ ✓ Create a learning culture to continually improve.☐ ✓ Encourage, inspire and implement research & innovation at all levels.☐ ✓ Maximise and use our resources intelligently and efficiently. x☐ ✓ Attract and inspire the best people to work here.☐ ✓ Continually improve our partnership working. x☐		
Risk / legal implications: Risk Register Ref	A key risk to delivering the winter plan for the NOAP directorate relates to staffing requirements should additional bed capacity on ward 4 be required. *Cross reference Directorate risk number 972 (staffing)*		
Resource Implications: Funding Source:	Should additional surge capacity be required for EMI assessment in the health economy there will be an opportunity to provide further beds on ward 4 (up to 20 beds in total). To enable this an agreement will need to be made with commissioners regarding funding and a plan on recruitment of suitable staff.		
Diversity & Inclusion Implications: (Assessment of issues connected to the	The provision of a strong winter plan will ensure that the population of older people in the locality will not be disadvantaged or discriminates against by		

Equality Act 'protected characteristics' and other equality groups)	reason of age or mental health need.
Recommendations:	For assurance

Executive summary

All A&E Delivery Boards are required to submit comprehensive winter plans (covering 01 December 2017 up to Easter 2018). In a letter from NHSI on 14th July the priorities were set out for CCG's and covered the following themes:

- Wider system preparation
- Front door (A&E)
- Flow
- Discharge
- Better planning for peaks in demand over weekends and bank holidays

A number of these areas are system wide and relate to organisational partners and a number require NSCHT to develop our own internal plans to manage times of surge and pressure in the coming winter months.

This paper describes the NSCHT response to the winter planning requirements and in particular addresses expectations on:

1) Delayed Transfers of Care
2) Seasonal influenza planning
3) Demand and capacity planning
4) Winter Pressures Action Plan

1) Delayed Transfers of Care

Delayed transfers of care have a significant impact on flow across the health economy and can lead to service inefficiencies and poor patient experience. On the 24th August, NSCHT presented a DTOC paper to the A&E Delivery Board. This was well received by the board, and partners committed to being accountable for escalation of concerns where actions are not taken to support flow in a timely manner.

For NSCHT there are internal pressures around Delayed Transfers of Care and external areas that require support from partner agencies, such as progression of Direction on Choice Protocol, timely access to assessment and rapid approval of funding arrangements.

The highest proportion of delays is from within the NOAP and adult inpatient directorates. Within the older people's wards DTOCs are currently running at 19%. The 3 top reasons for delays at present are **Care Home Placement** (33.5%) followed by **Choice** (31.7%) and then **Public Funding** (18.8%)

- **Care Home Placement**

There remain difficulties in accessing specialist placements and waiting for providers to come and assess patients. Ward staff emphasise the need to assess in a timely manner and progress is chased on a daily basis.

Further work across the local health economy is required in order to ensure that local provision is adequate to meet the population demands. Where appropriate providers are supported by the Outreach service to "settle" patients into new accommodation and provide initial support to independent providers.

- **Choice Delays**

The legislative framework provides that a patient must have the right to choice of accommodation in a care home or supported living setting, where this is to be arranged by the local authority. However it is also clear that there is not right to remain in hospital when medically fit for discharge while preferred choice is awaited. (Care Act 2014 s30, Care and Support and After-care ; Choice of Accommodation Regulations 2014.

The Care Act (s.25) mandates that that the Trust has a responsibility to offer choices / involve the patient in preparation of a care and support plan (Care Act 2014 s25).

Following discussion at the A&E Delivery Board on 24th August the CCG committed to having the new Direction on choice protocol signed off and ready for implementation on the 1st September. NSCHT will work with partners to train the multi-disciplinary teams around robust application of the process.

- **Public Funding**

During March there was also an agreement from the local Authority and CCG to develop a new role that would help speed through funding decisions related to section 117 funding. This was a welcome development as the agreement was that patients would be discharged to placements with "without prejudice funding" arrangements in place.

We are supporting the development of the role and remain hopeful that this will have a positive outcome for patients whose discharge is delayed due to funding decisions between health and social care. Whilst supportive of the resolution, to some extent this remains outside of the influence of NSCHT.

Patients cannot remain in a hospital bed whilst such decisions are awaited and there are still a number of examples where there are delays between the CCG and social care agreeing what proportion of the funding should be health or social care responsibility.

This matter was escalated to A&E Delivery Board where partners agreed to ensure that "without prejudice placements" were supported and decisions were reached around funding matters without undue delay.

The action plan below reflects the current Trust position on Delayed Transfers of Care:

Action Plan (Internal)

Action	Lead	Timescale for completion	Progress
Implement and roll out "red to green" programme.	Jane Munton-Davies/ Natalie Larvin	complete	• Rolled out to all inpatient areas • Daily reporting in place.
Twice weekly bed management meetings, (Adult)	Natalie Larvin	Ongoing	• To continue
Matron level weekly review (NOAP)	Josey Povey	Ongoing	• Takes place as part of weekly ward managers meeting.
Funding delays escalated to Local Authority and CCG	Jane Munton-Davies/ Natalie Larvin	Immediate escalation	• Progressed on an individual basis.
Implement Choice Policy	Sharon Maguire (CCG)	September 2017	• EIA being completed with Local Health Economy. • Choice letters being finalised. • Cascade Training being planned for September 2017 • Existing policy being implemented until this time.
Care Home Support (NOAP)	Jane Munton-Davies	August 2017	• Support offered through Care Home Liaison and Outreach to provide confidence in complex patient

			transfers.

Action Plan (Partner Agencies)

Action	Lead	Timescale for completion	Progress
Rapid resolution of funding arrangements (Continuing healthcare, Section 117, joint funding, social care funding)	Local Authorities and CCGs	September 2017	• Discussion and agreement required
Implementation and roll-out of Direction on Choice Protocol	CCG (Sharon Maguire)	September 2017	• Finalise policy and agree training plan
Provider Capacity	Local Authority and CCG	September 2017	• Discussion and action plan required
Timely Social Care Assessment	Local Authorities	September 2017	• Dedicated social work support in place for City Social care for Ward 6/7 • Same required for County • Dedicated resource required for Ward 4 from City and County

The following protocol has been developed in NOAP to support the "action" element of red to green.

"Red to Green" Escalation Protocol

This protocol is intended to give a guiding framework to NSCHT services to ensure that timely and appropriate escalation takes place to reduce the risk of patients experiencing days occupying a hospital bed that are of no value to them ("red" days).

It is an operational tool that sits behind the daily "Red to Green" reviews and should be considered in conjunction with the "Rapid Improvement Standard Operating Procedure (SOP) for Red & Green Bed Days".

The following are categories that broadly capture the primary actions that patients are waiting for on a day to day basis:

- Social Work Allocation
- Social Work Assessment
- Section 117 funding process
- Continuing Healthcare Funding Process
- Social care funding approval
- Wards actions
- Care Home to assess
- Care Home capacity
- Patient Choice

Whilst there are likely to be other reasons for delay the areas above tend to be the most common in older people's inpatient services.

The following actions and timescales have been agreed with partners and will form the basis of improved relationships across the health economy, supporting clarity of role and function.

Escalation should only take place if the required actions have not been completed in the agreed timescales and there is a block to them being completed.

Waiting For….	**Expected standard and timescales**	**Responsible for escalation**	**Escalate to ….**	**Contact details**
Social worker allocation	Within 24 hours	Ward Manager	City – Craig Bayliss/Sarah Totten/Ian Clarke County- Christine Wheeler/ Lisa Duncan	**Craig Bayliss** I Strategic Manager – Adult Social Care 01782 231560 craig.bayliss@stoke.gov.uk **Sarah Totten** – Team Manager City Social Care – UHNM – 01782 679141 Ian Clarke Strategic Manager T 01782 238595 ian.clarke@stoke.gov.uk **Lisa Duncan** 07814831637 01782 679141

				Lisa.Duncan@ssotp.nhs.uk **Christine Wheeler** Area Manager Tel: 01782 485069 Mob: 07814831935
Social Work Assessment	Three days from allocation	Ward Manager	City – Craig Bayliss/Sarah Totten County- Christine Wheeler/ Lisa Duncan	**Craig Bayliss** I Strategic Manager – Adult Social Care 01782 231560 craig.bayliss@stoke.gov.uk **Sarah Totten** – Team Manager City Social Care – UHNM – 01782 679141 Ian Clarke Strategic Manager T 01782 238595 ian.clarke@stoke.gov.uk **Lisa Duncan** 07814831637 01782 679141 Lisa.Duncan@ssotp.nhs.uk **Christine Wheeler** Area Manager Tel: 01782 485069 Mob: 07814831935
Section 117 funding	To be considered by CCG within 48 hours of assessment and paperwork completion	Ward Manager	Ron Daley	Lead Commissioner for Mental Health and Specialised Groups Stoke-on-Trent Clinical Commissioning Group, North Staffs Clinical Commissioning Group Tel: 01782 298279(F/N 8279) Fax: 01782 298190(Safe haven) Email: ron.daley@northsstaffordshireccg.nhs.uk
CHC Funding	To be considered outside of panel where	Ward Manager	Elaine Churchman	Elaine Churchman Mental Health Continuing Health & Complex Case Manager

	possible.			Tel No. 0300 404 2999 Direct dial 01782 298163 Mobile no. 07545422186 clinical.cover@nhs.net
Social Care funding	Within 24 hours of assessment completion	Ward Manager	City – Craig Bayliss/Sarah Totten County- Christine Wheeler/ Lisa Duncan	**Craig Bayliss** I Strategic Manager – Adult Social Care 01782 231560 craig.bayliss@stoke.gov.uk **Sarah Totten** – Team Manager City Social Care – UHNM – 01782 679141 Ian Clarke Strategic Manager T 01782 238595 ian.clarke@stoke.gov.uk **Lisa Duncan** 07814831637 01782 679141 Lisa.Duncan@ssotp.nhs.uk **Christine Wheeler** Area Manager Tel: 01782 485069 Mob: 07814831935
Ward actions	Same day actions and decisions	Ward Manager	Matron	Matron
Care Home to assess	Within 3 days	Ward Manager	Home Manager/ Social Worker	Individual Care Home Manager
Care Home capacity	Escalate to Ward Manager/ CCG/ Social care if no capacity	Ward Manager	Matron/ Social Worker	Matron/ Social Worker

Patient choice	Follow Direction on Choice Protocol	Ward Manager	Matron/ Social Worker	Matron/ Social Worker
Care package at home	If not sourced within 48 from assessment completion	Ward Manager	Social Care	**Craig Bayliss** I Strategic Manager – Adult Social Care 01782 231560 craig.bayliss@stoke.gov.uk **Sarah Totten** – Team Manager City Social Care – UHNM – 01782 679141 Ian Clarke Strategic Manager T 01782 238595 ian.clarke@stoke.gov.uk **Lisa Duncan** 07814831637 01782 679141 Lisa.Duncan@ssotp.nhs.uk **Christine Wheeler** Area Manager Tel: 01782 485069 Mob: 07814831935

2) Seasonal influenza

NSCHT has an influenza plan to support both the prevention and management of influenza. There is a target to vaccinate 75% of staff this year. This was achieved last year and the Trust is confident in meeting this target again for the coming year.

Patients are being encouraged to access flu clinics for vaccination and staff will support patients to access appointments if required. In-patients will be screened for uptake and flu vaccinations will be administered where appropriate.

North Staffordshire Combined Healthcare

Seasonal Flu Campaign 2017/2018

RAG	Recommendation	Action	Completion date	Lead Person	Comments
	Order vaccines dependant on agreed Denominator with P&W	Order vaccines with team Prevent once costs agreed	22/08/2017	Amanda Miskell	Awaiting arrival at Team Prevent for distribution
	Raise awareness among staff and offer vaccination training	Infection Prevention & Control Team training and Communications	30/09/2017	Amanda Miskell/Mark Fletcher	Materials ordered
	Promote the start of the flu campaign and offer opportunity for staff to have the vaccine	"Feel Good Friday" Event with Team Prevent available to offer advice and perform vaccinations	01/10/2017	Dan Hooper (Team Prevent)	
	Comply with NSCHC policy with regards to medicine management and extended staff roles.	Formalise and complete Flu Patient group Direction (PGD)	08/09/2017	Louise Jackson/Amanda Miskell	PGD ready for sign off by Medical Director
	Consider extending the storage of flu vaccinations into Pharmacy as well as Dragon Square and Ward 5.	Order fridge and amend PGD	22/08/2017	Louise Jackson	Extra fridge ordered and delivered funded from Flu campaign budget
	Prepare vaccinators for role	Vaccinator training to be delivered by IPC team	30/09/2017	Amanda Miskell	Dates booked for August and September
	Budget for financial cost of purchasing "injecting arms"	Raise Purchase order and approve	22/08/2017	Amanda Miskell/Fay Smallman	Completed

	Competency sign off for vaccinators	Vaccinator Competence assessment October 2017	31/10/2017	Dan Hooper (Team Prevent)	
	Collaborative working across teams with OH "Team Prevent" flu campaign	Team Prevent to organise core clinics across the trust	31/08/2017	Dan Hooper (Team Prevent)	All clinics have been scheduled
	Data collation	Team prevent will receive all forms completed by their vaccinators. NSCHT flu vaccinators will collate and distribute this data supported by Fay Smallman.	31/03/2018	Alex Shaw (Team Prevent)	All completed consent forms obtained by NSCHT vaccinators are to be delivered to Fay Smallman for her to collate & deliver to Team Prevent
	Check all Cool boxes with medicool packs to maintain cold chain for vaccines	IPCT to check and store	22/08/2017	IPCT	Completed
	Accessibility and awareness	Reminder about flu clinics and roving vaccinators	31/12/2017	Comms	
	Leadership and accountability	Promote clinics through CEO Blog and the importance of receiving the jab for patient safety	31/12/2017	Comms	
	Leadership and accountability	Flu fighters information leaflets to be attached to October 2016	31/10/2017	Kerry Smith/Amanda Miskell	

		payslips			
	Myth Busting and role modelling	Launch of flu clinics with photos taken at first senior meetings of staff receiving jab – reminder about getting the jab & flu myth of the week	18/10/2017	Vaccinators/ Comms	
	Myth Busting and role modelling	Flu page in Comms/SID promoting clinics, myth busting, hand hygiene and featuring a chat with DIPC/IPCT about the importance of getting the jab and pics of some key staff having received the jab	Nov-17	Comms	
	Leadership and accountability	Include remaining flu clinic dates and reminder to staff about their responsibility to protect patients and service users – thank staff who have had their jab	30/11/2017	Comms	
	Leadership and accountability	Still time to beat flu this winter - Further reminder of remaining clinic dates & flu myth of the week	01/12/2017	Comms	

	Leadership and accountability	Final reminder from Caroline through CEO Blog of flu clinics	01/12/2017	Comms	
	Leadership and accountability	Time's running out to get your jab! – Promote final few clinics & flu myth of the week	12/12/2017	Comms	
	Awareness, accountability and acknowledgment	Final chance to get your flu jab! - Reminder of final clinics & thank everyone who has had jab	19/12/2017	Comms	

3) Demand and Capacity

The winter plan has for NSCHT has been developed using intelligence from previous year's activity and has been adjusted to take into account current system pressures and amended structures. This includes the refocussed discharge to assess model and shifts in assessment demand to outside of the Royal Stoke hospital site.

Over the last few months the staffing structure has been reviewed to include a clinical lead on site and this has supported the focus in meeting the demand in a timely manner. Taking into consideration the demand from October to March last year the capacity in the service should enable us to meet winter pressures demand.

Demand in assessments to identify and transfer patients to ward 4 has put an additional pressure on the team; however this has been mitigated by a revised protocol for transfer in conjunctional with ward 4 staff.

In 2016/17 Inpatient capacity for older people (wards, 4, 6 and 7) was able to match demand. Arguably without the impact of delayed transfers of care (DTOCs), this would still be the case this year. However, with DTOC's running at 19% in older people's services this leads to a silting up of the system and a subsequent impact on system flow. At the present time the Royal Stoke site has a deficit of 17 patients who require an EMI assessment facility to enable discharge. Whilst these will not all be appropriate for the Harplands site there is clearly a current demand for dementia assessment beds.

There is a potential option to increase capacity on site on ward 4 from 15 beds to 19 beds. This will require the completion of a business case, negotiation with commissioners and the mitigation of the risk related to recruiting staff.

The chart below captures the key NSCHT services that support winter pressures and details demand, capacity, variance and any relevant mitigations.

Service	Currency	Forecasted C/D/V	Oct	Nov	Dec	Jan	Feb	Mar
RAID	Hours	Capacity	250 referrals per month	250 referrals per month	250 referrals per month	250 referrals per month	250 referrals per month	250 referrals per month
	7am-11pm	Demand	253 referral	263 referral	246 referrals	295 referrals	260 referrals	293 referrals
		Variance	3 referrals	13 referrals	+4 referrals	45 referrals	10 referrals	43 referrals
Mitigation/s	• Prioritisation will be given to supporting ward 4 flow and responding to referrals from emergency portals and meeting 1 hour target. • Streamlined transfer process to support transfer within 24 hours of referral.							
Net Position			-3	-13	+4	-45	-10	-43
Complex Patients Ward 6	Beds 15	Capacity	15	15	15	15	15	15
		Demand	15	15	15	15	15	15
		Variance	0	0	0	0	0	0
Mitigation/s	• Red to Green /SAFER patient flow • Home first principles to support community early discharge/admission avoidance • Robust implementation of Choice protocol • Rapid escalation protocol in place to support immediate “red to green” actions							
Net position			15	15	15	15	15	15
Dual Care – Ward 4	Beds 15	Capacity	15	15	15	15	15	15
		Demand	15	15	15	15	15	15
		Variance	0	0	0	0	0	0
Mitigation/s	• Red to Green /SAFER patient flow • Home first principles to support community early discharge/admission avoidance • Robust implementation of Choice protocol • Rapid escalation protocol in place to support immediate “red to green” actions							
Net position			15	15	15	15	15	15
Functional Patients	Beds 20	Capacity	20	20	20	20	20	20

Ward 7								
		Demand	20	20	20	20	20	20
		Variance	0	0	0	0	0	0
Mitigation/s	• Red to Green /SAFER patient flow • Home first principles to support community early discharge/admission avoidance • Robust implementation of Choice protocol • Rapid escalation protocol in place to support immediate "red to green" actions							
Net Position			20	20	20	20	20	20
Crisis Resolution Home Treatment Capacity	Staff	Capacity	35	35	35	35	35	35
		Demand	35	35	35	35	35	35
		Variance	0	0	0	0	0	0
Mitigation/s	• Traffic light system in place to support prioritisation • Liaison and support across the crisis pathway • Staffing flex across crisis pathway to support surge							
Net position			35	35	35	35	35	35
Health based place of safety	24 hour place of safety	Capacity	1 place (24 hours)	1 place (24 hours)	1 place (24 hours)	1 place (24 hours)	1 place 24 hours)	1 place (24 hours)
		Demand (number of referrals)	42	19	33	29	16	33
		Actual Usage	28	15	24	24	14	23
		Variance	-14	-4	-9	-8	-2	-10
Mitigation/s	• Demand is highly variable – alternative provision is sought from Stafford if not available on site.							
Net Position			-14	-4	-9	-8	-2	-10

4) <u>Winter Pressures Action plan</u>

In the following months NSCHT will engage fully in the system wide planning sessions and ensure that changes in demand or surge are responded to proactively. The Trust will also ensure that capacity and demand modelling is reviewed and adjusted should there be any significant changes in the system during this time. In advance of winter the following assurances can be given around the Trust's actions:

- Focus on length of stay to ensure headroom capacity prior to Christmas period

- Implementation of "red to green" programme and rapid escalation to minimise blockages and support flow.
- Staff teams / resources to be used flexibly in order to meet surge demand.
- Additional actions to support capacity and flow as below:

Action	**Purpose/Impact**	**Lead**
Daily attendance by RAID at the CDU meetings to identify and pull suitable patients for RAID, Outreach or Ward 4.	To identify MFFD patients who may be suitable for Ward 4 or Outreach. Ensure effective navigation/signposting through MDT discussion. Facilitate timely discharge/step-down.	Phil Wardle/Leanne Heath Janine Burgess Matron – Josey Povey
Dedicated RAID worker on elderly care to support signposting, early discharge through Outreach / care home liaison or transfer to Ward 4 if appropriate.	Identify patients who are MFFD or coming up to that point within the next 72 hours.	Phil Wardle/ Leanne Heath Matron – Josey Povey
Close working with Track and Triage team to effectively navigate patients to the most appropriate resource.	To minimise delays through eliminating unnecessary hand-offs /re-work.	Phil Wardle/ Leanne Heath Matron – Josey Povey
Focus on LOS and DTOCs on Ward 4 to create capacity leading into Christmas to allow additional headroom. Weekly LOS meetings to address blockages Review of patient information pack. Operational policy in place with clear flow process including early setting of EDD's Implementation of Red to Green programme	Create headroom capacity leading into Christmas period. Ensure rapid escalation of blockages to discharge. Ensure that patients / carers' expectations are managed from the point of preadmission/admission.	Janine Burgess Matron – Josey Povey

RAID team focus on front of house to identify and navigate frequent attenders. Proactive engagement with AEC and working with track and triage to implement "Home First" principles.	To avoid admission into emergency portals/wards	Phil Wardle/ Leanne Heath Matron – Josie Povey
Community CPN's to link with RAID practitioners to alert when care home resident is admitted to track and support discharge. RAID to link with Community teams to enable timely discharge and enhanced support to care homes on discharge.	To provide advice and support to care homes and encourage reassessment in place of ordinary residence. To provide enhanced support through DPCL/Outreach and ICT to manage patients safely in care homes.	Matron – Darryl Gwinnett
Care home physio service to identify opportunities for early supported discharges back to care homes. Relationships with care home providers will be strengthened to reduce the risk of avoidable admissions.	To reduce unnecessary admissions and support early discharge	Andy Powell

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No: 13

Date of Meeting:	7th September 2017		
Title of Report:	Fire Annual Report 2016.17 & Update for 2017 & Fire Policy		
Presented by:	Dr Nasreen Fazal-Short, Acting Director of Operations		
Author:	Mick Daniels, Fire & Security Officer		
Executive Lead Name:	Dr Nasreen Fazal-Short, Acting Director of Operations	Approved by Exec	☒

Executive Summary:	Purpose of report	
North Staffordshire Combined Healthcare NHS Trust (NSCHT) remains committed to providing and maintaining exemplary standards of fire safety in all premises for which it is responsible and to work alongside partners to support these standards in those buildings. The Annual Report from 2016.17 and the update report in 2017 are presented alongside the reviewed Fire Policy with the intention of demonstrating such a commitment and bringing to attention activity and actions in support of the existing arrangements and fire safety standards within the Trust. The reports were approved by the Quality Committee 31st August 2017.	Approval	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	1
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	✓ To enhance service user and carer involvement.☒ ✓ To provide the highest quality services ☒ ✓ Create a learning culture to continually improve.☒ ✓ Encourage, inspire and implement research & innovation at all levels.☐ ✓ Maximise and use our resources intelligently and efficiently. ☒ ✓ Attract and inspire the best people to work here.☒ ✓ Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	The main risk remains related to staff mandatory training on fire. A trajectory is included to achieve compliance.		
Resource Implications: Funding Source:	No additional		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	These have been reviewed in the policy and statements are included.		
Recommendations:	For assurance		

North Staffordshire Combined Healthcare NHS Trust

Fire Safety Report 2016/17

Towards Outstanding

We're on a journey...

CQC Organisational Rating - GOOD

Our main website: www.combined.nhs.uk
Our jobs website: www.discoveryourfuture.co.uk

@CombinedNHS
@CombinedNHSJobs

safe • personalised • accessible • recovery focused

spar

COMPASSIONATE
APPROACHABLE
RESPONSIBLE
EXCELLENT
PROUD TO CARE

Mick Daniels Dip Mgt MICM MIFireE ASMS
Fire Safety and Security Advisor
North Staffordshire Combined Healthcare NHS Trust

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Executive Summary

Period 01/04/16 – 31/3/17

North Staffordshire Combined Healthcare NHS Trust (NSCHT) remains committed to providing and maintaining exemplary standards of fire safety in all premises for which it is responsible.

This report is presented with the intention of demonstrating such a commitment and bringing to attention current arrangements and fire safety standards within the Trust.

The Fire Safety arrangements are the responsibility of the Chief Executive. This is delegated at board level to the Director of Operations. The head of estates and senior estates manager are responsible for the day to day management of the fire safety arrangements. The fire and security advisor is accountable to the head of estates for all matters of fire safety.

Fire safety advice, assessments, training, audits, and investigations are carried out by the fire and security advisor.

The Trust operate from approximately 30 different sites and during the period there have been **29** reported fire and smoking related incidents. There were no serious injuries or deaths reported as a result of these incidents.

Completion of mandatory Fire training was slightly below the Trusts own target and should be a priority to demonstrate the continued commitment to a strong fire safety culture. This is particularly important for staff that have direct patient contact. A training needs analysis based on risk has been completed so that training is relevant and timely; a new e-learning package has been developed in house in liaison with the training department and will be rolled out in July 17.Some groups of staff will not require face to face training for 3 years. Cascade trainers are in place across the Harplands Wards and have assisted in developing a relevant walk / talk / show training checklist session as opposed to an on-line / presentation package. There is an opportunity to increase the numbers of cascade trainers over the next 12 months to cover resource centres.

Specialist training for NSCHT premises Fire Wardens, Duty Senior Nurses and potential Incident Controllers is ongoing.

For smaller sites continuation of the approach to ensure all staff are aware of their responsibilities under the Regulatory Reform (Fire Safety) Order 2005 is emphasised at training sessions. Local procedures are assessed and audited to ensure they reflect those requirements. It is for the responsible persons of all owned/leased NSCHT premises to ensure that fire evacuation exercises take place to test staff knowledge and prove procedures. On wards where full evacuations are difficult a table top / theoretical evacuation is carried out on a more frequent basis.

The Trust had a CQC inspection and no fire related information was requested at the time of the inspections or actions required subsequently following publication of its findings. The Trust is required to ensure a safe and healthy environment (fire), to meet its responsibilities under the Care Quality Commission (CQC) Essential standards of quality and safety Outcome 10: Safety and suitability of premises. This includes maintaining documented evidence to support Outcome 10.

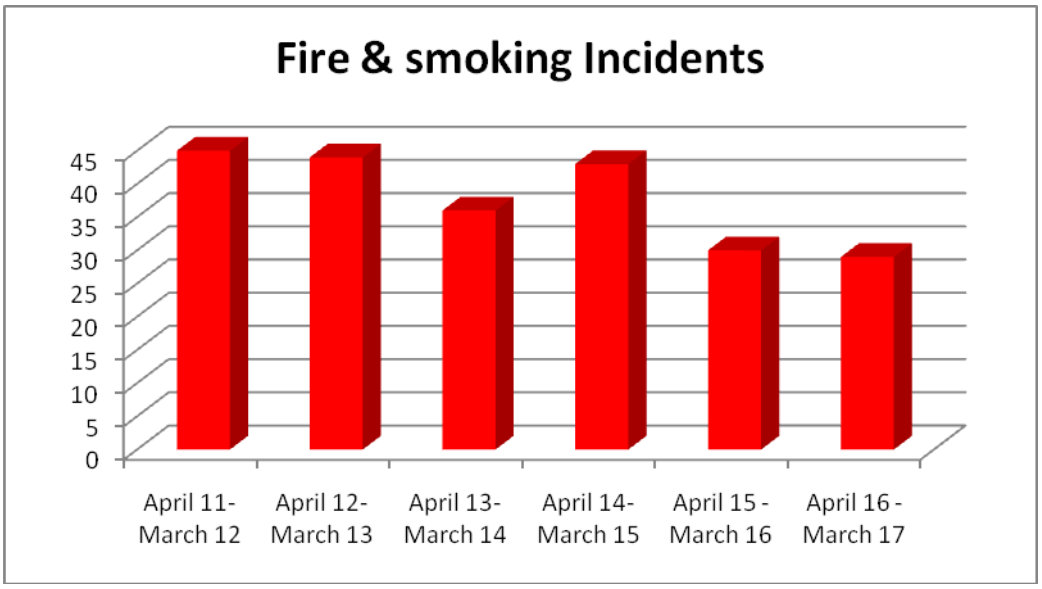
Communications and learning lessons have been provided to staff on specific areas of fire safety either following incidents or as part of prevention activity.

Staffordshire Fire and rescue Service also have attended a Learning lessons session to deliver learning on a fatal house fire in which a Trust patient sadly died. Details of the Fire Services offer of free hazard spotting training – ‘Olive Branch’ training and their Free ‘Safe and secure ‘checks are provided in the Trust mandatory fire training sessions.

NSCHT
ANNUAL REPORT ON FIRE SAFETY 2016/17

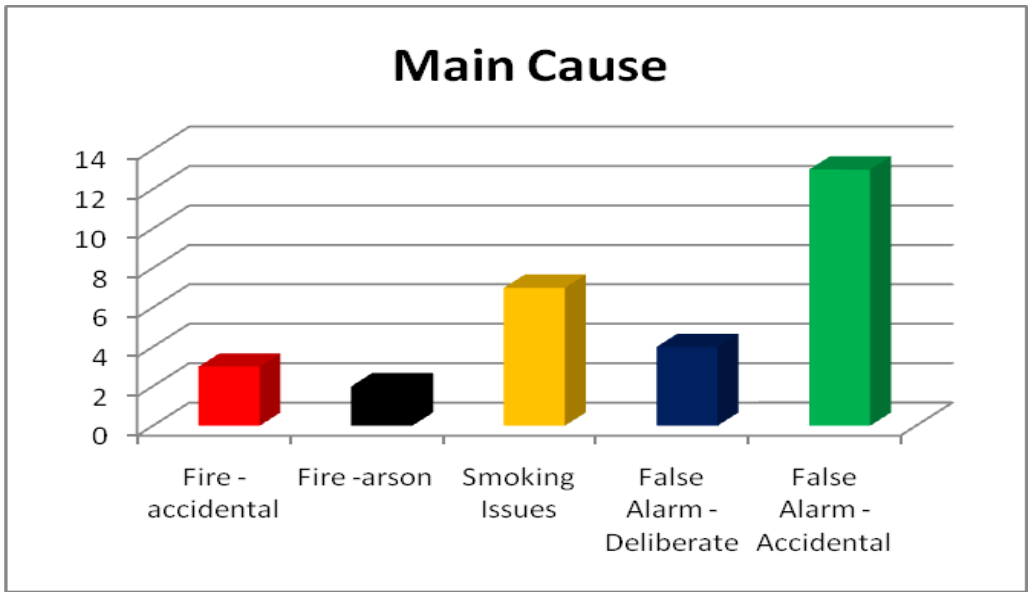
1.0 Fire and Smoking related incidents

There were **29** reported incidents on the Trusts safeguard system



The average number of incidents over the last 6 years is **37** per year – The current trend is still downward with a reduction of 1 incident from the **30 reported** in 2015/16 (*2013 / 14 – new reporting system implemented)

1.1 Main causes



The cause groups are initially identified as Fire or Smoking issues.
From this they are then placed into 5 causes. (As above) Further details of the incident are entered as free text and a severity rating is applied.

1.2 Sub Cause – Root

There are no recorded sub causes – Root within the safeguard system and these are extracted from the free text information provided within the incident reports.
Whilst false alarms account for over half of all incidents (17) the greatest risk of fire can be attributed to patient involvement with the access and control of ignition sources and smoking materials.

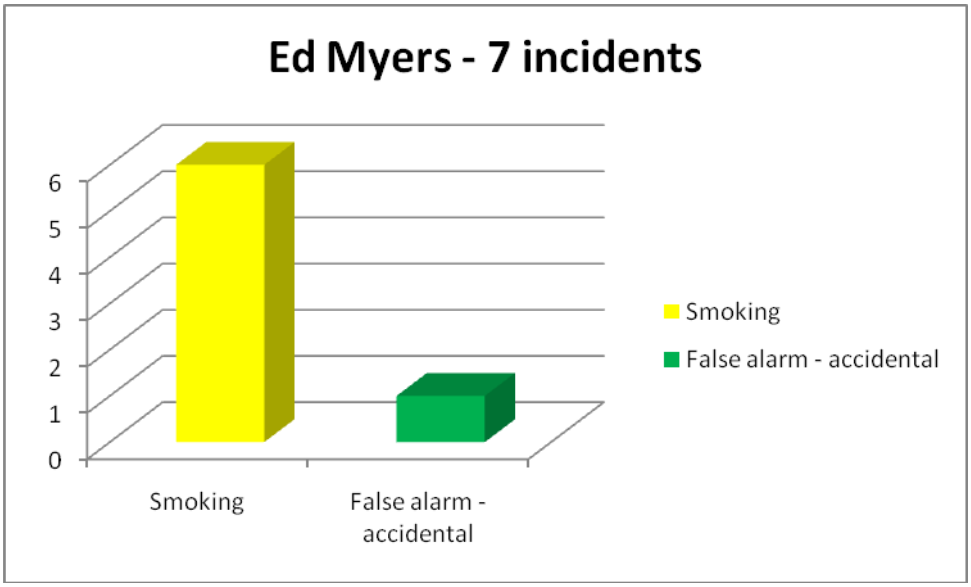
1.3 Fire - Actual

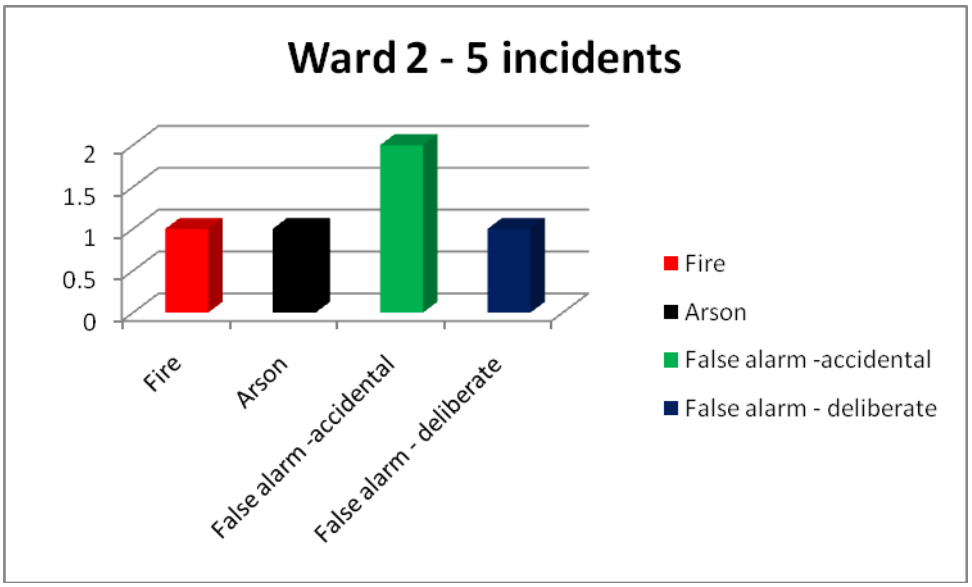
There was a total of 5 fires with 2 being recorded as arson, 2 other incidents can also be attributed to patient involvement. All involved ignition sources. A more detailed fire investigation was completed for a fire on ward 1. The Fire and Rescue Service attended 2 of the incidents. The others were dealt with by staff.

Where **fire** incidents have occurred of this nature there has been a follow up investigation to try and learn and prevent further occurrences. On some occasions ignition sources have been passed to patients from visiting relatives or friends or been brought back onto the Ward following a period of leave. Vigilance, Risk Assessments and knowledge of the patient are essential to prevent such incidents. Ozi-lite external cigarette lighters are provided on all the acute Wards (1 – 3) where the highest risk of a fire starting exists. This means patients should not be in possession of ignition sources. Where incidents of smoking indoors have occurred patients have been reminded of the law that smoking inside public buildings is not permitted and also of the Trust smoking policy as to where smoking is permitted. The incidents of patients smoking indoors at the Edward Myers Unit may be down to a number of factors, including the location and distance of the Unit to the external garden area.

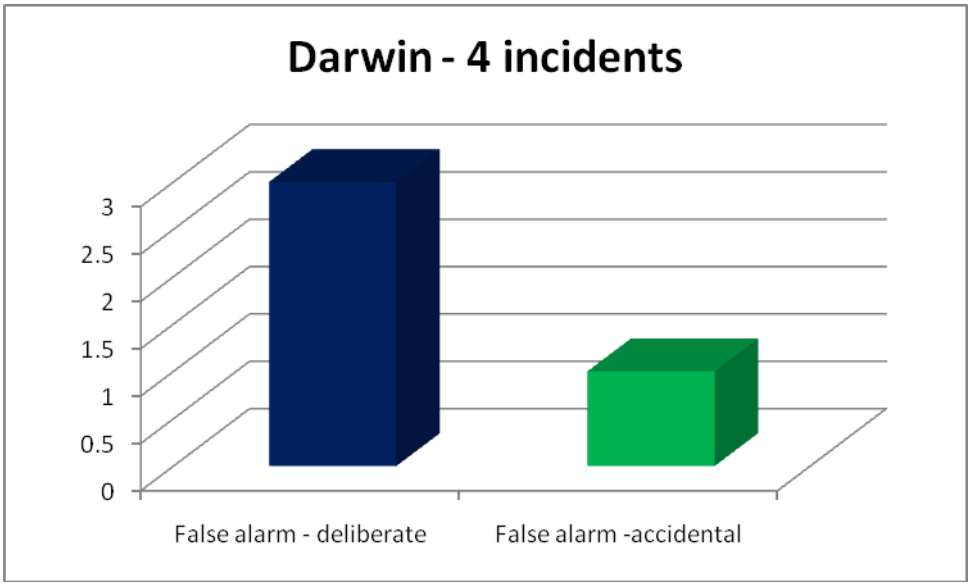
1.4 Departments with 3 or more incidents

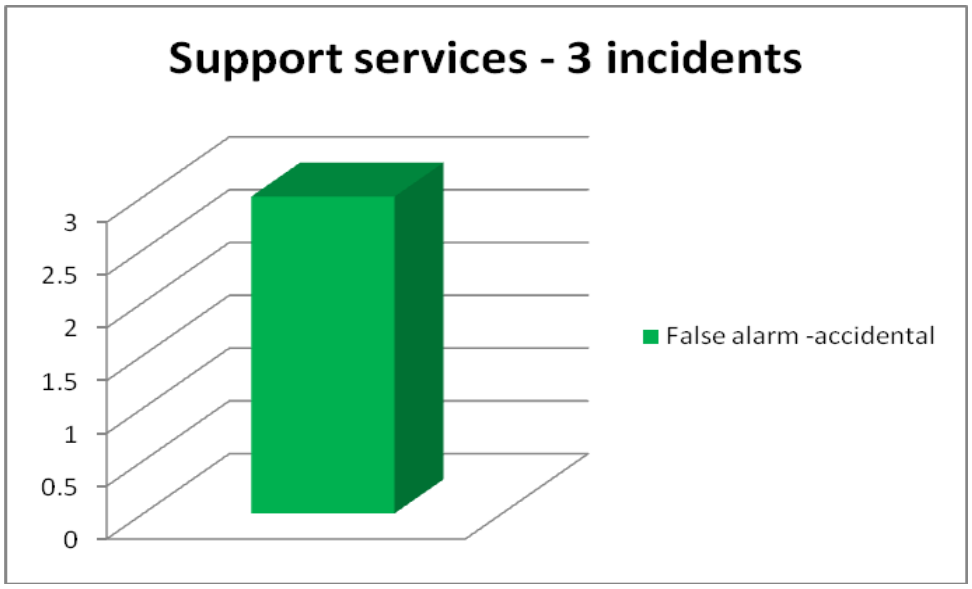
Smoking – patients breaching smoking laws (smoking indoors)



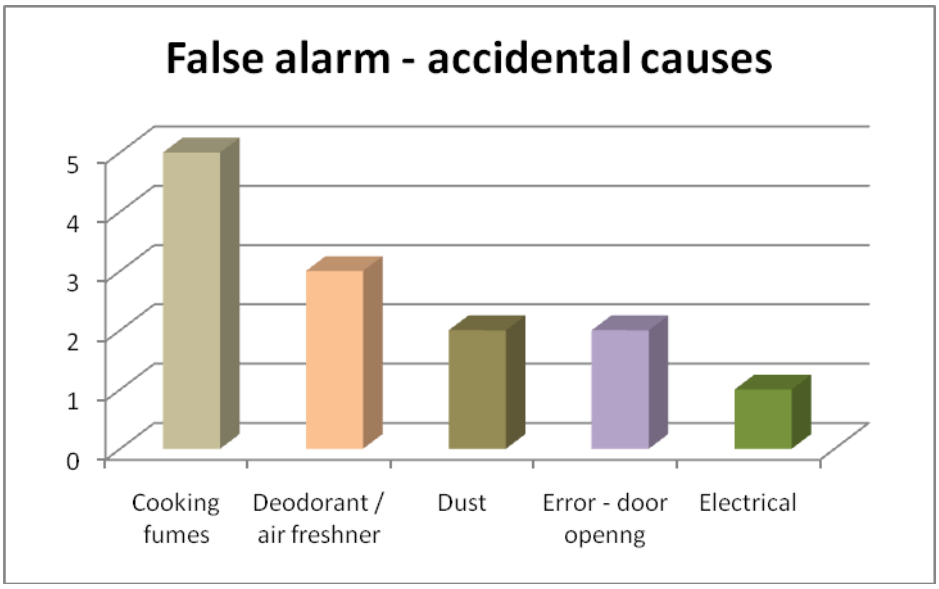


The causes of the four false alarms at the Darwin Centre are three deliberate activations by patients breaking the break glass alarm points. A decision was made to put plastic covers with cable ties over the alarm points as a deterrent. The one accidental cause was by a kettle with steam activating a smoke detector.





2.0 Unwanted Fire signals - False Alarms – Accidental



The recorded 13 accidental False Alarms above could have been prevented, however on a positive side it can act as a drill / evacuation and test local procedures. The majority of these calls were dealt with by staff locally and did not require the attendance of the Fire and Rescue Service.
This reflects well that the Trust are managing and dealing with the False Alarms that it generates. This fits with the policy and model that the Fire and Rescue Service have implemented around their non-attendance at False alarms. There is a safety net for the Trusts in-patient units and a minimum response will be provided during the hours of 20.00hrs to 08.00hrs.

3.0 Staff Training and fire drills

In the current year fire safety training has been delivered as part of the Trusts Mandatory and Corporate Induction training sessions.

Mandatory Training Compliance 2016/17

Overall Compliance rate – 83%

Fire	**83%**

At 31st March 2017 Mandatory training compliance was at 83% across the Trust. Training compliance is monitored by the Training department and each Directorate / team managers / individual. Directorates and Heads of Departments are aware of the non-attendance or over-due personnel for mandatory fire sessions. A training needs analysis has been completed by the Fire Safety Advisor and the new mandatory training requirements for each staff group and role will be in place from 1st April 2017 so that staff are correctly completing the right sessions (face to face and or on-line) and at the correct intervals.

Other Training during the period was delivered to Cascade Fire Trainers, Premises Fire wardens and Duty Senior Nurses.
In future additional training may be required for the premises responsible person who may be required to undertake the role of 'Incident Controller'.

Fire drills are carried a minimum of once per year across all Trust sites. These comprise of a full evacuation of the premises, 30 drills were completed across all Trust sites. The only exception is Wards 1 to 7 at Harplands, the A & T / Telford unit and bungalows 4 & 5 at Dragon Square (Childrens) where it is not a requirement to do a full evacuation drill as the mode of evacuation is based on staged (phased) horizontal movements from compartment to compartment based on a minimum of 2 x 30 minute fire doors away from the incident, so to test this table top and walk through exercises are conducted with staff twice per year. Fire drills at sites that we multi – occupy are completed via the responsible landlord.

4.0 Fire Safety Policy

A current fire policy is in force and was reviewed in 2014 and approved by the Quality committee and Trust Board on 25th September 2014.It is subject to review on 30th September 2017 or sooner if deemed necessary. The fire policy will be reviewed and updated by the fire safety advisor before September 30th 2017.

5.0 Risk Assessments

The 'Regulatory Reform (Fire Safety) Order 2005 'introduced in October 2006 is legislation which consolidates previous fire safety legislation. It covers all aspects of fire safety management in the workplace. The legislation changes the emphasis of compliance from that previously involving fire certification to a risk based assessment undertaken by or on behalf of the owner/occupier.
Fire risk assessments and annual reviews have been carried out at all Trust sites and are subject to a risk based programmed inspection regime, with the highest risk premises: the main hospital and all in- patient sleeping risks having the most frequent inspections, i.e. at least once annually and as required if any circumstances change or following any incidents. All other Trust premises such as Day Centre's / office accommodation / joint partnerships etc. have a less frequent inspection based on the risk and these can be between 18 months to 3 years.

5.1 Key Issues From Risk Assessments

These are contained within each individual Premises Risk Assessment of which a copy is held on the premises site and a copy in the Estates Department. Progress on the significant findings and action plans are subject to risk severity and are discussed and fed back to the area / site responsible person.

Alterations to buildings which involve any fire safety equipment/protection are agreed prior to the works starting and are monitored to the conclusion with certificates and documents to confirm works meet the required standards.

6.0 Fire Safety Monitoring

The monitoring of fire safety compliance is the responsibility of the Head of Estates. The Senior Estates Manager and Fire Safety Advisor meet six monthly with a representative of the Fire Protection department at Staffordshire Fire and Rescue Service to discuss and review all relevant Fire Safety matters. There is also a good relationship with the Fire Services Prevent department with the promotion of their 'Olive branch 'training following a couple of fatal fires in clients homes and the sharing of lessons learned. The Safety Advisor also meets on a monthly basis as part of security role with the Executive Director –Director of Operations who has responsibility for Fire at NSCHT.
In addition a Harplands Fire Safety Group has been formed with representatives from all stakeholders meeting on a quarterly basis to review site Fire Safety matters. Both these groups are reported via the fire safety advisor to the Trust Health , Safety and Wellbeing (HSW) group which meets Quarterly and is chaired by the Director of Nursing.

7.0 Annual Statement of Fire Safety

Each year Chief Executives are required by NHS to confirm compliance with the Department of Health fire safety policy, by applying Firecode standards or some other suitable method in satisfying these arrangements. This endorsement applies to all aspects of fire safety in buildings within their control and I can confirm that NSCHT is in compliance.
The Annual Statement indicates at 2 where significant risks have been identified in the premises fire risk assessment that action plans are put in place to reduce or eliminate the risk – these are site specific. – An example of an action plan is contained in **Appendix 1 – Harplands Hospital**

The requirement to send NHS Estates the annual statement has been withdrawn, however it is recommended the practice remains and records kept locally as an indicator of compliance with legislation and codes of practice, alternatively improvement programmes are in place.

***See pages 10 -11 below for a copy of the annual statement.**

8.0 Conclusion

There has been a steady downward trend in reported Fire and Smoking related incidents. Half of the incidents were false alarms. There were 5 fires of which none spread from the room of origin and were either dealt with by the prompt actions of staff or by attendance of the Fire and Rescue Service. There were no serious injuries or deaths within Trust properties. Staff demonstrate a positive and responsible attitude to Fire Safety and are pro-active to try and prevent incidents occurring or to learn when incidents have. Checks, testing regimes and assessments are in place to ensure a good standard of Fire Safety is maintained by staff and in Trust properties. Training compliance was below the Trust target however a new e-learning package and Learning Management system will be live from July 2017 so this should increase compliance rates.

Annual Statement of Fire Safety 2016 - 17

NHS Organisation Code: RLY	NHS Organisation Name: North Staffs Combined Healthcare NHS Trust	
I confirm that for the period 1st April 2016 to 31st March 2017, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (*please tick the appropriate boxes*):		
1	There are no significant risks arising from the fire risk assessments.	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment.(This is in premises fire risk assessment- Action Plans)	Yes
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks.*	N/A
*Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date: N/A		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? (Delete as appropriate) If Yes - Please outline details of the enforcement action in Annex A – Part 1.	No
5	Does the organisation have any unresolved enforcement action pre-dating this Statement? (Delete as appropriate) If Yes Please outline details of unresolved enforcement action in Annex A – Part 2.	No
AND 6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.	Yes
Fire Safety Officer	Name: Mick Daniels	
	E-mail: Mick.Daniels@northstaffs.nhs.uk	
Contact details:	Telephone: 01782 275083	
	Mobile: 07720337403	
Chief Executive Name:	Caroline Donovan	
Signature of Chief Executive:		
Date:		
Completed statement to be kept on file as evidence of good practice and included in any annual report.		

ANNEX A

Part 1 – Outline details of any enforcement action during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.
None - N/A
Part 2 – Outline details of any enforcement action unresolved from previous years, including the original date, and the action the organisation has taken so far. Include any outstanding proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.
None - N/A

NHS Organisation Code: RLY

NHS Organisation Name: North Staffs Combined Healthcare NHS Trust

Date: 1/8/2017

Appendix 1 – example of Action plan following Fire Risk asessments being completed – Harplands Hospital

Harplands Hospital						
Action Tracker for Fire Risk Assessment 2016						
Area	**No**	**Description**	**Risk**	**Responsibility**	**Completed**	**Comments**
Common Internal Access Areas and External Roadways	13	Reception desk - ensure all portable items within the Reception desk office have been PAT tested	6	Carillion	Complete	
	14	Level 0 - ASIST office - domestic type extension lead in use under desk - PAT tested, but not acceptable for healthcare setting	6	Carillion	Complete	
	15	Voluntary groups/volunteers (ASSIST etc.) - Ensure they have received appropriate induction/training as required.	9	Training Dept	complete	
	16	Outside Hazelhurst entrance - cars parking close to entry/exit point - in non-designated parking areas.	9	Head of Estates/Carillion		Potential Variation - awaiting approval
Roof Spaces	3	Carillion/Estates to draw up roof space plans to show fire compartments-escape hatches/routes	3	Carillion	Complete	
	5	Emergency escape ladders should be provided from all the access hatches that can be deployed from within the roof space to the floor below.	12	Carillion	1 ladder left to fit	Carillion to advise when this is complete
	6	Provide signage on the underside of the hatch (ward side) with wording such as 'escape hatch - ladder could deploy without warning - keep area below clear' CSS surveyor also recommends beacon and sounder activation on operation of the hatch door	12	Carillion	Complete	

	8	Provide fire escape signage in the roof space to indicate the alternative route to the access hatches.	12	Carillion	Complete	
	11	An audit of selected areas of the roof spaces took place. Old pipework has been removed and new pipework has been installed and there has been disturbance at where the pipes penetrate fire compartment walls and floors. This has been fire stopped and sealed by an approved contractor. Certificates of compliance are required from the contractor to confirm the work has been completed in line with the manufacturer's instructions and to the right standards to achieve the necessary degree of fire protection.	3	Carillion	Complete - copy and report supplied to Estates.	
Carillion Facilities Dept	12	Fire doors to office opposite Reception and kitchen door- wedges were observed propping open the doors with no one present in either room - remove from use	9	Carillion	Complete	
	13	Heat detector covered up in catering wash room. Cover removed during inspection and details of unauthorised hot works having been carried out by contractor	16	Carillion	Complete	
	14	Laundry room fire doors - a single leaf was being held open by a manual foot lock. In the event of a fire alarm this will not release automatically. If required to be left open it should be operated by a detent linked into the fire warning system of a Dorguard	9	Carillion	Complete	
	15	Laundry/Dryer - Mop room (20) fire door is not closing properly onto rebate	9	Carillion	Complete	

	16	Caravan unit - an appropriate fire action notice should be displayed adjacent to the break glass call point	6	Carillion	Complete	
	17	Plant room - assess the level of storage/paints and maintain safe access/egress	6	Carillion	Complete	
	18	Cross corridor fire doors - CSS.D.15 - cabin hooks are present on the doors, these should be removed. If these doors are required to be left open then they should be operated by a detent linked into the fire warning system or a Dorguard unit	9	Carillion	complete	
	19	Service Yard - behind the caravan unit/porta cabin bags of shredded paper are being stored in a metal basket up against the main building. These should be removed and combustible waste should be stored in an appropriate container, preferably secured.	8	Carillion	Complete	
Management Office	21	Corridor area outside the photocopier room - combustible storage was observed on top of the metal cupboards - this should be removed.	8	Management Suite Staff	Complete	
		Fire door at the top of the rear escape staircase (adjacent room 16/17). The nearest break glass alarm point is beyond this door and any staff activating this alarm will be unable to return into the corridor to assist in evacuation, check rooms etc. because the door has a lock on its outside face. The lock should be exchanged for a thumbturn device on the outside face.	9	Carillion	Complete	
	23	Store Room at mid corridor point - security issue. It was observed that confidential files were being stored on	9	Management Suite Staff		Corridor managers – staff to review

		shelving in this room. Although this door is locked the access is on a master key.				
Central Therapies	14	Weights/exercise room - domestic type extension lead in use. Replace or remove.	6	Central Therapies/Carillion	Complete	
	15	Gym Store - No evidence of PAT test on AIWA CD player	6	Carillion	Complete	
	16	Cross corridor fire door, LIA.D.05. Dorguard unit not required – remove	6	Carillion	Complete	
	17	Garden area - wooden shed - not secure - secure with padlock	6	Central Therapies	Complete	
	18	Physio store - No evidence of PAT testing fan in store	6	Carillion	Complete	
	19	In patient consultant room (09) LIA.D54 - Dell monitors and base units - no evidence of PAT test	6	Carillion	Complete	
	20	OT Kitchen (15) No evidence of kettle or freezer being PAT tested.	6	Carillion	Complete	
	21	Staff kitchen (14) - Swan toaster and Hinari - no evidence of PAT test	6	Carillion	Complete	
	22	Staff Kitchen fire door LIA.D14 - door does not close fully onto rebate	8	Carillion	Complete	
Adult Psychology/ Liaison Psychiatry	14	Escape staircase lobby from Academic Suite - the door housing the IT server was observed as open. This should be secured closed and a suitable sign attached 'Fire Door Keep Locked'	8	Carillion	Complete	Door locked and sign fitted 24/03/16
	15	Acute Home Treatment Room (15) LIA.D15 self closing door not closing properly onto rebate	8	Carillion	Complete	
	16	Raid Office - White kettle - no evidence of PAT test	6	Carillion	Complete	
	17	Reception Lobby - Car park log in device on wall plugged in. Does this need Pat Testing?	6	Carillion	Complete	
	18	Room 29, End corridor - 1 Dell monitor/base unit - no evidence of Pat test	6	Carillion	Complete	

Hazelhurst Unit	13	The issue of parked cars immediately outside the unit entrance still exists - access and egress for emergency vehicles, fumes, potential fire risk	9	Unit Staff/Carillion		Potential Variation - awaiting approval
	14	Observations during inspection, temporary fan heaters in use whilst the main heating system is being upgraded. Unit staff to ensure all heaters are switched off when areas are unoccupied.	9	Unit Staff	Complete	
Academic Suite	13	It was observed that waste paper and cardboard was being stored in the photocopier room - this should be removed and practice cease	6	Academic Suite Management Staff	Complete	
	14	Door wedges used to hold back fire doors in dead end corridor section. These should be removed and if the doors are required to be left open then a detent linked into the fire warning system or a Dorguard unit should be provided.	8	Academic Suite Management Staff	Not required – staff control	BB to provide options to Dept. Manager
Ward 1	22	Ward Manager's Office - black leather effect chair showing signs of wear and tear – replace	4	Ward Manager	complete	
	23	Ward Office - confirm that charger for PITS has been PAT tested	6	Carillion/Ward Manager	Complete	
	24	Ward Office - 1 pictogram fire action notice required next to fire alarm point	4	Carillion	complete	
	25	Kitchen - confirm that toaster has been PAT tested	6	Carillion	Complete	
	26	Dining Room - A yellow chair is ripped exposing the inner foam. Replace	6	Ward Manager	complete	
	27	Dining g Room - A charger/Radio requires confirmation of PAT testing.	6	Carillion	Complete	

	28	Fire doors held back on crucifix appear to close quickly when tested - adjust so they meet EFA 2015/006 dated 03/12/15 - all automatic self closing fire doors should be checked and adjustment should be made, where appropriate, to lengthen the closing times to the higher end of the tolerance in patient areas to an agreed time.	9	Carillion	Complete	All doors checked monthly and above 3 second minimum. Times for doors on Wards 4, 5, 6 & 7 to be increased to 20 seconds.
	29	Electric cupboard - Room 35 remove 2 rolls of flooring material	6	Carillion	Complete	
	30	Provide support to staff to complete mandatory fire training/ward cascade fire training as required over the next 12 months	4	Ward Manager/cascade trainer/Fire Safety Advisor	Complete	on-going - cascade
Ward 2	22	Store Room - general tidy up and remove damaged/condemned items	4	Ward manager	complete	
	23	Kitchen - confirm that toaster has been PAT tested	6	Carillion	Complete	
	24	Dining Room - Confirm radio has been PAT tested	6	Carillion	Complete	
	25	Nursing Office - fire action pictogram notice required by fire alarm point	4	Carillion	Complete	
	26	Fire doors held back on crucifix appear to close quickly when tested - adjust so they meet EFA 2015/006 dated 03/12/15 - all automatic self closing fire doors should be checked and adjustment should be made, where appropriate, to lengthen the closing times to the higher end of the tolerance in patient areas to an agreed time.	9	Carillion	Complete	
	27	Provide support to staff to complete mandatory fire training/ward cascade fire training as required over the next 12 months		Ward Manager/cascade trainer/Fire Safety Advisor	complete	On-going – cascade trainers

Ward 3	23	Rear bottom corridor - double swing fire doors not closing together properly to form a fire resistant barrier - adjustment required	6	Carillion	Complete	
	24	Clinic Room - Confirm LEC mini fridge has been Pat tested	6	Carillion	Complete	
	25	Lounge - confirm large TV has been Pat tested	6	Carillion	Complete	
	26	Resource Room - confirm PC/Printer has been Pat tested	6	Carillion	Complete	
	27	Remove 2 x mattresses stored in Store Room	4	Ward Manager		
	28	Fire doors held back on crucifix appear to close quickly when tested - adjust so they meet EFA 2015/006 dated 03/12/15 - all automatic self closing fire doors should be checked and adjustment should be made, where appropriate, to lengthen the closing times to the higher end of the tolerance in patient areas to an agreed time.	9	Carillion	Complete	
	29	Provide support to staff to complete mandatory fire training/ward cascade fire training as required over the next 12 months	4	Ward Manager/cascade trainer/Fire Safety Advisor	Complete	on-going – cascade trainers
Ward 4	20	Nurse base - heavy duty extension lead in use, Pat tested. Consider installing additional wall sockets as required	4	Carillion	Complete	
	21	Examination Room - confirm if computer monitor and base unit and induction loop system have been Pat tested	6	Carillion	Complete	
	22	Clinic Room - Confirm if the 2 x small fridges have been Pat tested	6	Carillion	Complete	
	23	Fire doors held back on crucifix appear to close quickly when tested - adjust so they meet EFA 2015/006 dated 03/12/15 - all automatic self closing	6	Carillion	Complete	

		fire doors should be checked and adjustment should be made, where appropriate, to lengthen the closing times to the higher end of the tolerance in patient areas to an agreed time.				
	24	Provide support to staff to complete mandatory fire training/ward cascade fire training as required over the next 12 months	4	Ward Manager/cascade trainer/Fire Safety Advisor	Complete	On-going cascade trainers
Ward 5	18	Small Lounge - The fire blanket is hanging from the wall on one screw. Secure with a 2nd screw	6	Carillion	Complete	
	19	Double doors to lounge and Dining Room - it was observed that the doors are being reversed in their use to allow patient access/egress to be maintained i.e., fixed leaf is left in the open position and the self closing leaf is closed. To allow this to be maintained it is recommended that the self closing leaf has a hold back device fitted(Dorguard or mains system) so that in the operation of the fire alarm the leaf will close automatically.	6	Ward Manager/Carillion	Complete	Increase closing time to 20 seconds
	20	Fire doors held back on crucifix appear to close quickly when tested - adjust so they meet EFA 2015/006 dated 03/12/15 - all automatic self closing fire doors should be checked and adjustment should be made, where appropriate, to lengthen the closing times to the higher end of the tolerance in patient areas to an agreed time.	9	Carillion	Complete	
	21	The Ward Manager's Office and Ward Clerks Office are regularly required to be open which results in the doors being wedged. To	6	Ward Manager/Carillion	Complete	

		prevent this practice it is recommended that hold back devices (Dorguard or mains) are fitted to the doors.				
	22	A number of patients are often smokers, currently the staff control and manage patients ignition sources. It may be advisable to provide an external wall mounted Ozilite ignition source similar to the other wards to further reduce the risk of patients retaining ignition sources.	4	Ward Manager/Carillion	Not progressed	Staff control
	23	Provide support to staff to complete mandatory fire training/ward cascade fire training as required over the next 12 months	4	Ward Manager/cascade trainer/Fire Safety Advisor	Complete	on-going - cascade
Ward 6	20	Store Room R47 - extension lead still in use. No evidence of Pat Testing	6	Carillion	Complete	
	22	Large Lounge - Confirm TV has been Pat tested	6	Carillion	Complete	
	23	Kitchen - confirm that fridge has been PAT tested	6	Carillion	Complete	
	24	Activity Room - door to this room was being wedged open. If this door is required to be open during use for patient access/egress recommend that a holdback device (Dorguard or mains) is fitted	6	Ward Manager/Carillion	Complete	
	25	Patient portable electrical equipment must be Pat tested	6	Ward Manager	Complete	Staff aware
	26	Small Lounge - confirm TV and DVD player are Pat tested	6	Carillion	Complete	
	27	Clinic Room - confirm fridge has been Pat tested	6	Carillion	Complete	
	28	Double corridor fire doors by bedroom 1 - Dorguard unit on left leaf is not releasing the door correctly. Catching on the floor. Adjust as required	6	Carillion	Complete	
	29	Office/Seminar Room - confirm	6	Carillion/IT Dept	Complete	

		photocopier/printer have been Pat tested				
	30	Sitting Room double fire doors out of alignment and not closing correctly at top of doors, adjust as required	9	Ward Manager/cascade trainer/Bank Staff Co-Ordinator	Complete	
	31	Sitting Room - confirm large TV is Pat tested	6	Carillion	Complete	
	32	Double corridor fire doors by bedroom 15 - Dorguard unit on left leaf is not releasing the door correctly. Catching on the floor. Adjust as required	9	Carillion	Complete	
	33	Fire doors held back on crucifix appear to close quickly when tested - adjust so they meet EFA 2015/006 dated 03/12/15 - all automatic self closing fire doors should be checked and adjustment should be made, where appropriate, to lengthen the closing times to the higher end of the tolerance in patient areas to an agreed time.	9	Carillion	Complete	
	34	Provide support to staff to complete mandatory fire training/ward cascade fire training as required over the next 12 months	4	Ward Manager/cascade trainer/Fire Safety Advisor	Complete	on-going - cascade
Ward 7	18	Ward Manager's Office - black leather effect chair Fan heater not Pat tested	6	Carillion	Complete	
	19	Fire doors held back on crucifix appear to close quickly when tested - adjust so they meet EFA 2015/006 dated 03/12/15 - all automatic self closing fire doors should be checked and adjustment should be made, where appropriate, to lengthen the closing times to the higher end of the tolerance in patient areas to an agreed time.	9	Carillion	Complete	
	20	Electric cupboard of crucifix (13 - W7.D.43) has	4	Carillion	Complete	

		extension lead on floor - although not observed as in use it has not been Pat tested				
	21	Throughout ward - the ward has had new curtains and drapes provided since the last assessment. There is no evidence that they comply to any standards of fire retardency.	6	Ward Manager/Carillion	Complete	
	22	Provide support to staff to complete mandatory fire training/ward cascade fire training as required over the next 12 months	4	Ward Manager/cascade trainer/Fire Safety Advisor	Complete	on-going - cascade
ECT	11	Confirm that portable fan in corridor to treatment room has been subject to a Pat test	6	Carillion	Complete	
EMU	28	First Floor - Fridge in Sluice Room not Pat tested	6	Carillion	Complete	
	35	First Floor - Remove Dorguard unit to door to day Room. If door needs to be open provide an automatic self closing device interlinked to the fire alarm system	6	Carillion	Complete	MW Request to be raised
	36	Ground Floor area - Photocopier lobby - Rexel shredder no evidence of Pat test	6	Carillion	Complete	
	37	Ground Floor area - Photocopier lobby - general housekeeping in area, waste/rubbish bags on floor. Coat rack now in position/use - coats covering the door release button	9	Unit manager/staff	Complete	
	38	Ground Floor - Kitchen door - Dorguard unit attached is not working correctly and a waste bin was observed to be holding the door back.	9	Carillion/Unit manager/Staff	Complete	
	39	Ground Floor - Secretary's Office, domestic type extension lead plugged in - Pat tested but not acceptable for healthcare setting	6	Carillion	Complete	
	40	Ground Floor - Room OUT	6	Carillion	Complete	

		25 (door MYG.D.36). IT equipment - no evidence it is Pat tested.				
	41	Ground Floor - Room OUT 20 (door MYG.D41) Rest Room - no evidence that fridge is Pat tested.	6	Carillion	Complete	
	42	fails open on activation of the fire alarm (door secured and on escape route)	6	Carillion	complete	
	43	First Floor - Family Lounge, the arm on the small blue chair is ripped exposing the filling. Repair or replace.	4	Unit manager/staff	Complete	
	44	First Floor - Electrical cupboard 20 (door MYF.D41) gap in floor slab where IT cables penetrate requires filling	6	Carillion	Complete	
	45	First Floor - corridor 60 minute fire door(door MYF.D44) smoke seal is damaged and coming away at bottom edge.	9	Carillion	Complete	
Pharmacy & Pharmacy Office	2	Means of escape - following recent incident where staff were locked in the Pharmacy unit due to failure of lock - provide satisfactory solution that provides access/egress and maintains security + add lock to routine checks/servicing/replacement programme	9	Carillion	Complete	Due 4th April 2016

North Staffordshire Combined Healthcare NHS Trust

Fire Safety update report 2017/18

Towards Outstanding
We're on a journey...
CQC Organisational Rating - GOOD

Our main website: www.combined.nhs.uk
Our jobs website: www.discoveryourfuture.co.uk
@CombinedNHS
@CombinedNHSJobs

safe • personalised • accessible • recovery focused
spar

COMPASSIONATE
APPROACHABLE
RESPONSIBLE
EXCELLENT
PROUD TO CARE

Mick Daniels Dip Mgt MICM MIFireE ASMS
Fire Safety and Security Advisor
North Staffordshire Combined Healthcare NHS Trust

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Executive Summary

Period 01/04/17 – 25/8/17

North Staffordshire Combined Healthcare NHS Trust (NSCHT) remains committed to providing and maintaining exemplary standards of fire safety in all premises for which it is responsible.

This update report is presented with the intention of demonstrating such a commitment and bringing to attention activity and actions in support of the existing arrangements and fire safety standards within the Trust.

Following the recent Grenfell Tower fire there has been various requests for information from National Regulators. The information and data returned demonstrated that the Trust had no significant issues of concern and was meeting its statutory and mandatory obligations under The Regulatory Reform (Fire safety)Order 2005.These are detailed in the report.

1.0 Post Grenfell Tower fire requests and actions

The Grenfell Tower fire in London occurred on the **14th June 2017.**

The following day once it became apparent that the exterior cladding had played a significant part in the development of the fire, the Trust Fire Safety Advisor obtained from various sources the trade name of the material involved which was identified as 'Reynobond PE'. He then carried out a check of all Trust properties to see if any had this type of cladding. No Trust premises were found to have this type of cladding system. This was reported to the Head of Estates and no further action was required.

Requests for information to the Trust - Post Grenfell and activity
19th June – request from NHS Estates and Facilities
This was for information on the type of cladding fitted on all our Trust buildings and the name of the contractor if fitted / height of buildings / inpatient services / and if a Fire Risk Assessment had been completed in the previous 12 months. Returns were sent indicating that the Trust had decorative timber cladding systems fitted to 5 of our buildings namely: Harplands Hospital, Greenfields Centre, Sutherland Centre, Ashcombe Centre and the Bennett Centre. None were more than 2 storeys high and listing those inpatient units and that Fire Risk assessments had been completed within the last 12 months. Returns sent 20th June & further return sent on 21st June listing all of our Trust buildings.

24th June – request from NHS improvement authority
The request was sent on a Saturday mid-day to Trust CEO's to ask them to ensure their local Fire and Rescue Service to undertake inspections of ALL their Trust properties by close of play on Sunday 25th June to ensure there were no urgent safety risks. The on call executive officer Paul Draycott Director of Leadership and Workforce was asked by the CEO to complete this task. A call was made to Staffordshire Fire and Rescue Service and an arrangement was made to carry out an inspection at Harplands hospital on Sunday 25th June. A fire officer carried out the inspection in the company of the on call manager and positive feedback was provided indicating a well-run facility recognising that fire procedures and staff briefing were clearly in place. There were a few minor issues for consideration but nothing of an urgent nature. These were: 1.Some paper being stored in the printer room 2. Metal filing cabinets on some corridors 3. Glass panels on doors not marked as fire resisting glass – but they likely to be, check ,but not urgent 4 .Carillion kitchen area ,tidy up. A return was sent to NHS Improvement authority informing them of the above actions on 25th June.

27th June – Letter from Chief Fire Officer / CEO of Staffordshire Fire & Rescue Service
This was in direct response to the request made by NHS Improvement on the

24th June (detailed above) where Fire and Rescue services locally and nationally had been overwhelmed by demands placed on them without any prior notification or discussion from the NHS improvement. The letter stated that the Fire and Rescue Services are best placed to make their own decisions about prioritising inspections and actions and their focus was on residential High rise buildings. The NHS as a landlord has its own responsibilities under the Regulatory Reform (Fire Safety) Order 2005. The NHS National picture was 38 priority sites of which 9 gave the greatest concern in terms of cladding and fire risk assessments. None of the 38 sites were in Staffordshire or Stoke on Trent.
Four recommendations were provided on fire safety actions to be undertaken by Trusts: 1.Fire Risk assessments to be suitable and sufficient; 2.Staff are trained and familiar with what to do in a fire; 3.Means of escape are maintained sterile, evacuation is prompt and emergency access is maintained; and 4.building works underway or recently completed comply with the relevant Building Regulations Standards.

28th June – Fire Safety Advisor

The Fire Safety Advisor informed the Director of Operations on how the four recommendations in the above letter from the Chief Fire Officer /CEO of Staffordshire Fire and Rescue Service were being met and who the information should be communicated to for further action. The Director of Operations communicated this information to Directorates and Heads of Department and re-enforced this at the senior operational team meeting.

The four **recommendations** along with our actions were:
1.Fire Risk assessments and Fire Policy up to date and current (Action: Fire safety advisor to continue with Fire Risk Assessments programme of which a copy of the Fire Risk Assessment is held for each premises by the fire safety advisor and a copy held by the department / unit / ward manager in accordance with the Regulatory Fire Safety Order 2005.Where any significant findings are identified they are contained in an action plan at the rear of the Fire Risk Assessment with the responsible person identified i.e. local manager, estates etc with a time scale based on risk to complete. These are reviewed based on the timescales involved. If any serious breaches are found then these are reported to the Local manager immediately and Head of Estates. A review of the fire safety policy has taken place in August 2017 by the Fire Safety Advisor and is subject to approval by the Quality committee for implementation in September 2017)
2.All staff are trained and familiar with what to do in event of fire (Action: Communicated to Directorates / Heads of Department for theirs and their staff to action - All staff are trained and familiar with what to do in the event of a fire as this forms part of induction, mandatory training and annual fire drills, however some staff are overdue on their compliance dates in terms of mandatory training which they and their managers are aware of as this now automatically updates from the Learning Management System (LMS)-

additional sufficient courses and a new e-learning module has been produced by the Fire Safety Advisor to enable compliance by all staff)
3. Ensure means of escape sterile, evacuation quick and safe, access for emergency services (Action: Directorates / Heads of Department / Service Leads / Dept Managers for them and their staff to check on a daily basis as part of their local responsibilities and arrangements in line with the Trust Fire safety policy (Local Management) and that this is being complied with. The Fire Safety Advisor carries out compliance checks on visits, risk assessments and fire drills as well as responding to any concerns or providing advice to local managers and staff, or after any incident where an investigation has taken place.
4. Recent building works or any underway are checked with compliance with Building Regulations standards. (Action: Head of Estates to check all current and recent works. An example of this has been the checks and monitoring of work, materials and standards as part of the work being carried out on Ward 1/PICU buildings work. There has also been checks on most recent works completed i.e. Darwin Centre)

12th July – request for further information from NHS Improvement /DCLG / Cabinet Office

This information request was for all buildings which did not have overnight accommodation and were 18 metres or more in height and had Aluminium Composite Material (ACM) cladding. A nil return was sent for this. There were also other sections to complete on various elements of fire safety such as Risk assessments, Fire Safety advisors role and qualifications, Training and Fire Wardens. A return was sent on the 19th July. The returns indicated there were no significant issues of concern.

2.0 Staff Training and fire drills

Staff fire training is a mandatory requirement. The fire safety advisor has carried out a training needs analysis in early 2017. This is based on risk and has been completed so that fire training is relevant and timely depending on individual role and work location; A new fire e-learning package has been developed by the fire safety advisor in liaison with the training department and has been rolled out on the new Learning Management System (LMS) to the workforce in early July. There are many benefits including relevant training delivered in the workplace, less disruption to staff being away from the workplace, less travelling, parking issues and less cost to the organisation.
For example some staff groups will not require face to face training for 3 years, with e-learning being carried out in the between years. Cascade trainers are in place across the Harplands Wards and have assisted in developing a relevant walk / talk / show training checklist session as opposed to an on-line / presentation package. There is an opportunity to increase the numbers of cascade trainers over the next 12 months to cover resource centres and cascade training courses are programmed.

Training compliance is compiled by the Training department as part of the new Learning Management System (LMS). The most recent compliance rates are detailed below:

Mandatory Training Compliance 2017-18 June- July

Target 85%	Jun-17	Jul-17
Trust Board and Secretariat	70%	79%
Directorate of Strategy and Development	N/A	80%
Directorate of Medicine & Clinical Effectiveness	50%	61%
Directorate of Nursing and Quality	87%	97%
Finance & Performance Management Directorate	68%	89%
Operations (Corporate Services)	54%	58%
Workforce and Leadership Directorate	66%	74%
Corporate services	58%	74%
AMH Community Directorate	76%	79%
AMH In Patient Directorate	82%	74%
Children and Young People Directorate	64%	73%
Learning Disabilities Directorate	74%	87%
Neuropsychiatry and Old age Psychiatry Directorate	72%	70%
Substance Misuse Directorate	82%	86%
Bank	45%	42%
Trust Total (Exc Bank)	71%	76%

A trajectory for improvement on Mandatory compliance 2017-18

Target 85%	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17
Trust Board and Secretariat	80%	85%	90%	95%	95%
Directorate of Strategy and Development	80%	85%	85%	90%	95%
Directorate of Medicine & Clinical Effectiveness	70%	80%	85%	85%	90%
Directorate of Nursing and Quality	97%	95%	95%	95%	95%
Finance & Performance Management Directorate	89%	90%	90%	90%	95%
Operations (Corporate Services)	58%	70%	80%	85%	90%
Workforce and Leadership Directorate	74%	80%	85%	85%	90%
Corporate services	74%	80%	85%	85%	90%
AMH Community Directorate	80%	85%	85%	90%	90%
AMH In Patient Directorate	74%	80%	85%	90%	95%
Children and Young People Directorate	75%	80%	85%	90%	90%
Learning Disabilities Directorate	87%	90%	90%	90%	95%
Neuropsychiatry and Old age Psychiatry Directorate	72%	80%	85%	90%	90%
Substance Misuse Directorate	86%	89%	90%	90%	90%
Bank	45%	65%	75%	85%	85%
Trust Total (Exc Bank)	76%	82%	85%	85%	90%

Because of the below target compliance rates identified an action plan has been put in place to ensure that all staff can meet their mandatory requirements.
The action plan consists of:
1) The fire safety advisor has provided further information to the Training team to put onto the Learning Management System (LMS) so staff have clarity on which type of training they should completing and at what frequency. i.e. face to face and / or e-learning. This has seen an increase in bookings for face to face training.
2) The fire safety advisor has provided extra training dates because of demand to enable staff to complete face to face training on time.
3) The fire safety advisor has provided 'train the trainer' courses for in-patient fire cascade trainers who can train their own colleagues within their own workplace setting.
4) The fire safety advisor has provided the Training department with additional availability and options to train Bank Staff where they are not directly or regularly used by a particular team or department. This number equates to 125 staff. An additional 12 days of training have been identified creating 252 available training places.
5)The Director of Operations has communicated both in writing and verbally to Directorates and Heads of Department to ensure staff complete their mandatory fire training on time.
6)The new fire e-learning module on the Learning Management System (LMS) have been operational since 1st July and there has been an increase in staff accessing the courses. All staff will now get a reminder at 30,14 and the day before in addition each manager now has access to their teams real time data and when fully operational in terms of the face to face registering etc then managers will receive an e mail alerting them when a staff member is logged as a Did Not Attend (DNA). Most training sessions have a number of DNA's however a recent training session had a 58% DNA rate. Managers will also receive an email when a staff member goes out of date – which will be sent out every 2 weeks until the staff member becomes compliant.

Fire Training Places Analysis

Total number of places booked and available

- Total places available 520
- Total staff booked on already 185
- Spaces available 338

Staff requiring Fire Face to Face by Directorate

AMH Community Directorate	82
AMH In Patient Directorate	128
Bank	192
Business Development and Strategy	2
Chief Executives Office	4
Children and Young People Directorate	54
Directorate of Medicine and Clinical Effectiveness	3
Directorate of Nursing and Quality	4
Estates Agency	16
Finance and Performance Man Directorate	6

Learning Disabilities Directorate	60
Neuropsychiatry and Old age Psychiatry Directorate	128
Operations (Corporate Services)	3
Substance Misuse Directorate	36
Workforce and Leadership Directorate	30
Grand Total	**748**

Staff Requiring E-Learning by Directorate	
AMH Community Directorate	182
Business Development and Strategy	7
Chief Executives Office	8
Children and Young People Directorate	32
Directorate of Medicine and Clinical Effectiveness	8
Directorate of Nursing and Quality	14
Estates Agency	8
Finance and Performance Management Directorate	10
Learning Disabilities Directorate	36
Neuropsychiatry and Old age Psychiatry Directorate	48
Operations (Corporate Services)	10
Rechargeables	1
Substance Misuse Directorate	7
Workforce and Leadership Directorate	23
Grand Total	**394**

Additional spaces in planning

There are additional places in the planning stage for whole day Fire Face to face training back to back. This should generate an additional 60 places per day.(see no 4 of action plan above)

Also, some cascade Fire Training will take place that isn't included in the figures for spaces available.(see no 3 of action plan above)

Fire drills are carried a minimum of once per year across Trust sites. These comprise of a full evacuation of the premises – the only exception is Wards 1 to 7 and the A & T / Telford unit at Harplands hospital where table top / walk through exercises are conducted with staff twice per year. 30 drills were completed in 2016/17 and these will be repeated again on the annual cycle. Multi – occupied site drills are completed via the responsible landlord.

3.0 Fire Wardens

The size and complexity of some of the Trust's buildings necessitate the appointment of local Fire Wardens.

The Fire Wardens essentially are the "eyes and ears" within the workplace but do not have an enforcing role. They report any issues identified to their line manager and/or head of service or departmental managers and if necessary to the Fire Safety Adviser or Fire Safety Manager as required.

The Fire Wardens role is to:

- Act as the focal point on fire safety issues for the local staff;
- Organise and assist in the fire safety regime within local areas;
- Raise issues regarding local fire safety with their line management;
- Support line managers in their fire safety issues.
- Carry out rapid and methodical area searches and evacuation procedures and report to the most senior person (incident controller).
- Give encouragement to other employees, patients, visitors and reassure them during fire related incidents.
- Ensure that fire escape routes remain available for use at all times.
- Identify and report fire hazards in or close to the workplace.

Fire Warden training on request is carried out by the Trust Fire Safety advisor.

Because of staff changes, leave, sickness, retirement's etc.it is important that the relevant workplace manager is aware of their Fire Warden situation and is able to provide suitable nominations for Fire Warden training.
To help identify any gaps, a question is in the workplace Quarterly Health and Safety audits:
*Do you have enough trained Fire Warden's to assist an evacuation and carry out a sweep of the work place? If yes who?**
**(Contact Mick Daniels Fire Safety Advisor for training)*

Additionally the fire safety advisor will look to implement a system where Fire Wardens names are listed on view to all in the relevant workplace so all staff are aware. Where for whatever reason there happens to be no trained Fire Wardens or because there are insufficient permanently based staff in the workplace there will be a system that in an emergency evacuation the remaining workforce are able to complete a prompt sweep to confirm that everyone has been accounted for. This will be reflected in the details below and indicated as an ALL staff duty.

Since 2014 the Fire safety advisor has trained 123 staff in the Fire Warden role across all Trust sites.

Fire Wardens

Hospitals

Harplands	Fire Wardens	Comments
Non – Ward areas only	26	Ward areas and A& T / Telford are progressive horizontal evacuation – all other areas are Full evacuation

Centres

Site	Fire Wardens	Comments
Greenfields Centre & Summers View	All	In patient unit -Full evacuation
Sutherland Centre & Florence House	All	In patient unit - Full evacuation
Ashcombe Centre	3	

Lymebrook Centre	3	
Brandon Centre (Cheadle Hosp)& Estates	All	Multi occ premises – Hospital SSOTP
Parent & Baby Service	3	
Bennett Centre	5	
Dragon Square – Day / CAMHS	4	Full evacuation except Short stay Children's Unit which is progressive Horizontal evacuation

Centres

Site	Fire Wardens	Comments
Darwin Centre	All	In patients -Full evacuation
Maple House & Estates	All	Multi – occ premises – Hospital SSOTP
The Eaves / Marrow House	3	Multi – occ premises – care home
Blurton Health Centre	2	Multi – occ premises – SSOTP

Others

Site	Fire Wardens	Comments
Trust HQ & Ashtenne units	16	2 separate buildings
Hillcrest	All	Joint staff –Partnership & multi occ premises
Earl House, Newcastle		Joint staff –Partnership
Eaton House, Leek		Joint staff – Partnership & multi occ premises
Hope Centre	10	Multi – occ premises
Roundwell Street	3	
Growthpoint/Kniveden	All	Small units on each site
Holly Lodge	All	Small house in Cemetery
Broom Street	3	
HMP Stoke Heath		Crown property
The Observatory	All	Joint staff & multi – occ premises
One recovery Stafford	3	Joint staff –Partnership
One recovery Leek	3	Joint staff –Partnership
One recovery Burton	3	Joint staff –Partnership
One recovery Tamworth	3	Joint staff –Partnership
One recovery Newcastle	2	Joint staff –Partnership
One recovery Cannock	2	Joint staff –Partnership
Raid Team		Joint staff - Partnership – Hospital UHNM
Longton Hospital – Estates & Staff counselling	All	Multi – occ premises – Hospital SSOTP
Lifeline - Tunstall		Joint staff –Partnership

Lifeline -Hanley		Joint staff –Partnership
UHNM - Staff counselling		Joint staff – Partnership & multi occ premises UHNM

4.0 Fire and smoking related incidents.
Period 1st April to 25th August 2017

Total number recorded on the Trusts Safeguard incident reporting system:**21**

Fire - deliberate x 5 incidents.
1.Harplands - Client discharged from Ward 3 – attempted to set fire to signs. Staff member sustained slight reddening to hand. Incident linked to other offences – Police arrested individual. No charges followed.
2.Hillcrest Unit, Hanley – Client set fire to external wheelie bin – prevented spreading to inside unit. Full evacuation carried out. Staff actions were exemplary. Fire Service attended. Police arrested individual. No Charges followed.
3.Intensive Support Team – external location (Non Trust site) Client starting fires linked to other issues including assault (not involving our staff)Police attended
4.Hillcrest Unit, Hanley - self harm ,client setting fire to clothing, staff extinguished fire. Client sustained superficial burns.
5.Darwin Centre, Penkull - Client set fire to towels in communal bathroom. Staff completed full evacuation, tackled fire and extinguished it. No significant damage. Client suspected of starting fire had 6 previous arson - with 3 charges pending. Police attended - no charges due to insufficient evidence. Some learning points identified from the incident which will be produced by the Fire Safety Advisor and communicated to staff via learning lessons bulletin and communications from the Director of Operations.

Fire – accidental x 1 incident
Harplands Ward 3 – intoxicated patient in garden area setting fire to pillow – Staff member sustained slight blisters to fingers.

Unauthorised smoking x 5 incidents.
Harplands Ward 2 x 4 incidents -Patients smoking in bedrooms / corridors (included 1 E-cigarette)
Darwin Centre x 1incident – Patient smoking in bedroom

False alarm (accidental) x 7 incidents
Various causes at different locations / sites
1.Steam from shower 2.Steam from kettle 3. Aerosol sprayed by patients 4. Key operated fire alarm accidentally operated. 5. Electrical fault 6.Contractors carrying out dusty work

False alarm (deliberate) x 3
Darwin centre - patients deliberately breaking break glass alarm points. Planning to change break glass points to key operated points to prevent future activations

5.0 Fire Policy

A current fire policy is in force and was reviewed in 2014 and approved by the Quality committee and Trust Board on 25th September 2014.It has been reviewed in August 2017 by the fire safety advisor and is subject to approval by the quality committee and Trust Board for to implementation by the review date of 30th September 2017.

6.0 Fire Risk Assessments

The 'Regulatory Reform (Fire Safety) Order 2005 'introduced in October 2006 is legislation which consolidates previous fire safety legislation. It covers all aspects of fire safety management in the workplace. The legislation changes the emphasis of compliance from that previously involving fire certification to a risk based assessment undertaken by or on behalf of the owner/occupier.

To comply with legislation the Trust has to carry out Fire risk assessments and reviews to all its Trust premises and this is an – on-going process based on the level of risk and forms part of a risk based programmed inspection regime, with the highest risk premises: the in- patient sleeping risks having the most frequent inspections, at least once annually and as required if circumstances change. Other premises such as Day Centre's / office accommodation / joint partnerships / multi – occupied premises etc. have a less frequent inspection regime in place unless there has been any alterations or significant changes when a review will take place. Fire Risk assessments are completed by the Trust Fire safety advisor.

6.1 Key Issues From Risk Assessments

Any findings are contained within each individual Premises Risk Assessment of which a copy is held on the premises site and a copy in the Estates Department. Any significant items found are recorded in an Action Plan which is at the rear of the Risk Assessment with a priority timescale rating given, a responsible person to action it and a completion date. A review of action plans is carried out based on the priority timescale and these are discussed and fed back to the workplace / site responsible person.

Alterations to buildings which involve any changes to the fire safety arrangements are discussed and agreed prior to the works starting and are monitored via the Trust Estates team to the conclusion of works.

7.0 Conclusion

Staff continue to demonstrate a positive and responsible attitude to Fire Safety and are pro-active to try and prevent incidents or to learn when incidents have occurred. Checks, testing regimes and assessments are in place to ensure a good standard of Fire Safety is maintained by staff and in Trust properties.
A new fire e-learning package has been developed and the new Learning

Management system has been live from July 2017 so this should help to increase staff compliance rates across the Trust.
The fire policy will be reviewed and a new one implemented.
Statutory Fire Risk Assessments will continue as normal in line with identified Risks or significant changes or events.
Fire drills will be carried out to test procedures and make sure staff carry out the right actions and respond in the correct manner.
Specialist fire roles – cascade trainer, fire warden and incident controller will continue to be delivered by the fire safety advisor as required and requested.

To put fire and smoking into some context, whilst its always possible that a fire may start either accidentally or deliberately, it is rare in a workplace setting for someone to be seriously injured or killed due to fire regulations, statutory laws, training and staff compliance. The reality for the Trust is that fire incidents never appear or are reported in any data or statistics by the Trust Patient Safety Group because the numbers are low and their impact although having potential does not appear to be significant. That is a reflection on Staff who maintain a high standard to prevent such occurrences and when there are incidents respond competently often in challenging circumstances.

The fire in Grenfell Tower although shocking to us all occurred not in a workplace but in the one place where the Fire Safety Order 2005 does not apply - a single private dwelling or person's own home - that is why it is important for community based staff to undertake Staffordshire Fire and Rescue Services free 'Olive Branch ' training so the most vulnerable in society can be identified and signposted to a key partner to prevent fire occurring in the first place. Three fire fatalities in patients own homes over the last 3 years have been shared with us from Staffordshire Fire and Rescue Service and presented as part of the Trusts 'learning lessons' - all of these had the potential to be prevented had training taken place and information shared.

There should be no complacency and fire should remain uppermost and in people's daily work in terms of awareness and prevention.

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REPORT TO: TRUST BOARD

Enclosure No:14

Date of Meeting:	7th September 2017		
Title of Report:	Service User & Carer Council Report		
Presented by:	Tess Tainton Vice Chair, Service User & Carer Council		
Author:	Tess Tainton , Vice Chair, Service User & Carer Council		
Executive Lead Name:	Maria Nelligan	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report has been prepared to provide an update of the Service User & Carer Council since the last meeting held in July 2017.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement☐ 2. To provide the highest quality services X☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work herex☐ 7. Continually improve our partnership working. X☐		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	The Trust Board receives the update for information and assurance		

Service User and Carer Council update for Trust Board September 2017

North Staffordshire Combined Healthcare NHS Trust

1. **Voting of the Vice Chair of The Council :**
   This occurred 30th August there was only one expression of interest. The council were very pleased to offer congratulations and wish Tess (Theresa Tainton) well for her future as vice chair

2. **The bi monthly meeting format :**
   Items covered in business meeting: Access Team Report: Friends and Family feedback updates: Person Centred Care : Quality Strategy Work plan (2017)

   Workshop meeting held In August covered a presentation from Research and Development team this was to encourage service users and carers to become actively involved in Research including opportunities to influence possible research topics. Also discussed was Dragons Den and there will be a joint proposal from Service User and Carer Council and Research and Development team to take the concept forward
   The REACH awards an update was given by MF there were concerns raised by the council members re: criteria to be used, as there are other categories that cover all areas , time left to nominate and then time to discuss and chose appropriately. They voted unanimously not to nominate this year rather than feel it was not an appropriate choice
   An update was given on the Suicide Prevention Work plan; this has gone out to the council for comment.

3. **Further discussions took place on :**
   Lorenzo . BB will come to a future meeting to discuss and share changes that may be made
   Northstaffs Voice for Mental Health have had their funding from CCG cut from end of September. If their Big Lottery application is unsuccessful they will close at the end of December
   Under the same tranche of cuts ASIST advocacy will no longer be able to provide advocacy support for voluntary patients in Staffordshire

4. **Other areas of the trust that service user and carer council have been involved in this month include:**
   - Service users and carers continue their involvement in a wide variety of recruitment and stake holder panels across the trust
   - Unannounced visits
   - PICU meetings
   - Directorate meetings

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REPORT TO Trust Board

Enclosure No: 15

Date of Meeting:	07/09/2017		
Title of Report:	Finance Report		
Presented by:	Suzanne Robinson		
Author:	Lisa Dodds		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

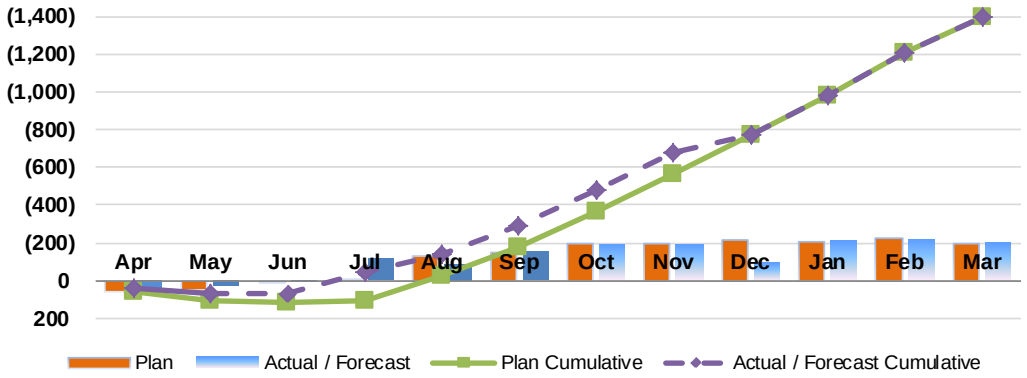
Executive Summary:		Purpose of report	
The report summarises the finance position at month 4		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)			
Recommendations:	Note the year to date performance of finance performance against the plan as at month 4 and approve the reported position to NHSI.		

Financial Overview as at 31st July 2017

Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	104	(49)	(153)	147	G
FOT	(1,400)	(1,400)	0	0	G

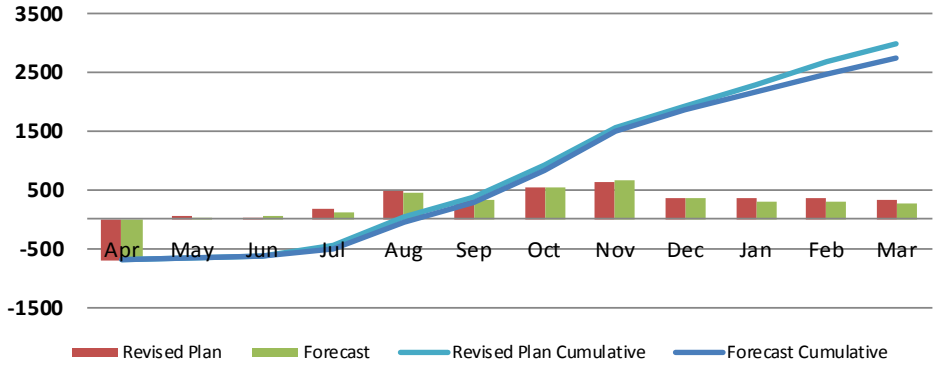
Retained (Surplus) / Deficit Run Rate 2017/18



Net Capital Expenditure / (Receipts)

£000	Plan	Actual	Var	%	RAG
YTD	(493)	(451)	42	(9)	G
FOT	2,979	2,731	(248)	(8)	G

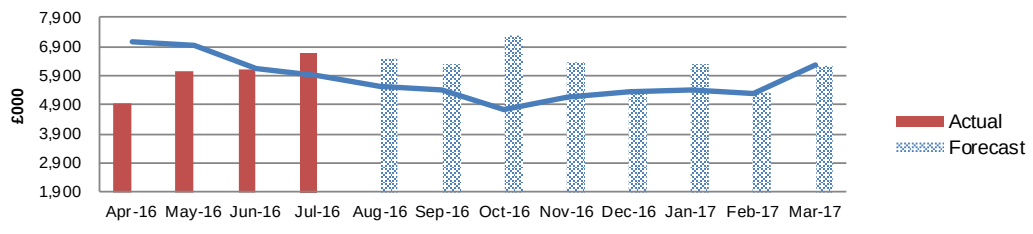
Net Capital Expenditure - Plan / Forecast 2017/18



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	5,889	6,636	747	11	G

Cash Balances - Actual/Forecast against Plan 2017/18



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	468	189	(279)	(60)	(738)	R
Corporate	120	31	(89)	(74)	370	G
Total	588	220	(368)	(63)	(368)	R

Use of Resource

Overall Risk Rating	2
Liquidity Ratio	1
Capital Servicing Capacity	3
I& E Margin	2
I&E Margin Variance to Plan	1
Agency Spend	2

1. Introduction:

The Trust's 2017/18 financial plan is to deliver a trading position of £0.9m surplus. The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.4m surplus which includes £0.5m from the Sustainability & Transformation Fund.

2. Income & Expenditure (I&E) Performance

Table 1 below summarises the Trust financial position in the Statement of Comprehensive Income (SOCI):

- During month 4, the trust had an in month trading position of £92k surplus against a plan of £15k deficit; **a favourable variance of £107k**. Sustainability and Transformation funding has been assumed at £33k for month 4, bringing the overall trust control to a £117k surplus against plan of £10k; **a favourable variance of £107k**.

- The trust has a year to date trading position of £59k deficit against a plan of £212k deficit; **a favourable variance to plan of £153k**. After Sustainability and transformation funding (£108k), the trust has a Control Total surplus of £49k against a plan of £104k deficit; **a favourable variance to plan of £153k**.

- To reduce overall reliance on Agency and improve resilience post EPR implementation, the trust has utilised substantive staff to support the implementation of the ROSE programme. There is a benefit to the financial position of £124k YTD through not backfilling these posts during this period. This non-recurrent benefit accounts for the majority of the YTD surplus.

Table 1: Summary Performance	Annual Budget £'000	In Month Budget £'000	In Month Actuals £'000	In Month Variance £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Forecast Budget £'000	Forecast Actual £'000	Forecast Variance £'000
Income	(82,146)	(7,055)	(6,785)	270	(27,874)	(27,334)	540	(82,301)	(81,551)	750
Pay	62,465	5,311	4,860	(451)	21,347	19,894	(1,453)	62,745	60,614	(2,131)
Non-Pay	16,118	1,540	1,613	73	5,829	6,589	760	15,993	17,307	1,314
EBITDA	**(3,564)**	**(205)**	**(312)**	**(108)**	**(698)**	**(851)**	**(153)**	**(3,564)**	**(3,630)**	**(66)**
Other Non-Op Costs	2,664	228	228	0	910	910	(0)	2,664	2,729	66
Trading Surplus	**(900)**	**23**	**(84)**	**(107)**	**212**	**59**	**(153)**	**(900)**	**(900)**	**(0)**
Sustainability & Transformational Funding	(500)	(33)	(33)	0	(108)	(108)	0	(500)	(500)	0
Control Total	**(1,400)**	**(10)**	**(117)**	**(107)**	**104**	**(49)**	**(153)**	**(1,400)**	**(1,400)**	**(0)**

3. Income

Table 2 below shows the trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. The Trust is showing an under performance of £117k year to date on Stoke-on-Trent CCG's, relating partly to invoice disputes for 2016/17;

- Under recovery of £24k year to date on Associates Contracts is due to a reduction in indicative activity and £61k under recovery on Out of Area Treatments (OATs) due to an underperformance of actual activity compared to planned activity levels (£40k of this is due to the underperformance of the sale of substance misuse beds);

- Stoke on Trent public health is under performing by £39k due to a reduction in referrals from community service provided by lifeline to Substance Misuse Inpatients.

- STF is earned quarterly for trusts operating within its agreed control. The total for 2017/18 is £500k and is phased 15% for Q1, 20% for Q2, 30% for Q3 and for 35% Q4. **£108k is reflected at month 4**.

		Month 4			Year-to-Date			Forecast		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(35,615)	(2,974)	(2,974)	(0)	(11,970)	(11,853)	117	(35,745)	(35,629)	117
NHS North Staffordshire CCG	(24,389)	(2,032)	(2,032)	(0)	(8,132)	(8,132)	(0)	(24,389)	(24,389)	(0)
Specialised Services	(3,097)	(258)	(300)	(42)	(1,032)	(1,075)	(42)	(3,097)	(3,139)	(42)
Stoke-on-Trent CC s75	(3,947)	(401)	(305)	96	(1,316)	(1,220)	96	(3,947)	(3,947)	0
Staffordshire CC s75	(1,056)	(88)	(88)	0	(352)	(352)	0	(1,056)	(1,056)	0
Stoke-on-Trent Public Health	(1,392)	(131)	(117)	14	(323)	(284)	39	(1,392)	(1,268)	124
Staffordshire Public Health	(613)	(51)	(51)	0	(204)	(204)	0	(613)	(613)	0
ADS/One Recovery	(1,497)	(125)	(125)	0	(499)	(499)	0	(1,497)	(1,497)	0
Associates	(756)	(23)	(50)	(27)	(252)	(227)	24	(756)	(701)	55
OATS	(760)	(103)	(40)	64	(253)	(193)	61	(760)	(574)	186
Total Clinical Income	**(73,123)**	**(6,186)**	**(6,082)**	**105**	**(24,334)**	**(24,039)**	**294**	**(73,253)**	**(72,814)**	**439**
Other Income	(9,023)	(869)	(703)	166	(3,540)	(3,294)	246	(9,048)	(8,737)	311
Total Income	**(82,146)**	**(7,055)**	**(6,785)**	**270**	**(27,874)**	**(27,334)**	**540**	**(82,301)**	**(81,551)**	**750**
Sustainability Transformation Funding	(500)	(33)	(33)	0	(108)	(108)	0	(500)	(500)	0
Total Income Incl. STF	**(82,646)**	**(7,088)**	**(6,818)**	**270**	**(27,982)**	**(27,442)**	**540**	**(82,801)**	**(82,051)**	**750**

4. Expenditure

Table 3 below shows the Trust's expenditure split between pay, non-pay and non-operating cost categories.

		Month			Year-to-Date			Forecast		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	7,685	638	558	(80)	2,529	2,196	(333)	7,685	6,942	(743)
Nursing	27,927	2,321	2,215	(106)	9,415	8,892	(522)	28,201	27,763	(438)
Other Clinical	15,083	1,294	1,046	(248)	4,990	4,273	(716)	15,091	13,726	(1,366)
Non-Clinical	10,817	937	835	(102)	3,638	3,288	(350)	10,815	10,361	(453)
Non-NHS	954	122	206	85	775	1,244	470	954	1,823	869
Total Pay	**62,465**	**5,311**	**4,860**	**(451)**	**21,347**	**19,894**	**(1,453)**	**62,745**	**60,614**	**(2,131)**
Drugs & Clinical Supplies	2,378	200	186	(14)	775	739	(36)	2,378	2,334	(45)
Establishment Costs	1,754	148	123	(25)	577	461	(117)	1,754	1,503	(251)
Information Technology	535	45	28	(17)	178	307	129	535	680	145
Premises Costs	2,105	178	163	(14)	696	690	(6)	2,105	2,206	100
Private Finance Initiative	4,087	341	353	12	1,362	1,420	58	4,087	4,187	100
Services Received	3,348	304	365	60	1,155	1,228	74	3,348	3,483	135
Residential Payments	1,708	214	152	(62)	569	670	101	1,708	1,966	257
Consultancy & Prof Fees	270	(5)	37	42	90	185	95	270	413	143
Unacheived CIP	(2,411)	(47)	0	47	(368)	0	368	(2,364)	0	2,364
Other	2,343	161	206	45	793	888	95	2,172	536	(1,636)
Total Non-Pay	**16,118**	**1,540**	**1,613**	**73**	**5,829**	**6,589**	**760**	**15,993**	**17,307**	**1,314**
Finance Costs	1,293	108	108	0	431	431	0	1,293	1,293	0
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	561	47	47	0	187	186	(1)	561	559	(2)
Investment Revenue	(14)	(1)	(1)	0	(5)	(3)	2	(14)	(9)	5
Fixed Asset Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	824	74	74	(0)	297	296	(1)	824	887	63
Total Non-op. Costs	**2,664**	**228**	**228**	**0**	**910**	**910**	**(0)**	**2,664**	**2,729**	**66**
Total Expenditure	**81,246**	**7,078**	**6,700**	**(378)**	**28,086**	**27,393**	**(693)**	**81,401**	**80,650**	**(751)**

"Unachieved CIP" is CIP not yet transacted. Until a scheme is transacted, it remains on the unachieved CIP line, including in the forecast.

4. Directorate Summary

Table 4 below summarises Pay, Non Pay and Income by Directorate:

	Pay			Non Pay			Income			Total		
Table 4: YTD Expenditure	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
AMH Community	5,933	5,306	(627)	1,425	1,666	241	(736)	(620)	117	6,622	6,352	(270)
AMH Inpatients	2,114	2,153	39	67	123	55	0	(2)	(2)	2,181	2,274	93
Children's Services	2,179	1,907	(271)	181	219	38	(222)	(225)	(3)	2,137	1,902	(236)
Substance Misuse	910	890	(20)	287	247	(40)	(197)	(161)	36	1,000	976	(24)
Learning Disabilities	1,803	1,624	(180)	136	101	(34)	(18)	(17)	1	1,920	1,708	(212)
Neuro & Old Age Psychiatry	3,631	3,542	(89)	271	206	(65)	(309)	(334)	(25)	3,593	3,413	(179)
Corporate	4,777	4,471	(305)	4,373	4,938	565	(26,499)	(26,083)	416	(17,349)	(16,674)	676
Total	**21,347**	**19,894**	**(1,453)**	**6,739**	**7,499**	**760**	**(27,982)**	**(27,442)**	**540**	**104**	**(49)**	**(153)**

5. Cost Improvement Programme

The trust target for the year is £3.2m, as reported to NHSI. This takes into account the requirement to deliver a £1.4m control surplus for 2017/18. The table below shows the achievement by Directorate towards individual targets at M4. The Trust wide CIP achievement is 37% at M4 compared to plan.

		YTD @ M4			Forecast					
CIP Delivery	Annual CIP Target 2017/18	Plan	Transacted	(Under)/Over Achievement	Plan	Total Schemes	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Forecast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Clinical										
AMH Community	1,084	199	24	(175)	1,084	650	(434)	60%	108	539
AMH Inpatients	379	70	2	(68)	379	45	(334)	12%	12	114
Children's Services	333	61	0	(61)	333	278	(56)	83%	0	335
Learning Disabilities	256	47	61	14	256	256	0	100%	139	220
NOAP	495	91	102	11	495	478	(17)	97%	439	602
Total Clinical	**2,547**	**468**	**189**	**(279)**	**2,547**	**1,707**	**(840)**	**67%**	**698**	**1,809**
Corporate										
CEO	49	9	0	(9)	49	21	(28)	43%	0	40
Finance, Performance & Digital	61	11	21	10	61	124	63	203%	71	145
MACE	62	11	1	(10)	62	19	(43)	31%	5	20
Operations	29	5	1	(4)	29	33	4	114%	10	35
Quality & Nursing	13	2	2	(0)	13	11	(2)	85%	13	13
Strategy (Core)	10	2	3	1	10	16	6	160%	20	20
Trustwide	365	67	0	(67)	365	478	113	131%	0	667
Workforce & OD	61	11	3	(8)	61	76	15	125%	20	80
Total Corporate	**650**	**120**	**31**	**(89)**	**650**	**778**	**128**	120%	**139**	**1,020**
Total	**3,197**	**588**	**220**	**(368)**	**3,197**	**2,485**	**(712)**	**78%**	**837**	**2,829**

Below 75%	
Below 90%	

Target	**3,197**
Variance	**(368)**

- The 2017/18 year to date CIP achieved stands at £220k (37%)
- The recurrent value of schemes transacted is £837k against £3.2m target. The recurrent forecast as at M4 is £2.829m (88%); this represents a recurrent shortfall against the target of £368k (12%).

6. Statement of Financial Position

Table 6 below shows the Statement Financial Position of the Trust.

Table 6: SOFP	31/03/2017 £'000	30/05/2017 £'000	30/06/2017 £'000	31/07/2017 £'000
Non-Current Assets				
Property, Plant and Equipment	28,037	27,963	27,901	27,942
Intangible Assets	222	213	235	240
NCA Trade and Other Receivables	1,426	1,426	1,426	1,426
Other Financial Assets	897	897	897	897
Total Non-Current Assets	**30,581**	**30,499**	**30,458**	**30,505**
Current Assets				
Inventories	88	78	91	81
Trade and Other Receivables	5,146	6,049	6,559	5,843
Cash and Cash Equivalents	6,964	6,059	6,092	6,636
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**12,198**	**12,186**	**12,743**	**12,560**
Total Assets	**42,780**	**42,685**	**43,202**	**43,065**
Current Liabilities				
Trade and Other Payables	(7,472)	(7,535)	(8,097)	(7,891)
Provisions	(333)	(314)	(311)	(302)
Borrowings	(457)	(633)	(633)	(633)
Total Current Liabilities	**(8,262)**	**(8,482)**	**(9,041)**	**(8,825)**
Net Current Assets / (Liabilities)	**3,937**	**3,704**	**3,702**	**3,734**
Total Assets less Current Liabilities	**34,518**	**34,203**	**34,160**	**34,240**
Non Current Liabilities				
Provisions	(474)	(474)	(474)	(474)
Borrowings	(12,189)	(11,937)	(11,899)	(11,861)
Total Non-Current Liabilities	**(12,663)**	**(12,411)**	**(12,373)**	**(12,335)**
Total Assets Employed	**21,855**	**21,793**	**21,788**	**21,905**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,648	7,648	7,648
Retained Earnings reserve	3,987	3,924	3,919	4,036
Revaluation Reserve	9,323	9,323	9,323	9,323
Other Reserves	897	897	897	897
Total Taxpayers' Equity	**21,855**	**21,793**	**21,788**	**21,905**

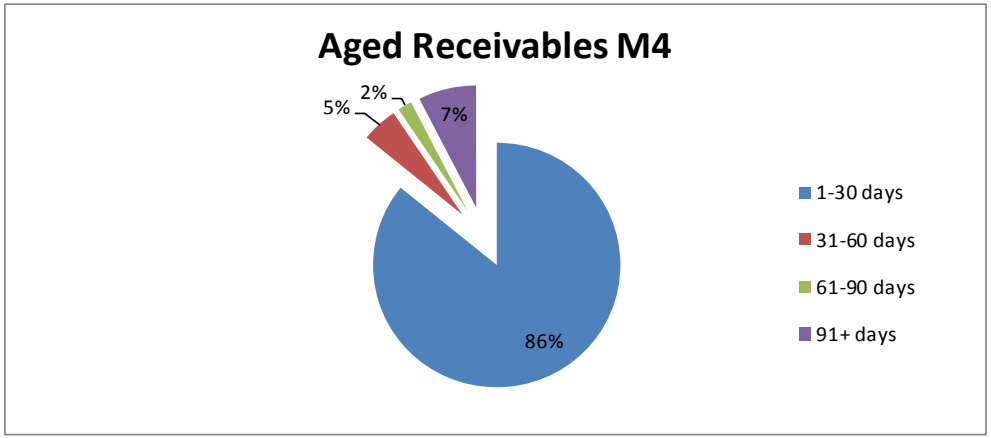
Current receivables are £5,843k

- £2,754k is based on accruals (not yet invoiced) and relates in the main to STF and income accruals paid at the end of each quarter.
- £3,089k in awaiting payment on invoice. (£1,575k within terms)

£436k is overdue by 31 Days or more and therefore subject to routine credit control processes;

- £10k has been escalated to management /solicitors;
- £14k has been formally disputed through the M12 Agreement of Balances process;
- £412k has not been formally disputed and full payment is anticipated.

Table 6.1 Aged Receivables/Payables	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	520	4	6	43	573
Receivables NHS	2,132	141	51	191	2,515
Payables Non NHS	844	44	52	64	1,004
Payables NHS	1,494	118	198	81	1,891

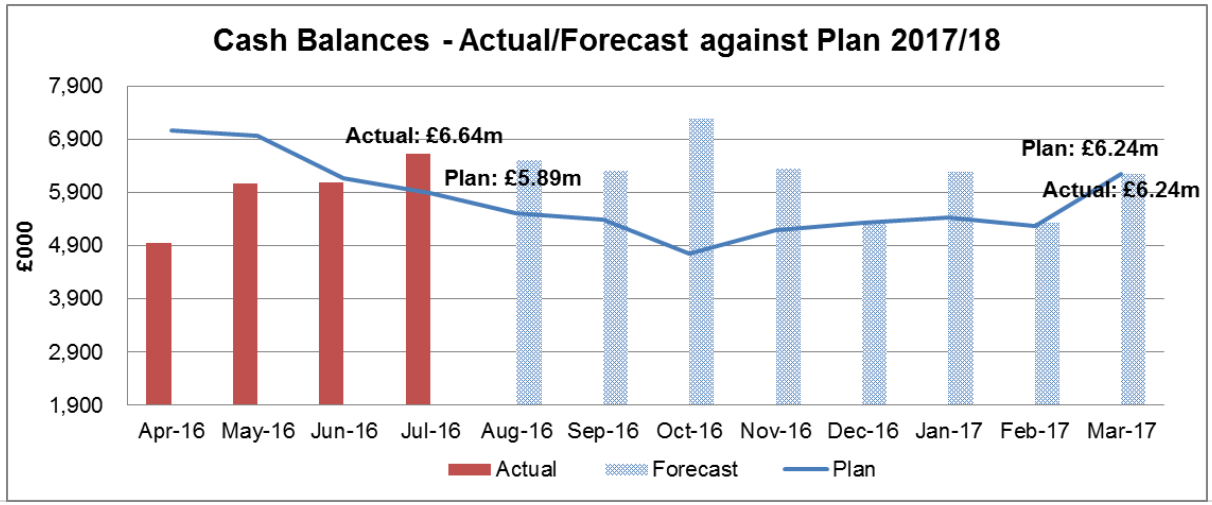


7. Cash Flow Statement

The Trust's cash position was £6.964m at 31st March 2017. The cash balance at 31st July 2017 has decreased to **£6.636m** due to an increase in the value of receivables and a reduction in the payables. The Trust cash position at 31st July 2017 is **£747k higher than planned,** however the Trust anticipates be on plan by March 2017.

Table 7 below shows the Trust's cash flow for the financial year.

Table 7: Statement of Cash Flows	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000
Net Inflows/(Outflow) from Operating Activities	(2,674)	1,184	116	702
Net Inflows/(Outflow) from Investing Activities	692	(31)	(45)	(120)
Net Inflows/(Outflow) from Financing Activities	(38)	(38)	(38)	(38)
Net Increase/(Decrease)	**(2,019)**	**1,115**	**32**	**544**
Opening Cash & Cash Equivalents	**6,964**	**4,945**	**6,059**	**6,092**
Closing Cash & Cash Equivalents	**4,945**	**6,059**	**6,092**	**6,636**
Plan	7,064	6,964	6,164	5,889
Variance	**2,119**	**905**	**72**	**(747)**



Summary of Outstanding Income		
Receivables	**£'000**	**RAG**
Invoices		
NHS Digital	526	
Stoke CCG	563	
SSSFT	580	
SSOTP	357	
Other NHS Providers	489	
Other Non NHS Providers	141	
Accruals		
STF	108	
TOTAL	**2,764**	

8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2.979m. Table 8 below shows the planned capital expenditure for 2017/18 as submitted to NHSI.

		Year to Date			Forecast		
Table 8: Capital Expenditure	**Annual Plan £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Place of Safety	660	9	9	(0)	660	660	0
Temporary Place of Safety	83	0	0	0	83	83	0
Psychiatric Intensive Care Unit	2,153	179	112	(67)	2,153	1,993	(160)
E-rostering	102	41	44	3	102	102	0
Information Technology	235	1	6	5	235	235	0
Environmental Improvements (backlog)	120	25	24	(1)	120	120	0
Reduced Ligature Risks	217	7	7	(0)	217	217	0
Equipment	50	0	0	0	50	50	0
Darwin	0	0	26	26	0	26	26
Ward 4	30	0	0	0	30	30	0
Lymebrook MHRC	36	0	0	0	36	36	0
VAT Recovery on 2016/17 Schemes	0	0	(7)	(7)	0	(9)	(9)
Contingency	6	0	0	0	6	6	0
Total Gross Capital Expenditure	**3,692**	**262**	**220**	**(42)**	**3,692**	**3,549**	**(143)**
Bucknall Hospital (Part)	(713)	(713)	(713)	0	(713)	(818)	(105)
Total Capital Receipts	**(713)**	**(713)**	**(713)**	**0**	**(713)**	**(818)**	**(105)**
Total Charge Against CRL	**2,979**	**(451)**	**(493)**	**(42)**	**2,979**	**2,731**	**(248)**

- The **Operating Plan** as reported to NHSI forecast there would be a total charge against the CRL of £743k by month 4, including £713k Capital Receipts for the sale of Bucknall Hospital and £1,456k Capital Expenditure.
- **Actual Capital Expenditure** as at month 4 is £220k against an updated Capital Expenditure plan of £262k.

9. Use of Resource Metrics

The Framework covers 5 themes, quality of care, finance and use of resource, operational performance, strategic change, leadership and improvement capability. The metrics below will be used to assess the Trust's financial performance.

Table 9: Use of Resource	Year to Date £'000	RAG Rating
Liquidity Ratio (days)		
Working Capital Balance	3,653	
Annual Operating Expenses	26,482	
Liquidity Ratio days	17	
Liquidity Ratio Metric	**1**	
Capital Servicing Capacity (times)		
Revenue Available for Debt Service	963	
Annual Debt Service	769	
Capital Servicing Capacity (times)	1.3	
Capital Servicing Capacity Metric	**3**	
I&E Margin		
Normalised Surplus/(Deficit)	50	
Total Income	27,442	
I&E Margin	0.2%	
I&E Margin Rating	**2**	
I&E Margin Variance from Plan		
I&E Margin Variance	0.60	
I&E Margin Variance From Plan	**1**	
Agency Spend		
Providers Cap	1,107	
Agency Spend	1,245	
Agency %	12	
Agency Spend Metric	**2**	
Use of Resource	**2**	

Table 9.1: Use of Resource Framework Parameters				
Rating	**1**	**2**	**3**	**4**
Liquidity Ratio (days)	0	(7)	(14)	<(14)
Capital Servicing Capacity (times)	2.50	1.75	1.25	<1.25
I&E Margin	1%	0%	-1%	<=(1%)
I&E Margin Variance	0%	-1%	-2%	<=(2%)
Agency Spend	0	25	50	>50

The Capital Servicing Capacity is level 2 due to small YTD surplus.

In later months where there is a planned surplus, due to phasing of delivery of CIP's, the Capital Servicing Capacity and the I&E Margin Ratings will improve.

10. Better Payment Practice Code

The Trust's target is to pay at least 95% of invoices in terms of number and value within 30 days for NHS and Non-NHS suppliers.

At month 4, the Trust has under-performed against this target for the number of invoices, having paid 87% of the total number of invoices (88% for 2016/17), and paid 92% based on the value of invoices (95% for 2016/17).

In order to meet its statutory obligation, to operate within its External Financing Limit (EFL), the trust reduced payment runs in M12, maintaining cash balances. Performance in month 4 is reflective of a number of breaches, triggered upon payment of an invoice in Month 1 which exceeds the 30 day target.

Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2016/17			2017/18 Month 4			2017/18 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	508	13,183	13,691	53	837	890	216	3,601	3,817
Total Paid within Target	459	11,610	12,069	42	723	765	184	3,145	3,329
% Number of Invoices Paid	90%	88%	88%	79%	86%	86%	85%	87%	87%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-4.6%**	**-6.9%**	**-6.8%**	**-15.8%**	**-8.6%**	**-9.0%**	**-9.8%**	**-7.7%**	**-7.8%**
Value of Invoices	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Total Value Paid (£000s)	6,860	29,380	36,240	746	2,959	3,705	2,549	10,015	12,564
Total Value Paid within Target (£000s)	6,385	27,914	34,299	731	2,792	3,523	2,427	9,117	11,544
% Value of Invoices Paid	93%	95%	95%	98%	94%	95%	95%	91%	92%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1.9%**	**0.0%**	**-0.4%**	**3.0%**	**-0.6%**	**0.1%**	**0.2%**	**-4.0%**	**-3.1%**

11. Recommendations

The Trust Board is asked to:

Note:

- The reported surplus of **£49k against a planned deficit of £104k**. This is a favourable variance to plan of £153k.

- The M4 CIP achievement:
  - YTD achievement of £220k (37%); **an adverse variance of £368k**;
  - 2017/18 forecast CIP delivery of £2,485k (78%) based on schemes identified so far; an adverse variance of £712k to plan;
  - The recurrent forecast delivery at month 4 of £2,829k representing a **recurrent variance to plan of £368k**.

- The cash position of the Trust as at 31st July 2017 with a **balance of £6,636k**; £747k better than plan.

- Year to date Capital receipts for 2017/18 is £493k compared to a net planned capital receipt of £451k;
  - The original operating plan submitted to NHSI in December 2017 planned net capital expenditure of £743k by Month 4.

- Use of resource rating of **2**.

Approve

- The month 4 position reported to NHSI.

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REPORT TO TRUST BOARD

Enclosure No:16

Date of Meeting:	7TH SEPTEMBER 2017		
Title of Report:	Finance and Performance (F&P) Committee Report to the Trust Board – 31st August 2017		
Presented by:	Mr Patrick Sullivan on behalf of Mr Tony Gadsby		
Author:	Mike Newton		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☐

Executive Summary:		Purpose of report	
This paper details the issues discussed at the Finance and Performance Committee meeting on the 31st August 2017. The meeting was quorate with minutes approved from the previous meeting. . Progress was reviewed and actions confirmed taken from previous meetings.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	N/A		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	The Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.		

Assurance Report to the Trust Board
Thursday, 7th September 2017

Finance and Performance (F&P) Committee Report to the Trust Board – 7th September 2017

This paper details the issues discussed at the Finance and Performance Committee meeting on the 31st August. The meeting was quorate with minutes approved from the previous meeting on the 3rd August 2017. Progress was reviewed and actions confirmed taken from previous meetings.

Executive Director of Finance Update

The following updates were given by the Executive Director of Finance;

- A 5 year Cash and Capital Plan, evaluating the affordability of the current plan against statutory limits. Shortfalls on cash were identified which reduced the overall funding available for 2017/18 capital, including the under delivery of Cost Improvement and reduction in depreciation due to year end impairments.

  The sophistication and detail of the cash flow model, implemented in June 2017, enables the Committee to give assurance the accuracy of future cash projections. The Committee therefore supports the recommendation to:

  - Set a minimum cash balance of £3.5m, which the trust will not fall below;
  - Reduce the 2017/18 Capital plan to allow a maximum capital spend of £2.041m.

- A Block Contract Disaggregation analysis has been shared with commissioners, which breaks down the CCG block contract income by service specification. This has been done primarily to support commissioners to understand the cost of services commissioned but also supports the design of future payment mechanisms, informs commissioning intentions, priority areas for investment and demonstrate the value for money of the provider.

- The Model Hospital single oversight framework, was shared as this is likely to feature in the assessment criteria for the CQC.

Finance

The Finance position was presented showing a position that is £153k better than plan. This is supported non recurrently through benefits associated with ROSE implementation. The Trust is forecasting to meet its agreed control surplus.

There was a reflection on the Q1 Deep Dive, presented at the F&P meeting on 3rd August, providing a detailed consideration of the impact of emerging risks on the 2017/18 forecast position, as well as mitigation plans required to ensure the Trust delivers its required control total.

Cost Improvement Programme (CIP)

The Committee received an update for Cost Improvement for month 4 and were concerned that the total identified was still significantly short of the target. £2.485m is currently forecast to be delivered against the £3.197m target.

The Q1 Deep Dive, presented at the Committee on 3rd August 2017, reflected on some of the issues in the delivery and identification of Cost Improvement. There remains a risk that the majority of schemes identified are not transformational and therefore, presents a risk around the long sustainability of plans.

The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2017/18. The Committee were assured that all remaining schemes will be transacted at Month 5, to provide greater visibility around the deliverability risk, of schemes included in the 2017/18 forecast.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Agency utilisation report
- Capital spend and forecast
- Treasury and Cash Management

Performance:

- **Activity Report**

The report detailed M4 activity against plan using traditional reporting methods and clustering. The Committee is not able to give assurance around the activity reported, particularly around the use of Care Clusters, due to issues with the quality of recording by operational staff.

- **Performance Report (PQMF)**

The report provides the Committee with a summary of performance to the end of Month 4 (July 2014.)

Care Plan Compliance remains an issue in respect of 12 month reviews undertaken. The implementation of ROSE has led to some issues reporting at the granular detail, which the Performance Team are supporting clinical teams to resolve. Although performance has dipped, the Committee were assured around plans to rectify the data quality around reporting and that performance was not overstated.

Delayed Transfers of Care show a small reduction and remain to be an issue. A paper presented at the A&E Delivery Board around delays was included for information. This enhanced and supported the previous assertions made by the trust; that delays were

largely due to access to funding and social care beds. The Committee asked for a Q2 Deep Dive which reflects on the progress of actions agreed at the A&E Delivery Board.

Trust vacancies remain a challenge, being impacted by the recruitment of substantive posts to Ward 4, where many new starters are yet to take up posts, as well as service transformation and redesign. The trust has invested in a new system called TRAC, designed to streamline the recruitment process. This is expected to significantly improve the fill rate of posts.

- **CYP Waiting Times (PQMF)**

The CYP waiting times were presented, showing a dip in performance against the local, 4 week target, to 88%. CYP were over performing against national 18 week waiting time target. The Committee raised concerns around the 4 week target, having previously been assured by the Head of Directorate over the improved performance. It was noted that the transformation of Children's Front of House Services (The HUB) is likely to have a positive impact on performance of CAMH's waits.

It was noted that the performance around ASD waiting lists was a real success story, where the legacy waits had all been seen. The Committee is assured that CYP has a robust understanding of demand and capacity, to effectively manage waits in the future.

Terms of Reference

An updated Terms of Reference was approved by the Committee, which had been updated to include representation from Quality in the membership.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Draft Single Oversight Dashboard
- Financial Risk Register

Recommendation

The Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby – Chair of Finance and Performance Committee

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REPORT TO: Trust Board

Enclosure No: 17

Date of Meeting:	7 September 2017		
Title of Report:	Assurance Report from the Quality Committee meeting held on 31 August 2017		
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee		
Author:	Sandra Storey, Associate Director Medical & Clinical Effectiveness		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 31 August 2017 The full papers are available to Trust Board members, as required.		Approval	☒
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	Approved by Chair of Quality Committee and Executive Lead	Document Version No.	
Committee Approval / Review	• Summary of key points from Quality Committee 31 August 2017, approved by Chair, Patrick Sullivan		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. 2. To provide the highest quality services 3. Create a learning culture to continually improve. 4. Encourage, inspire and implement research & innovation at all levels. 5. Maximise and use our resources intelligently and efficiently. 6. Attract and inspire the best people to work here. 7. Continually improve our partnership working. The business of the Quality Committee is applicable to all strategic objectives.		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	The Trust Board is asked to 1. Receive for assurance/information purposes 2. Approve policies noted in the report.		

North Staffordshire Combined Healthcare NHS
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Key points from the Quality Committee meeting held on 31 August 2017 for the Trust Board meeting on 7 September 2017

1 Introduction

This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee with items aligned to the Trust's SPAR objectives.

2 Patient Story

The meeting opened with a story presented by the Clinical Director from the Learning Disabilities Directorate which included a short video from a client sharing her experience of in-patient and community services. In particular, feelings were shared about the Independent Living Support Service and the positive impact in helping this lady to develop tools and techniques for improving the quality of her life. This was a powerful story and was well received by the committee.

3 Nurse Staffing monthly reports – June and July 2017

The Committee received the safer staffing performance report on a shift by shift basis for June and July 2017. Delivery of Registered Nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards. During July the Trust achieved staffing levels of 83% for registered staff and 99% for care staff on day shifts and 82% and 106% for nights respectively. Overall a 93% fill rate was achieved. Where 100% fill rate was not achieved the Quality Committee were assured that safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties. The data reflects that while challenges remain in terms of recruitment, Ward Managers are staffing their wards to meet increasing patient needs as necessary.

4 Performance & Quality Management Framework Month 4 2017/18

Committee members discussed performance by exception and the rectification plans in place. Month 4 was noted to have 4 targets rated as red and 1 as amber, with all other indicators within expected tolerances. The following performance highlights were noted as follows:

- 97.2% of patients have been gate kept by the Crisis Resolution / Home Treatment Team.
- 98.9% of patients on Care Programme Approach for at least 12 months have received a health of the nation outcome score (HONOS) assessment.
- 90.7% of S136 assessments have been completed within 3 hours.
- Readmission has significantly reduced from 15% in April to 5% in July.

The following points were also noted:

- The hard work of staff and review of systems and processes has impacted positively on CAMHS waiting times.
- A new system is being introduced in HR namely 'TRAC' which will significantly reduce the timescale for recruitment.
- Following introduction of Lorenzo in May 2017 there is confidence that this will improve data quality going forward. This will be reported on again in October 2017.
- Monitoring recruitment activity and compliance with completing and recording of supervision.

5 Reports received for Assurance

5a Director of Quality Report

The Committee received the Director of Quality Report under the SPAR qualities priorities with notable items as follows:

Safe:

- **New Patient Safety Bill on the horizon.** Reflects the Government's commitment to help improve safety in the NHS and instil a greater public confidence in the provision of healthcare services.

Personalised:

- **Driving Personalisation across health and social care – a new framework for people, carers and families.** While aimed at Commissioners, important for health colleagues to be aware of the new framework with additional 'quick guides' that provide a helpful resource.

Accessible:

- **Religious observations for adults lacking capacity.** A new decision from the Court of Protection provides helpful guidance for Providers and Commissioners particularly when considering placements where issues relating to religious beliefs and values feature.

Recovery focused:

- **Government promises mental health reform.** The Government will begin to consider what further reforms of mental health legislation is necessary including how the Act is implemented on the ground**.**

5b Reports received for review and approval

- ✓ Health & Safety Annual Report 2016/17 (noting Inspector complimentary of work undertaken)
- ✓ Restraint Annual Report 2016/17 (reflects quarterly updates to Committee)
- ✓ Safeguarding Annual Report Children's & Adults 2016/17 (noting that Dr Barton has taken over the role as Named Doctor for safeguarding).
- ✓ Complaints & PALS Annual Report 2016/17 (noting review and progress of complaints service).
- ✓ Quality Strategy and Action Plan (review of strategy and progress against plan). Quality Improvement strategy will be developed going forward.
- ✓ Research and Development Annual Report 2016/17. The committee noted the extension to the work of the Research and Innovation Strategy and this document will be circulated virtually prior to the next meeting of the Committee. Also noted input from service users in developing this visual and well received annual report.
- ✓ Quality Committee Annual Report 2016/17 (to comply with Terms of Reference)

- ✓ Infection, Prevention & Control Q1 2016/17 and annual statement, Terms of Reference for group, and approval of Strategy for programme of work. (Noted good PLACE scores and no infections, also the work around sepsis which is part of the national agenda).

- ✓ Fire Annual Report 2016/17 (update for 2017 and update to policy).

- ✓ Winter Plan 2017 (this was approved by the Committee to support progression of the winter plan and implementation as part of the overarching system wide response).

5c **Policy report** – the recommendations were supported by the Committee for ratification of policies by the Trust Board for 3 years or otherwise stated as follows:

- ✓ 1.44 Dual Diagnosis
- ✓ 1.05 Attendance at Coroner's Court
- ✓ MHA21 Transportation Policy and Procedure
- ✓ Covert Medication Policy
- ✓ 1.03 Medicines Management Policy
- ✓ 1.42 NICE Policy and Procedure
- ✓ 4.23 Psychological Interventions Policy
- ✓ R08 Personal Searches
- ✓ Seclusion Policy (addendum added)
- ✓ 1.64 Care Management and Care Co-ordination Policy5.05 Fire Policy
- ✓ 5.21 Gas Escapes
- ✓ 5.22 Management of Mercury guidance
- ✓ 5.23 Safe Use of Mobile Phone
- ✓ 5.26 Sharps Find Procedure
- ✓ 5.27 Safe Use and Purchase of Electrical Equipment
- ✓ 5.29 Unsafe Gas
- ✓ 5.36 Central Alert System

- ✓ It was noted that from April 2017, Trusts are required to collect and publish information on how they intend to respond to and learn from deaths of people who die under the management of their care. It was agreed that it was appropriate for this guidance be appended to the Trust's current Serious Incident (SI) Investigation Policy 5.32.

6 **Learning from Experience Report April/May 2017**

The Committee received this bi-monthly learning from experience report detailing emerging issues, learning and action taken following the feedback from Trust services. The following points were noted:

- While increase in number of incidents reported on the previous two months, a high number recorded as no harm. Falls incidents are reviewed by the Physical Health Group.
- Guidance issued to staff on the use of seclusion while the room is temporarily unavailable during the PICU build.
- NHS Choices feedback reviewed and discussed at the Service User and Carer Council.

7 Clinical Effectiveness Report

The committee received this assurance report on the outputs of the work of the following groups:

- Medicines Optimisation
- Mental Health Law Governance Group
- Research and Development Group
- Clinical Records and System Design Group
- Clinical Effectiveness Group

Of note were the case law updates, the increasing number of requests for reports (S49) and the implications for the Trust alongside the imminent changes to the Police and Crime Act.

8 NICE Report Q1 2017/18

The Committee received for assurance a report detailing the process for responding to NICE guidance. The report highlighted the NICE guidance presented to the Clinical Effectiveness Group from 1 April – 30 June 2017, noting those directly applicable and actions taken.

9 Directorate Performance Reports

Each Directorate presented in detail their performance as part of the new reporting arrangements to the Committee. Committee members felt that this new style of reporting, capturing information from performance reviews enabled a much more focussed discussion around cross cutting issues.

Items to note for report to the Board:

Adult In-patient Service – PIU challenges and opportunities. The Directorate managed staffing challenges during peak holiday time. Overall generally positive. Sickness at lowest level for 12 months.
Adult Community – it was noted that Stoke Healthy Minds (IAPT services) recovery rates are best in West Midlands. Medical recruitment is a challenge but reflects regional position.
CAMHS – Sustained improvement in respect to waiting times. Significant investment in staff, systems and processes.
Learning Disability Service – Service to be proud of and to celebrate, particularly in comparison to service delivery nationally. "We have a fantastic model!".
NOAP – to recognise RAID improved performance. Recognise challenge as move towards winter months.
Substance Misuse – Took over new service in 2 weeks which was remarkable and a significant achievement. Staff commended. The importance of Substance Misuse maintaining a profile in with the STP process.

10 Risks to Quality of Services as at July 2017

Committee members considered the report for quality risks, particularly those scoring 12, which have been reported to the Committee previously and how they interrelate to Directorate risks. Members discussed the risk treatment plans in place and assurance about the actions being taken. It was agreed that safer staffing would be added to the risk register to ensure on-going review and close monitoring.

11 NHSI Patient Safety Review and Response Report

This report was received for information purposes. It covered the period April – September 2016, and was published June 2017, detailing how the NHSI reviewed and responded to patient safety issues.

12 Serious Incident Q1 2017/18 and progress against thematic review action plan

This report provided a review of the Trust's serious incidents drawing a comparison from Q4 and Q1. The Committee were provided with assurance about the process for learning lessons and robust monitoring processes in place. The Committee also received a progress update on the action plan following the thematic review that had been commissioned by the Medical Director. While some improvement required to maintain consistent care and process, no causative factors were identified and the good progress against the action plan was noted.

13 Complaints Service – audit of compliance with policy

The Committee received a report detailing the outcome of an audit into the complaints service. This followed unacceptable delays being identified in response to complaints in 2016. In response an action plan was implemented with progress being monitored through the Committee. While some improvement has been noted, a review of the complaints policy has identified areas that can be further strengthened and this is currently being updated and will be presented to the Committee at its next meeting.

14 Board Assurance Framework Q1 2016/17

The Committee received a verbal update on progress against the quality objectives that have oversight by the Committee. It was noted that one objective is rated at red which relates to maintaining vacancies at less than 5%. Plans to mitigate this risk are in place. It was also noted that Mental Health Act compliance is making good progress and work remains on-going to continually improve compliance in this area.

15 Unannounced Assurance Visits Report – Q1 2017/18

The Committee received a detailed summary of the findings from assurance visits, key themes and progress to date.

16 Quality Impact Assessment of Cost Improvement Schemes (CIP)

The Committee received a position paper. It was noted that there were no issues to report by exception. There is continuous monitoring in place for those schemes approved with key performance indicators in place that monitors closely for any negative impact on quality of service.

17 Eliminating Mixed Sex Accommodation - Statement of Compliance

This report gave assurance to the Committee on the compliance with standards and work in progress.

18 State of Mental Health Services, Trust Self-Review against CQC report

This report was provided to give assurance and highlight areas for on-going improvement against the four areas of concern highlighted by the CQC. It was noted that much progress has been made and there is a process is in place to continue to monitor this.

19 Next meeting:
Thursday 26 October 2017 2pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director Medical and Clinical Effectiveness

1 September 2017

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REPORT TO TRUST BOARD

Enclosure No:18

Date of Meeting:	7th September 2017		
Title of Report:	Summary of the Audit Committee held on 30th August 2017		
Presented by:	Mr Tony Gadsby, Chair / Non Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Miss Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a summary of the key headlines from the Audit Committee held on the 30th August 2017. The full papers are available as required to members.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Receive for information and assurance purposes		

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Summary Report of the Audit Committee

30th August 2017

Board Assurance Framework – Q1

Mrs Wrench, Associate Director of Governance, presented the Board Assurance Framework for Quarter 1 which provides assurance against the trust Strategic Objectives and assurances that have been completed in Q1. The committee confirmed that each strategic objective is overseen by sub-committee of the Board and has a nominated Executive lead and that work on level of risk appetite in line with Good Governance Institute risk appetite guidelines was underway.

The committee learnt that the BAF has a total of 127 metrics with 41 (32%) due in Q1 delivered as follows:

- 28 rated green
- 9 rated amber and
- 4 rated red relating to retaining clinical vacancy rates at less than 5%, achieving 100% compliance in mental health act audits, embedding a system for the recoding of talent management and, the in-month CIP position which had moved on significantly since the reporting at Q1.

The committee took further assurance in terms of operational risk management in that risk continues to be embedded at clinical and corporate team level and that risk is overseen by the senior leadership team and through performance monitoring. The committee also took assurance around the risk escalation and de-escalation process that has been embedded into practice.

The Committee took assurance that risk is well managed across the organisation

Audit Recommendations – Tracking Report

Miss Robinson, Director of Finance, presented a report detailing the Internal Audit actions and progress in terms of implementation as of August 2017.

The committee noted that 3 reports had been completed since May 2017:

1. Charitable funds – ward administration
2. Medicines management
3. IT disaster recovery and business continuity

Fifteen actions were yet to be completed with 8 not yet due and 7 with extended deadline dates which were agreed by the committee.

Policy Approval

The following policies were presented for approval:

- Reimbursement - Approved
- Patient's Property - Approved
- Property and Land Transactions - Approved
- Local Counter Fraud - Approved

It was noted that a desktop review of committee approval of policy would be undertaken to ensure the most appropriate committee is the committee giving final approval of the policy.

The committee ask for final ratification by the Board

Terms of Reference:

The committee approved the refreshed Terms of Reference for the Audit Committee that had been shared with committee members in May 2017. Changes related to clarification that all Non-Executive Directors were members and that the Chair of the committee was also a Non-Executive Director.

The committee ask for final ratification by the Board

SFIs and Scheme of Delegation

Members noted the summary of key changes and approved the required changes. The committee ask for final ratification by the Board

IG Incident – Action Plan

Miss Robinson, Director of Finance, Performance and Digital presented the IG incident action plan that had previously been discussed by the committee. The committee was informed that the Information Commissioner had concluded that as a result of the robustness of the action plan that no further action would be taken against the trust and acknowledged the trust's positive response to the incident. The committee noted that 4 actions in progress were due in June 2017 and that action leads had failed to provide an update against progress. It was agreed that a further report detailing progress would come to a future Audit Committee.

Data Protection Standards – Action Plan

The committee received the action plan presented by Miss Robinson, Director of Finance, Performance and Digital and learned that the trust had commissioned a further independent review to be undertaken by RSM in November 2017. The biggest challenge to the delivery of actions related to consent.

The committee received a number of reports for assurance purposes as follows:

- **Reference Cost Assurance -** All systems are compliant with guidance
- **Review of Single Tender Action -** At Q1 the trust has approved 4 totalling 919,788.

- **Losses Register for Debts to be written off -** Total 11,419

RSM Internal Audit Progress Report

The committee received the RSM internal Audit Progress Report covering 4 main areas:

1. Completed reports
2. Added value work
3. Changes to the audit plan
4. Internal audit benchmarking

Completed Reports:

1. Charitable funds – ward administration – awarded substantial assurance with 1 medium action agreed
2. Medicines management – which was an advisory piece of work
3. IT disaster recovery and business continuity – awarded reasonable assurance with 2 low and 1 high level action.

Added Value Work - Added value work included the undertaking of analytical work for Accounts Payable and Payroll

Changes to the Audit Plan – the committee noted 5 changes to the plan since the last audit committee and took assurance that although these had been deferred slightly, they would still be completed in-year.

Internal Audit Benchmarking:
The committee received the benchmarking report on internal audit assurance levels across all assurance reviews completed in 2016/17 which shows that the trust is well above average in terms of substantial assurance when compared to all clients nationally scoring 55% in 2015/16 and 41% in 2016/17 compared to the national figure of 19%. It was also noted that during the last 2 years reviewed, the trust had received no 'no assurance' ratings with the national figure being 4%.

RSM were keen for the committee to understand that although the trust scored highly in terms of substantial assurance this was not because the audit programme focussed on areas known to be performing well and that the trust did also review 'tricky' areas.

NHS Protect Report - LCFS

Mr Mike Gennard, Internal Audit, presented the report to the committee detailing findings of a recent NHS Protect focussed quality assessment for which the trust benchmarked well. An action plan has been developed and will continue to be monitored alongside the internal audit programme action plan. The committee approved the report and action plan ahead of submission to NHS Protect.

Ernst and Young External Audit

The committee received the Annual Audit letter from external auditors EY which provides a summary of the audit results report and details that the trust received an unqualified opinion for both the annual accounts and in terms of value for money. The letter also acknowledged the trust was meeting its financial targets and also acknowledged the recent CQC inspection report.

Standing Business Items:

As per standing business items, the committee received the following:

- Summary of the Quality Committee –22 June 2017
- Summary of the Finance and Performance Committee –1 June and 5 July 2017
- Summary of the People and Culture Development Committee - 3 July 2017
- Summary of the Business Development Committee –23 June 2017
- Minutes of the Information Governance Steering Group –3 July 2017
- Minutes of the Data Quality Forum –1 June, 26 June, 24 July 2017

Laurie Wrench

Associate Director of Governance on behalf of

Mr Tony Gadsby, Chair and Non-Executive Director

1st September 2017