MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 9th November 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 – 5th October 2017** *To APPROVE the minutes of the meeting held on 5th October 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.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
7.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
8	**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
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	**PATIENT STORY – SUMMERSVIEW - CAROLYN WILKES** *To RECEIVE Patient Story from Summers View to be introduced by the Executive Director of Nursing, Maria Nelligan*	Verbal
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
11	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
12.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Wendy Dutton, Chair of the Service User and Carer Council*	Assurance Enclosure 5
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
13.	**MEMORANDUM OF UNDERSTANDING WITH STAFFORDSHIRE UNIVERSITY** *To RECEIVE the Memorandum of Understanding from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 6
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
14.	**NURSE STAFFING MONTHLY REPORT - September 2017** *To RECEIVE the assurance report on the planned versus actual staff variances from Ms M Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 7
15.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 6** *To RECEIVE the Month 6 Performance Report from Miss Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 8
16.	**QUARTER 2 SERIOUS INCIDENT REPORT** *To RECEIVE the Quarter 2 Serious Incident Report from Dr Buki Adeyemo, Medical Director*	Assurance Enclosure 9
17.	**CQC STATE OF CARE PROVIDER REPORT** *To RECEIVE the CQC State of Care Provider Report from Mrs Laurie Wrench, Associate Director of Governance*	Assurance Enclosure 10
18	**UPDATE ON STAFFORDSHIRE SECTION 75 AGREEMENT** *To RECEIVE an update on the Staffordshire Section 75 Agreement from Dr Nasreen Fazal-Short, Acting Director of Operations*	Assurance Enclosure 11

19.	**DELEGATED AUTHORITY FOR CHARITY ACCOUNTS** *To RECEIVE an Update from Mrs Laurie Wrench, Associate Director of Governance*	Verbal
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
20.	**EQUALLY OUTSTANDING** *To RECEIVE for discussion Equality and human rights good practice resource from Mr P Draycott, Director of Leadership and Workforce*	Assurance Enclosure 12
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
21.	**FINANCE REPORT – MONTH 6 (2017/18)** *To RECEIVE for discussion the Month 6 financial position from Miss S Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 13
22.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 2nd November 2017 from Mr Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 14
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
23	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 6th November 2017 from Ms L Barber, Chair/Non-Executive Director*	Assurance Tabled
24	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 26th October 2017 from Mr P Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 15
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
25	*To RECEIVE a verbal update on progress from Mr A Hughes, Joint Director of Strategy, Development and Estates (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, 11th January 2018 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, 5th October 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 N Fazal-Short Acting Director of Operations
Ms J Walley Non-Executive Director	Mr P Draycott Executive Director of Leadership &Workforce	Dr K Tattum GP Associate Director
Miss S Robinson Director of Finance, Performance and Digital	Ms M Nelligan Executive Director of Nursing and Quality	Mr A Hughes Joint Director of Strategy and Development
Mr T Gadsby Non-Executive Director	Miss L Barber Non-Executive Director	Mr Ganeshan Mahadea Non-Executive Director

In attendance:

Mrs L Wrench Associate Director of Governance	Mrs L Wilkinson Acting Corporate Governance Manager (minutes)	Mr J McCrea [part] Associate Director of Communications
Ms W Dutton Chair of Service User Carer Council	Mr T Crowley [Observing] MIAA (Mersey Internal Audit Agency) Managing Director	Dr Chris Link [part] Consultant Psychiatrist

Members of the public:
Hilda Johnson
Phil Copestake
Russell McAusland - Liaison

Staff Retirements
Julie Keates

REACH Team Recognition Award
Access and Home Treatment Team
Cath Walesiewicz
Simon Bratt
John Clayton
Glynis Hartford
Joanne Willis
Cath Raper
Dr Siraj Saludeen
Sue Parkes

The meeting commenced at 10:00am.

		Action
819/2017	**Apologies for Absence** Apologies were received from: Ms J Harvey, Staff Side Representative Ganeshan Mahadea was welcomed and introduced by Mr Rogers as a new Non-Executive Director for the Trust. Gan is a qualified account and an important addition to the Trust's Board. Mr Rogers welcomed Mr Tim Crowley, the Managing Director for MIAA (Mersey Internal Audit Agency) who was invited to observe the North Staffordshire Combined Healthcare's Trust Board. Ahead of the CQC Well Led Review AQUA and MIAA have been commissioned to undertake a full well led review which will provide an excellent baseline for our Trust's Board Development Plan going forward and help us in our journey to become outstanding. AQUA has a vast experience with Mersey Internal Audit (MIAA) of performing well led reviews.	
820/2017	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
821/2017	**Declarations of interest relating to any other business** There were no declarations of interest relating to any other business.	
822/2017	**Minutes of the Open Agenda – 7ᵗʰ September 2017** The minutes of the open session of the meeting held on 7ᵗʰ September 2017 were approved.	
823/2017	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- *811/17 – CAMHS Assurance Report – Agenda item for today's Trust board meeting.*	
824/2017	**Chair's Report** Mr Rogers advised his focus is currently on how we are viewed from a national perspective highlighting there needs to be more integration between Trusts, a more patient centred approach to care and also a move of resources into mental health and the public health realm. The focus of change tends to be where there are 'hotspots' i.e. challenging areas at present, North Staffordshire is one of those that stands out nationally, there is a focus on the Acute Hospital with a huge deficit and also issues around A & E. This is receiving attention and in a sense that attention is taking	

	priority over the wider STP as we approach winter. Mr Simon Stevens, CEO NHS England will be visiting the area and the acute hospital at the beginning of December 2017. A big focus for winter is flu. Our #CombinedFluFighter campaign is in full swing and staff across the Trust have been receiving the vaccination to protect themselves, their colleagues, patients, friends and family. Our dedicated team of vaccinators continue to hold clinics at locations throughout the Trust. The Trust are holding the Annual REACH Awards this is a positive event taking place this evening which everyone is looking forward to. ***Received***	
825/2017	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in September 2017 and draws the Board's attention to any other issues of significance or interest. **CARE QUALITY COMMISSION (CQC) RETURN TO TRUST** The CQC arrived this week as part of the new inspection regime. The Trust has received feedback every evening; on the whole the visits have gone very well. Areas of learning have been picked up and the response from our staff has been fantastic. Overwhelmingly there is a lot to celebrate and a lot of positive feedback. The Well Led Review commences 30th October with particular focus on the Executive Team / Stakeholders and Board. A number of focus groups will be held during that week to obtain a rounded view of how the Trust is led. We are the second organisation nationally to have received the Well Led Inspection. Miss Barber asked if a date had been confirmed for formal feedback following the core services visits, Miss Donovan advised it had not. **CAMHS IN SCHOOLS TEAM LEADER JULIA FORD SHORTLISED FOR HSJ AWARDS** Julia Ford, our CAMHS in Schools Team Leader, has been shortlisted in the national HSJ Awards. Julia has been chosen as a finalist in the Clinical Leader of the Year category for her inspiring work in leading the team, which provides mental health services and support to a number of local schools. Julia and her colleagues travelled to London on 2nd October 2017 to give a presentation to the judging panel and will find out whether they have won when the awards are held on 22nd November 2017.	

VISIT TO HARPLANDS HOSPITAL BY POLICE AND CRIME COMMISSIONER

The Trust welcomed Matthew Ellis, Staffordshire's Police and Crime Commissioner to Harplands Hospital on 12th September 2017 to meet with staff and directors and discuss the importance of working together in partnership to protect and keep safe the most vulnerable within our communities. Matthew heard from Ward 1 Manager Maxine Tilstone and Ward 3 Manager Laura Jones, as well as members of our Community Triage Team about the work we do to support our service users. He also saw first-hand the work that is underway to build our new Psychiatric Intensive Care Unit, which is due to open in 2018.

The Police & Crime Commissioner is supportive of plans to develop facilities within Staffordshire and for a second place of safety specifically in the North of the County.

CHRISTINE MALBON WINS FESTIVAL OF LEARNING TUTOR AWARD

Well done to STR Worker Christine Malbon, who has been announced as the regional winner of the Festival of Learning Tutor Award from the Learning and Work Institute, an independent policy and research organisation dedicated to lifelong learning, full employment and inclusion. Christine won the Central region award for her exceptional achievements in adult education. The award recognises those who have supported learners to go on and lead successful and rewarding lives. To become a support worker, Christine needed to re-train and completed a Level 3 Community Mental Health Care certificate. She also began to give advice and support to fellow learners who had low confidence levels, helping them achieve success.

Her calm, reassuring and confident approach was noticed and she soon began to teach the Community Mental Health Care certificate. She has now started her own journey delivering education programmes for health care support workers. She was nominated by Julie Richardson, Residential and Resettlement Coordinator, who said: "Christine is committed to her work, extremely knowledgeable of her subject and passionate about recovery in mental health. It is these values that come shining through when she is delivering the training."

LEADING WITH COMPASSION SCHEME A FINALIST AT KATE GRANGER COMPASSION AWARDS

The Leading with Compassion scheme made it to the final three in the Organisation Category of the Kate Granger Awards for Compassionate Care, presented at the NHS EXPO in Manchester. Our Chair David Rogers, Director of Leadership & Workforce Paul Draycott, and Laura Rogers, Staffordshire Leadership and OD Lead, attended the event on behalf of the Trust. The scheme has been rolled out across 11 NHS organisations in the region. To date, more than 500 Combined staff have been recognised and received a personalised badge and card recognising the impact they have made. Kate Granger, who sadly passed away in 2016, worked tirelessly to raise awareness around compassion in the NHS.

BECOMING A NATIONAL DIGITAL EXEMPLAR

As part of the Trust's ambition to become a national exemplar in the use of digital, a bid will be submitted for funding from NHS Digital and DXC (our partner in the implementation of our ROSE electronic patient record (EPR)) to improve children's mental health. The bid will be made via NHS Digital and DXC's £12m funding pot to support innovation and good practice across trusts which use the Lorenzo EPR. The Children and Young People's directorate have done such a fabulous job in enabling young clients to access community services in a much more timely way. They receive a high number of referrals that don't need to be seen by CAMHS services and through strengthening our working with schools young people and other agencies we can improve services even more. This is an exciting opportunity that I hope we will be successful in.

We have also bid for national funding to make our RAID service an all age one so children and young people can be supported more effectively at Royal Stoke University Hospital. We are partnering with commissioners and providers across Staffordshire, Shropshire and the Black Country in this.

Mrs Walley advised one of the main themes for the City of Culture bid is Digital and asked if there was any scope for the bid to make reference to the City of Culture Bid. It was confirmed this could be referenced as the whole focus of the bid is around prevention.

RECORD-BREAKING REACH AWARDS

Each year the Trust recognises staff, teams, partners, service users, carers and volunteers who have truly excelled and made a real difference through the REACH Awards. The Trust has attracted a record number of nominations for this year's REACH – almost 300! Our REACH ceremony takes place this evening at the Moat House Stoke-on-Trent and is sure to be a fantastic occasion and a celebration of those who have truly inspired us. The Event will be live streamed on Facebook.

TONY SCOTT NEW BEGINNINGS GARDEN OFFICIALLY OPEN

The Trust is delighted that the Tony Scott New Beginnings Garden at Harplands Hospital is now officially open. A tea party was held to launch the garden, which has been made possible thanks to a £12,000 grant from Tesco's Bags of Help scheme. Staff and service users from Growthpoint carried out the work to the garden – named in memory of Tony Scott, one of the founder members of the independent The Trust was pleased to welcome Tony's family, who were among those in attendance.

NATIONAL RECOGNITION FOR TRUST'S DIVERSITY AND INCLUSION WORK

Work on Diversity and Inclusion has received national recognition in two separate ways. Lesley Faux, Diversity and Inclusion Lead, and staff side Chair Jenny Harvey attended an event on 13th September 2017 at the House of Lords organised by the Employers' Network for Equality and Inclusion (ENIE). ENIE is the UK's leading employer network promoting equality and inclusion in the workplace. The following day, Lesley travelled to Leeds to give a presentation to colleagues from NHS Employers

about **Symphony of Hidden Voices** – a series of events, activities and online places where hidden voices with perspectives on mental health care can find and engage with each other.

STP LEADERSHIP PROGRAMME
On 6th September 2017 the Trust commenced its primary care leadership programme to provide twenty one local clinical leads, from the Staffordshire localities the opportunity to develop systems leadership skills. This will enable them to work as a network together moving the New Models of care agenda forwards. Simon Whitehouse, the Staffordshire STP Director opened the course with a discussion session.

This 8 day programme will run over an 8 month period and will teach core management skills and also equip local leaders with wider OD and political skills in order to navigate the new healthcare system. This will be underpinned with action learning and coaching in order to share learning and establish a sustainable network.

Alongside leadership development the programme will be supplemented with knowledge inputs. These inputs will relate to new contractual relations and performance measures synonymous with these new care models, as well as imparting knowledge from related vanguard schemes.

The participants will undertake a project throughout the life of the programme and will present findings on 26th April, 2018. Regular progress updates will feed into the North Staffordshire and Stoke-on-Trent Alliance Board as well as the Staffordshire STP OD and Leadership work stream.

NEWCASTLE ACCELERATED DESIGN EVENT
North Staffordshire and Stoke-on-Trent Alliance Board agreed at its meeting on the 14 June 2017 that Newcastle-Under-Lyme would be its first pilot area. The first initial meeting took place on the 4 July 2017 where it was agreed that the approach to develop a locality model would be to apply an Accelerated Design Event (ADE) to consider an Extensivist Model.

An Accelerated Design Event is an event that brings together groups of people to work through challenges and issues quickly and develop action. Every ADE is unique; it is created to achieve specific outcomes, using a variety of techniques and methods (including environment, facilitation processes, technology, knowledge and collaborative work techniques) that have been shown to create the conditions for large scale change.

NHS PROVIDERS SIGNALS WARNING ON WINTER PRESSURES
In a new report published at the start of September, NHS Providers gives its latest assessment of the state of play on planning for what is currently heading for a worse winter than last year – widely regarded as the worst winter for the NHS in recent times. The report has been informed by regular feedback from front-line NHS trusts and discussions with system leaders, as well as analysis of the latest data on key performance targets such as the four hour A&E standard and bed occupancy levels.
The report finds that the level of planning and support for this winter – led

jointly by NHS England and NHS Improvement – is considerably more developed than last year and emergency care performance has been given greater priority. Extra social care funding is helping to increase capacity in about a third of local areas and this should help to reduce the delays faced by some patients in those areas when they are medically fit to leave hospital but unable to do so because of a lack of available support in the community. Local trusts and systems are also putting huge efforts into early resilience planning to ensure patients are protected and face fewer delays.

We are involved activity with our partners in developing a whole system winter plan. The Trust's local plan is complete and will feed into the Staffordshire Plan to ensure that A&E is supported through the winter. The Trust's offering in winter will include increased capacity on ward 4, which is the shared care ward, taking us up to 19 beds. The Trust is also increasing its capacity in outreach services, supporting both A&E in 'pulling' people out of the system and supporting care homes in taking people back with additional support on challenging behaviour management.

NEW RESEARCH PUBLISHED ON CHILDREN'S MENTAL HEALTH

New research published by the National Children's Bureau and University of Liverpool – which shows a quarter of girls (24%) and one in 10 boys (9%) are depressed at age 14 – attracted national attention.

Commenting on the Report, Claire Murdoch, National Mental Health Director at NHS England, said: "NHS services for children and young people are expanding at their fastest rate in a decade. This year the NHS will treat an additional 30,000 children and young people, supported by an additional £280 million of funding. The report demonstrates how critical it is that all services – schools, youth services as well as the NHS – play their part in spotting problems early, and offering solutions."

Having made significant and sustained progress in reducing the waiting lists across the CYP Directorate, we are now beginning a transformation project to further develop the Central Referral Hub. This will be achieved through reconfiguration of existing resource and the introduction of an evidence based, brief intervention clinical pathway. Building on the existing model of care provided by the Central Referral Hub, this transformation will improve the front door experience for children, young people and their families - working in partnership to deliver an integrated, recovery based, preventative model that is flexible in meeting the needs of children and young people.

Looking ahead the Trust is planning to expand the CAMHS in school's project. This model delivers clinical evidenced based programmes to whole class and year groups as well as staff training and staff support sessions aimed at improving mental Health & wellbeing, building resilience and early interventions within the Schools directly. Key learning is the importance of promoting school based interventions and the importance of CAMHS specialist support being located in the schools as part of the school community and team enables clinicians/practitioners to work more effectively with the whole school to promote good mental health and

	supporting pupils experiencing some mental Health difficulties at the earliest opportunity. **Received**	
826/2017	**REACH Team Recognition Award October 2017** **Access and Home Treatment Team, Adult Mental Health Community Directorate** The Access and Home Treatment team is the Trust's front door, offering a 24/7 service to those in crisis. Staff are welcoming and friendly and provide support for individuals and referrers to assist them in accessing the right services. The team take the least restrictive approach to ensuring the mental health needs of service users are met. Major progress has been made in the responsiveness of the service to people's needs and in the delivery of comprehensive assessments – with a big focus placed on being compassionate at the point of contact and working alongside people. They work with a multitude of Trust services and external partners to help reduce attendance at both A&E and mental health inpatient wards and support people in crisis in their own homes. The team are embracing new ways of working to support the development of MCPs locally and are working alongside Trust directorates to ensure urgent care provision is as comprehensive, responsive and robust as possible. The value that best represents the team is 'Compassionate'. They take a multi-faceted response to ensure the needs of service users are met as swiftly as possible, with person centered care being at the heart of everything they do. Sue Parkes, Service Manager introduced the team and talked about the change the team have had to embrace. Cath Raper, Clinical Lead shared a patient story. I had 40+ attendances during a year at A & E and felt isolated and insecure. I was experiencing difficulties with my accommodation the lift in their building was out of order which made access difficult due to using a mobility scooter, the boiler and heating was broken. These issues were affecting my health and mood resulting in drinking more and eating less I felt so ill I would go to hospital as I felt safe there. Cath visited me in hospital and helped me to access my GP to no longer drink alcohol, alcohol services were offered, I had emotional support and they gave me reassurance with a great listening ear and supported me to find a new home, its lovely. Its early days and is taking some getting use to but I am determined to make it work my life now is really good. Jenny from Partnership Working at the Red Cross read a poem written by a	

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patient.

Joanne Willis from the Home Treatment Team shared another patient story MC was schizophrenic and lived alone for the last 9 years over the last few months they found it increasingly difficult to manage living alone and felt isolated and lonely which increased psychotic symptoms with intrusive thoughts which led to admission at the North Stoke hospital. Subsequently they MC was transferred to ward 2 at the Harplands and after a short stay moved to the Hillcrest. The flat offers 24 hours accommodation in a 24 hour care environment. MC became engaged in activities at the Observatory, activities at Florence house, engaged with growth point who were going to tend his garden at his property. MC was overwhelmed by support and warmth of the staff, his negative thoughts are now positive and he has been thinking of volunteering. MC's stay in the step on bed has been beneficial and he has made new friends all this progress has been made within two weeks.

Sue Parkes delivered a presentation which provided an overview of the service.

Mrs Donovan highlighted the service receives 190 calls a day with an average response time of one minute. Sue Parkes explained the team has a cohort that are the highest users of A & E. There has been a lot of work undertaken with STR workers. Mrs Donovan asked if there were more patients that could be seen with more resource. Mrs Donovan asked Dr Fazal-Short to look into high volume users capacity.

Mrs Walley advised Access and Home Treatment Teams evidence can help with work we have to do with the Health and Wellbeing Board in Staffordshire around cut backs. Sue Parkes confirmed there is a national rise in Substance Misuse for legal highs and alcohol co morbidity is prevalent which we are monitoring to capture people coming through needing clinical intervention / treatment.

Dr Tattum asked what percentage of total caseload is self-referring as there are concerns with regards to access that people with acute psychiatric problems are not deemed as an emergency. Cath Raper advised 50% approximately.

Dr Tattum highlighted the service has improved beyond recognition. This is a responsive team who have dealt with patients with compassion. Dr Tattum thanked the team and advised they should be proud of their achievements.

Mr Gadsby asked if four flats at Hillcrest is enough. Sue Parkes advised the team are piloting the demand as it is quite high.

Mr Sullivan acknowledged the stories from services users were excellent and asked if there is anything the Board can do to make the job better. Cath Raper advised the team can have intoxicated service users who have nowhere to wait and staff have to sit in the reception area with them. It

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	would be good to have a space for them to wait or for them to recover to provide a safe assessment. The team are looking at the Urgent Care Centre at the moment. Cath is working with the Duty Senior Nurse at the Harplands. Mr Sullivan agreed facilities and services can be discussed outside of the Board. **Received**	
827/2017	**Staff Retirements** Mrs Donovan recognised a member of staff who is retiring this month as follows: **Julie Keates – Healthcare Support Worker** Julie has worked as a Health Care Support Worker since 1989. Starting at St Edwards Hospital before moving to the Ashcombe Centre Inpatient unit. She then developed her skills, knowledge and experience in various settings across the Trust before returning to the Ashcombe Community Centre. Julie was especially skilled in British Sign Language supporting our clients from the deaf community; she was an active participant in the walking group and in physical health skills and rehabilitation. Julie doesn't plan to take it all that easy in retirement and has many plans - some of which she has already started working on; she has invested in a VW Campervan and has already 'done' her first wedding, she is a highly skilled artist and intends to continue to develop her skills and invest more time in this as it's something she really enjoys. She also has two young grandchildren whom she will be spending more time with, enjoying the joy they bring. Julie will be greatly missed by the whole team and we all wish her the very best of times. *Received*	
828/2017	**Questions from the public** Hilda Johnson commented that Healthwatch Stoke met with the Access Team recently and were made to feel very welcome. There has been a noticeable change within the Access Team who have worked really hard. Hilda asked for this to be acknowledged. Hilda also wanted to thank the team for the Step on bed at Hillcrest as this is helping patients to move on from the Harplands and releasing beds for others.	
829/2017	**RESEARCH AND INNOVATION STRATEGY** Dr Adeyemo, Executive Medical Director welcomed Dr Chris Link, Director	

of Research and Innovation.

Dr Link provided some national context to research and talked about why research is important, he also looked at local context and what the Trust has previously achieved and how we are going to take this forward.

The refreshed strategy has been written to support the Trust's organisational objectives and provide a framework to encourage, inspire and implement research at all levels.

The document has been written in line with the organisation's business plan and links into other key trust strategies and reflects the current NHS research priorities as identified by the National Institute for Health Research high level objectives.

The strategy also reflects extension of the team's remit to include innovation and commitment to working with services users, carers and staff to develop this strategy further during the course of 2017/18. As such, the strategy will evolve and will be a dynamic document to support the organisation's future needs.

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Dr Link discussed the NIHR study and target for bloods. Dr Link will circulate a leaflet via Lisa Wilkinson for Board members.

Mrs Walley talked about the recent meeting with Keele University's Vice Chancellor and asked how much work being undertaken is connected to the strategic concept we have? Dr Link advised he presented this strategy to Keele and left feeling filled with enthusiasm. The Trust does need to continue to work with them, Dr Adeyemo advised there is work being undertaken with Professor Chris Mallon MSC around Phd and the Mier Hub Evaluation work where Dr Mark Williams has been involved in meetings to develop strategies.

Mr Sullivan acknowledged in terms of research it is important that we have a culture where research is paramount as this has a massive impact on clinical care and secondly in terms of times when recruitment is difficult it can be what attracts people to the organisation.

Ms Dutton commented she was glad to hear the strategy includes Allied Health Professionals as a lot are reaching masters and phd level.

Ms Nelligan advised it is the strategic ambition of the nursing strategy to be more research focused and innovative.

Miss Robinson advised we could attract high quality doctors. Dragons Den would be a good opportunity to link around work for value makers. Funding will be attached to that also.

Hilda Johnson highlighted that some of the NSUG members have been involved in research and development and suggested it might be an idea to involve patients / service users in research and studies.

	Received	
830/2017	**NURSE STAFFING MONTHLY REPORT – August 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 August 2017 in line with the National Quality Board requirements. The performance relating to fill rate during August 2017 was 82% for registered staff and 94% for care staff on day shifts and 84% and 105% respectively on night shifts. Overall a 91% 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.	
	Ms Nelligan highligthed that August is always a challenging month in all organisaitons with the impact of vacancies and national shortage of registered nurses this has compunded this month.	
	There were 8 incident forms completed by in-patient wards during August 2017 relating to nurse staffing issues. No harm to patients arose from these incidents.	
	Examination of ward staffing for the past 12 months demonstrates a downward trend for overall ward staffing and for RN staffing. There is a clear correlation between the opening of Ward 4, to support the local health economy, and the downward trend. The period prior to Ward 4 opening, June - November 2016, was showing an upward trend.	
	Safe staffing reporting indicated challenges in staffing wards during August 2017. Vacancies across all wards 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 when newly qualified registered nurses graduate. The Board should note the further challenges associated with the temporary increase of beds on Ward 4 in the response to the winter pressure in the health economy. Looking forward to next year, challenges will also be experienced with the planned opening of PICU. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.	
	In October 2017 we will be having 18 registered nurses commencing on preceptorship.	
	There has been progression around the proposal of changing the shift	

	system. There are a number of wards looking at piloting. This includes a mixture of shifts supporting our staff to choose what shift suits their work life balance but obviously ensuring safety and delivering the service. We have continued with rolling recruitment events including bank. Weekly meetings are taking place looking at incidents over the weekend and planning for the week ahead. We opened Ward 4 to support the HEE and have opened an additional four beds on Ward 4 to do the best for person centred care and for families however this challenging in maintaining registered nurses and supporting them. We are supporting this with overtime and temporary staffing. Miss Barber asked if looking forward we are confident for the winter period? Ms Nelligan advised we are as confident as anyone else, we are the highest vaccinated Trust nationally and the ambition is to better that this year. Mrs Walley asked that in terms of UHNM referring patients to us is there any scope for additional staffing resource to be made available. Ms Nelligan advised she has had a number of conversations with the UHNM Chief Nurse who is looking at development roles i.e. ANP role and working with their bank. Mr Rogers asked if the trend could be illustrated in future monthly reports. ***Received***	**MN**
831/2017	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 5** Miss Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. The following performance highlights should be noted; • 100% of IAPT service users referred treated within 6 weeks of referral against target of 75%. This has been 100% for the last 3 months. • 100% of patients have been seen within 4 hours of referral to the crisis assessment team • The readmission within 28 days of discharge continues to reduce below target (7.5%) to 4.7%, from 5% in month 4. **Exceptions** DTOC - 12.9% at M5 from 15.9% at M4. Rapid escalation had had an impact and there have been no funding delays across the wards. CPA - There were 6 care plans not recorded in month 5. However, only one is a true breach as the other 5 are reporting issues. It was noted it is important to present both pictures. A new Standard Operating Procedure is in development and data entry guidance will be updated in light of this to ensure compliance with this key indicator. Miss Robinson asked the Board to take assurance that rectification plans	

	are being discussed at Committees.	
	Received / Approved	
832/2017	**EMERGENCY PLANNING RESPONSE AND RESILIENCE** Dr Nasreen Fazal-Short, Director of Operations, presented the report and highlighted the following. We have completed the 2017/18 self-assessment and are confident that we will meet substantial compliance with this submission. We have a further work plan to move us to full compliance for the next submission in 2018. We will receive the outcome following the confirm and challenge session on 13th October 2017. The Board is asked to note the contents of the report and approve the work plan for 2017/2018. *Approved / Received*	
833/2017	**SERVICE USER AND CARER COUNCIL** Ms Wendy Dutton, Chair of the Service User Carer Council provided a verbal update. A formal report was unavailable as there was no meeting in September as the date of the meeting clashed with the Rethink Conference. Main area for discussion at the conference was the Care Act. This was very useful and a positive session. Ms Dutton wished to note that the SUCC feel very included in the Service Development of PICU discussions and are happy to see their views are being taken seriously. *Noted*	
834/2017	**WRES – WORKFORCE RACE EQUALITY STANDARD** Mr Paul Draycott, Director of Leadership and Workforce presented the report. Mr Draycott recalled that the Board spent development time with Yvonne Coghill from the NHS England WRES Implementation Team looking at this. The Trust has improved in 7 out of 9 areas but there is still significant work we want to undertake captured within the action plan. Mrs Donovan highlighted one of the keys things we are going to set up is the BME Network and we have appointed Cherelle Laryea, Trainee Clinical Psychologist (Diversity and Inclusion Champion). It is great to have	

	someone with her energy and Yvonne Coghill recognised she was a star in the making using that enthusiasm to help us to pull this together and get things moving.	
	Received / Approved	
835/2017	**DIVERSITY AND INCLUSION STRATEGY UPDATED ACTION PLAN**	
	Mr Paul Draycott, Director of Leadership and Workforce presented the report.	
	Mr Draycott advised this is an update to the strategy that came to Trust Board last year and to provide an update on the plan associated with the diversity and inclusion strategic plan. The strategy has been brought to Trust Board to provide assurance.	
	There will be a future Board Development Session to look at the information again following on from the Board Development session held with Yvonne Coghill from the NHS England WRES Implementation Team to achieve a better understanding.	
	Received	
836/2017	**FINANCE REPORT – MONTH 5 (2017/18)**	
	Miss Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points.	
	During month 5, the Trust had an in month trading position of £133k surplus against a plan of £95k surplus; a favourable variance of £38k. Sustainability and Transformation funding has been assumed at £33k for month 5, bringing the overall trust control to a £166k surplus against plan of £128k; a favourable variance of £38k.	
	The Trust has a year to date trading position of £74k surplus against a plan of £117k deficit; a favourable variance to plan of £191k. After Sustainability and transformation funding (£141k), the trust has a Control Total surplus of £215k against a plan of £24k surplus; a favourable variance to plan of £191k.	
	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 £151k YTD through not backfilling these posts during this period. This non-recurrent benefit accounts for the majority of the YTD surplus.	
	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.	
	The 2017/18 year to date CIP achieved stands at £491k (58%)	
	The recurrent value of schemes transacted is £1,521k against £3.2m target. The recurrent forecast as at M5 is £2.737m (86%); this represents a recurrent shortfall against the target of £460k (14%).	
	We have seen a significant improvement from Month 4 – 5 but still a challenge. Recurrent CIP is one of the top 3 Trust risks.	
	The cash balance at 31st August 2017 has decreased to £6.243m due to an increase in the value of receivables and a reduction in the payables; however the Trust cash position at 31st August 2017 is £726k higher than planned. The Trust anticipates be on plan by March 2018.	
	➢ The Operating Plan as reported to NHSI forecast there would be a total charge against the CRL of £1,106k by month 5, including (£713k) Capital Receipts for the sale of Bucknall Hospital and £1,819k Capital Expenditure.	
	➢ Actual Capital Expenditure as at month 5 is £355k against an updated Capital Expenditure plan of £732k	
	Capital expenditure will be reviewed on a quarterly basis. Use of resource rating of 2.	
	Miss Robinson and Dr Fazal-Short have set up a series of CIP workshops with Directorates.	
	Approved	
837/2017	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE**	
	Mr Gadsby, Chair of the Finance and Performance Committee/Non-Executive Director, presented the report from the meeting held on the 28th September 2017 highlighting the following:	
	The committee cannot give assurance yet that CIP can be achieved this year and will keep close to this going forward.	
	The M5 Capital forecast was presented which factored in the new Internal Capital Resource Limit of £2.041m, which will be reviewed every quarter. The Committee were assured that the Trust had a robust understanding of the Capital Affordability through the cash management tool, but noted the	

challenge around the remaining contingency for the year.

Policies

The following Policies are due to expire on 30th September 2017. The Committee approved an extension to be presented at the next Finance and Performance Committee in October for ratification by Board in November.

- Cash and Treasury Management
- Anti-Bribery Policy
- Standing Orders

Performance - The report detailed M5 activity against plan using traditional reporting methods and care pathway clustering. There is a small over performance on Care Clusters in month, but an underperformance against traditional reporting. 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. Actions are in place to improve the data quality of activity and care clustering.

A deep dive of Readmissions was reported to the Committee in July. A supporting action plan implemented has resulted in a significant improvement in performance. The emergency readmission rate continues to reduce from 15% in April to 4.7% in August.

The committee agreed the following changes:

- Digital will sit under Finance and Performance Committee. The Finance and Performance Committee will be changed to Finance, Performance and Digital.
- Estates compliance will move from Finance, Performance and Digital to the Business Development Committee.
- Emergency Planning will also report through to the Business Development Committee.

The Terms of reference will be updated in terms of key risks and responsibilities of each committee.

Received

| 838/2017 | **CYBER SECURITY REPORT** | |

Miss Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points.

The purpose of this paper is to provide an update of the Trust's approach to cyber security following the Wannacry incident in May 2017, and to provide the Board with assurance that future attacks are mitigated against. This paper does not directly address the operational response lessons learnt from the Wannacry attack in May 2017 (which has been received at Audit Committee), but focuses on the wider cyber security controls that the Trust must ensure are in place if it is to remain safe from future cyber-attacks.

The Trust has already taken steps to reduce the risks posed by cyber-

attacks.
- Testing
- Patching
- Training
- Policies and procedures
- Perimeter Security
- Device Replacement
- Security and Access Controls

Miss Barber asked how this links to the wider economy across STP moving to shared records. Mrs Donovan advised shared care records won't replace everyone's individual records; every organisation will have to remain responsible for their own security.

Mr Hughes stated that during the cyberattack regulators were sending out instructions via e-mail. Mrs Donovan advised that regulators have done a deep dive for learning and apologised.

Mr Gadsby asked if the plan was to have this externally audited on an annual basis whether they think we are secure or not to provide further level of assurance. Miss Robinson advised this is part of our internal audit report.

Received

839/2017	**CAMHS ASSURANCE REPORT**	

Dr Fazal-Short, Director of Operations presented the report highlighting the following:

The Assurance Report provides detail on the substantial progress that has been made by the CYP Directorate in meeting the needs of Children and Young People. It details the level of access through waiting time data to a range of interventions that promote recovery. It also highlights improved performance on clinical areas that were highlighted by CQC. Additionally, it describes future developments to promote sustainability.

Access to Treatment – A number of additional interventions were established to improve waiting time from assessment to treatment.

Waiting lists and waiting times - The service has refined its systems and processes and has implemented a comprehensive action plan to ensure that all children and young people, who were identified as waiting for specialist interventions following assessment, will be in treatment by the end of October 2017. All children and young people have an allocated care co-ordinator who is responsible for facilitating the delivery of their care and maintaining regular contact with them.

In the absence of any nationally recognised metrics, the Trust has developed local KPIs to provide further assurance that children and young people are seen for assessment and treatment in a timely manner:
- 4 week wait from referral to assessment (all CYP services excl.

	ASD) - This will be measured by the presence of the first face to face or telephone/ digital (Skype) contact. • 18 week from referral to treatment (all CYP services excl. ASD) - This will be measured by the presence of the second face to face or telephone / digital (Skype) contact. An action plan was established which addressed the feedback from the CQC inspection in September 2015. This action plan was refreshed following the 2016 CQC inspection and a programme of audit and assurance was implemented. Having made significant and sustained progress in reducing the waiting lists across the Directorate, the service is now beginning a transformation project to further develop the Central Referral Hub. This will be achieved through reconfiguration of existing resource and the introduction of an evidence based, brief intervention clinical pathway. Building on the existing model of care provided by the Central Referral Hub, this transformation will improve the front door experience for children, young people and their families - working in partnership to deliver an integrated, recovery based, preventative model that is flexible in meeting the needs of children and young people. The Board was asked to note the significant improvement in supporting children and young people with timely access to treatment and note the systems in place to monitor and maintain improved performance. Excellent feedback has been received by the CQC. Mrs Donovan referred to the parent who attended Open Trust Board expressing concern about her experience. Dr Fazal-Short advised there is now a CYP Council and a sister Parent Council – the parent that attended Trust Board is now a member of the Parent Council and Ms Dutton advised she is still linked with her also. **Received**	
840/2017	**TOWARDS OUTSTANDING ENGAGEMENT REPORT** Mr Paul Draycott, Director of Leadership and Workforce presented the report. This paper provides a high level summary of the Trust's Towards Outstanding Engagement Programme in response to the initial Pulse Survey conducted in May 2017 which will inform our baseline position from which we can benchmark our performance and improvement. Initial results from the Trust's first Pulse Survey on balance provide a favourable staff engagement result. With some identified areas requiring focus and improvement. The second pulse check will allow the Trust to benchmark and review progress providing more timely and meaningful staff engagement and cultural feedback. Further, discussions and monitoring to	

	take place at PCD and JNCC. *Received*	
841/2017	**PARTNERSHIP STRATEGIC PLAN** Mr A Hughes, Joint Director Strategy and Development presented the paper highlighting the following: The report aims to outline a plan for partnership for the Trust. It focuses on the maintenance of existing partnerships and the development of new partnership opportunities. It provides structure and governance to all partnership arrangements and offers a structure to all levels of partnership engagement. Partnership will be a theme of the business planning process and this is offers a toolkit for those discussions. The Plan was received by the Business Development Committee at its September meeting. It was acknowledged as a largely academic and theoretical document but also welcomed as an evidence-based approach to better governance. The Directorate of Strategy and Development launched this year's planning process at the Leadership Academy on 4 October 2017. Over the coming quarter (and beyond) the aim will be to complete a comprehensive review and compile a detailed review of all existing partnership. The work will provide a baseline assessment of the nature of our partnerships and, even more critically, of the resource that is currently being used – often in informal or unseen ways – to manage those relationships. The Trust Board is asked to note the process that is being followed as part of the business planning process and be that the Directorate of Strategy and Development is gaining further grip and insight regarding the Trust's partnerships. Mrs Walley highlighted what matters is understanding what partners we have and how we are working together to meet our objectives. Mr Rogers highlighted that we have to manage risk in terms of partnership and this is a route to doing that. Mr Rogers would like to see the list of partners we have at a future Trust Board meeting. *Received*	**AH**
842/2017	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE (VIRTUAL MEETING)** Mr Patrick Sullivan, Chair of the Quality Committee / Non-Executive Director presented Outputs from the Quality Committee for the Trust Board meeting on 5 October 2017 and highlighted the following: During the month of September 2017, the Quality Committee were asked to consider a number of policies. This was undertaken by virtual review in the	

	absence of a meeting. The purpose of this report is to notify the Trust board of the outcome of this work and to recommend ratification of policies and procedures a follows: The recommendations were supported by the Committee for ratification of policies by the Trust Board for 3 years or otherwise as stated. • 1.02 Professional Registration – extend to 31.12.2017 • 5.40 Transport Policy – updated and approve for 3 years • 1.25 Food & Waste Guidelines – reviewed – extend to 28.02.2018 • 4.27 Protected mealtimes – reviewed – extend to 28.02.2018 • 1.67 Smoking policy – extend to 31.12.2017 • All Infection Control (IC) policies to have same review date 31.01.2018 • 1.12b Staffs and Stoke Safeguarding Adult Partnership Board Procedure - remove procedure from SID. Overarching policy remains in place. ***Received/Approved***	
843/2017	**ANY OTHER BUSINESS** **MENTAL HEALTH COMMISSIONERS VOLUNTARY SECTOR BUDGET CUTS – Ms Dutton** Ms Dutton discussed how the CCG are managing cuts to funding to the voluntary sector. Ms Dutton attended a recent North Staffs Voices Group and had the distinct impression the agenda was already set before the meeting and had to fight to get Commissioners to have the conversation with Service Users with the general feeling is the impact is not being measured properly. Mrs Donovan advised this is an item that is for discussion within the Closed Session of today's Trust Board. Commissioners have advised they have undertaken a deep analysis of the voluntary sector contracts and board governance of the CCGs through various sub-committees have looked at QIA's. It has been suggested that we should work together with Brighter Futures and ask to meet with MPs and go to CCG Board and talk about the impact - we will continue to challenge formally. Mr Sullivan highlighted this is a major issue around the quality of services and we cannot provide high quality services with just a statutory sector we need a non-statutory sector too. **NORTH STAFFS USERS GROUP** Hilda Johnson wished to thank everyone for their support and wished to highlight the reasons for funding being pulled is that the group are not a service provider but a sign posting service. Bids are being submitted. The service is available at the moment until December 2017.	

844/2017	**Date and time of next meeting**	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 9th November 2017 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
845/2017	*** 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 12.56pm

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
05-Oct-17	829/2017	Research and Innovation Stategy - Dr Chris Link to circulate leaflet via Lisa Wilkinson to Trust Board members	Dr Buki Adeyemo	09-Nov-17	Complete
05-Oct-17	826/2017	Access and Home Treatment Spotlight - Dr Fazal-Short to look into high volume users capacity.	Dr Fazal-Short	11-Jan-18	
05-Oct-17	830/2017	Safer Staffing Nursing Report - August. Mr Rogers asked for trend to be illustrated in future reports	Ms Nelligan	11-Jan-18	6 month staffing report to go to January Board inlcuding fill rate trend due to changes in shift patterns
05-Oct-17	841/2017	Partnership Strategic Plan - Mr Rogers asked to see the list of partners we have at a future Trust Board meeting.	Mr Hughes	11-Jan-18	

REPORT TO Trust Board

Enclosure 4

Date of Meeting:	Thursday 9 November 2017
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: Name: Date: Email:	Caroline Donovan, Chief Executive Caroline Donovan Thursday 9 November 2017 caroline.donovan@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	
Purpose / Intent of Report:	For information
Executive Summary:	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.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Quality Strategy • Digital Strategy • Governance Strategy • Innovation Strategy • Workforce Strategy • Financial Strategy
Relationship with Annual Objectives:	n/a
Risk / Legal Implications:	n/a
Resource Implications:	n/a
Equality and Diversity Implications:	n/a
Relationship with the Board Assurance Framework	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
Recommendations:	To receive this report for information

Chief Executive's Report to the Trust Board
9 November 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. CQC UPDATE

Much of October was taken up with the CQC Inspection of clinical core services and the well-led review. The CQC visits started in the week commencing, Monday 2nd October with the Community CAMHS Team at Dragon Square and Adult Community team at Greenfields. As we had self-assessed learning disability wards, Florence House and Summers Views as Outstanding, the CQC also came to have a look at these services. The well-led review took place in the week commencing 30th October.

The feedback we have had at this stage has been overwhelmingly positive. Where improvements have been identified, we will work to make improvements as part of our continual journey of improvement.

I am also delighted that Combined has been identified as an exemplar by the CQC as one of the fastest improving trusts in the country. The CQC exemplar team were on site in October to interview many of our staff and running focus groups to learn about how we have progressed our journey of improvement. The CQC will now develop a case study narrative to be published nationally for all to learn. This is such great news and a true testament to the excellent work our staff are leading on.

2. NEW CHAIR FOR STP

I was really pleased to have meet Sir Neil McKay, the newly-appointed chair for Staffordshire STP. Neil has previously been Chief Operating Officer at the Department of Health and was Chief Executive of the East of England Strategic Health Authority. He's a great appointment and I really look forward to working with him. It has been very helpful to hear his views, particularly his support of the Alliance Boards and integrated locality working.

3. BOMB SCARE AT HARPLANDS

Sometimes the best successes are when something is dealt with calmly and professionally whilst remaining relatively unseen to the rest of an organisation. We had exactly this with an incident at Harplands Hospital, which showed the sheer professionalism and abilities of our staff.

On Friday 6th October, we received a bomb threat which claimed that a device had been planted in Harplands Hospital. All staff worked together to support an evacuation of the hospital while the police supported us with checking the main hospital and giving the all clear on the bomb threat. The staff then calmly supported

all patients back to the wards. In the early and preliminary debrief we have already picked some key lessons and put into place a number of measures to rectify anything that needed immediate attention. We will be carrying out a full debrief and will invite those involved to participate and then will develop our detailed lessons and implement those. The Trust emergency planning accountable Officer (Nasreen Fazal-Short) and operational lead (Natalie Larvin) have been in touch with all staff to remind them about the important processes to follow in such evenet

4. STP DIGITAL WORKSTREAM AGREES BUSINESS CASE FOR INTEGRATED CARE RECORD

The STP Digital Workstream, which I lead, took a significant step by approving the draft Business Case for the Integrated Care Record. The draft is now being taken to each organisation in the STP for their agreement.

It's not simply introducing technology for technology's sake, but really concentrating on the benefits it can deliver for local care:
- It will enable health and care practitioners to view information relevant to the individual they are caring for in any given place and time in a safe and confidential way;
- Practitioners will be able to see an incrementally comprehensive record for their patients' medical and care needs, making care safer and reducing duplication;
- whether individuals are being treated by their GP, in a community-based service or in hospital, their shared digital care record will be accessible 24/7 with appropriate permissions and consent;
- it will prevent patients from being asked for their information repeatedly and ensure their preferences such as information about resuscitation, mental capacity and end of life wishes are shared and understood by all practitioners caring for them.

5. NEWCASTLE ACCELERATED DESIGN EVENT

We have been working in recent months with the NHS Chief Transformation Officer, Helen Bevan, to develop a series of Accelerated Design Events. This is an innovative approach to transformation, getting people together to be creative and problem-solving in addressing major challenges across our local health and care economy,

As part of my role leading the System Leadership workstream for the Staffordshire STP, I spent a fascinating and really enjoyable time at an excellent Accelerated Design Event supported by the team at Combined together with Helen and Dr Emma Dutton looking at how we can build on the work we have been developing with the Staffordshire and Stoke-on-Trent Alliance to develop a new model of care in Newcastle.

We heard presentations from a range of speakers, including the excellent Dr Mark Williams and Newcastle GP Dr Emma Sutton and Dr Dawn Moody who reminded us of the benefits of a more patient centred model for patients. We spent time during the day planning how we are going to establish the new model.

We'll be feeding the ideas from the event not just into our work supporting the Alliance, but more widely across the STP in terms of its own developing thinking on how to be innovative about how we deliver care.

6. MEIR PARTNERSHIP CARE HUB WINS NATIONAL AWARD

An innovative partnership service that brings together health and social care services to deliver more effective services to those living within Meir in Stoke-on-Trent has won a national award. The Meir Partnership Care Hub beat tough competition to win the Mental Health and Social Care category at the Positive Practice in Mental Health Awards. The award recognises the work that is taking place within the hub to deliver fully integrated services to the patients of five GP practices in Meir. The hub has been running since October 2016 and is a partnership of North Staffordshire Combined Healthcare NHS Trust and Stoke-on-Trent City Council, with involvement from Staffordshire and Stoke-on-Trent Partnership NHS Trust, Staffordshire Fire and Rescue Service, Staffordshire Police and the voluntary sector. It has been supported by the Cooperative Working Partnership within Stoke. It puts patients first by working together to address a person's needs and identifying sustainable solutions that, where possible, prevent them from spending unnecessary time in the health and social care system. Positive Practice is a user led multi agency collaborative of 75 organisations, including NHS trusts, clinical commissioning groups, police, third sector providers, charities and service user groups. Its aim is to identify and share positive practice in mental health services.

7. FINANCE TEAM SHORTLISTED FOR NATIONAL TRAINING AWARD

Well done to the Finance team, who have been shortlisted in the Havelock Training Award at the 2018 Healthcare Financial Management Association (HFMA) Awards. The team have achieved some great things in 2017, including the innovative Valuemakers initiative, getting consultants engaged in key financial projects and the excellent animated film of our 2016/17 Annual Accounts that was produced for our most recent AGM which you can view via our YouTube channel.

8. LOCAL MPs DEBATE FINANCIAL SITUATION FACING NORTH STAFFORDSHIRE'S NHS IN HOUSE OF COMMONS

MPs representing Stoke-on-Trent took part in a debate in the House of Commons on Monday 23 October into the serious financial challenges facing the NHS in North Staffordshire. Thank you to Gareth Snell, MP for Stoke-on-Trent Central, for securing the debate and also to Jack Brereton, MP for Stoke-on-Trent South, who made the following comment highlighting Combined Healthcare's financial performance: "I recognise that there are significant financial challenges, particularly around the hospital, but North Staffordshire Combined Healthcare NHS Trust, for example, has made significant improvements in the wider health economy."

It is very welcome that the worrying financial situation facing the local health and social care economy is being debated at this level and I am pleased that Philip Dunne, Health Minister and MP for Ludlow has agreed to visit the area to see first-hand the situation on the ground. Thank you also to Stoke-on-Trent North MP Ruth Smeeth and Stafford MP Jeremy Lefroy or taking part in the debate.

9. REACH AWARDS A HUGE SUCCESS

Our biggest REACH Awards yet were held on 5 October, with more nominations and awards than ever before. We received almost 300 nominations – a record number – and the winners and highly commended in each category are set out below in full:

Leading with Compassion Award (sponsored by Browne Jacobson)
- Winner – Chris Link
- Highly Commended – Maxine Tilstone and Karen Stone

Proud to CARE Award (sponsored by BBC Radio Stoke)
- Winner – Wendy Wardell
- Highly Commended – Carol Sylvester, Desi Summers and the NOAP Activity Workers

Volunteer/Service User Representative of the Year
- Winner – Hilda Johnson
- Highly Commended – Gabrielle Gay Hoban, New Beginnings, Linda Lock and John Davies

Developing People
- Winner, Lillian Machin
- Highly Commended – Alison Duffell and Jacqui Shenton

Innovation
- Winner – Stevan Thompson and Georgina Jackson
- Highly Commended – Access Team and Looked after Children Team

Valuemaker
- Winner – Jane Munton-Davies
- Highly Commended – Anne Wilson, Cath Walasiewicz and Jenny Washington, High Volume Users Service

Partnership (sponsored by RCN)
- Winner – Julia Ford
- Highly Commended – Glynis Harford and John Clayton from the MCP Team and North Staffs Voice for Mental Health

Unsung Hero (sponsored by Unison)
- Winner – Julie Fuller
- Highly Commended – Harplands Reception, Faye Rathbone, Gaynor Pearce and Gavin Bridgwood

Rising Star (sponsored by Town Hospitals)
- Winner – Mike Newton
- Highly Commended – Deborah Elson, Emma Mellor and Terri Wright

Team of the Year
- Winners – Community CAMHS and Substance Misuse
- Highly Commended – Diversity and Inclusion Team and RAID Team

Chairman's Award

- Winner – Chris Link

A very special part of the evening was the launch of the Justin Griffiths Scholarship Award - an annual award which will support Social Workers, Best Interest Assessors and Approved Mental Health Professionals (AMHPs) to develop their knowledge and skills, improve the lives of others, encourage research, development and education within our mental health and learning disability services reflecting the work practice of the above professionals; and provide a scholarship(s) to those who are undertaking professional development through study, research or experiential learning. We will be publishing details on how to apply for the scholarship shortly. It was really lovely having Nicky Griffiths and her two delightful daughters Nya and Eva with us on the night. We were delighted to showcase our first ever Combined Healthcare Nursing Badge and thanked Deb Scragg and Sue Wood for their great design skills, while we also gave a special presentation to Paul Draycott, Director of Leadership and Workforce, for his service to the Trust over many years. You can still view the online stream of the REACH Awards via the Trust's Facebook page here at www.facebook.com/NorthStaffsCombined/.

10. OLDER PEOPLES' COMMUNITY SERVICES AWARDED PRESIGIOUS KITE MARK FROM THE ROYAL COLLEGE OF PSYCHIATRISTS

The Trust has been granted accreditation for the next two years from the Royal College of Psychiatrists' (RCP) Memory Services National Accreditation Programme – the premier and highly prestigious kite mark for quality of care in memory clinics. Congratulations in particular to Rachael Birks, Memory Team Manager, and Claire Barnett, Advanced Nurse Practitioner, who led the application to the programme. This required substantial work and co-ordination with the MNSAP Inspection Team and involved a rigorous peer review process which has not only led to our Trust getting accreditation, but also the recognition of both leads as MSNAP Peer Reviewers in their own right. This means that clients and carers can see the City Memory Service not only provides the highest memory diagnosis rates in the region, but is also recognised as being safe, progressive, inclusive and innovative in the provision of quality care.

11. DR RAVI BELGAMWAR APPOINTED NEW REGIONAL TRAINING DEPUTY DIRECTOR

Congratulations to Dr Ravi Belgamwar, Consultant Psychiatrist at the Lymebrook Centre, who has been appointed as Deputy Training Program Director for General Adult Psychiatry at the West Midlands Post Graduate School of Psychiatry. Dr Belgamwar will start this this role from 1 December 2017 and will work closely with Dr Derrett Watts, Substance Misuse Clinical Director, to ensure the delivery of good quality training, particularly in relation to the assessment process and curriculum requirements to help improve the quality of the training across the region.

As College Tutor for last eight years, Dr Belgamwar has played a vital role in maintaining and developing the academic and educational activities within the Trust. The recruitment process will commence shortly for a replacement College Tutor.

12. PARTNERSHIP WITH KEELE UNIVERSITY DELIVERS RESULTS

One of our most valued partnerships is that with Keele University. We're proud to be able to be called a Keele University Teaching Trust and, as part of the assurance overseeing this partnership, I spent some really rewarding time welcoming the Dean of the University and the School of Medicine QA monitoring panel to Harplands Hospital. The panel were able to meet with students, doctors, tutors and other health professionals and I know we gave a really good account of ourselves and the training and education we provide.

The feedback we received was overwhelmingly positive. It is so important that our students and trainees have a great learning experience when they come to Combined - they are much more likely to want to come and work with us. A very big thank-you to Dr Buki Adeyemo, Dr Dennis Okolo, Dr Ravi Belgamwar and Dr Darren Carr who demonstrated their excellent leadership in leading medical education across our Trust. I felt really very proud of them.

We are also delighted that Keele University has been ranked joint first with the University of Oxford for producing the most psychiatrists of any medical school in England. Keele has had the most graduates progress to a career in psychiatry in the past three years, placing joint first with Oxford University in a new table published by the Royal College of Psychiatrists (RCPsych). The new figures show that in the last three years, Keele University produced on average more than double the number of psychiatrists than the University of Cambridge. Between 2014 and 2016, 4.3% of medical school graduates from Keele went on to become psychiatrists.

13. FREEDOM TO SPEAK UP GUARDIAN

Ward 7 Manager Dan Platt has been appointed as the Trust's new Freedom to Speak Up Guardian. Dan has taken over the role from Jan Summerfield and, as Guardian, is in a position to provide confidential advice and support to staff on concerns they have about patient safety and the way their concerns have been handled.

Guardians do not have a remit to assist staff employed outside of the organisation and they don't get involved in investigations or complaints, but help to facilitate the process where needed, ensuring organisational policies relating to raising concerns are followed correctly.

14. FLU FIGHTER CAMPAIGN

Following the success of last year's Flu Fighter campaign, which saw Combined become the top performing mental health trust in the country, the 2017/18 Flu Fighter campaign is well underway and already proving a success, with hundreds of staff having received the vaccination, thereby protecting themselves, their colleagues, patients, friends and family from the flu virus. Our dedicated team of vaccinators continue to hold flu clinics at locations throughout the Trust and held a 24-hour Jab-a-thon on October 20th and 21st where they delivered the vaccine at locations throughout the Trust. The Trust is also working with partner organisations throughout the region to promote the #StayWellThisWinter campaign via social media and other communications channels. The campaign encourages everyone to get the flu

vaccine, but in particular those people who are pregnant, are a parent of a young child, are living with a long term health condition, are aged over 65 or are a carer.

15. PERSON CENTREDNESS FRAMEWORK PLANNING DAY HELD

I was delighted to open our first Person Centredness Framework Planning Day on 3 November at Port Vale for staff to learn more about what person centredness really means – the results of which will inform our new person-centred framework. This will be co-produced with people who access our services, as well as their carers, families and our staff. The framework will celebrate and support us all as unique individuals with our own strengths, abilities, needs and aspirations.

NATIONAL UPDATE

16. CHILDREN'S COMMISSIONER PUBLISHES REVIEW OF MENTAL HEALTH SERVICES FOR CHILDREN

On 10th October, the Children's Commissioner published a review of mental health services for children. The Commissioner said that children's mental health was the issue most often raised with her over the past year, and it was the top of the list in her consultation with children about her priorities for the year ahead.

The review concluded:

- between 1 in 4 and 1 in 5 children with a mental health condition received help last year;
- the overwhelming majority of NHS mental health spending goes towards those with the most severe needs;
- This is despite the fact that early intervention is much cheaper to deliver and highly cost-effective in preventing conditions escalating:
- the Government's prioritisation of mental health has yet to translate into change at a local level;
- there is a massive discrepancy between children's and adult's mental health.
- Most local areas are failing to meet NHS benchmarks for improving services and providing crisis care.
  - o Nearly 60% of local areas are failing to meet NHS standards on improving services
  - o Over 55% of local areas are failing to meet NHS standards on providing crisis care in A&E and other settings

The Commissioner recommends:
- The forthcoming Green Paper presents an opportunity to transform children's mental health services. Its ambition should be to bring about a system designed around three principles:
  - o A mental health service that is designed for children and built to meet their needs.
  - o A service that supports children in the right place at the right time.
  - o High quality, evidence based services, from the classroom to hospital care.
- In order to achieve this, the Green Paper needs to set clear expectations as to what a child can expect in terms of mental health support and achieve consistency in every area of the country, and whose responsibility it is to

provide this. To underpin this, we need a more transparent and accountable system.

17. CQC PUBLISHES REVIEW OF CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

On 27th October, the Care Quality Commission (CQC) published its '*Review of children and young people's mental health services*' on the challenges facing providers of services for children and young people's mental health. The report is the first phase of a CQC review into the quality and accessibility of mental health services for children and young people and summarises the current state of knowledge from across a range of sources. A link to the report can be found [here]

The Report found

- The system as a whole is complex and fragmented. Mental health care is funded, commissioned and provided by many different organisations that do not always work together in a joined-up way. As a result, too many children and young people have a poor experience of care and some are unable to access timely and appropriate support.
- Where the CQC has seen good care, it has found collaboration within services and also between different organisations and services. it also found examples of creative approaches that help some services provide good or outstanding examples of person-centred care.
- People who work with children and young people do not always have the skills or capacity to identify mental health problems. They may not be able to help children and young people access the right support at the right time.
- More children and young people are being diagnosed with some types of mental health problems than in the past.
- Safety is seen as the greatest overall area of concern in specialist child and adolescent mental health services.

To coincide with the publication of the CQC Report, we published updated waiting time figures, demonstrating the significant improvement and quality of services being delivered by our CAMHS service. Over the last two years, we have made significant progress in ensuring children and young people are seen in a timely manner for an initial assessment, they receive a good quality risk assessment and care plan and that everyone is allocated a care coordinator, with the result that:

- Two thirds of children and young people are seen for a first assessment within four weeks - no child waits more than 18 weeks.
- 97% of children and young people receive treatment within 18 weeks.

Our children and young people's services has also:
- Developed a multiagency single point of access service at the Bennett Centre in Stoke-on-Trent enabling children and young people receive the right service at the right time in the right place.
- Rolled out a new programme of high intensity evidence based treatment groups supporting children with a range of mental health disorders, including self-harm, anxiety and depression.
- Introduced attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) skills workshops in children and adolescent mental health service (CAMHS) sites across the whole of Stoke-on-Trent and North Staffordshire;

- Developed a new specialist community eating disorder team, with 100% of children and young people receiving treatment within four weeks of referral for routine cases; and one week for urgent cases.
- Unveiled a new garden at the Trust's Tier 4 CAMHS service at the Darwin Centre as part of a programme of investment to improve therapeutic environments.

We have also recently joined forces with local schools to launch a nationally leading new mental health and wellbeing strategy. The strategy has been launched as part of an exciting partnership between Combined Healthcare and a number of partner schools across Stoke-on-Trent.

Our updated figures were covered approvingly by BBC Radio Stoke, together with comments from Dr Matt Johnson.

18. GOVERNMENT ANNOUNCE NEW £15M GRANT SCHEME TO IMPROVE MENTAL HEALTHCARE

The Department of Health has launched a £15m fund to better support people at risk of experiencing a mental health crisis – called the Beyond Places of Safety scheme, which promises to improve support services for those needing urgent and emergency mental healthcare. This includes conditions such as psychosis, bipolar disorder, and personality disorders that could cause people to be a risk to themselves or others. The scheme will focus on preventing people from reaching crisis point in the first place, and helping to develop new approaches to support people who experience a mental health crisis. Click here to read more.

The Heads of Directorate for Adult Inpatients and Adult Community attended a workshop led by the mental health commissioners for North Staffordshire and Stoke-on-Trent CCGs on 27th October. We will continue to input into a bid against this capital for the benefit of our local residents.

19. NHS CYBER ATTACK REPORT

The National Audit Office (NAO) published a report into the WannaCry cyber attack which was released worldwide in May 2017 and disrupted more than a third of NHS organisations. Among the key findings of the report included that the Department of Health was warned about the risks of cyber attacks on the NHS a year before WannaCry and although it had work underway it did not formally respond with a written report until July 2017. At least 6,900 NHS appointments were cancelled as a result of the attack, although no patient data had been compromised or stolen and the response of staff was praised. Sir Amyas Morse, Head of the NAO, who compiled the report said: "The WannaCry cyber attack had potentially serious implications for the NHS and its ability to provide care to patients. It was a relatively unsophisticated attack and could have been prevented by the NHS following basic IT security best practice. There are more sophisticated cyber threats out there than WannaCry so the Department and the NHS need to get their act together to ensure the NHS is better protected against future attacks." A link to the report can be found here.

I previously reported to the Board in June 2017 the actions we had taken in response to the attack. Our staff worked tirelessly and professionally over the weekend of 13th – 15th May to continue to provide the highest quality care, to manage the impact and to resolve the problems. We worked with colleagues across the health economy to

ensure that patient care was not compromised and I am pleased to report that no data was lost or illegally accessed. We also were able to use our social media channels and website to very good effect to ensure local patients and the local media were kept informed and reassured and we were able to answer any questions that arose

As a result, the attack was dealt with calmly and effectively.

The attack came just hours before we were due to 'Go Live' with our new Electronic Patient Record (ROSE). However, the careful planning we had put in place to prepare for the migration of our records from the old CHIP system to the new Lorenzo system put us in good stead to deal with the cyber attack.

REPORT TO: TRUST BOARD

Enclosure No:5

Date of Meeting:	9 November 2017
Title of Report:	Service User & Carer Council Report
Presented by:	Wendy Dutton, Chair, Service User & Carer Council
Author:	Wendy Dutton, Chair, Service User & Carer Council
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality

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 on 25 October 2017.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐

Seen at:	SLT ☐	Date:
	Execs ☐	Date:

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 identified
Resource Implications: Funding Source:	None identified
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Service User & Carer Council supported the principle of increasing representation across the Protected Characteristics when reviewing the Diversity and Inclusion Strategy. They also committed to supporting inclusive services and workforce in their review of the Strategy.
Recommendations:	The Trust Board receives the update for information and assurance.

Version	Name/group	Date issued
1	Trust Board	2 November 2017

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SERVICE USER AND CARER COUNCIL UPDATE
FOR TRUST BOARD ON 9 NOVEMBER 2017

1.   The bi-monthly meeting format:
Items covered in business meetings on:-

1.1   *26 September 2017*
This meeting was postponed given that a RETHINK Conference was organised on the same day which members of the Service User & Carer Council attended.

1.2   *25 October 2017*

- The Council was updated on Section 75 and the Trust's current position. Concerns were raised re lack of engagement with the Trust, robust consultation process with the public and service user's, the agreed preferred provider and clarity of what this means in real terms going forward. A long and frank discussion took place which highlighted the need for an individual and Group response to Staffordshire County Council in relation to Section 75 consultation.

- Work on care plans is suspended until after the Person Centred Planning Day on the 3 November 2017. It was agreed to consider a 1 page profile and link this to further work on care plans.

- Reviewed the updated Smoke Cessation Action Plan for which 3 service user's are currently involved with the Smoke Free Task & Finish Group.

- The Citizens Jury report was due for review, however at the last meeting held on 10 Oct 2017 with the current Jury, it was advised that the report will now be delayed until 6th December 2017. Issues relating to the loss of such organisations as North Staffs Voice for Mental Health, Echo and Safer Spaces were raised.

- Service User and Carer Strategy - this is to be simplified on a 1 page document as is the Restraint Reduction Strategy.

- 2nd Open Space Event scheduled for Monday 29 January 2018 at Port Vale FC. Thoughts will be put on paper as soon as possible to ensure clarity and timeliness of flyers.

- CQC Well-Led Review week commencing 30 October 2017. Focus Groups and individual interviews have been scheduled accordingly.

- Membership and Equality & Diversity Strategy was discussed and agreed to look at adding to membership.

- Service User representatives identified for sub-Committees of the Trust Board, in particular: Wendy Dutton for Quality Committee, Hilda Johnson for People, Culture & Development Committee; Steph Pacey for Business Development Committee and Sue Tams for Finance, Performance & Digital Committee.

1.3   Further discussions took place on:

Valuemakers which attempts to teach non-finance people about finance. Service User & Carer Council members are asked to send any ideas through the Valuemakers website, to reduce waste or duplication, be more efficient and put more money back into patient care which will help to improve the quality of care.

2.   Educational/Workshop on 29 November 2017
The above will include:-

Acute Care Pathway - Natalie Larvin agree to put on paper along with a presentation.

3.   Other areas of the Trust that the 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 stakeholder panels across the Trust
- Unannounced Visits
- PICU meetings
- Directorate meetings

REPORT TO OPEN TRUST BOARD

Enclosure No:6

Date of Meeting:	9 November 2017		
Title of Report:	Memorandum of Understanding Staffordshire University		
Presented by:	Dr Adeyemo, Medical Director		
Author:	NSCHT/Staffordshire University		
Executive Lead Name:	Dr Adeyemo, Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
A Memorandum of Understanding with Staffordshire University and the Trust was agreed and signed on 19 September 2017. This is in line with the Trust exploring new opportunities for research, evaluation and partnership working to restore and reinvigorate academic links and collaborations with local Universities. This summary provides an update..		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date: Not seen	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	Not directly as a result of this report		
Resource Implications: Funding Source:	Not directly as a result of this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Not directly as a result of this report		
Recommendations:	For information and assurance purposes		

Memorandum of Understanding Staffordshire University

Introduction

The purpose of this briefing paper is to provide a summary of developments and next steps for the Memorandum of Understanding

The Trust has begun to explore new opportunities for research, evaluation and partnership working to restore and reinvigorate academic links and collaborations with local Universities. Over the last 10 months there has been significant momentum and enthusiasm to progress this work forward.

Developments

Staffordshire University & Centre of Health and Development (CHAD)

The opportunity with Staffordshire University arose from individual engagement and discussions with Professors, the Associate Professor at the University, and Centre for Health and Development (CHAD), when scoping out individual evaluation and projects,

In August 2017, engagement with Staffordshire University was formalised in a Memorandum of Understanding (MoU) to explore research development, capability and capacity building. The Memorandum of Understanding links to three aspects of the Trust Strategic Objective to: Encourage, Inspire and Implement Research and Innovation at all levels

1. To develop and agree and formal partnership with Higher Education in areas of mutual interest,
2. Increase external funding for research by 10% from baseline
3. Increase the number of research collaborations from baseline.

This serves as an undertaking for one year to agree to explore opportunities for academic collaboration for mutual benefit with a view to continuing this arrangement thereafter. The MoU sets out four key areas of development:

- Development of research programmes which are mutually beneficial;
- Exchange in Research, including exchange of publications and reports;
- Exchange of staff for purposes of staff development, including teaching, research and practice;
- Discussion of other areas of interest, including joint programmes and centres of excellence.

Progress so far

With just over a month of implementation, the key aspects of the MoU have quickly progressed;

- A joint tender submission for implementation and delivery of a national evaluation and engagement work to explore joint working for future bids and peer-reviewing projects.
- Commenced exploring opportunities to work together for Substance Misuse research and research capacity and capability building within the Directorate.

Next Steps

Staffordshire University

- Continue to explore and realise opportunities to work together for Substance Misuse research and research capacity and capability building within the Directorate;
- Scope out potential developments for staff and student engagement and professional development, i.e. student placements, staff opportunities for research modules;
- Explore a new research process for:
    - R&I researchers to become Associates of CHAD, and also explore extending this to Staffordshire University;
    - R&I to explore a process to make CHAD Research Associates and Staffordshire University Professors Associates of the Trust's R&I Department also.

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REPORT TO: TRUST BOARD

Date of Meeting:	9 November 2017
Title of Report:	September 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

| Executive Lead Name: | ... | 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 September 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during September 2017 was 85% for registered staff and 89% or care staff on day shifts and 82% and 106% respectively on night shifts. Overall a 90% 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 Managers are staffing their wards to meet increasing patient needs as necessary.		Approval ☐	
		Information ☐	
		Discussion ☒	
		Assurance ☐	

Seen at:	SLT ☐	Date:
	Execs ☒	Date:31.10.17

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 Trsut complies with National Quality Board standards.
Resource Implications:	Temporary staffing costs.
Funding Source:	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

Version	Name/group	Date issued
1	Julie Anne Murray	27.10.17
2	Executive Team	31.10.17
3	Trust Board	09.11.17

1   Introduction
This report details the ward daily staffing levels during the month of September 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 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. This was originally planned to be reported to November Board however, due to the current management of change (MoC) relating to shift patterns, it was agreed at October Quality Committee to delay the report in order to capture the outcome of the MoC.

3   Trust Performance
During September 2017 the Trust achieved a staffing fill rate of 85% for registered staff and 89% for care staff on day shifts and 82% and 106% respectively on night shifts. Taking skill mix adjustments into account an overall a 90% fill-rate was achieved. Where 100% fill rate was not achieved, staffing 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 provided in Appendix 2. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

The Safer Staffing Group oversees the safer staffing work plan on a bi-monthly basis, the plan which sets out the actions and recommendations from staffing reviews.

4   Impact
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 10 incident forms completed by in-patient wards during September 2017 relating to nurse staffing issues. **No harm to patients arose from these incidents**.

Breakdown by ward is summarised as follows:

Ward	Incident Reports
Darwin	One occasion where it was challenging to maintain clinical observations as 2 members of staff were required escort a young person in A&E.
A&T	Eight incidents where it was challenging to maintain high levels of observations.
Ward 4	One incident where DSN and access had to cover nightshift due to late cancellation of agency RN.

4.2   Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During September 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 safer staffing the following actions were taken by the Ward Manager during September 2017:

- 39 staff breaks were cancelled (equivalent to approximately 0.8 % of breaks)
- 0 staff breaks were shortened (equivalent to 0% of breaks)
- 226 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 185 RN shifts were covered by HCSW where RN temporary staffing was unavailable.   A total of 52 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 or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

4.5   Staffing Trend

Examination of ward staffing for the past 12 months demonstrates a downward trend for overall ward staffing and for RN staffing. There is a clear correlation between the opening of Ward 4, to support the local health economy, and the downward trend. The period prior to Ward 4 opening, June - November 2016, was showing an upward trend.

The following actions have been taken to strengthen RN staffing:

- 18 RNs commencing preceptorship in October 2017
- Shift patterns are being altered in response to staff feedback
- A rolling recruitment of events including bank continues
- Increasing the presence of Duty Senior Nurses (DSN), Nurse Practitioners and WMs on wards

- Review of the Master Vendor contract and seek agency suppliers beyond this, if required

5.   Summary

Safe staffing reporting indicated challenges in staffing wards during September 2017. Vacancies across all wards 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 Board should note the further challenges associated with the temporary increase of beds on Ward 4 in the response to the winter pressure in the health economy. Looking forward to next year, challenges will also be experienced with the planned opening of PICU therefore the 6 month staffing review will make recommendations in relation to this. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

We have been invited to participate in the NHSI Retention Support Programme which we intend to pursue, as it provides us with the opportunity to learn from other Trusts and gain support.

6.   Recommendations

The Trust Board is asked to:-

- Receive the report
- Note the challenges with recruitment and mitigations/action in place
- Note the challenge in filling shifts
- Be assured that safe staffing levels are maintained

Appendix 1 September 2017 Safer Staffing

2017
August

Ward name	DAY Registered nurses			DAY Care staff			NIGHT Registered nurses			NIGHT Care staff			Average fill rate - registered nurses (%) DAY	Average fill rate - care staff (%) DAY	Average fill rate - registered nurses (%) NIGHT	Average fill rate - care staff (%) NIGHT	Overall fill rate	Safe staffing was maintained by:	Vacancies	Vacancies minus those in recruitment	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	1508	1508	1121	1350	1800	1464	643	643	322	965	965	1201	74%	81%	50%	124%	84%	Nurses working additional unplanned hours and altering skill mix. Cross cover was also provided to other wards.	3.2 B5 2.81 B3	3.2 B5 1.81 B3	91%	↓	12.1%
Ward 2	1493	1493	970	1350	1350	1393	643	643	322	643	643	911	65%	103%	50%	142%	87%	Altering skill mix.	5.2 B5 1.21 B3 2B2	4.2 B5 1.21 B3	98%	↑	15.1%
Ward 3	1508	1463	1215	1350	1343	1385	643	643	418	643	654	868	83%	103%	65%	133%	95%	Cancelling non-direct care activity, altering skill mix. Cross cover was also provided to other wards.	2.8 B5 1.36 B3 1 B2	0.8 B5 1.36 B3	87%	↓	1.7%
Ward 4	1508	1508	1125	1350	1350	1336	281	281	281	675	675	672	75%	99%	100%	100%	90%	Nurses working additional unplanned hours and altering skill mix.	9.2 B5 7.2 B3	5.2 B5 0.2 B3	81%	↑	0.0%
Ward 5	1058	1508	956	900	1350	1512	281	281	285	843	843	843	63%	112%	101%	100%	90%	Cancelling non-direct care activity, altering skill mix.	4.3 B5 0.4 B3	3.5 B5 1.4 B3	103%	↓	0.0%
Ward 6	1050	1020	998	1800	2250	1635	281	281	328	835	1127	1051	98%	73%	117%	93%	86%	Nurses working additional unplanned hours, the multi-disciplinary team supporting the nursing team and altering skill mix.	1 B6 2.1 B5 1.35 B3	1 B6 2.1 B5 0.5 B3	97%	↓	8.7%
Ward 7	1148	1148	1014	1350	1350	1278	281	281	275	563	618	618	88%	95%	98%	100%	94%	Nurses working additional unplanned hours and altering skill mix.	0 B6 2.4 B5	1 B6 2.4 B5	100%	↓	0.0%
A&T	1500	1305	1562	1350	1800	1213	323	323	323	968	1613	1613	120%	67%	100%	100%	93%	Cancelling non-direct care activity, altering skill mix.	2.23 B5 5.11 B3	0.77 B 5 4.31 B 3	92%	↑	10.5%
Edward Myers	960	1035	964	900	900	859	281	281	291	563	563	524	93%	95%	104%	93%	95%	Nurses working additional unplanned hours.	1.4 B5 0 B3	0.4 B5 0.9 B3	93%		7.0%
Darwin Centre	1065	1115	1063	1350	1161	1102	323	323	323	645	667	667	95%	95%	100%	100%	97%	*	2.4 B5 1.2 B3	1.4 B5 0.8 B3	73%	↓	4.7%
Summers View	979	979	812	900	908	765	322	322	322	643	632	632	83%	84%	100%	100%	89%	The mutlidisciplinary team supporting the nursing team.	1 B3 0.2 B2	0.2 B2	81%	↓	6.5%
Florence House	529	529	596	900	780	527	322	322	322	322	322	322	113%	68%	100%	100%	90%	The mutlidisciplinary team supporting the nursing team.	0.5 B3	0.8 B5 0.5 B3	94%	↓	5.4%
Trust total	14303	14607	12394	14850	16341	14467	4624	4624	3810	8307	9320	9921	85%	89%	82%	106%	90%	* over 95%		red = over			

Appendix 2 Staffing Issues

- There has been challenges and 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. We have also worked with UHNM with regards to access to their bank.

- There are currently 34.2 WTE RN vacancies reported within in-patient wards. Of these, 14.6 WTE are in the recruitment process. We continue to advertise for the remainder.

- With the exception of Ward 4 the highest RN vacancies are across the Acute AMH wards with Wards 1, 2 and 3 currently having B5 vacancies of 3.2, 5.2 and 2.8 WTE respectively of which 7 WTE newly qualified nurses have been recruited. The remaining posts have been advertised externally and are included within the recruitment events with limited success. Therefore we are reviewing skill mix and shift patterns.

- 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 and are based on wards as opposed to Nursing Office from September.

- 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). In the six month staffing review, the number of vacancies on these wards has made this challenging to achieve consistently.

- With regard to sickness on Wards 1 and 2, no themes are evident. However, Ward 1 has had 3 staff on long term sick, 2 of which have returned to work. Ward 2 has had 4 staff on long term sick, 2 of which have returned to work and 2 continue to be supported. HR are supporting Ward Managers with the management of attendance.

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

REPORT TO Trust Board

Enclosure No:8

Date of Meeting:	9th November 2017		
Title of Report:	Performance & Quality Management Framework Month 6		
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 September 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 the supporting PQMF dashboard.

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. | | Approval | ☒ |
		Information	☒
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☐ Execs ☒
Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒
• Finance, Performance & Digital 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	In Month 6 there are 4 target related metrics rated as Red and 2 targets related as Amber; all other indicators are within expected tolerances.
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: | There are potential contractual penalties if the Trust is not able to meet reporting requirements. There is an agreement with Commissioners for the Trust to have 6 months period following the implementation of the new EPR in order to ensure that all reports can be made available, or to identify further | | |

	actions and timescales for delivery agreed in the Data Quality Improvement Plan.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.
Recommendations:	The Trust Board is asked to • Receive the Trust reported performance, management action and committee oversight on the Month 6 position • Note the rectification plans received through Board sub-committees

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD

Date of meeting:	9th November 2017
Report title:	**Performance & Quality Management Framework Performance Report – Month 6 2017/18**
Executive Lead:	Director of Finance, Performance & Digital
Prepared by:	Performance & Information Team
Presented by:	Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for September 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 date behind the KPI reported in this paper, following the transition to the new Lorenzo EPR, which went live in May 2017.

2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- **98.6%** of inpatient admissions have been gate kept by the crisis resolution/home treatment team
- **64.9%** of people accessing the IAPT service are moving to recovery (50% target)
- **100%** of RAID referrals have been seen within 4 hours

In Month 6 there are **4** target related metrics rated as **Red** and **2** as **Amber**; all other indicators are within expected tolerances.

White KPIs are those where targets are yet to be agreed or where the requirement is to report absolute numbers rather than % performance.

Contracted (National/Local CCG) & NHSI KPIs					
Metric	Red	Amber	Green	White	TOTAL
Exceptions – Month 4	3	1	26	40	70
Exceptions – Month 5	4	1	22	24	51
Exceptions – Month 6	4	2	21	19	46

Month 6 Performance for Trust Board

- Red 9%
- Amber 4%
- Green 46%
- White 41%
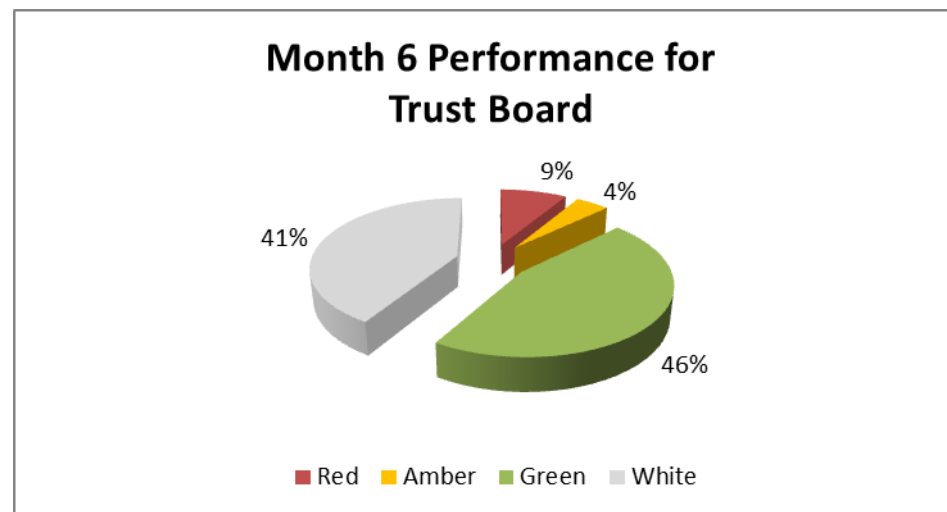
3 Rectification Plans

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 for month 6:

- Suspected suicides year to date figures have been amended following a data quality review
- % of clients in employment year to date figures have been revisited post report timeframe

5   Exceptions - Month 6

KPI Classification	Metric	Exec/Op Lead	Target	M5	M6	Trend	Commentary
National	Agency Spend: % year to date agency spend compared to year to date agency ceiling	Dir of Leadership & Workforce	0.0%	RED 26.0%	RED 24.0%	↘	**24.0% at M6** Ward 4 – 2.0% at M6 (1% at M5) Core – 11.0% at M6 (7% at M5) ROSE – 11.0% at M6 (18% at M5) Cumulative YTD plan is £1,316k against actual £1,627k - £311k worse than plan (24%) The main drivers of negative variance are: • ROSE: **£143k:** The trust extended the use of additional agency staff as part of the implementation of the ROSE project to ensure a safe transition. • Medical Locums : **£162k** This reflects the national shortage of medics. The trust is investigating a number of ways to attract medical staff. The trust is forecasting that the agency cap will not be achieved in 2017/18. Rectification Plan : People, Culture Development and Finance, Performance & Digital Committee

KPI Classification	Metric	Exec/Op Lead	Target	M5	M6	Trend	Commentary
National	Delayed Transfers of Care: DTOC	Dir of Ops	7.5%	**RED** 10.8% (previously reported 12.9% in M5)	**RED** 8.8%	↘	360 delayed days from 3,041 OBDs AMH IP – 11.2% at M6 from 8.3% at M5 NOAP – 8.1% at M6 from 16.4%

Commentary continued:

Trust

Reason for Delay	Total Pts	Total Days	Days as % of Total
Care Home Placement	9	171	47.5%
Public Funding	8	87	24.2%
Completion of assessment	6	43	11.9%
Housing-patients not covered by NHS and Community Care Act	2	34	9.4%
Patient or family choice	3	25	6.9%
Total	*28*	*360*	*100.0%*

Total delays North staffs CCG: 126 days
Total delays Stoke on Trent CCG: 234 days

AMH

Reason for Delay	Total Pts	Total Days	Days as % of Total
Care Home Placement	8	157	69.8%
Housing-patients not covered by NHS and Community Care Act	2	34	15.1%
Patient or family choice	2	18	8.0%
Completion of Assessment	2	9	4.0%
Public Funding	1	7	3.1%
Total	*15*	*225*	*100.0%*

There has been an increase in Adult Inpatient DTOCs to 11.2% in September from 8.3% in August. 70% of the DTOCs were as a consequence of delays in accessing care home placements. Weekly DTOC meetings take place to manage the processes and issues are escalated to health and social care

KPI Classification	Metric	Exec/Op Lead	Target	M5	M6	Trend	Commentary
							commentators for resolution.

NOAP

Reason for Delay	Total Pts	Total Days	Days as % of Total
Public Funding	7	80	59.3%
Completion of Assessment	4	34	25.2%
Care Home Placement	1	14	10.4%
Patient or family choice	1	7	5.2%
Total	*0*	*135*	*100.0%*

There has been a significant reduction in NOAP DTOCs from 16.4% in August to 8.1% in September. Within NOAP, the delays continue to be associated with access to NHS or residential funding or placements and family choice (75% of all delays). The Directorate is implementing a rectification plan to address the delays associated with choice which is having a positive impact and continue to focus on internal factors that contribute to delays. However, there is an expectation that a larger number of delays will be reported in Month 7 as there is a current lack of or availability of nursing and residential placements.

Rectification Plan : Developed at Directorate Level

KPI Classification	Metric	Exec/Op Lead	Target	M5	M6	Trend	Commentary
National	Care Programme Approach: Reviews completed within 12 months The proportion of those on Care Programme Approach (CPA) for	Dir of Ops	95.0%	AMBER 94.5%	AMBER 92.2%	↘	92.2% at M6 from 94.5% at M5 In summary, 1,454 people eligible for review 1,341 people have received a review within 12 months 113 people have no recorded review within 12 month AMH Community – 92.9% at M6 from 95.2% at M5 (99 out of 1,394 have no a recorded review)

KPI Classification	Metric	Exec/Op Lead	Target	M5	M6	Trend	Commentary
CCG	at least 12 months having a formal review within 12 months Percentage of adults who have received secondary mental health services who were on a Care Programme Approach who have had at least one formal review in the last 12 months	Dir of Ops	95.0%	GREEN 95.4%	AMBER 90.6%	↘	LD – 87.5% at M6 from 89.2% at M5 (4 out of 32 have not received a recorded review) NOAP – 65.4% at M6 from 68.0% at M5 (9 out of 26 have not received a recorded review) C&YP – 50.0% at M6 from having no CPA reviews due in M5 (1 out of 2 have not received a recorded review) CPA Review compliance overall was 90.6% with 188 patients overdue a review. From audit data it is clear that more reviews are being undertaken than recorded. This is a result of the change process associated with the new EPR. The Trust will continue to embed the guidance and ensure that staff refers to the Quick Reference Guides to clarify the correct way of recording CPA status and review completion. Further communications have been issued to clarify the requirements and the Systems Team and Lorenzo Super users in each Directorate are tasked with supporting individuals and teams to record data according to the Lorenzo requirements.
CCG	Bed Occupancy: Bed Occupancy (including home leave)	Dir of Ops	85% (90% AMHIP)	RED 92.3%	RED 90.0%	↘	90.0% at M6 from 92.3% at M5 AMH IP – 89.0% at M6 from 96.0% at M5 (on target) LD – 79.0% at M6 from 76.0% at M5 (on target) NOAP – 95.0% at M6 from 96.0% at M5 C&YP – 73.1% at M6 from 77.2% at M5 (on target) The high reported bed occupancy levels for ward 5 (Neuro) has been investigated revealing that the return leave end date has not been completed on Lorenzo. This is being rectified and will be compliant from Month 7. The pressure on older adult inpatient beds is impacted by the levels of

KPI Classification	Metric	Exec/Op Lead	Target	M5	M6	Trend	Commentary
							delayed transfers of care (8.8% in September) and length of stay. These are a consequence of internal factors and whole system pressures. An action plan is being monitored through the regional A&E Delivery Board. This seeks support from partner agencies to improve processes, such as timely assessment and rapid approval to funding.
CCG	Care Programme Approach: care plans

(All service users to have a care plan in line with their needs (% service users on CPA with a Care Plan) | Dir of Ops | 95% | RED 84.2% | RED 82.5% | ↘ | 82.5% at M6 from 84.2% at M5

In summary,
15,648 people should have a care plan
12,895 people have a care plan recorded
2,753 people do not have a care plan recorded

AMH Community – 82.4% at M6 from 84.9% at M5
(1,160 out of 6,591 do not have a care plan recorded)
LD – 88.8% at M6 from 92.4% at M5
(100 out of 893 do not have a care plan recorded)
NOAP – 80.0% at M6 from 80.9% at M5
(1,156 out of 5,765 do not have a care plan recorded)
C&YP – 86.4% at M6 from 87.3% at M5
(337 out of 2,399 do not have a care plan recorded)

Audit data has confirmed that there is better compliance than currently reported from Lorenzo. This is due to some clinicians making modifications and corrections to the existing care plan (as they did on CHIPS) rather than creating a new care plan which is required on Lorenzo. To support clinicians with data entry, the care plan form is being redesigned to enable copy forward and guidance and training provided to ensure accurate recording.

The Trust will continue to embed the guidance and ensure that staff refers to the Quick Reference Guides. Regular reports are provided by the |

KPI Classification	Metric	Exec/Op Lead	Target	M5	M6	Trend	Commentary
							Performance Team to Directorates to enable them to ensure full compliance.

6 Recommendations

The Trust Board is asked to;
- Receive the Trust reported performance, management action and committee oversight on the month 6 position
- Note the rectification plans received through Board sub-committees

PQMF for Trust Board

CCG	NHS Standard Contract Reporting
National	NHS Improvement metric (Unify)
Trust Measure	Locally monitored metric

↗	Trend up (positive)	↘	Trend down (negative)	
↘	Trend Down (positive)	↗	Trend Up (negative)	
↔	No change	↘	Trend Down (Neutral)	
		↗	Trend Up (Neutral)	

Rectification Plans-Target to be Achieved By

Incomplete-Rectification Plan received but trajectory not advised

Not Received-No rectification plan received

	Metric	Frequency	Target (2016/17) 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target to be achieved by	YTD	Trend Rate
CCG	Average Length of Stay: North Staffs CCG	Monthly	No Target	18.0	31.6	30.0	22.7	40.1	26.1								28.1	
CCG	Adult IP	Monthly	No Target	15.7	21.4	15.0	11.1	32.6	8.1								17.3	
CCG	CYP	Monthly	No Target	0.0	67.1	122.5	81.4	129.3	56.7								76.2	
CCG	NOAP	Monthly	No Target	117.3	68.4	101.6	37.9	63.3	101.3								81.6	
CCG	LD	Monthly	No Target	0.0	157.5	2.6	131.7	4.0	3.2								49.8	
CCG	Average Length of Stay: Stoke CCG	Monthly	No Target	23.6	33.0	31.7	31.2	35.4	36.9								32.0	
CCG	Adult IP	Monthly	No Target	25.6	34.1	41.0	30.2	50.2	33.5								35.8	
CCG	CYP	Monthly	No Target	88.2	51.1	88.0	95.9	32.5	44.6								66.7	
CCG	NOAP	Monthly	No Target	106.3	86.3	86.5	95.7	66.4	116.9								93.0	
CCG	LD	Monthly	No Target	0.0	0.0	2.4	20.0	2.4	2.5								4.6	
CCG	Ward 4-EMI: Length of Stay	Monthly	No Target	62.0	99.0	64.0	74.0	62.0	90.0								451.0	
CCG	Ward 4-EMI: Number of Admissions	Monthly	No Target	8.0	3.0	9.0	4.0	10.0	6.0								40.0	
CCG	Bed Occupancy (Including Home Leave)	Monthly	85%	93.6%	89.4%	92.9%	92.6%	92.3%	90.0%								91.8%	↘
National	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	94.3%	93.9%	91.5%	91.8%	94.5%	92.2%								93.0%	↘
National	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	95.7%	96.9%	91.2%	90.0%	88.7%	97.4%								93.0%	↗
National	% clients in employment	Monthly	9%	10.5%	10.4%	10.2%	10.2%	9.8%	9.7%								10.1%	↘
National	% of clients in settled accommodation	Monthly	64%	88.5%	43.5%	86.4%	86.4%	84.8%	80.5%								79.2%	↘
CCG	Percentage of adults who have received secondary mental health services who were on a Care Programme Approach who have had at least one formal review in the last 12 months *CCG Measure*	Monthly	95%	95.3%	94.4%	92.3%	91.4%	95.4%	90.6%								93.2%	↘
CCG	All Service Users to have a care plan in line with their needs (North Staffordshire CCG) % on CPA with a Care Plan	Monthly	95%	93.4%	97.1%	90.9%	92.7%	92.5%	89.3%								92.7%	↘
CCG	All Service Users to have a care plan in line with their needs (Stoke-on-Trent CCG) % on CPA with a Care Plan	Monthly	95%	96.1%	98.2%	93.2%	90.8%	90.6%	87.7%								92.8%	↘
CCG	IAPT: The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (Target: 3.75% per quarter, 1.25% p/month)	Monthly	3.75% quarterly (1.25% monthly)	1.05%	1.28%	1.21%	1.29%	1.30%	1.25%								1.23%	↘
National / CCG	IAPT : The number of people who are moving to recovery. Divided by the number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at initial assessment	Monthly	50%	67.1%	68.5%	65.1%	65.9%	69.5%	64.9%								66.8%	↘
CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 6 weeks of referral	Monthly	75%	99.7%	99.3%	100.0%	100.0%	100.0%	99.7%								99.8%	↘
CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 18 weeks of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	↔
CCG	S136 (Place of Safety) Assessments	Monthly	No Target	23.0	33.0	35.0	43.0	22.0	20.0								176.0	↘
CCG	- Formal Admissions	Monthly	No Target	4.0	6.0	2.0	5.0	4.0	0.0								21.0	↘
CCG	- Informal Admissions	Monthly	No Target	4.0	2.0	6.0	7.0	3.0	4.0								26.0	↗
CCG	- Under 18 Yrs Old	Monthly	No Target	0.0	0.0	0.0	1.0	1.0	0.0								2.0	↘
CCG	Patients seen within the access service (Stoke-on-Trent CCG): Emergency 1 hour	Monthly	No Target	New	New	New	New	New	New									
CCG	Patients seen within the access service (Stoke-on-Trent CCG): Urgent 4 hours (% of referrals that were reported as urgent)	Monthly	No Target	12.3%	8.1%	8.5%	5.9%	1.7%	4.0%								6.8%	↗
CCG	Patients seen within the access service (Stoke-on-Trent CCG): Routine 24 Hours (% of referrals that were report as routine)	Monthly	No Target	7.9%	9.2%	10.5%	12.1%	12.2%	6.0%								9.7%	↘
CCG	Patients seen within the access service (North Staffordshire CCG): Emergency 1 hour	Monthly	No Target	New	New	New	New	New	New									
CCG	Patients seen within the access service (North Staffordshire CCG): Urgent 4 hour hour	Monthly	No Target	12.3%	5.7%	8.3%	8.2%	2.1%	6.8%								7.2%	↗
CCG	Patients seen within the access service (North Staffordshire CCG): Routine 24 hours	Monthly	No Target	21.0%	20.7%	32.6%	23.9%	31.4%	27.2%								26.1%	↘
CCG	Medication Errors leading to Moderate/Severe harm/death	Monthly	No Target	0.0	0.0	0.0	0.0	1.0	1.0								2.0	↔

	Metric	Frequency	17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target to be achieved by	YTD	Trend Rate
CCG	Preventing Future Deaths Regulation 28	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Unexpected Deaths	Monthly	No Target	1.0	2.0	1.0	7.0	6.0	4.0								21.0	↘
CCG	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Community Patient (in receipt)	Monthly	No Target	1.0	2.0	1.0	7.0	6.0	4.0								21.0	↘
CCG	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0								0.0	●
CCG	Use of Restraint: Number of patient restraints-prone	Monthly	No Target	1.0	4.0	5.0	0.0	3.0	1.0								14.0	↘
CCG	Self Harm Events: Inpatient	Monthly	No Target	48.0	25.0	35.0	44.0	34.0	33.0								219.0	↘
CCG	Self Harm Events: Community	Monthly	No Target	35.0	31.0	28.0	26.0	19.0	29.0								168.0	↗
CCG	Slips Trips & Falls	Monthly	No Target	43.0	23.0	45.0	31.0	27.0	30.0								199.0	↗
CCG	Slips Trips & Falls leading to Moderate/Severe harm/death	Monthly	No Target	6.0	4.0	1.0	2.0	2.0	0.0								15.0	↘
CCG	Suspected Suicides	Monthly	No Target	0.0	0.0	0.0	2.0	4.0	1.0								7.0	↘
CCG	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Community Patient (in receipt)	Monthly	No Target	0.0	0.0	0.0	2.0	4.0	1.0								7.0	↘
CCG	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0								0.0	➡
CCG	Preventing Category 3 and 4 Avoidable Pressure Ulcer	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0								0.0	●
CCG	MRSA Screening (% of patients screened on admission)	Monthly	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	●
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%		7.0%	20.0%	10.0%	28.0%	24.0%									
National	Sickness Absence Percentage: Days lost	Monthly	5.1%	3.1%	3.5%	2.4%	3.9%	4.9%	4.8%								3.8%	
National	Corporate	Monthly	5.1%	1.8%	2.7%	2.6%	1.8%	3.4%	2.7%								2.5%	↘
National	AMH Community	Monthly	5.1%	3.8%	3.7%	2.7%	4.2%	4.7%	4.7%								4.0%	↘
National	AMH IP	Monthly	5.1%	4.4%	5.3%	2.8%	5.2%	7.6%	8.5%								5.6%	↗
National	C&YP	Monthly	5.1%	1.4%	2.6%	2.0%	2.9%	3.4%	3.3%								2.6%	↘
National	LD	Monthly	5.1%	0.9%	2.8%	1.9%	3.3%	4.8%	3.5%								2.9%	↘
National	Neuro and Old Age Psychiatry	Monthly	5.1%	3.8%	2.5%	1.7%	5.1%	4.9%	5.4%								3.9%	↗
National	Substance Misuse	Monthly	5.1%	6.4%	7.4%	3.5%	5.6%	8.9%	9.5%								6.9%	↗
National	Staff Turnover (% FTE)	Monthly	>10%	0.9%	1.1%	0.6%	0.6%	1.5%	1.4%								0.01	↘
National	Corporate	Monthly	>10%	0.8%	1.3%	0.4%	0.0%	3.8%	2.5%								0.01	↘
National	AMH Community	Monthly	>10%	0.7%	0.9%	0.6%	0.8%	1.4%	0.9%								0.01	↘
National	AMH IP	Monthly	>10%	0.7%	0.0%	1.3%	0.7%	0.0%	1.8%								0.01	↗
National	C&YP	Monthly	>10%	1.6%	1.6%	1.7%	0.9%	1.7%	0.0%								0.01	↘
National	LD	Monthly	>10%	0.9%	2.2%	0.0%	1.5%	0.9%	1.5%								0.01	↗
National	Neuro and Old Age Psychiatry	Monthly	>10%	0.8%	0.7%	0.7%	0.0%	0.9%	1.3%								0.01	↗
National	Substance Misuse	Monthly	>10%	2.2%	2.3%	0.0%	0.0%	0.0%	1.8%								0.01	↗
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0		0.0	0.0	0.0	0.0								0	●
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention) (Excluding ASD)	Monthly	92%	93.5%		82.4%	94.3%	95.1%	94.9%								92.0%	↘
CCG	AMH IP	Monthly	92%	100.0%		100.0%	100.0%	100.0%	100.0%								100.0%	●
CCG	AMH Community	Monthly	92%	89.0%		77.5%	91.9%	94.9%	95.9%								89.8%	↗
CCG	Substance Misuse	Monthly	92%	100.0%		100.0%	100.0%	100.0%	100.0%								100.0%	●
CCG	LD	Monthly	92%	100.0%		85.2%	100.0%	94.1%	92.3%								94.3%	↘
CCG	NOAP	Monthly	92%	97.4%		82.3%	94.3%	94.9%	95.4%								92.9%	↗
CCG	C&YP	Monthly	92%	100.0%		93.7%	100.0%	95.4%	90.3%								95.9%	↘
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	●
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%									●
National	Mental health delayed transfers of care (target NHSI) (M1-4.7%, M2-4.5%, M3-4.2%, M4-4.0%, M5-3.7%, M6-3.5%) Target revised to 7.0% in M3	Monthly	7.5%	11.0%	8.4%	13.0%	12.7%	10.8%	8.8%								10.8%	↘
National/Trust Measure	AMH IP	Monthly	7.5%	7.2%	9.1%	7.5%	5.8%	8.3%	11.2%							Incomplete	8.2%	↗
National/Trust Measure	LD	Monthly	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								0.0%	●
National/Trust Measure	NOAP	Monthly	7.5%	23.5%	24.1%	17.1%	19.0%	16.4%	8.1%							Incomplete	23.5%	↘
CCG	RAID response to A&E referrals within 1 hour	Monthly	95%	94.0%	94.0%	97.0%	96.0%	98.0%	97.0%								96.0%	↘
National	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target-17/18-50%, 18/19-53%)	Monthly	50%	76.9%	81.8%	63.6%	100.0%	70.0%	50.0%								73.7%	↘
Nationsl/CCG	Overall safe staffing fill rate	Monthly	No Target	95.2%	95.3%	94.8%	93.4%	91.2%	90.4%								93.4%	↘
CCG	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0								0.0	●

	Metric	Frequency	17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target to be achieved by	YTD	Trend Rate
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0								0.0	●
CCG	All service users who have been in hospital/long term inpatient health care for more than one year should have a physical health check	Quarterly	95%			100.0%			100.0%									
CCG	DNA Rate Analysis by Directorate (North Staffs CCG)	Monthly	No Target	4.9%	8.2%	8.2%	7.3%	7.4%	5.6%								6.9%	↘
CCG	AMH IP	Monthly	No Target	0.0%	0.0%	9.4%	5.9%	0.0%	8.5%								4.0%	↗
CCG	AMH Community	Monthly	No Target	5.6%	6.0%	11.1%	9.3%	9.2%	6.6%								8.0%	↘
CCG	LD	Monthly	No Target	1.4%	1.2%	2.4%	2.2%	1.9%	3.0%								2.0%	↗
CCG	NOAP	Monthly	No Target	4.3%	6.4%	4.1%	4.8%	4.3%	3.2%								4.5%	↘
CCG	C&YP	Monthly	No Target	5.2%	6.0%	6.4%	6.6%	8.1%	6.4%								6.5%	↘
CCG	DNA Rate Analysis by Directorate (Stoke on Trent CCG)	Monthly	No Target	6.2%	6.2%	7.1%	6.7%	6.7%	5.9%								6.5%	↘
CCG	AMH IP	Monthly	No Target	4.5%	6.8%	4.8%	1.1%	2.7%	0.8%								3.5%	↘
CCG	AMH Community	Monthly	No Target	6.4%	6.6%	7.8%	7.3%	6.7%	5.2%								6.7%	↘
CCG	LD	Monthly	No Target	3.8%	2.3%	3.4%	2.8%	3.2%	6.5%								3.6%	↗
CCG	NOAP	Monthly	No Target	5.4%	5.7%	6.6%	5.7%	5.9%	4.7%								5.7%	↘
CCG	C&YP	Monthly	No Target	9.3%	8.3%	8.2%	9.2%	12.1%	10.7%								9.6%	↘
CCG	Completion of Mental Health Services Data Set ethnicity coding for all Service Users	Monthly	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	●
CCG	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Monthly	99%	99.8%	99.7%	99.3%	99.9%	99.9%	Awaiting publication								99.7%	

REPORT TO OPEN TRUST BOARD

Enclosure No:9

Date of Meeting:	9TH NOVEMBER 2017		
Title of Report:	QUARTER 2: SERIOUS INCIDENT REPORT		
Presented by:	DR O ADEYEMO, EXECUTIVE MEDICAL DIRECTOR		
Author:	JACKIE WILSHAW, HEAD OF PATIENT & ORGANISATIONAL SAFETY		
Executive Lead Name:	DR O ADEYEMO, EXE4CUTIVE MEDICAL DIRECTOR	Approved by Exec	☒

Executive Summary:		Purpose of report	
Increase in SIs noted during Q2 – interim briefing paper demonstrated no causative or linking factors. Mortality Surveillance Quarterly report – completion of actions required following publication of CQC/NHSi 'Learning from Deaths' Paper		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			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Consideration of matters relating to Diversity and Inclusion are included in the review of the SI investigations. No issues identified		
Recommendations:	For Assurance		

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 July 2017 to 30th September 2017 (Quarter 2. 2017/18) and details the following:

- the status of SIs currently open and trend data for Q1 2017/18 and Q2 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 Q2

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 September 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	6			**8**
Pending review- unexpected/potentially avoidable death	0	10	7	6	**23**	6	11			**17**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (non-fatal)	0	1	1	1	**3**	1	0			**1**
Disruptive, aggressive behaviour meeting SI criteria	1	0	0	0	**1**	0	0			**0**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (suspected suicide)	7	11	4	2	**24**	3	6			**9**
Unexpected/potentially avoidable injury causing harm	0	1	0	0	**1**	0	0			**0**
Apparent/actual abuse						0	1			**1**
Total	10	23	13	11	**57**	12	24			**36**

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The table below demonstrates Serious Incidents by team for the period October 2016 to September 2017.

Serious Incidents reported by month: October 2016 to September 2017													
Team / Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	total
Access Team				1			1			2			4
AHTT/Greenfield Centre										1			1
CJMHT											1		1
Criminal Justice MH Team								1					1
Edward Myers Centre		1	1										2
Greenfield Centre	1	1	1	2			1				1		7
Liaison Psychiatry			1										1
Lymebrook/One Recovery North			1										1
NS Wellbeing Service				1									1
One Recovery East (Burton)					1			2		1	1		5
One Recovery Newcastle										1			1
One Recovery North (Leek)				1						2			3
One Recovery North (Newcastle)			1										1
One Recovery West (Cannock)						1							1
RAID			1			1					1	1	4
Staffs Older People CMHT			1										1
Sutherland Centre								1	1		1		3
Ward 2								1		1			2
Ward 3	1												1
Ward 4				1		1	2			1	1		6
Ward 5											1		1
Ward 6		1	1								1		3
Stoke substance misuse CDAS*												2	2
Lymebrook											1		1
Darwin												1	1
Neuropsychiatry (Bennett)												1	1
A+T												1	1
Grand Total	2	3	8	6	1	3	4	5	1	9	9	6	57

*Stoke Substance Misuse Services came into operation June 2017.

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During Q2, 25 incidents were initially reported onto StEIS but after consideration with the CCG Quality Lead, 1 incident was downgraded. Therefore 24 incidents are undergoing SI investigation.

The main points to note are;

- There were 7 unexpected deaths in the Substance Misuse Directorate. This is an increase on the deaths reported in previous quarters. However due to new contracting arrangements, Combined Healthcare is now providing services within a wider geographical area as part of Stoke Substance Misuse Services and this has accounted for 2 of the deaths within the directorate.
- There were 7 unexpected deaths in the Adult Community Directorate. Of this number, 2 of the people had been in single contact with services some months before their death.
- There were 7 incidents in the NOAP Directorate; this included 4 Slip, trip and fall incidents where the person suffered a fracture. The frailty of the client group on ward 4 remains a factor in the impact of falls severity.
- Within the Adult Inpatient Directorate, there was 1 incident meeting SI criteria. This relates to a person who sustained injuries during absconding from the ward.
- In the CAMHS Directorate and following new instruction from NHSE, an incident was reported where a young person sustained a fracture whilst on leave from the Darwin Centre.
- Following the introduction of Lorenzo, an error occurred in the management of the monitoring process for MHA renewal processes. This error resulted in a person in the LD Directorate being unlawfully detained following the lapse of the MHA detention.

From an initial review of the incidents, we have been able to determine that care and service delivery problems did contribute to 2 of the above incidents. These investigations are ongoing; however the initial learning indicates the following:

- The monitoring oversight with regards to MHA renewal dates contributed to the lapse of the MHA and the subsequent unlawful detention of a LD client. *Action has been taken to ensure that monitoring arrangements and alerts have been strengthened.*
- Possible poor practice in relation to assessment of absconding risk. *Recommendations for actions have been discussed and will form basis of the action plan for this investigation.*

Investigations for Q2 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 Q2 in terms of causative or linking factors. However there was an increase in the number of SIs reported during Q2. This increase was noted in a briefing paper to the executive team completed in August 2017. This review paper concluded that despite the short term increase, the 12 month trend demonstrated that the numbers were constant and that suspected suicides were decreasing. However within substance misuse services an upward trend in unexpected deaths in the past 12 months had been identified. This follows a downward trend in the previous 12 months and a slightly upward trend when considering both years together.

Additionally, SI's arising from slips, trips and falls are showing an increasing trend line over the past 12 months. Actions are being taken to address this increase through the Falls rapid improvement group.

The graph below shows the number of Serious Incidents reported monthly over the previous 12 months

SIs by month Oct 2016 to Sept 2017
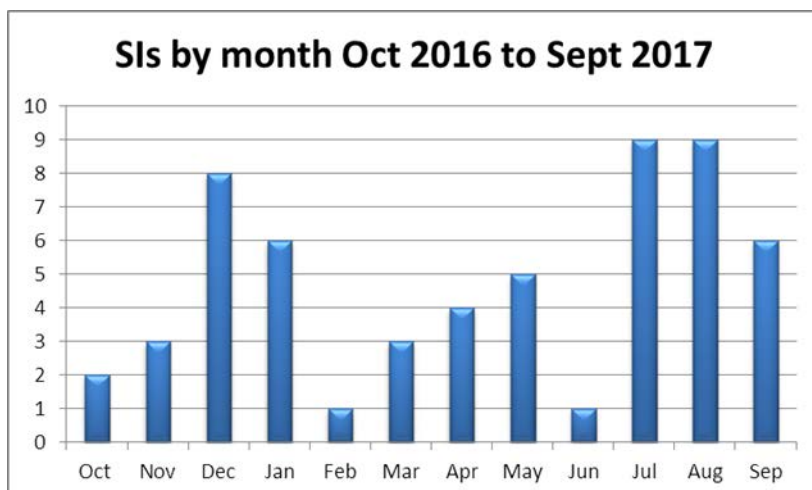
In Q2 there were 6 unexpected deaths where suicide was suspected. This is an increase from Q4 2016/17 when there were 3 suspected suicides. In comparison there were 11 suspected suicides in Q2 of 2016/17. In 2016/17 there was an average of 6 deaths by suspected suicide per quarter however for 2017/18 the average is 4.5 deaths per quarter.

The graph below shows the number of SIs per quarter for the 2 year period, October 2015 to Sept 2017.

SIs per Quarter
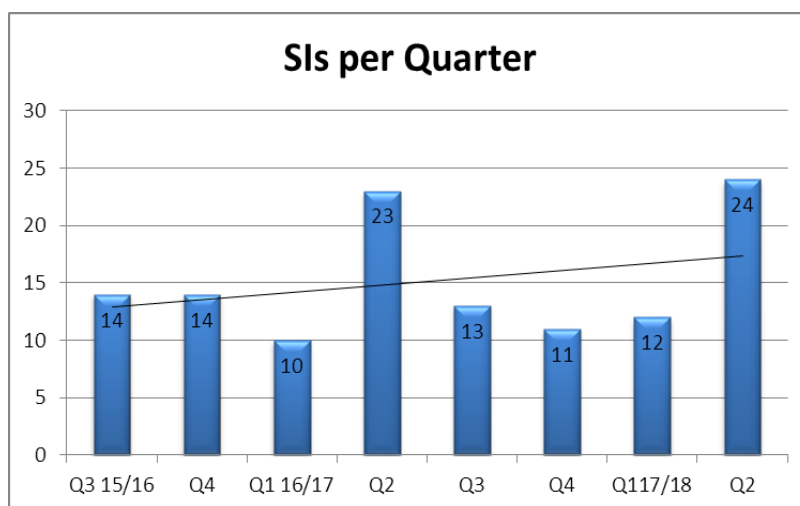
The graph demonstrates that there has been a very slight increase in the trend line over this two year period. The average is 15 serious incidents per month, the trend line ranges from 14 to 16 incidents over this period. A planned report will provide further analysis of SIs over a 5 year period.

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 2 investigations is outlined below:

- A Learning Lessons workshop was held, reminding clinical teams of the need to communicate with all external agencies which are being accessed by service users. Areas for discussion included the need to obtain the service users consent for appropriate information sharing between agencies when assessing risks and formulating care plans.
- Learning following 2 incidents on ward 4, resulted in recognition of the need for greater collaborative working with UHNM, with regards to clearly identifying the criteria for admission to ward 4. Since

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then, there have been improvements noted in the management of the assessment of people prior to admission to the ward. This has also lead to improved handover information, with greater clarity regarding the care needs of the patients on admission. Ward 4 has also recruited a physio into the team in its aim to strengthen its MDT approach to care planning.

- Several investigations revealed a need to improve family and carer involvement in care and discharge planning. A practice note was issued to the wards and Home Treatment Team, reminding staff of the need to ensure family/carer engagement is promoted and that action is taken to support service users and their families post discharge, with all parties (staff/service users and families) having clear and agreed understanding and expectations.

There were a number of investigations where no recommendations for action were made.

5. Duty of Candour (Quarter 2 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 20 incidents which are being investigated and consideration of the DoC requirements will be made as part of this process.

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 Q2 are set out in the table below:

Directorate	Cause	DoC Process	Potential DoC managed via SI process	Potential DoC managed via Mortality Surveillance Review Process	DoC breach
Adult Community	Sudden/Unexpected death – in receipt	0	8	0	0
Substance Misuse	Sudden/Unexpected death – in receipt	0	5	0	0
Children and Young People	Slip, trip fall	0	1	0	0
NOAP	Deterioration in physical health	1	6	0	0
Total		**1**	**20**	**0**	**0**

The NOAP Duty of Candour incident related to the care of a people on ward 4. The local investigation revealed that transfer to RSUH should have happened in a timelier manner. A letter was sent to the service use/family within the statutory reporting period.

6. Mortality Surveillance (Quarter 2 report)

Following the publication of Learning, candour and accountability (CQC, December 2016), from April 2017 the Trust is required to collect and publish a quarterly account of specified information on deaths. This report forms part of the SI quarterly report and 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 table below denotes the total number of deaths reported through the Trust performance team and reviewed by the P+OS Team.

	Reported as SI	Open to services at time of death- natural causes including alcohol related deaths	Substance Misuse deaths			Learning Disability deaths, managed through LeDer (operational from 1st October 2017)
			North Staffs	Stoke	Staffs*	
Apr	2	12	0	0	0	0
May	3	8	0	0	2	0
Jun	1	7	1	0	0	0
Jul	4	7	2	0	1	0
Aug	4	5	0	0	1	0
Sep	0	6	0	3	0	2

*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

All unnatural deaths where the person is in receipt of services are 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. The preliminary report of a recent internal audit from the Trust auditors RSM indicates that the board can take *'substantial assurance that the control on which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively'* (18th September 2017).

Natural cause deaths (where the person is open to services at the time of death), as identified by HM Coroner, are not subject to SI investigation, however the Trust already undertakes local investigations in order to ensure that there are no gaps/omissions in service delivery or missed opportunities for learning. These investigations include alcohol related deaths as these too are classed as natural cause deaths. This work will be developed over the next 12 months in line with NHS England's expectations for Learning from Deaths (LfD). The Trust received a LfD briefing paper at April 2017 Quality Committee in which the expectations of the CQC and NHS Improvement were outlined. The Patient and Organisational Safety Team have developed a process for investigating natural cause deaths and a monthly mortality surveillance group will be held to identify and review any learning/actions from these investigations.

The P+OS team recently attended an NHSE event regarding the LfD approach where the above approach was supported by NHSE. It was clearly stated that no defined methodology for reviewing and learning will be provided centrally and that Trusts are on a 'continuous process of learning together'. However there was

considerable emphasis on Trusts understanding that the data will be discrete to each organisation and must not be used for comparison purposes.

From 1st October 2107, the Trust will be reporting all deaths of people with Learning Disabilities through the LeDeR process to the national allocations team based at Bristol University. The national team will be responsible for contacting the LeDeR project lead at East Staffs CCG, who in turn will coordinate all the reviews of deaths of people with Learning Disabilities. The Trust is supporting a number of staff to undertake LeDeR review training and the LD matron will be representing the Trust at the Staffordshire-wide LeDeR group.

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

As required by NHS England the Trust published its Mortality Surveillance policy on to the external website on October 2nd 2017. This is an amendment to the SI Policy and reflects the process to be used to review and learn from 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 causative or linking factors in the completed Serious Incidents investigations however all learning identified during these investigations has been disseminated to staff. The SI's related to falls will be monitored via the Falls group. 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. During this quarter the Trust has developed it's methodology for reviewing and learning from this process, however more national guidance is expected in Spring 2018 and therefore further change is likely as the process develops.

REPORT TO Trust Board

Enclosure No: 10

Date of Meeting:	09.11.17		
Title of Report:	CQC State of Care Report		
Presented by:	Laurie Wrench		
Author:	Laurie Wrench		
Executive Lead Name:	Caroline Donovan	**Approved by Exec**	☒

Executive Summary:		Purpose of report	
The Care Quality Commission (CQC) has now completed its programme of comprehensive inspections of all specialist mental health services in England, which began in 2014, and has rated services provided by 54 NHS Trusts and 221 independent mental health locations. As of 31 May 2017, they had rated 68% of NHS core services as Good and 6% as Outstanding. Among independent services, 72% of core services were rated as Good and 3% as Outstanding.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date: 31.10.17	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	The Trust is legally required to be registered with the CQC.		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Diversity and Inclusion is a significant consideration for the CQC when assessing the quality of services		
Recommendations:	That the Board receive the report for information and assurance.		

Report Summary
The State of Care in Mental Health Services 2014 to 2017
Care Quality Commission

The Care Quality Commission (CQC) has now completed its programme of comprehensive inspections of all specialist mental health services in England, which began in 2014, and has rated services provided by 54 NHS Trusts and 221 independent mental health locations. As of 31 May 2017, they had rated 68% of NHS core services as Good and 6% as Outstanding. Among independent services, 72% of core services were rated as Good and 3% as Outstanding.

- Some types of service performed particularly well, especially community mental health services for people with a learning disability or autism (80% rated as Good and 9% as Outstanding) and community-based mental health services for older people (76% rated as Good and 10% as Outstanding). In these services, the CQC found with more consistency that staff were skilled and appropriately trained, patients were involved in planning their care, and there were systems in place to deal with urgent referrals.

- Between April 2015 and March 2017, the CQC issued 21 Warning Notices to NHS mental health trusts and 91 to independent mental health providers. Across the whole sector, they also issued one urgent notice to impose a condition, one non-urgent notice to impose a condition, and 2 non-urgent notices to cancel registration.

- Services that needed to improve had made real progress when they had taken the CQC's findings on board and committed to tackling problems proactively and learning from others. Sixteen of the 22 NHS Trusts (73%) that were first rated as Inadequate or Requires Improvement improved their rating on re-inspection.

- At 31 May 2017, 25% of NHS core services were rated as Requires Improvement, as were 23% of independent core services. Seven core services (1%) in NHS Trusts and 3 core services (1%) in independent services were rated as Inadequate.

Comparison of national findings and NSCHT CQC Inspection 2016

Figure 9: Overall ratings for each core service (NHS and independent combined), as at 31 May 2017

Source: CQC ratings data as at 31 May 2017. Figures on bars are percentages.
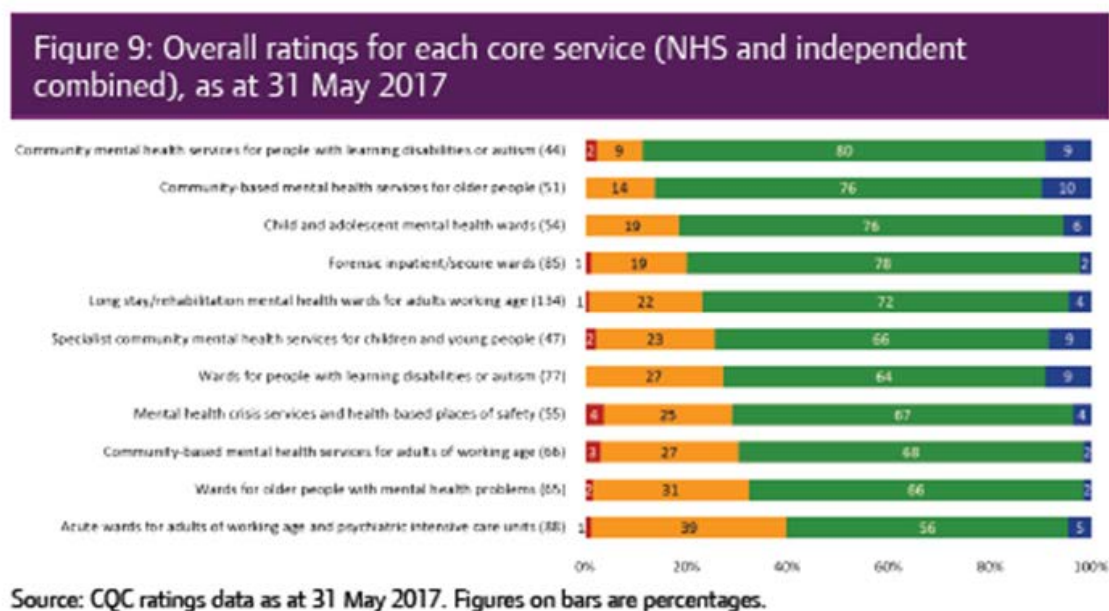
Trust ratings:

Adult Inpatient	Good
CAMHS	Requires
Community	Improvement
CAMHS Wards	Good
Adult Community	Good
Crisis	Good
Community LD	Good
LD Inpatient	Good
Rehab	Good
OP Community	Outstanding
OP Inpatient	Good
Substance Misuse	Good
Overall	Good

Key Findings

Mental health services can be proud of their staff

- The overwhelming majority of NHS and independent services were rated as Good or Outstanding for having caring and compassionate staff (NHS: 88% Good, 9% Outstanding; Independent: 93% Good, 5% Outstanding).

With very few exceptions, staff formed relationships with their patients that were respectful and compassionate and treated patients with dignity and respect. The CQC saw many examples of staff involving carers and families and of services providing specific support for

carers. Families complimented the attitudes of staff and the support they had received, with staff ensuring that families were involved with care planning and receiving regular updates. The one area in which the CQC found that mental health staff could do better as caring professionals was by engaging patients as true partners in their care. Inspectors noted that in too many services care plans did not truly reflect the patient's voice. This is an area which the CQC is planning to pay closer attention to in future inspections.

Services need good leadership to become outstanding

- The CQC concluded that 39% of NHS Trusts and 15% of independent services needed to improve in terms of their leadership.
- Having analysed a number of inspection reports, the CQC found 6 key themes that contributed to a rating of Good or Outstanding for Well-Led:
  - Leadership
  - A clear vision and set of values
  - A culture of learning and improvement
  - Good governance
  - Quality assurance
  - Engagement and involvement

As reported by the NHS Staff Survey, those who work in mental health and learning disability trusts report poorer levels of overall satisfaction than their counterparts in the acute sector and they are less likely to recommend the organisation as a place to work or receive treatment. On the other hand, they report better experiences of staff support, team working, line management and working practices. A higher proportion of mental health staff also reported experiencing harassment, bullying, abuse or physical violence from patients, relatives or the public in the 12 months prior to the survey.

Physical healthcare of people with mental health conditions

- CQC inspectors found a mixed picture in relation to the goal for people living with severe mental health problems to have their physical health needs met, as reflected in the Five Year Forward View.

Inspectors found some excellent examples, particularly in forensic wards, of staff enabling patients to access GPs, dentists and healthcare clinics, and promoting physical exercise and healthy eating in response to the growing numbers of patients at risk of obesity and associated conditions such as diabetes. However, they also found community mental health services where staff did not ensure that patients had their annual health checks and where they failed to monitor the effects of medication, and services for older people where there was a lack of integration of physical and mental health care.

Quality of care plans

- Inspectors were often critical of the quality of care plans.

Regardless of whether they were recorded on paper or in an electronic system, inspectors sometimes found that care plans were not personalised, did not cover all areas of need, did not fully take account of the patient's strengths and wishes, and were not being kept up to date.

Examples of Good Practice

Examples of services rated as Outstanding, with reasons for these ratings being given, are provided within the report as follows:

- *Outstanding Service – Northumberland, Tyne and Wear NHS Foundation Trust.*
  One of the largest mental health and disability trusts in England, the Trust was rated as Outstanding following the CQC inspection in May and June 2016 due to a combination of innovation and high-quality care.

- *Outstanding Service – Newbridge House*
  Newbridge House is a small independent hospital providing a specialist eating disorder service for children and young people aged 8-18 years, which was rated as Outstanding by the CQC following their inspection in January 2016.

- *Outstanding Leadership – East London NHS Foundation Trust*
  The Trust had inspiring and approachable leaders who shared a clear vision that was known and understood by staff working across the Trust. They welcomed innovation and celebrated success..

- *Outstanding Leadership – East London NHS Foundation Trust*
  The Trust had inspiring and approachable leaders who shared a clear vision that was known and understood by staff working across the Trust. They welcomed innovation and celebrated success.

- *Improvement – Lincolnshire Partnership NHS Trust*
  The Trust moved from Requires Improvement in December 2015 to Good overall in June 2017.

- *Improvement – Oxford Health NHS Foundation Trust*
  The Trust moved from Requires Improvement in October 2015 to Good overall.

- *Improvement – Dartmouth House (Formerly Harriet Tubman House)*
  The service went into special measures in December 2015 and the building was subsequently closed for refurbishment. The service re-opened in July 2016 and was rated as Good, coming out of special measures in March 2017.

Areas of Concern

Safety of services

- At 31 May 2017, 36% of NHS and 34% of independent core services were rated as Requires Improvement for Safe. A further 4% of NHS core services and 5% of independent services were rated as Inadequate for Safe.

For both NHS and independent mental health services, safe was the key question that was most often rated as Requires Improvement or Inadequate. A number of factors contributed to these ratings: the physical environment of many mental health wards located in older buildings are not designed to meet the needs of today's acute patients; some services were struggling to ensure that wards were safely staffed at all times; and staff in both inpatient and community services were not always managing medicines safely.

Persistence of restrictive practice

- The CQC found that there are about 3500 beds in locked mental health rehabilitation wards, with about two thirds managed in the independent sector.
- The CQC found great variation between wards in terms of how frequently staff used restrictive practices and physical restraint to manage challenging behaviour.

More than 30 years after the introduction of mental health legislation that enshrined the principle of least restriction, some patients still receive care that is overly restrictive. Locked mental health rehabilitation wards are often situated a long way from the patient's home, meaning that people are isolated from their friends and families. Inspectors were concerned that some of these hospitals were in fact long-stay wards that risked institutionalising patients, rather than being a step on the road back to a more independent life in their home communities.

The CQC noted that those wards where the level of restraint to manage challenging behaviour was low or had been reduced over time, had staff who were trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm.

Access and waiting times

- The CQC found that a number of people have difficulty in accessing the service that is best equipped to meet their needs.

In some cases, inspectors identified unmet needs directly on inspection: for example, long waiting times in a community child and adolescent mental health service, a mental health crisis team that did not provide 24-hour cover, or patients' discharged being delayed because of the unavailability of a community care package. It was harder for inspectors to gauges other instances of unmet need – for example, how many people had been admitted to a distant independent hospital because a bed was not available locally. Also, the CQC could not always attribute responsibility for this unmet need to the providers that they regulate as these difficulties with access to local services were sometimes due to decisions made by Commissioners rather than providers.

Poor clinical information systems

- Many of the clinical staff the CQC talked to voiced their frustration about the clinical record systems they have to work with.

Staff told the CQC that they were often unable to locate or retrieve information recorded by others, that they had to enter essential clinical information into a number of different systems which "do not talk to one another", or that they had to work with a confusing combination of electronic systems and paper. The CQC found that this problem consumed staff time that could be better spent in face-to-face contact with patients, that it increased the likelihood of essential information about risk not being communicated appropriately, and that it could lead to care plans that did not reflect the contribution of all members of the multi-professional team or, sometimes, the voice of the patient.

Key Findings: Children and Young People's Services

- 76% of children's and young people's wards were rated as Good and 6% as Outstanding; 66% of community services were rated as Good and 9% as Outstanding.

- Getting access to services in the first place can be a significant problem for both inpatient and community care.

- Many young people are admitted to a ward a long way from home, which can make it difficult for them to maintain close contact with their families and for families to participate in treatment.

- The CQC saw good examples of multidisciplinary working, with staff from diverse and different disciplines working well together, supported by a positive working culture.

Key Findings: Services for Working Age Adults

- 56% of acute wards for working age adults were rated as Good and 5% as Outstanding. For long stay / rehabilitation wards, 72% were rated as Good and 4% as Outstanding. Among community services, 69% were rated as Good and 2% as Outstanding.

- The CQC had concerns about the model of care provided by locked rehabilitation wards, especially in independent hospitals

- The impact of the national shortage of mental health nurses was most apparent on acute mental health wards.

- Many acute wards and PICUs are located in old buildings that were not designed to meet the needs of these patients.

- The CQC found many examples of commitment to continuous improvement amoung services for working age adults.

Key Findings: Older People's Services

- 66% of older people's wards were rated as Good and 2% as Outstanding; 76% of community services were rated as Good and 10% as Outstanding.

- A substantial number of services reported that some older people remained in hospital beyond the point at which they required that level of mental health care.

- The CQC were concerned to find that, in some services, staff had not carried out a risk assessment, or had recorded one that was formulaic or lacking in detail.

- The CQC had concerns about the ward environment in some older people's services, such as potential ligature anchor points and failure to comply with the guidance on eliminating mixed sex accommodation.

Key Findings: Mental Health Crisis Care

- 67% of crisis care services were rated as Good and 4% as Outstanding.

- The use of police custody as a place of safety fell by 56% from 2014/15 to 2015/16. The rollout of street triage schemes across the country has contributed to this.

- Not all parts of the country are yet commissioned to provide fully functioning crisis services 24 hours a day, 7 days a week for all groups of patients who might benefit.

- Crisis care staff often did not receive regular supervision, which was a concern because these staff are caring for the most at-risk patients in a context that lacks the structure of an inpatient setting.

Key Findings: Services for People with a Learning Disability or Autism

- 64% of wards for people with a learning disability or autism were rated as Good and 9% as Outstanding; 80% of community services were rated as Good and 9% as outstanding.

- The CQC found examples where staff had achieved a marked reduction in the use of physical restraint and seclusion. However, they remain concerned about the high use of restrictive interventions in some inpatient services.

- Many services worked well with other health and social care services to build partnerships to meet the needs of people using the service and their carers.

- Contrary to the aims of the Transforming Care Programme, some patients had been in hospital for a long time and their care plans lacked evidence of active discharge planning.

- Staff in too many services were not applying the Mental Capacity Act properly.

Key Findings: Forensic Services

- 78% of forensic / secure wards were rated as Good and 2% as Outstanding.

- While some services had enough staff available to meet people's needs, some had multiple vacancies on wards.

- A number of forensic services had schemes that provided patients with employment opportunities within secure care, making an important contribution to the patient's rehabilitation.

- The CQC saw a range of good practice in services in attending to patients' physical health needs.

Conclusion and Next Steps

- Going forward, through the next phase of the regulatory approach, the CQC will work closely with national partners to contribute to work to address some of the widespread problems highlighted in the report:
  - The high number of people of all ages who are forced to accept care in wards many miles from their home
  - Long waiting times for some specialist treatments
  - The great variation in use of physical restraint
  - The poor and unsafe condition of many mental health wards

- In both the NHS and the independent sector, the staff are mental health services' greatest asset. More staff of the same calibre are urgently needed and services must provide the leadership and support to develop existing staff and the incentives to retain them.

- The CQC will play an active role in both the government's commitments to improve mental health care for children and young people and to reform the Mental Health Act to better protect those most severely affected by mental ill-health.

- The CQC were impressed by the generous way in which the best NHS mental health trusts have advised and supported those that have just started their improvement journey and by the general willingness of leaders of mental health providers to share ideas and work together with their peers in other providers.

REPORT TO Open Trust Board

Enclosure No:11

Date of Meeting:	09.11.2017	
Title of Report:	Open board briefing regarding the dissolving of the Section 75 agreement with Staffordshire County Council.	
Presented by:	Dr Nasreen Fazal-Short	
Author:	Ms Samantha Mortimer - Head of Directorate, Adult Community	
Executive Lead Name:	Dr Nasreen Fazal-Short: Acting Director of Operations	Approved by Exec ☒

Executive Summary:		Purpose of report	
The attached paper provides the Board with an update on the current positon regarding the dissolving of the Staffordshire Section 75 Partnership Agreement following the decision by Staffordshire County Council to award the agreement to a preferred provider.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date: 19.09.17	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	Risk to integrated health and social care delivery.		
Resource Implications: Funding Source:	Reduction in staffing and related income.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	Request for the board to accept the report and have oversight of actions being undertaken.		

Briefing to Open Board Regarding the Dissolving of the Staffordshire Section 75 Partnership Agreement

9th November 2017

Samantha Mortimer: Head of Directorate Adult Community

Introduction

Section 75 Partnership Agreements allow budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated and functions can be re-allocated between partners.

North Staffordshire Combined Healthcare NHS Trust have responsibility for the delivery of two Section 75 Partnership Agreements; one with Stoke-on-Trent City Council and one with Staffordshire County Council. Both have been operational for a number of years.

The Staffordshire Section 75 Partnership Agreement incorporates the provision of social care to citizens of The Moorlands (The Ashcombe Centre), Newcastle-under-Lyme (The Lymebrook Centre) and through the Access team.

North Staffordshire Combined Health Care Trust were informed by Dr Richard Harling, Director for Health and Social Care for Staffordshire County Council on the 23rd December 2016 of their intention to dissolve the Section 75 Partnership Agreement by awarding current social care provision to a preferred provider. It is suggested that the preferred provider identified by the Council is South Staffordshire and Shropshire Healthcare Foundation Trust.

The partnership agreement with North Staffordshire Combined Healthcare NHS Trust contractually came to an end on 31st March 2017. We are continuing to deliver the service as contractually described on a month-by-month basis.

In the best interests of the wellbeing of the citizens of North Staffordshire, we have challenged this decision; despite our best efforts, the decision to dissolve the partnership agreement with North Staffordshire Combined Healthcare NHS Trust for the delivery of social care to the citizens of North Staffordshire is going ahead.

The Section 75 Partnership Agreement between Stoke-on-Trent City Council and North Staffordshire Combined Healthcare NHS Trust remains in place and is not currently at risk.

During August 2017 there have been two high level meetings with the council and South Staffordshire and Shropshire Healthcare Foundation Trust to discuss the next steps relating to the dissolving of the Section 75 Partnership Agreement.

At the meetings held in August with the Council, we have of course committed to continuing our partnership working with the new provider to deliver the optimum outcome for health and social care provision for North Staffordshire citizens that continues to be safe, effective and responsive.

High Level Time Line

Since receipt of the intention to dissolve the Partnership Agreement there have been various meetings with the council to agree the most appropriate way forward for both our staff and the citizens of North Staffordshire.

At a meeting held in August the following timeline was agreed:

1. Staff Engagement Session to be undertaken on **29 September 2017** hosted by the Council.

In attendance were affected staff (Combined), Head of Directorate, Social Care Lead for North Staffordshire Combined Healthcare Trust, identified executives for North Staffordshire Combined Healthcare NHS Trust, Staff Side Representatives, the Council and representatives from South Staffordshire and Shropshire Healthcare Foundation Trust.

Representatives from the three organisations Communications Teams have been in contact to agree a clear narrative for the engagement meeting.

2. High level TUPE (Transfer of Undertakings Protection of Employment) list to be developed by North Staffordshire Combined Healthcare NHS Trust.

The Head of Directorate, Human Resources Business Partner and Finance have worked on the partnership agreement and associated TUPE list.

North Staffordshire Combined Healthcare NHS Trust will work in partnership to ensure our contractual and legal obligations under TUPE rules, including the provision of data 28 days before anticipated handover date.

3. Public/staff consultation by local authority anticipated in **October 2017**.

The public consultation will be undertaken within the usual timescale of eight weeks.

4. Sign-off from Council Cabinet anticipated December 2017.

The County Council Cabinet will meet in December to review the outcome of the consultation and sign-off accordingly or agree further actions required.

5. Staff interviews under TUPE guidance to commence following sign-off.

It is anticipated that the TUPE interviews with staff will be undertaken through December and into January; due to Christmas holidays the anticipated conclusion is likely to be January 2018.

6. Handover is anticipated to be **2nd February 2018**.

It has been acknowledged that there may be some slippage on the dates agreed; however this will not exceed the end of the financial year 31st March 2018.

Risks

- There is a risk that the desegregation of a health and social care model might create a gap in timely care provision for citizens of North Staffordshire.

- There is a risk that the senior social work expertise lost by North Staffordshire Combined Healthcare NHS Trust will impact upon service development.

- There is a risk that the already identified gap in the provision of approved mental health practitioners (AMHPs) currently managed and influenced in partnership through the agreement, will widen for North Staffordshire citizens within the new model of social care delivery.

- There is a risk that a number of patients with complex care needs both within area and out of area who will not receive the continued joint health and social care approach to care delivery.

- There is a risk to partnership working should there be an inability to form a close working alliance with the new partner.

- There is a risk to the citizens of North Staffordshire that their social care interventions might not be provided locally.

- There is a risk that the pathway remodelling will be complicated and confusing for referrers and impacting upon the timely care provision.

Preparation Work Being Undertaken by North Staffordshire Combined NHS Healthcare Trust

Currently there is a review being undertaken of all caseloads within the County Teams to establish the percentage split between health and social care need. This analysis will identify the cases that will be transferred to South Staffordshire and Shropshire Foundation Healthcare NHS Trust and those with health needs who will remain under the care of North Staffordshire Combined Healthcare NHS Trust.

An understanding of the numbers of service users currently supported within specialist placements funded through social care is required. These service users will be transferred to the new provider.

A re-modelling of healthcare delivery will be required for the north of the County, including pathways for crisis and social care delivery. This will also include an estates review.

Recommendations

For the Board to receive the information in this paper, including the actions taken and those planned.

REPORT TO Trust Board

Enclosure No:12

Date of Meeting:	9th November 2017		
Title of Report:	Summary of 'Equally Outstanding: Equality and Human Rights Good Practice Resource' by CQC		
Presented by:	Paul Draycott		
Author:	Lesley Faux		
Executive Lead Name:	Paul Draycott	Approved by Exec	☐

Executive Summary:	Purpose of report	
This good practice guide by the CQC seeks to demonstrate how those services that have the improvement of equality and the recognition of human rights at their core, provide better services for the public. The document clearly sets out the ethical, economic, business and legal cases for approaches that put D&I at the centre of patient and staff experience.	Approval	☒
	Information	☒
	Discussion	☒
	Assurance	☐

Key
- Improving on delivery on equality and human rights is part of the solution to the NHS challenge, and the best providers are embracing this in their service improvement approach
- Providers cannot operate alone if they are to maximise on improvements in health inequalities. Health and social care leaders need to look beyond provider boundaries. They need to ensure the community involvement of individuals. They need to develop broader, more holistic services that meet the needs of diverse communities. Sustainability and transformation partnerships (STPs) have an important role to play in reducing health inequalities.
- Some inequality needs addressing at a service level – not on the individual basis possible through person-centred care. Eg Lower wellbeing is linked to poorer health and life expectancy. There is a difference in reported wellbeing for Black and Minority Ethnic (BME) people in the UK compared to white people. This is true even if factors such as differences in employment, housing and household income are taken into account. This could lead to poorer physical and mental health outcomes for BME people, including lower life expectancy.
- Diverse teams perform better. Research shows "diversity trumps ability" in tasks which require teamwork. This suggests we often need the best team for the job – not always the best person for the job, if this leads to a lack of diversity.

Success factors from across the case studies:-
1. **Committed leadership:** The key role of leaders who are enthusiastic and committed to equality and human rights. We need to move away from "heroes and heroines" to making this the business of all leaders.
2. **Equality and human rights principles into action:** These principles run through as a thread from organisational values, through leadership behaviours and actions to frontline staff and their work.
3. **Culture of staff equality:** They developed a culture of equality and human rights for their staff as a basis for quality improvement. This is likely to include both broad work to develop an open and inclusive culture and, particularly in larger organisations, work to tackle specific workforce inequalities.
4. **Apply equality and human rights thinking to improvement issues:** They started with the quality improvement issue, created some space to innovate and

then applied "equality and human rights thinking" to the issue – rather than thinking "we must do something about equality and/ or human rights".

5. **Staff as improvement partners:** All staff were involved as partners in the thinking about, planning and delivery of the equality and human rights interventions to improve the quality of care. This was done within a "no blame" culture of learning and is aligned to collective leadership approaches.
6. **People who use services at the centre:** The rule was "how do we serve this person?" – Person Centredness! They listened carefully to people who used the service and viewed them as people with a life beyond their immediate need for a service – including their future aspirations.
7. **Use external help:** They linked to the outside – reaching out to others for help and being prepared to have a mirror shone on their work.
8. **Courage:** They were courageous and bold in their approaches – including positive risk-taking, being honest about issues and tackling difficult problems.9.
9. **Continuous learning and curiosity:** They were curious and humble – they started somewhere, learned from mistakes and were always looking for the next thing that they could improve – whether for a small service like Shadon House that was how to best meet the needs of the next person admitted, or for larger services what project to focus on next or service to develop.

The report case studies included some transferable ideas and approaches that could be considered in relation to improving some of our local Trust services at NSCHT, eg:-

- 'Namaste' multi-sensory programme promoting dignity for advanced dementia patients approaching end of life (p22)
- A project to reduce violence on acute mental health wards, including ward community discussions and displaying 'safety crosses' in each area (calendars with red marks and green marks denoting incidence or absence of violence on each day). (p23)
- A project looking at human rights in psychiatric intensive inpatients services. (p23)
- Approaches to staff supervision and support, including a daily coffee time debrief for clinicians and a monthly service meeting for all staff. (p24)
- Guidance on developing accessible resources for people with dementia and people who are blind or partially sighted. (p29)
- Some good video resources – Gender equality by design (p33); What matters to different groups, listening to transgender voices etc (p41)

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	None – document is about how to improve services and experience for all our service users
Resource Implications: **Funding Source:**	No specific impact
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	This document is focussed on developing more equal service experiences for all service user groups and individuals. It is centred on embedding diversity and inclusion within NHS services. It outlines the business case for diversity and inclusion, provides good practice examples and resources, and outlines approaches to overcoming commonly experienced challenges, including those of involving and empowering our local communities.

Recommendations:	• To consider the content and intent of the CQC report 'Equally Outstanding' and:
	    o Consider potential application for the Trust
	    o Recognise work already undertaken in enhancing our approach to diversity and inclusion
	    o Provide continued commitment and support for additional development and embedding work to be undertaken by the Trust
	• Agree that People and Culture Development Committee will:
	    o Oversee embedding this approach in to the Trusts Diversity and Inclusion Strategy by end of quarter 4
	    o Further embed the Equality Impact Analysis process and receive quarterly reports for assurance

Care Quality Commission

Equally outstanding

Equality and human rights – good practice resource

How can a focus on equality and human rights improve the quality of care in times of financial constraint?

Enter ▷
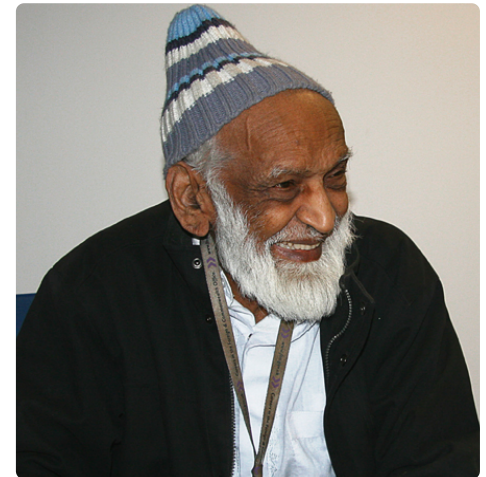
Foreword

One of CQC's aims is to encourage improvement in health and social care services. To achieve this we are working with a wide range of partners to understand and develop best practice among providers. This publication is a part of that process. It demonstrates how those services that have the improvement of equality and the recognition of human rights at their core, provide better services for the public.

Most of our inspection reports give the service a rating – the best being outstanding. Here we demonstrate that some of those outstanding services have also developed practices that deliver equality and safeguard human rights for both the public and staff. This demonstrates that it is wrong to see a focus on equality as, in some way, a distraction. Improving the rights of people is a mainstream part of the delivery of health and social care.

Increasingly, CQC recognises that we are limited in what we can achieve on our own. Therefore, while we have been responsible for organising this publication, we have developed and published it with others. Given that we want the document to be used, rather than just read, we felt that the wider the set of partnerships that helped to develop it, the wider the audience might be that would use it.

We also recognised that we needed help to gather wider evidence from other organisations that either had deeper experience of equality and human rights, or represented providers.

This is not a linear document with a beginning, a middle and an end but is a resource that invites different readers to construct their own path through its material. We have published the case studies online so that they can be easily searched and linked to our assessment framework.

We have also decided to publish it as a 'beta' version, which will allow us to rework the links and other material after six months when we will have a better idea about how it has actually been used and how we can improve it.

Paul Corrigan
CQC Non-Executive Director and
Board equality and human rights champion

Introduction

Welcome to this good practice resource.

In times of financial constraint, we often see equality and human rights as a challenge. We rarely look at equality and human rights as a solution.

Yet, there is growing evidence that equality and human rights for people using services and staff needs to play a central role in improving the quality of care. And we are finding that some of the best providers are doing this successfully – even in times of constraint.

This is what we want to explore in this resource. We want to help providers put equality and human rights at the heart of their improvement work so that the quality of care gets better for everyone.

Who is this resource for?

- Managers of health and social care services
- Quality improvement and organisational development staff
- Senior managers and Board members
- Frontline staff with an interest in equality and human rights
- Regulators, commissioners and policy makers
- People who use services and their representative organisations

This resource is also available online at www.cqc.org.uk/EquallyOutstanding

This resource has been produced by the Care Quality Commission with our partners:

Summary

1. Often people see equality and human rights as a problem – not a solution. Especially in times of financial constraint.

Yet, there are **ethical**, **business**, **economic** and **legal** arguments for providers to pay attention to equality and human rights. Human rights principles of fairness, respect, equality, dignity and autonomy are at the heart of good care provision.

There is a strong link between the quality of care and equality for staff that requires work on basic fairness and building an inclusive culture that recognises and celebrates diversity. There is also a link between the quality of care and whether people who use services say their human rights are upheld.

Research shows that money spent on reducing health inequalities is the most efficient way of improving health outcomes for a local population. Equality and human rights is likely to become more important over time because of demographic and system changes, as well as financial constraint.

▶ **Go to '1. Why focus on equality and human rights?'**

2. Many providers could learn from the best providers in using equality and human rights to improve the quality of care.

This work involves promoting human rights and ensuring equity in access, experience and outcomes. Importantly, it means empowering people who use services, their families and friends – and staff working in services.

Outstanding care providers build on strong person-centred care and inclusive leadership. Attention to equality and human rights at a service level is also needed to tackle specific quality improvement issues.

None of the common 'success factors' in the best providers took a large amount of resources. Their success was based on changing behaviours and thinking about issues. In particular:

- Leadership committed to equality and human rights
- Putting equality and human rights principles into action
- Developing a culture of staff equality
- Applying equality and human rights thinking to improvement issues
- Putting people who use services at the centre
- Using external help and demonstrating courage and curiosity.

▶ **Go to '2. Case studies'**

3. Providers may still face challenges in times of constraint

There might be a need to reduce costs, reduce service demand or increase income – such as through fees or charges.

However, there are ways to minimise the impact of these changes on people who use services or staff, if careful attention is paid to mitigating any negative impacts on equality and human rights.

▶ **Go to '3. Overcoming challenges'**

4. Providers cannot do this work alone.

- **Commissioners** can help by building equality and human rights into contracts and monitoring. They also need to mitigate any potential negative impacts of the way they commission services. They can also consider commissioning to meet the needs of specific groups.

- **Regulators** need to build equality and human rights into their regulatory frameworks. They need to ensure there are no "unintended consequences" of regulation, e.g. risk aversion. They should reward people acting in an innovative way around equality and human rights. A focus on outcomes for people will help this.

- **Policy makers** need to support providers through ensuring they embed equality and human rights into national policy and system wide co-ordination.

▶ **Go to '4. Empowering people and communities** Whole system approach**'**

5. Empowering people and communities is essential to advance equality and human rights.

To do this, health and social care leaders need to look beyond provider boundaries. They need to ensure the community involvement of individuals. They need to develop broader, more holistic services that meet the needs of diverse communities.

Local system leadership is important too. Sustainability and transformation partnerships (STPs) have an important role to play in reducing health inequalities. There is some emerging good practice about how to look at equality in STP work.

▶ **Go to '4. Empowering people and communities** Empowering services**'**

1. Why focus on equality and human rights?

Often people see equality and human rights as a problem – not a solution. Especially in times of financial constraint. Yet, there is an:

- **ethical case**

- **business case**

- **economic case**

- **legal case**

for providers to pay attention to equality and human rights.

Questions for reflection

- Which reasons for a focus on equality and human rights are most important or compelling in the organisation or service that I work in – the ethical case, business case, economic case or legal case?

- What evidence is there to back up these reasons?

  - e.g. feedback from people using the service or staff, identified quality improvement issues or staff equality data

- Will different reasons appeal to different people I work with?

  - e.g senior managers, managers, clinical staff, care staff, other staff groups, people using the service, their families and friends , service commissioners

FOREWORD, INTRODUCTION AND SUMMARY

1. WHY FOCUS ON EQUALITY AND HUMAN RIGHTS?

Ethical case | Business case | Economic case | Legal case

2. CASE STUDIES

3. OVERCOMING CHALLENGES

4. EMPOWERING PEOPLE AND COMMUNITIES

Ethical case

Outcomes people want

Paying attention to equality and human rights improves care for people using services – because it gives people the outcomes that they want. Find out more from the resources section.

A policy priority

The importance of equality and human rights has long been recognised in national health and social care policy. From the founding principles of the NHS, through to the NHS Constitution. And more recently in the NHS National Quality Board shared commitment to quality and the Adult Social Care Quality Matters initiative.

Complexity – and simplicity

Sometimes this work can feel daunting. There are many different equality groups that a provider could consider. "Human rights" cover a wide range of topics. The human rights in healthcare framework covers the "FREDA principles" of fairness, respect, equality, dignity and autonomy.

Then there are the legal considerations which can seem complex. Yet, the outstanding providers featured in the case studies have tackled this by putting better outcomes for people at the heart of their service development

work through conscious attention to equality and human rights.

Person-centred care, equality and human rights

Person-centred care is a human rights approach to care. This is because it is based on respect and autonomy.

Person-centred care approaches will also help achieve equality. This is because individual needs will be met. This includes needs based on people's equality characteristics such as disability, culture, language, gender, religion, sexual orientation. This might include tackling barriers to equality faced by individuals. Removing these barriers might also improve care for others.

A focus on promoting human rights and providing equally good access, experiences of care and outcomes will create good quality care for all. However, equity does not mean treating everyone the same – it means treating everyone according to their needs. Our focus is on the role of providers but this is a dynamic system – see the person-centred model overleaf.

Person-centred care is one of the requirements in CQC regulations – in regulation 9. It is also in the assessment frameworks for health services and for adult social care services.

"Both ethical and instrumental cases for person-centred care have been made. The first makes a values-based argument, presenting person-centred care as respecting autonomy and being a good in its own right – the 'right thing to do' (nothing about me, without me) .The second justifies person-centred care as a means to achieve better outcomes." Health Foundation: Person-centred care: from ideas to action

Person-centred model

Person-centred model diagram:

Policy makers — Providers — Commissioners — Regulators

Human rights promoted → Equally good experience → Equity in outcomes → Equity in access (circular arrows)

Inner circles: People working in services / Person with health or social care need / Family and friends

Wider factors leading to health inequalities and inequality in life chances

There are "five groups who influence the quality of care" – providers, staff, people who use services and the public, commissioners and funders and regulators. Policy makers indirectly influence these five groups in relation to the quality of care and also influence other aspects of the "model" such as wider health inequalities and life chances.

The person needing services is not passive in the middle. The more that the person's influence can be strengthened, the greater the likelihood of equality and human rights for the individual. This will lead to good quality care and improved outcomes. The person also has "assets" that they can utilise. Their own strengths and skills and for most people, a network of family or friends. These need to be factored into the care provided.

Health and social care staff have a large influence over whether equality and human rights are secured for people using care services. Providers that promote equality and human rights for staff are more likely to ensure good quality care for people using their service.

All this is in a wider context of other factors leading to health inequalities: including poverty, poor housing or legal factors such as immigration status. Wider factors also lead to inequalities in life chances, important for social care outcomes. For example, discrimination leads to disabled people having a lack of opportunity to exercise citizenship and poor employment prospects.

Removing barriers at a service level

Some inequality needs addressing at a service level – not on the individual basis possible through person-centred care.

Staff may need support to understand – and act on – the needs of particular groups.

Example: Lesbian, gay, bisexual, transgender and intersex (LGBT&I) people can face discrimination, prejudice, misunderstanding or ignorance when using adult social care services. This means they can be afraid to "come out" when needing adult social care. This can affect their wellbeing and whether person-centred care is possible for them.

A project by Anchor and University of Middlesex aimed to address this. They worked with community advisors to develop more LGBT&I inclusive environments in 6 care homes in London. They found that a range of work was required to enable care home staff to deliver person-centred care for LGBT& I people. This included development of staff training, cultural safety, risk management and community engagement. The project developed a service assessment and development tool for use by the community advisors.

Read an inspection report for one of the participating care homes here.

Some groups may need specific service developments to achieve the same outcomes as others.

Example: Lower wellbeing is linked to poorer health and life expectancy. There is a difference in reported wellbeing for Black and Minority Ethnic (BME) people in the UK compared to white people. This is true even if factors such as differences in employment, housing and household income are taken into account. This could lead to poorer physical and mental health outcomes for BME people, including lower life expectancy.

Research Recommendations relevant to providers include:

- Improved engagement with communities: using "appreciative inquiry" to determine the actions needed for particular communities.

- Systematic analysis and reporting of data on the extent of ethnic differences in the quality of care.

- More action to address wellbeing per se, rather than using wellbeing just as a measure of success.

We discuss this further in "empowering people and communities".

| FOREWORD, INTRODUCTION AND SUMMARY | 1. WHY FOCUS ON EQUALITY AND HUMAN RIGHTS? | | | | 2. CASE STUDIES | 3. OVERCOMING CHALLENGES | 4.EMPOWERING PEOPLE AND COMMUNITIES |

1. WHY FOCUS ON EQUALITY AND HUMAN RIGHTS?

| Ethical case | Business case | Economic case | Legal case |

Removing barriers to people's human rights also sometimes needs action at a service level.

Example: The British Institute of Human Rights project "Connecting human rights to the frontline" provides useful examples of how providers have worked at a service level to improve the quality of care through tackling specific human rights issues in health and social care services.

Staff involved in the project said:

- "It has revolutionised decision making. People are thinking differently and making decisions differently. It needs to be rights based not just risk based."

- "Human rights helps you demonstrate what otherwise seems indemonstrable. Otherwise how do you monitor a compassionate approach."

- "It's very enabling and there have been many lightbulb moments – it's turned decision making on its head."

CQC regulations focus on care provided to individual people. So, removing barriers for groups of people is implicit rather than explicit in regulations. However, the need to look at equality and human rights at a service level is included in the assessment frameworks for health services and for adult social care services. Supporting staff to understand the needs of particular groups is also included. So, these issues contributes to CQC ratings.

Business case

Link between equality and inclusion for staff and good care

Improving the quality of care makes good "business sense" – it enhances the reputation of the service. And there is a "business case" for tackling workforce equality issues to improve the quality of care.

Research looking at the NHS staff survey and inpatient survey for different NHS Trusts found a number of correlations between equality for staff and the quality of care. For example, where Black and Minority Ethnic staff experienced discrimination, there tended to be lower levels of patient satisfaction.

Research by the Kings Fund has found widespread workforce inequality in the NHS across a range of equality characteristics.

The link between the quality of care and levels of staff discrimination and bullying and harassment is supported by CQC analysis of NHS trusts' ratings. This shows that staff in acute or combined trust with higher ratings are less likely to say they have experienced discrimination, bullying or harassment.

Though there has been less work on this topic in primary care and adult social care, our case studies show that the basic principle holds true – where organisations value and support staff equally, this will help lead to better care.

The development of inclusive organisational cultures and attention to workforce equality features strongly in the "well-led" key questions in the assessment frameworks for health services and for adult social care services.

Increasing staff equality will save money for providers

Turnover: Equality-related causes of high staff turnover include harassment, bullying and abuse at work, lack of flexible working options and lack of effective management action to deal with violence and harassment from members of the public. When a staff member leaves the NHS, the average immediate cost to a trust is £4,500. Long term costs in hiring and training new staff, are much greater. In social care, the average cost is estimated at £4,000.

Absenteeism: Equality-related causes of absenteeism include work-related stress due to harassment and bullying. Inclusive cultures, free from discrimination also lead to higher employee engagement which is linked to lower absenteeism. NHS staff are absent from work, on average, 10.7 days each year. This loses the service a total of 10.3 million days and costs £1.75 billion. This equates to the loss of 45,000 full time staff.

Unnecessary disciplinary and fitness to practice actions: Research shows that BME nurses and midwives (working in health and social care settings) are more likely to be referred by their employer to the Nursing and Midwifery Council fitness-to-practice process and more likely to have

to progress to the later stages of the process. However, they were less likely to be barred from practice as an outcome. This not only has a personal cost for the BME nurses and midwives involved, it has a financial cost to the health and social care system.

Values-based recruitment leads to cost savings: Skills for Care have found a return of £1.23 for every £1 spent on values based recruitment by adult social care providers. This is due to lower turnover and training costs for staff recruited this way. These values almost universally include Equality and Human Rights.

Having a diverse workforce adds value

Talent management: Removing barriers to equality widens the pool of talent available to providers. Values based recruitment can increase the diversity of applicants appointed, for example to recruit more men to work in frontline care roles. Social care employers also say that applicants recruited this way are more likely to deliver high quality care.

Staff profile reflecting the people using the service: This helps gain the confidence of people using the service as well as enabling "matching" staff and people using the service to provide more person-centred care. Though organisations need to handle "matching" carefully and this should always be the choice of the person receiving care. For example, some refugees fleeing persecution and lesbian, gay and bisexual people from minority ethnic groups may fear that "ethnic matching" might lead to confidentiality issues.

Organisation's leadership reflecting the local population: This helps gain the confidence of people using the service and of staff and can encourage under-represented groups to use the service. A diverse leadership can also provide the organisation with insight about equality and inclusion issues.

Diverse teams perform better. There is some academic debate over whether diversity is *a cause* of higher performing teams. But there is some research which shows that "diversity trumps ability" in tasks which require teamwork. This suggests we often need the best team for the job – not always the best person for the job, if this leads to a lack of diversity.

A link between the quality of care and performance on equality and human rights?

There is also a "business case" for improving equality and human rights for people using the service, if this leads to improved quality and therefore enhanced reputation.

Quality ratings: We looked at key **human rights-related questions in the NHS inpatient survey**. Patients in outstanding acute NHS Trusts are significantly more likely to say that they are treated with dignity and respect in hospital and that they have the emotional support that they need. Their overall satisfaction with their hospital stay was also higher.

When we looked at **responses to these questions by different equality groups**, outstanding trusts were more likely to have no difference in satisfaction between patients of different age groups. Lesbian

and gay patients were less likely to give positive responses to all 3 questions compared to heterosexual patients- except in outstanding trusts where they were more likely to give positive responses than heterosexual patients. However, due to small numbers of lesbian and gay respondents in outstanding trusts, these results were not statistically significant.

University of Lancaster looked at comments made about the quality of care for people with a learning disability in acute hospital inspection reports. They found that the proportion of comments that were positive increased in line with the Trust rating.

Looking at 14,000 adult social care "provider information returns", services rated good or outstanding were slightly more likely have undertaken some specific work on equality in the past 12 months. But there was a lot of variation when looking at whether services had done work on specific equality characteristics and comparing this to ratings.

The links between outstanding care and equality work were particularly strong for hospices. Seventy-five per cent of hospices rated as outstanding had carried out some work on equality for disabled people, but only 55% of other hospices had done so. Eighty-eight per cent of hospices rated as outstanding had carried out some work around equality for people of different religions and beliefs compared to 65% of lower-rated hospices.

Working on equality and human rights for people using services is good for staff

Skills building: Staff can gain good skills and experience through finding creative solutions to meet the needs of different people using their service. The same is true for working on quality improvement projects that improve equality or human rights for people using the service.

Morale: Some organisations take a corporate social responsibility approach to promoting equality and human rights beyond the service they deliver. This type of work often really engages staff – because staff in health and social care are keen to make a difference through their work.

Staff retention: A number of the case study organisations said that improved staff morale was a large business benefit for equality and human rights work because it improves staff retention . This is particularly true in sectors where there may be problems with staff retention – such as care staff in social care and GPs.

Example: Equality-focused change campaigns
Dimensions UK have carried out national campaign work on disability hate crime. They have developed the campaign #ImWithSam. This has benefits for people using the service, for staff and for the wider community– working together as citizens on a positive change campaign improves everyone's wellbeing.

Working on equality and human rights can lead to greater efficiencies – and win contracts

Work on equality or human rights can create organisational efficiency and save providers money. But there is little research to measure this. Here are just a few examples:

- Sending out appointment letters in the right format or language could reduce the number of missed appointments in a GP practice or hospital.

- Investing in environmental adaptations in social care settings could increase autonomy for disabled people and reduce the amount of staff help that people need.

- LGB&T people are more likely to present late for medical support due to lack of trust in the health system. This is particularly true for trans people. Creating an explicitly welcoming service can result in earlier diagnosis and treatment, saving money at a local and systemic level.

- Changing care pathways for particular equality groups using a GP practice can may improve care outcomes – and create greater efficiencies.

- Not-for-profit and private providers find that effective work on equality and diversity is often a requirement to win public sector tenders due to the public sector equality duty.

Example: Rights-respecting adult social care that saves money
Choice Support is national social care charity providing support to people with a learning disability. In this short video they show how person-centred care through Individual Service Funds:

- gives people more control and advances their citizenship

- increase the quality of care

- lead to good outcomes in terms of health and well-being

- and saves money.

Economic case

A focus on equality and human rights can save money for the health and social care "system"

This is through preventing ill health, or deterioration in people's health, **by tackling health inequalities or barriers to accessing health and social care services.**

Research in the US has shown that people in some minority ethnic groups are more likely to have multiple and chronic health needs which are costly to manage, have inappropriate and often costly health tests ordered and have longer and more frequent hospital stays. This led to an estimated excess cost to the health sector of $60 billion a year in 2009.

Research in the UK has generally focussed on inequality based on "levels of deprivation" in different areas where people live. In 2010, health inequalities were estimated to cost the NHS £5.5 billion per year. This is based on the cost of treating ill heath associated with these geographical health inequalities. It covers extra costs in acute care, prescribing and mental health but not primary care. There is evidence that restricting access to primary care costs more money than it saves, for example European research shows that reducing access to primary care for "irregular migrants" may have a public health impact and may cost more money than it saves.

One example of a costed impact of equality provision is work by the charity Sign Health. They asked health economists to calculate the cost to the NHS of failures to provide British Sign Language interpreters for Deaf people. The estimate was that lack of BSL interpreters was causing missed diagnoses and poor health which cost the NHS £30 million a year.

For local government, there has also been work on the "efficiency case" for improving the health of particular groups of people. This includes looking at the social factors that impact on health (sometimes called "social determinants"). This work aims to **prevent ill health that has a financial impact on both health and social care services**.

People may be experiencing more than one form of disadvantage. It is important to consider this. For example:

- Disabled people are more likely to be on low incomes than non-disabled people.
- BME people experiencing mental ill health have different outcomes from white people – such as higher levels of compulsory detention.
- Lesbian, gay and bisexual older people may be more reluctant to approach health and social care services than others, due to fear of discrimination. This can affect the well-being and therefore health status of these older people.

Public Health England produce a useful tool covering the wider determinants of health across England. This enables you to look at potential factors leading health inequalities in your local area and to

compare with other areas. They have also recently published a health equity report focusing on ethnicity. This report found a mixed picture, including:

- children in Black ethnic groups generally had poorer health outcomes than average for England
- health outcomes are generally poor for people of Bangladeshi or Pakistani origin.

A focus on equality and human rights can save money for the wider economy

Poor health leads to lower productivity – for example through greater staff sickness. It also leads to higher welfare benefits costs. This might be for people experiencing ill health – or their informal carers. So, health inequalities have a wider impact on the economy beyond the costs to the health and social care system.

Research in the US has shown that ethnic disparities in health led to $22 billion in lost productivity in 2009.

In the UK, the economic cost of geographical health inequalities was estimated at £33 billion in lost productivity in 2010. This inequality also led to an additional £20 billion cost to government – in lost taxes and increased welfare benefit payments.

A focus on workforce equality and developing employment in the sector can save money for the wider economy

The health and social care sector is also a major employer. So, through action on workforce equality, the sector can help to reduce the economic impact of employment inequalities.

The McGregor–Smith review has estimated a £24 billion potential benefit to the UK economy from full representation of BME individuals across the labour market - through improved participation and progression. Reducing employment inequality in the health and social care sector, as a major employment sector, would contribute to this.

The Equality and Human Rights Commission has argued that the social care sector, rather than being a "drain" on the economy could contribute to economic prosperity, if equality and human rights are taken into account. From an economic perspective, this includes:

- optimising the social and economic participation of people requiring support and their families
- agreeing a fair and sustainable approach to funding social care and for the role of informal care
- developing a committed and competent social care workforce
- addressing the changes needed for everyone to thrive in our ageing society.

Legal case

Considering equality and human rights is often a legal requirement – as well as a way to provide better care

The legal case is often the first "argument" used when people want organisations to consider equality and human rights. This argument is usually based on reputation and financial risks of non-compliance.

It is not always the most persuasive argument, particularly for wider culture change and outstanding care rather than basic compliance. But some of the "processes" associated with legal compliance, such as thorough equality impact analysis, can be helpful.

This is why we include a basic outline of legal requirements opposite.

Summary of legal requirements relating to equality and human rights:

- All providers of public services need to comply with the Equality Act 2010 sections that relate to service provision and to employment.

- Public sector providers will also need to comply with the Public Sector Equality Duty.

- Public sector organisations – and those carrying out "public functions" will also need to respect, protect and fulfil the Human Rights Act 1998.

- However, the benefits for all providers in complying with human rights law is shown in this video: and there is also guidance for all businesses on human rights.

- The Human Rights Act is a "foundation law" and many other pieces of legislation are designed to ensure that human rights are upheld, such as:

  – The Health and Social Care Act regulations used by the Care Quality Commission

  – The Mental Health Act 1983 and its Code of Practice and the Mental Health Act 2007

  – The Mental Capacity Act 2005 and its Code of Practice.

2. Case studies

There is a large gap between the best providers in using equality and human rights to improve the quality of care and others. Many providers could learn from the very best providers.

Closing this gap has the potential to lever substantial improvements in the quality of care for a large number of people. Those least well-served in health and social care will benefit most.

Outstanding care providers build on strong person-centred care and inclusive leadership. They develop approaches to equality and human rights for staff and people using the service. This work results in outstanding quality – even in times of financial constraint.

Attention to equality and human rights at a service-level is also needed to tackle specific quality improvement issues. This is necessary to remove organisational barriers and to empower frontline staff and people who use services.

Though these services vary greatly, there are a number of common features – particularly about organisational culture – that other services could learn from.

Looking at the common "success factors" in the best providers none of these took a large amount of resources.

Questions for reflection

- Which of the case studies inspired me – and why?
- Which of the case studies seemed most relevant to my organisation?
- Can I identify any common success factors in using equality and human rights approaches in these case studies?
- Looking at the "common factors" we identified across all the case studies – which ones are particular strengths in my organisation…
- And which ones need more development?
- What learning from the case studies could I transfer into my organisation?
- Who could help me with this?
- What resources could help me do this?

Shadon House   Dimensions Kent   Castlebar Care Centre   East London NHS Trust   The Christie NHS Trust   The Docs GP practice   Herstmonceaux integrative care centre
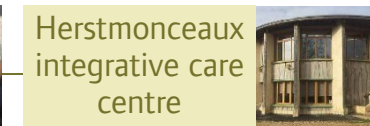
Success factors

The case studies in this section are quite different – ranging from private sector care homes to large NHS trusts. Yet there are some common factors that most , if not all, share.

These factors have helped to make the services successful in using equality and human rights approaches. But more than that, these factors have been crucial in developing outstanding care. None of these factors take large resources – they take shifts in thinking and in behaviours.

1. **Committed leadership:** The key role of leaders who are enthusiastic and committed to equality and human rights. We need to move away from "heroes and heroines" to making this the business of all leaders.

2. **Equality and human rights principles into action:** These principles run through as a thread from organisational values, through leadership behaviours and actions to frontline staff and their work.

3. **Culture of staff equality:** They developed a culture of equality and human rights for their staff as a basis for quality improvement. This is likely to include both broad work to develop an open and inclusive culture and, particularly in larger organisations, work to tackle specific workforce inequalities.

4. **Apply equality and human rights thinking to improvement issues:** They started with the quality improvement issue, created some space to innovate and then applied "equality and human rights thinking" to the issue – rather than thinking "we must do something about equality and/ or human rights".

5. **Staff as improvement partners:** All staff were involved as partners in the thinking about, planning and delivery of the equality and human rights interventions to improve the quality of care. This was done within a "no blame" culture of learning and is aligned to collective leadership approaches.

6. **People who use services at the centre:** The rule was "how do we serve this person?" They listened carefully to people who used the service and viewed them as people with a life beyond their immediate need for a service – including their future aspirations.

7. **Use external help:** They linked to the outside – reaching out to others for help and being prepared to have a mirror shone on their work.

8. **Courage:** They were courageous and bold in their approaches – including positive risk-taking, being honest about issues and tackling difficult problems.

9. **Continuous learning and curiosity:** They were curious and humble – they started somewhere, learned from mistakes and were always looking for the next thing that they could improve – whether for a small service like Shadon House that was how to best meet the needs of the next person admitted, or for larger services what project to focus on next or service to develop.

These nine factors are closely linked to six elements for cultures of inclusion in the Kings Fund report Making the Difference. In the resources section, we also link them to CQC key lines of enquiry and the NHSI culture assessment tool.

Case study 1: Shadon House Dementia Resource Centre

Shadon House is a care home for people with dementia providing respite care and assessment place for up to 23 people at a time. The service employs 30 staff. Shadon House was rated "outstanding" in June 2016 – read the inspection report here.

Shadon House bases its work on the Human Rights "FREDA principles": These principles are fairness, respect, equality, dignity and autonomy. Procedures and training for staff make FREDA 'live' every day through all the work.

Listening to people's needs – and their aspirations: Staff assess people's capacity on admission. They then tell the staff team about the person's needs. So all staff know about the person's life and how to support them to achieve next goal.

Staff respect, support and development: The whole management team works with all staff. Managers will not ask staff to do something they are not prepared to do themselves. This shows respect for staff at every level; good relationships with staff result in a good service to people staying in Shadon House.

All staff are engaged – there are three handover sessions a day which include all staff. Staff are well supported with supervision, discussion at staff meetings and development sessions. These sessions include human rights topics such as Deprivation of Liberty (DoLs), confidentiality and duty of candour. All staff attend the sessions including staff such as the cleaners.

Staff at Shadon House are passionate about what they do. There is good continuity of staff for people using the service (e.g. on respite visits) because staff 'don't leave'.

Reaching out: Shadon House makes links with the local hospital, charities and others. This helps to find ways to provide support and care for individuals. For example, one person was showing a lot of distress. Staff discovered that this was partly because they loved hens and were no longer able to care for them. Shadon House now has free range hens and this reduced the person's distressed behaviour. The hens also provide interest and happiness to other people using the service and staff.

Shadon House has also found external facilitators for arts and craft and drama from charities at no cost to the service. This enables people to live fulfilling lives: e.g, people using the service created their own book.

"When service users come into Shadon for assessment the greatest thing they learn is what they are capable of – they are revived and ready to live at home again with new found confidence. Our emphasis is on wellbeing and building on positives." (Joanne Matthewson – Registered Manager)

Case study 2: Dimensions Kent

Dimensions is one of the largest not-for-profit providers of support to people with learning disabilities and those who experience autism in the UK. Their Kent domiciliary care service was awarded an outstanding rating by CQC in December 2016 – read the inspection report here.

Vision and values into strategy: Equality and human rights are at the centre of their vision, mission and values. The vision is "An inclusive society where people have equal chances to live the life they want".

In 2010, Dimensions created a specialist equality and diversity role. Their first task was to develop an equality and diversity strategy to "bring to life" equality work for both staff and people using services. The strategy outlines the "business case" for equality and diversity, the work that Dimensions has taken and how progress will be monitored. This covers processes such as Equality Impact Assessments and governance. It also covers equality in key programmes of work – such as **learning and development, support planning and personalised technology**. These support the organisation's approach to person-centred care.

Equality for staff: The strategy commits Dimensions to participation in the Skills for Care Moving Up Programme to increase the number of BME employees in management positions. Dimensions are also developing their staff development programme to include tailored resources for people from minority backgrounds. The strategy also contains a commitment to increase the number of disabled staff and to offer appropriate support to disabled staff . This is enabled by making reasonable adjustments, flexible working and seeking advice and support from Access to Work.

Communicating and campaigning for change: Equality topics are featured in monthly staff bulletins, quarterly equality and diversity newsletters and in regular communications to families. Equality and diversity issues are built into surveys and complaints monitoring. Survey results are analysed demographically. There are two "Diversity matters" groups – one for staff and one for people Dimensions support – and a senior champion.

Dimensions also has strong national work on equality and human rights-based campaigns. They run campaigns around disability-related harassment – #ImWithSam and – removing barriers to people with a learning disability voting in elections – Love Your Vote. This Corporate Social Responsibility work is positive for the people they support, staff and the wider community. Engaging together as citizens to make positive changes improves people's wellbeing.

Local benefits: The benefit of this national work was evident on the Dimensions Kent inspection. There was strong person-centred care that took account of diversity. There was good staff awareness of human rights principles, such as dignity and autonomy. Staff were able to talk about the national communications that they receive around equality and the campaigns work – and how these are used in the local service. Staff praised the culture of the service. They spoke about the opportunities they had for personal development. They felt able to contribute to quality improvement, using the Dimensions values as their guide.

"The biggest challenge is enabling people to understand that equality and diversity is the thread that runs through everything and not a stand-alone issue. Clear, consistent and regular communication for both staff and the people we support has facilitated this, alongside our vision and the rationale of our equality and diversity business case." (Lisa Govier, Equality, Diversity and Inclusion Manager)

Case study 3: Castlebar Care Centre

Castlebar care centre is a private sector nursing home for 59 people in Lewisham, London. It owned by Excelcare, a family owned company which has grown slowly but now owns 33 care homes. Castlebar was rated outstanding in January 2017. Read the report here

Culture and values to promote individual rights: The culture and values of the organisation are important in promoting people's rights at Castlebar. This includes:

- celebrating and recognising diversity. In the care home, there are people living there originally from 12 countries, with staff from 27 countries.
- getting to know people well and discovering their history
- challenging accepted views to move from "risk aversion" to enabling people to live more fulfilled lives
- enabling people to do as much as possible for themselves,
- offering people choices that recognise their mental capacity and always looking for ways to provide the least restrictive care possible
- seeing change as the norm and being open about death and dying.

Investing in service development: In times of financial constraint, there may be a tendency to see quality and cost as in opposition. But, Excelcare have found that – by careful investment, sharing resources and devolving budgets – quality and cost can go hand-in-hand. They have invested in buildings, equipment, and staff recruitment, development and retention.

They have also invested in IT systems which incorporate care planning, human resources, audits and daily "dashboards".

Castlebar offers people new challenges and exciting opportunities with the view that "you are never too old to try something new". These activities include:

- Sweet readers – an intergenerational, arts based programme (pioneered in the USA) between Castlebar and a local school, recognised on the school curriculum
- Namaste – a multisensory programme for people with advanced dementia which includes individualised activities and promotes dignity at the end of life
- ballet classes
- an in-house physiotherapist
- a wide range of social activities both in the home and trips out to places of interest
- supporting significant days – such as a walk for International Day of Older People and a Caribbean Summer Party
- support for individuals to follow specific interests.

"Investment and culture change took patience and trust over time – but has led to big improvements in care and many areas of outstanding practice." (Terry O'Connor, Registered Manager)

Case study 4: East London NHS Foundation Trust

ELFT is a large, complex Mental Health and Community NHS Trust which serves East London , Luton and Bedfordshire and Richmond. In September 2016 ELFT was rated "outstanding" – read the report here.

Enthusiastic leadership: A few years ago the Trust Board changed the way it viewed performance. There was shift from performance matrixes to looking at the culture of the organisation and creating an environment which is supports staff to provide the best care.

Enthusiastic leaders are open to having conversations about how the Trust works. They have brought together quality improvement (QI) approaches and commitments to equality and human rights.

Bold with culture change and quality improvement to improve rights: QI methods were introduced, so that improvement became everyday business for all staff. The principle is that the people who know the problem are pivotal to creating the solution. Staff went to the board with a QI idea for a project to reduce violence on acute mental health inpatient wards. This is generally regarded as 'impossible to do', but the Board supported the idea because this issue had a big impact on staff and service users' experience and their rights. The project resulted in a massive reduction in violence in inpatient units.

A frontline focus on equality and human rights for staff and patients: Engaging frontline staff in equality and human rights related QI work is promoted through a clear equality, diversity and human rights strategy. A programme of specific projects are underpinned by an overall ambition: 'Our vision is for ELFT to be an exemplar of best practice in advancing equality, diversity and human rights in England by 2018.'

The Trust has embraced values-based recruitment. Trust values include respect and ensuring care is inclusive. In the recruitment process, candidates are asked questions to make sure potential staff share the Trusts values. The Trust has started to address race inequality in the workforce by looking at ethnicity variation in promotion and disciplinary cases. A programme of work is underway to tackle this.

The Trust recognised the need to do something in parallel about equality and human rights for patients. So, they started a project looking at human rights in psychiatric intensive inpatients services. They engaged an external human rights expert to find out the experience of service users anonymously. So, staff heard directly from service users about their experience of ward restrictions from a human rights perspective. They had to ask difficult questions and have outsiders shine a light on their service. This project is now developing training on human rights in Psychiatric Intensive Care wards. The Trust is also using data to look at experiences of people in different equality groups and restrictive interventions.

"Our biggest success is having people talking about equality and human rights in their day to day work while reviewing what they do. Naming the elephant in the room. Allow everyone to contribute to solutions. But we are not complacent – we need to continue to improve." (Lorraine Sunduza, Director of Nursing, London Mental Health)

Case study 5: The Christie NHS Foundation Trust

The Christie was the first specialist cancer hospital in the country to be rated 'outstanding' following inspection in May 2016. Three years ago, it was a different story. In 2013 there were some significant governance challenges. In 2014, Monitor reviewed the trust. Following this, the Board changed significantly, there was an external audit of leadership, and the Christie started a programme of culture change.

Principles and values drive culture change: The culture change work was based on the Christie Commitment of "we care, we discover, we teach". There are associated equality and human right behaviours including: "we treat everyone with compassion, dignity and respect" and "we promote a fair culture". The Christie developed a network of "Champions" to take forward culture change at a local level. They also made a number of pledges to staff which were developed through trust-wide work programmes, e.g. becoming a "Disability Confident Employer".

Using national equality programmes well: The Christie has made good use of national NHS equality programmes:

- Using EDS2 to agree specific improvements. For example, work with the leadership team has enabled the trust to move from "developing" to "achieving" for an EDS2 outcome about the board and senior leaders promoting equality.
- Work on bullying and harassment – including promoting the Trust approach and developing a network of staff advisors – has resulted in significant improvement in aspects of workforce race equality. In 2014, 28% of BME staff said that they had experienced bullying or harassment – in 2015 this decreased to 11%. But the trust recognise that they still need to reduce other "gaps" between BME and white staff. They have used the metrics in the Workforce Race Equality Scheme (WRES) to make this a priority for their equality work in 2016-2017.

Targeted work to address specific equality issues:

- Improved physical accessibility and easy read information on cancer treatments.
- Engaging the LGBT community in Manchester, through work with the LGBT Cancer Alliance and having a presence at Manchester Pride. Working with a Macmillan LGBT project worker, the trust has improved the understanding of LGBT issues amongst staff through learning sessions and an interactive display to support Trans Day of Visibility.
- Upgrading the chapel, prayer room and multi-faith room – which are now well-used by patients, visitors and staff with much positive feedback.

Feedback:

- The Christie see patient and staff feedback as essential to improving quality – including equality:
- All surveys include equality monitoring. Disclosure rates have improved – for example 97% of staff disclosure their ethnicity and 80% their sexual orientation.
- Professional interpreters are available to assist people using services to complete feedback questionnaires, if their first language is not English
- Responding positively to complaints has led to some improvements. For example, a complaint by a Deaf patient led to improvements in interpreting provision.

Monitoring data shows how this wide range of work reaps benefits, for example:

- 95% of staff believe that the trust provides equal opportunities for career progression
- The trust scored 9.7 out of 10 on the 2015 national patient survey for patients saying they were treated with dignity and respect.

Case study 6: The Docs GP practice, Manchester

The Docs is a GP practice in Manchester city centre with 7,500 patients and 17 staff. The Docs was awarded an "Outstanding" rating in August 2016.

The Docs has an unusual "mix" of patients: a high number of gay men, a small older Chinese population, students and international visitors. The practice has the highest number of patients with HIV in the UK. Unlike some other city centre practices, it has not been commissioned as a specialist GP practice to meet specific needs.

Focus on specific equality groups served: The practice has worked for years on sexual health and HIV care without stigma. The practice has developed services particularly for people who might be anxious of facing discrimination.

Many of the older Chinese people have moved away from the city centre, but still travel into the practice because of its welcoming nature. For example, the reception staff have learned some basic Cantonese. They have good links to interpreting services.

Go beyond clinical hierarchy: There is a team effort beyond clinical hierarchy – from the cleaners to the GPs. They make opportunities for everyone to contribute. Staff enjoy working on new projects to improve care for particular groups of patients. These have included:

- specialist sexual health nurse and community outreach clinics for people who are HIV+
- yoga on prescription
- links with voluntary sector mental health organisations

- work on domestic violence in same sex relationships
- currently looking at working on HPV vaccinations for men and emerging new sexual health risks like "chemsex".

Look after staff to look after patients: The practice staff look after themselves so they can look after patients well. This includes clinical support for each other and external clinical supervision – run as counselling sessions.

There is strong communication between staff. This includes a daily coffee time debrief for clinicians and a monthly practice meeting for all staff. There is a space for partners/leaders to 'disagree' – supported by a negotiated agreement.

The practice encourages all staff to act at level of competence and get it right first time, so patients only need to say something once. They also foster a learning environment with no blame – when things go wrong they view this as a learning opportunity.

All this means that the Docs "go the extra mile" for patients. The Docs have found their outstanding rating is good for attracting new staff. It is also good for recognising and motivating existing staff.

"Despite funding uncertainties, we are committed to developing sexual health work because it matches the needs of our patients and the service, in the form we offer it, is not available elsewhere. By growing, recruiting more expertise and treating more patients, we become harder to ignore." (Dr Matt Joslin, GP partner and trainer)

Case study 7: Herstmonceux Integrative Health Centre

Herstmonceux Integrative Health Centre is a GP practice serving 4,200 patients in rural East Sussex. The purpose-built centre, opened in 2014, provides a sustainable, calm and relaxing environment for patients. It has a "non-clinical feel": maximising natural light, with curved corridors and minimal environmental impact. The practice was rated outstanding in January 2017.

Mission: Integrative medicine is based on treating the whole person rather than just the illness and the symptoms. The centre has a five-year plan to deliver integrative medicine supported by the NHS. The practice's mission statement includes: "We are committed to sustainable living, sustainable working, providing safe and effective quality health care in an environment of equality and respect".

Autonomy and empowerment: The ethos is empowering patients to achieve their health goals. This aligns well with the human rights principle of autonomy:

- "Health curiosity talks" encourage people to engage with their own wellbeing.
- Patients with long term conditions work with their GP to develop a "Health Vision", and a council-funded "Health Coach" coach helps the person put this into practice.
- Alongside NHS clinics, there are complementary medicine practitioners available, who offer free "taster sessions". Patients can also access a range of classes on a private basis including tai chi, yoga, medicinal Pilates and meditation. The practice aims to evidence the benefits of these therapies and classes to increase access to people on low incomes through NHS funding.

Meeting everyone's needs: The practice runs free social prescribing and community based schemes. These include a patient library, singing workshops and healthy walks. Some focus on specific groups:

- A monthly coffee morning for older people to respond to social isolation.
- A "Vitality Villages" scheme promotes recreational activities. The scheme holds events for older people, families and children and those who are isolated. The centre is currently developing work with young men – the biggest users of the local food bank and vulnerable to poor mental and physical wellbeing.
- All staff at the centre are trained as "dementia friends". The centre is working with others in the parish to promote dementia-friendly practices.
- The centre is actively promoting the new Accessible Information Standard.

Patient feedback is good about being treated with dignity and respect and being involved in their care.

Strong patient and staff engagement: There is a very active patient participation group which has an impact on service development. The group suggested some popular projects such as the coffee mornings and a local resource list to help people find beneficial activities, such as art classes. Practice "Health walks" are now organised by two patients. The practice seeks out evidence-based research – particularly about tackling social issues that have an impact on patients' health. They have set up a "practice book club" for staff to read recently published work that could benefit patients.

"Do you want to be doing what you are doing today in 5 years' time? If not get involved in creating the right health movement for your patient population- exciting, innovative, community health care that is as empowering for your patients as it is for you." (Dr John Simmons, Lead GP)

3. Overcoming challenges

In other sections of this resource, we have rightly focused on how equality and human rights can be a solution to improve care. And how these solutions often cost little – because they are based on changing people's thinking and behaviour so they approach quality improvement in new ways. But we cannot ignore potential impacts on equality and human rights in times of financial constraint.

In this section, we do not aim to cover every single risk or solution. We just highlight some potential equality and human rights risks to trigger your thinking. We also point to some potential solutions.

In times of financial constraint, providers have some choices about how to balance budgets – see the diagram below.
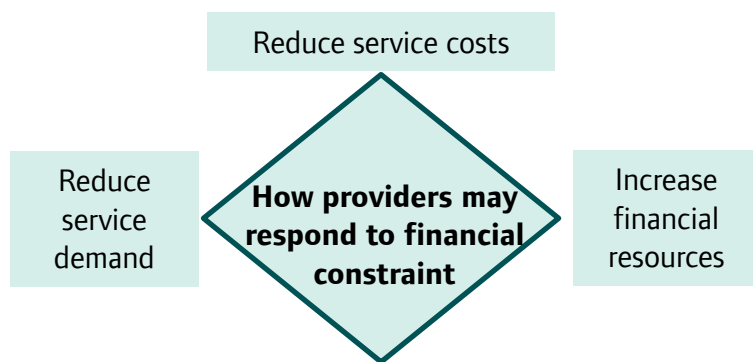
Questions for reflection

- Which challenges to equality and human rights do I currently face in my work, service or organisation? How could I assess challenges if I am uncertain of them?
- What might be the solutions to these challenges? How could I find solutions?
- How will I assess which are the best solutions?
- Who will be able to assist me with the analysis of challenges and solutions?
- Who will be able to assist me with implementing solutions?
- What resources will we need?

Reduce service costs

Reduce service demand

How providers may respond to financial constraint

Increase financial resources

Transformational service change (e.g. greater focus on prevention)

1. Reduce service costs

Change	Equality and human rights impacts	Ways of reducing these impacts
Reducing staffing numbers	• Reduced dignity as there is a relationship between staffing levels and meeting people needs in timely way. • Harder to provide personalised care – with an impact on individual choice, autonomy and meeting people's diverse needs. • Differential impact on staff equality groups – for example BME staff may be concentrated in job roles where there are greater redundancies or be less likely to have long lengths of service if this is used in redundancy decisions.	Equality Impact Analysis to see where staff reductions may have an adverse impact on particular groups – either staff or people using services. Use this to plan lawful positive action to mitigate any impact. See EHRC guidance on making fair financial decisions. Use staffing tools to ensure that people's dignity and other rights can be upheld if staff numbers are reduced. NHS Improvement are co-ordinating work on safe and sustainable staffing tools for a variety of settings including adult acute inpatient care and learning disability services. Improving workforce equality is covered later in this section.
Changing service delivery to save money e.g. moving towards generic "high volume" services rather than more "bespoke" services. Or not commissioning outreach services or other support services. Also "unintended consequences" of takeovers and mergers.	• Poorer access – lower uptake of services from particular groups. • Less innovation in equality and human rights practice – poorer outcomes. • Takeovers and mergers may mean that smaller user-led organisations or those for particular equality groups are unable to maintain an equality focus as part of a larger organisation. Momentum can also be lost on staff equality issues such as flexible working.	Equality Impact Analysis to see where service changes may have an adverse impact See EHRC guidance above. Commissioners need to take account of the Public Services (Social value) Act 2012 – to consider how to improve the economic, environmental and social wellbeing of local communities when procuring service contracts. The Voluntary Organisations Disability Group Social Value toolkit can help health and social care providers work with commissioners in delivering "social value" – including equality for people who use services and staff – when services are being recommissioned.

Change	Equality and human rights impacts	Ways of reducing these impacts
Changing service delivery to save money (contd)		British Institute of Human Rights health and human rights hub brings together resources which will help consider human rights when changing services. This covers social care as well as health services. As part of the General Practice Forward View, NHS England have published a guide for GP practices and commissioners – Improving access for all: reducing inequalities in access to GP services.
Reducing capital expenditure to save money	• Care environments less likely to meet people's needs – equality, dignity, autonomy. • This might have a particular impact on disabled or older people.	Providers must meet the Equality Act 2010 "reasonable adjustments" requirements. This includes making their premises more accessible to disabled people. This is an "anticipatory duty". So providers should consider this, even if no-one currently using the service needs the adjustment. See the EHRC Statutory Code of practice on providing goods and services, chapter 7. Some ways to improve accessibility of care environments are low cost. For example, keeping corridors clear or improving signage. Improving accessibility can be cheaper if considered as part of regular maintenance rather than a separate activity. For example, better colour contrast can be specified on all routine redecoration. Person-centred approaches to accessibility are important. So, discussing planned improvements with individual people, their relatives and staff cost little and can make a big difference. This will make a building more accessible to individual people with dementia as well as blind and partially sighted people.

2. Reduce service demand

Change	Equality and human rights impacts	Ways of reducing these impacts
Changing clinical criteria for treatment	Sometimes this can have hidden impacts on equality groups , for example: • People with a learning disability are more likely to be obese than others. A policy decision to recommend that all obese people lose weight before they are recommended for certain types of surgery could have a larger impact on people with a learning disability. • A recommendation that smokers quit smoking before treatment could have a larger impact on people with enduring mental ill health, who are more likely to be smokers. • Both these decisions are also likely to have a higher impact on people living in poverty.	Developing person-centred approaches to clinical decision-making – "shared decision-making" between clinicians and patients. Equality Impact Analysis to see where clinical policy may have an adverse impact on particular groups. Use this to review decisions. See EHRC guidance on making fair financial decisions. For NHS trusts, good use of the Equality Delivery System (EDS2) can help uncover where more consideration for particular equality groups might be needed for future service changes.
Not increasing services in line with increased demand	• Some social care services are under financial pressure and are "handing back" local authority contracts. Others are choosing only to expand their services for people who are self-funding. This is likely to have impacts on particular groups of older or disabled people who are more likely to need publicly funded social care. • Waiting lists in some health services are growing due to financial pressures. This is likely to have particular impacts on some groups – for example older people who use health services more than others.	These are some of the major national policy questions facing health and social care at the moment – and are beyond the scope of this resource. Solving these issues is beyond the control of a single provider and involves system transformation. Ensuring equality is considered within this system transformation is discussed in the section on "the whole system approach".

3. Increase financial resources

Change	Equality and human rights impacts	Ways of reducing these impacts
Charging for healthcare services This could be universal charges – such as prescription charges – or local charges such as hospital car parking fees. Or this could be increase in charges targeted at particular groups of people – for example NHS charges for non-urgent care for overseas visitors	• Universal charges can have impacts on different groups, even with exemptions policies in place. For example, there is international academic evidence that charging for prescriptions has a particular impact on older people as well as poorer people– and that it does not improve either efficiency or health equity. • If healthcare charges are targeted some people may be uncertain whether they will be charged for care. This can prevent them from seeking healthcare at an early stage in an illness, even if they are entitled to free care. Also, as we reported in State of Care 2015, staff working for healthcare providers may be uncertain about people's entitlements.	Carry out Equality Impact Analysis to see where proposed charging policies may have an adverse impact on particular groups. Use this to plan lawful positive action to mitigate any impact. See EHRC guidance on making fair financial decisions. Publicise people's entitlements to free care or to exemptions from charges. Ensure that staff understand these entitlements. For example, NHS England has produced leaflets about registering with a GP for Refugees and asylums seekers and members of the gypsy, Roma and travelling communities. These are useful for both patients and primary care staff.
Increasing fees in the social care sector	• More social care services are only available to self-funding people. This will have a different impact on groups of people including on the grounds of ethnicity, gender and disability as well as socio-economic status.	This is linked to major national policy questions around social care funding – beyond the scope of this resource and often beyond the control of a single provider. System transformation is needed. Ensuring equality is considered within this system transformation is discussed in the section on "the whole system approach".

| FOREWORD, INTRODUCTION AND SUMMARY | 1. WHY FOCUS ON EQUALITY AND HUMAN RIGHTS? | | | | 2. CASE STUDIES | 3. OVERCOMING CHALLENGES | 4. EMPOWERING PEOPLE AND COMMUNITIES |

1. WHY FOCUS ON EQUALITY AND HUMAN RIGHTS?
Ethical case | Business case | Economic case | Legal case

4. Improving staff equality

This is a big topic and one attracting much interest in terms of "what works".

There are particular challenges in times of financial constraint. For example, it might be harder to recruit externally if there are planned redundancies and this might have an impact on increasing diversity within an organisation. But there are also opportunities – for example to improve progression for BME staff within the organisation.

We can only give a very brief outline here to stimulate people's thinking. **There are 4 key steps to improving workforce equality:**

1. Understand where you are now

For large organisations, this will include making best use of your data. For NHS Trusts and independent healthcare organisations with NHS contracts, the Workforce Race Equality Standards Indicators are invaluable. But trusts can also extend this to look at other equality issues. And the Workforce Disability Equality Standard will come into effect in 2018/19 too.

For all organisations, you will need to listen to the views of your staff in different equality groups. This will help you to understand the data, for example whether inequality is a particular issue in specific services. In some circumstances, it might be necessary to get help from outside organisations to do this, particularly if staff have concerns about speaking up on equality issues.

2. Understand the root causes for any workforce inequality

This is a necessary step before looking at solutions to inequality but it is often missed out. Again, talking to staff is important is establishing causes. Sometimes, more analytical "root cause analysis" is needed. 2016 NHS Workforce Race Equality Standard data analysis report gives some examples. See the Chapter "What works – characteristics of effective interventions".

3. Apply effective interventions

There can be a willingness to tackle workforce inequality – but the interventions are often ineffective. Effort is put in, but the outcomes change little. To give two examples:

Research shows that a focus on equality training alone is not very effective. Unconscious bias learning has become very popular. Unconscious bias can explain some of the reasons why inequality happens. But learning about bias is not enough. Even willing people need support to change their behaviours rather than relying solely on individuals changing their minds. Institutional barriers to equality also need to be addressed.

A focus on changing policies and procedures may seem like the way forward in reducing institutional barriers. However, policies and procedures are not enough. Organisations need to be more proactive and preventative in their approach to tackling inequality.

There is developing work to show how tackling inequality can be "designed into" various activities at an organisational level rather than an individual level such as recruitment or disciplinary procedures. For example see this short video about gender equality by design.

The 2016 NHS Workforce Race Equality Standard data analysis report identifies 5 building blocks for effective interventions, these are:

- Accountability – at the centre of the other 4
- Leadership
- Metrics
- Voice of BME staff
- A convincing narrative and business case

Creating a broader positive culture change for all staff also has an impact on staff equality. The Kings Fund report Making the Difference suggests six key points for developing a culture of inclusion:

- A clear vision and values which managers consistently demonstrate
- Clarity of objectives and performance feedback for all staff
- Positive relationships – support, respect, care and compassion
- Quality improvement, learning and innovation which values diversity in the workforce, constructive debate and hearing all voices
- Team based working and a culture of co-operation.

- Collective and collaborative leadership – recognising how all staff play leadership roles at various points

These six points also chime well with the common features we found in outstanding providers who are using equality and human rights approaches to improve care.

4. Review your progress…and keep going

Workforce inequality can be complex to tackle. It is important not to be disheartened if change takes time.

Using a "Plan, do, check, adjust" cycle could help. This is a simple continuous improvement approach.

You can use annual data, such as workforce surveys to see the impact of your interventions. You also need to keep talking to staff about how they think the change is working.

You might also need to study each of the interventions in more detail to see what is working. And what is not making as much impact as you had hoped. This is particularly important if you bringing in more than one intervention at a time.

NHS trusts can also use the Equality Delivery System (EDS2) to review and plan their progress on workforce equality.

4. Empowering people and communities

Whole system approach

Providers cannot do this work alone. They need support from commissioners, regulators and policy makers to put equality and human rights at the heart of quality improvement.

Empowering people and communities is essential to advance equality and human rights. To do this, health and social care leaders need to look beyond provider boundaries.

Local system leadership is important too. Sustainability and transformation partnerships (STPs) have an important role to play in reducing health inequalities. There is some emerging good practice about how STPs can consider equality in their work.

Providers working together to improve people's rights

Sometimes, effective change can be brought about by providers supporting each other to change practice and improve people's rights – for example, the VODG STOMP campaign, which aims to stop the over-medication of people with a learning disability, autism or both.

Role of commissioners

Commissioners can help providers by:

- **Putting equality and human rights requirements into contracts:** This will help commissioners to fulfil their duties under the Equality Act 2010 and the Human Rights Act 1998.

- **Contract monitoring:** Some equality considerations are in national health contracts already – such as the NHS Workforce Race Equality Standard and – for NHS Trusts – use of Equality Delivery System 2. Commissioners have an important role in making sure these national schemes are implemented well. The Accessible Information Standard is also a legal requirement for publicly funded health and adult social care services , so is likely to fall within contractual requirements for providers to follow legal obligations.

- **Recognising equality and human rights implications of commissioning decisions:** by listening to people using services and to providers to mitigate any negative impacts of commissioning decisions. For example, the EHRC has provided training resources about commissioning for human rights in home care for older people.

- **Commissioning services to meet needs of specific groups:** Sometimes equity can be best achieved through commissioning services for particular groups. There are some good examples of this in the CQC review: "A different ending – reducing inequalities in end of life care". A key finding of the report was " where commissioners and services are taking an equality-led approach that responds to people's individual needs, people receive better care." The review "My diabetes, my care" also provides examples of good commissioning to meet the specific needs of Black and minority ethnic communities and people with a learning disability.

Role of regulators

Regulators can help providers by:

- **Ensuring regulatory frameworks support providers' work on equality and human rights as a core to the quality of care** For example , CQC uses a Human Rights Approach to regulation to ensure that equality and human rights are "embedded into" assessment frameworks. These were reviewed in 2017, including working with NHS Improvement to strengthen the focus on equality in the "well-led" question for all health and social care services.

- **Equipping regulatory staff consider and act on equality and human rights** At CQC, this includes:
  - building equality and human rights into our "intelligence" i.e. the evidence that we have available about services for inspectors to use

  - learning and development for inspection teams – for example our learning and development programme with British Institute for Human Rights. We are continuing to develop our equality and human rights capability. Over 250 staff have signed up to our equality and human rights network. They are supported by over 40 leads, as well as the small specialist Equality and Human Rights team of 3 staff.
  - equipping inspectors with methods, tools and information that cover equality and human rights – a range of support from guidance to specialists on hand to answer technical queries.

- **Ensuring there are no "unintended consequences" of regulation that might negatively impact on human rights** A regulatory focus on "minimising safety risks" might help with some rights – for example the right to life. However, it might make providers unduly risk-averse and reduce the autonomy of people using the service, potentially affecting other rights such as right to a private life. To counter this, regulators should use definitions of "risk of harm" which include risks to people's rights. This enables a rights-based approach to risks.

CQC has incorporated infringements of people's rights into "risk of harm" in our policy on what enforcement action we will take – our Enforcement Decision Tree.

We recognise that sometimes providers may think that we are more interested in "risk minimisation" rather than "rights maximisation". We hope that other work - such as publicising outstanding providers who work creatively to maximise people's rights whilst minimising risks – will help address this.

- **Sharing learning from regulation to encourage improvement across the quality spectrum**
  This ranges from what needs to be done to protect equality and human rights when the quality of care is poor to the sharing the best practice found through regulatory work. This project is an example of that work

  Examples of work on human rights from other regulators in other sectors and professional regulators can be found in the EHRC case studies from regulators, inspectorates and ombudsmen.

Role of policy makers

- **Policy makers can help providers to improve the quality of care by ensuring equality and human rights are embedded in policy and national system wide co-ordination:**
  - For example, there is an emphasis on equality, diversity and inclusion in recently published Developing People Improving Care – national framework for action on improvement and leadership development in NHS funded services. This is published by the National Improvement and Leadership Development Board.
  - Equality also features in the Shared commitment to quality framework published by the National Quality Board as part of the NHS Five Year Forward View.
  - Equality and human rights feature in Adult Social Care Quality Matters initiative.
  - In the NHS, the Equality and Diversity Council plays a key role in bringing national organisations together to work on equality for both patients and NHS staff.

Empowering services[i]

Why do some people have poorer experience and outcomes from care?

The persistence of comparatively poorer experience and poorer outcomes for black and minority ethnic communities who use health and care services has been explained by:

- Evidence on the continuing experience of racism. For example: even when regulatory activity has led to action (for example the inquiry into death of David 'Rocky' Bennett resulted in the NHS Delivering Race Equality national programme) it does not appear to result in the scale of change needed, or ensure that progress endures.

- The lack of spread of better practice For example: reports of better experiences and outcomes as a result of services provided black and minority ethnic-led voluntary and community organisations are rarely accompanied by the lessons learnt being replicated in mainstream provision.

- Uncertainty of what works with whom and in what context.

- At times this has been accompanied by an expectation that because a particular change is seen as valuable for one 'equality' group it will be so for all. An example is 'Direct Payments' which clearly made a difference to some disabled people's lives, but was not widely taken-up by black and minority ethnic disabled people.

There are lessons that if applied will make a difference. Some, but not all of these lessons are in the control of a provider.

Robert's story

Robert was interviewed when he was on his way back up. A few years earlier he had a complete breakdown in his mental health. In his case, this was a result of the childhood trauma of losing a parent to suicide. He ended up on the streets, frequently being arrested, sectioned, medicated and discharged.

Eventually he found actual help when he heard about a place for people who had a mental illness and who were African Caribbean. With a secure roof over his head, and an environment he found supportive, he could start working on his recovery, start working on putting back together a life that had been torn apart with his breakdown.

These were things that the police, NHS, and homelessness services had not done.

i. With thanks to Jabeer Butt and Samir Jeraj of the Race Equality Foundation for writing this section.

Keys to success: Broader services and more involvement

The Race Equality Foundation looked at examples of good and best practice in black mental health together with MHPF (now MHPA) in 2014. In particular, we found two keys to success:

- The inclusion of **broader services beyond specific and medicalised mental health services**. These services provide a more accessible and culturally appropriate way into discussing and addressing mental health issues. Services that seek to support the broad needs of the individual and the community they are in, and support their right to involvement in both services and the community creates a far more positive and engaged process. It is also a process that strengthens the rights of the individual, and those in their community who may need these services in future.

- **Service user involvement** was also a common feature, but had important differences between providers. The focus on what individuals can do, and can do now meant service users and former service users were involved in service design and delivery in some organisations. In other organisations, they became advocates within the community and/or were supported into representative roles on local boards and forums.

Dhek Bhal, Bristol

Dhek Bhal, an organisation supporting South Asian people provides:

- a 'sit-in service to give a break to carers,
- home care service for elderly, support around the home, washing, dressing, cooking, taking medication, cleaning, companionship, read the inspection report here.
- day care service and very vibrant luncheon club, a range of activities, talks on health, diabetes, heart disease.

Importantly, these services are an important gateway to addressing the key issue of mental health where it may otherwise be difficult.

Kadimah

Kadimah is an organisation which works primarily with non-practicing people of Jewish descent.

Although in contact with the local Orthodox community, they describe the relationship as "delicate" due to issues of stigma surrounding mental health.

The promotion of their services to Orthodox communities is therefore rarely explicit, but instead depends upon "people who have benefited from the therapies going out into the community to discuss their experiences and raise awareness in the community and to educate community elders about the issues."

Holistic approaches , complexity and challenges

Recent attempts to improve the quality of support available to people living with dementia have also emphasised the need for more holistic support, for example the Dementia, Equity and Rights report. For example, Macintyre have supported with people with learning disabilities who are living with dementia to maintain their independence as well as continue care for their peers.

A holistic approach does not overcome complexity. For instance enabling 'choice and control' has been widely accepted as the right approach and is consistent with rights-based approach. We may call it self-directed care or personalisation, but the key elements remain consistent:

> "It is important that individuals are supported in making their own decisions and deciding for themselves how support and services should be organised to meet their needs"
> In-Control, Supporting Choice and control

However, this can pose challenges. One young Asian disabled woman argued that she did not want an adapted flat to make her more independent, but did want her parents' house extended so she could have space of her own in the house.

This holistic human rights based approach has the potential to address the need for support in a personalised manner at the same time as ensuring everyone benefits. However, there are significant issues if there are inequalities of access – then there cannot be equality of experience or outcome.

System wide support to enable equity of access

Specific good practice in developing equity of access has to be accompanied by system-wide change to ensure that the benefits are available to all.

One example: the benefits of being able to access high quality community language interpreting services when providing care are now well-established. This has to be accompanied by everyone recognising that communicating effectively is a skill that has to practiced and is a fundamental part of a quality service which promotes equality and reduces health inequalities.

Transformational change

Transformational change is an essential option in times of financial constraint, which often involves reducing costs through preventing ill-health. This benefits both individuals and health and social care budgets.

There is a focus on tackling health inequalities in NHS Five Year Forward View (5YFV). The 'Health and wellbeing gap' is one of three gaps 5YFV aims to close. It is early days yet to see how this plays out in practice in Sustainability and Transformations Plans (STPs) and in the future through Accountable Care Organisations. Some STPs are looking at integrating equality into their plans – not only as a 'inequalities work stream' but to check the equality impact of all their work including radical service reconfiguration.

There can also be a shift towards "population health" models which are designed to improve health outcomes for a particular group of individuals. This could include some equality groups – such as older people, or people with a learning disability. These "system changes" often require new ways of organisations working together and could have a major impact on equality of access and outcomes.

Example: Devo Manc – Testing an equality approach to service transformation

The NHS Transformation Unit used the "Healthier Together" project as test of an equality approach. This focussed on the transformation of general surgery across Greater Manchester.

A community organisation undertook an Equality Impact Assessment (EIA) informed by a series of engagement meetings with equality groups. The EIA also included socio-economic impacts and travel impacts, as well as impacts on equality groups.

- The EIA was independently assured by an Equality Advisory Group (EAG): providers, commissioners, voluntary and community groups, local authorities

- The EIA had equal status to other factors in the option appraisal for the transformation

- The EAG prioritised the most important actions to mitigate any negative impacts on equality

- Disabled people's rights organisation carried out an access appraisal for different options

Mitigating actions and access requirements became conditions for implementing the service changes (e.g. advertising NHS travel vouchers, good signage, face to face communication skills)

Providers were "benchmarked" to enabled best practice relating to mitigating actions to be identified and shared by the EAG

Area action plans were drawn up to ensure equality was consistently addressed by preferred providers – bringing all up to the highest standard of the best providers

They are now rolling out this approach to other transformation projects. For more details contact: transformationunit@nhs.net

FOREWORD, INTRODUCTION AND SUMMARY

1. WHY FOCUS ON EQUALITY AND HUMAN RIGHTS?

Ethical case

Business case

Economic case

Legal case

2. CASE STUDIES

3. OVERCOMING CHALLENGES

4. EMPOWERING PEOPLE AND COMMUNITIES

Extra resources

The ethical case: People speaking up about equality and human rights

CQC short film on what matters to people in a range of different equality groups

Social Care Institute for Excellence videos:
- working with lesbian, gay, bisexual and transgender people
- issues important to Black and minority ethnic people using social care

A few of the many Local Healthwatch reports suggested by **Healthwatch England**:
- Healthwatch Hampshire: reports about people with a learning disability and people with dementia. And their powerful film about health care experiences of transgender people
- Healthwatch Hackney: the specific health and wellbeing needs of vulnerable sex workers
- Healthwatch Newcastle: the health needs of refugees and asylum seekers, Black and minority ethnic people's involvement in the ambulance service as patients and potential employees, and young people's mental well-being
- Healthwatch Leicester: inequality in health services faced by deaf people

- Healthwatch Blackburn with Darwen uses a human rights approach to health care. They work with British Institute of Human Rights and other advocacy organisations as part of the "Care and support: a human rights approach to advocacy" project. You can read some of the project success stories here.

National LGB and T Partnership: Out Loud, LGBT Voices in health and social care.

Quality improvement and health equity

The Institute for Healthcare Improvement in the US has done much work around improving equity of access, treatment and outcomes. They have many resources that can help a focus on health equity in quality improvement work which are also relevant to work in the UK.

Links between nine common factors in case studies and CQC key lines of enquiry

9 common factors	CQC adult social care key lines of enquiry	CQC health key lines of enquiry	Notes
Leadership enthusiastic and committed to Equality and human rights (E&HR)	W1.6, W1.7	W3.8	
E&HR runs as a thread	W1.6, C3.3, C3.5, R1.2, R3.1, S1.3	W3.8, W7.1, W7.2, S1.3, E1.2, R1.1,R2.1, R2.4, R2.5, R2.9	All key E&HR KLOEs here – collectively they amount to a "thread" starting from well-led
Equality culture for staff	W1.2, W1.3	W3.8, W1.4	
Apply E&HR thinking to Quality Improvement issue	W1.6	W2.5	
People who use services at the centre	C1.2, C1.4, R1.2, W3.1, W3.6	E5.3, C1.1, C1.5, C2.5, R2.7, R2.8, W7.1, W7.2	
Staff as improvement partners	W3.1, W1.8	W7.3, W8.4	
Linked to outside	W3.2, W5.1	W7.4	
Courageous and bold	W4.3	W8.1, W8.4, W8.5	Innovation
Curious and humble	W1.4, W3.3, W3.4, W3.6	W7.1, W7.2, W8.3, W8.4	Continuous improvement, responding to concerns

Links between 9 common factors in case studies and NHS Improvement 5 cultural elements in [Culture Assessment Tool](#)

	Vision & values	Goals & performance	Learning & innovation	Support & compassion	Team work
Leadership enthusiastic and committed to Equality and human rights (E&HR)	✓	✓		✓	
E&HR runs as a thread	✓	✓		✓	
Equality culture for staff	✓			✓	✓
Apply E&HR thinking to Quality Improvement issue			✓	✓	
People who use services at the centre	✓			✓	
Staff as improvement partners		✓	✓		✓
Linked to outside			✓		✓
Courageous and bold	✓		✓		
Curious and humble	✓		✓		

Further case studies

All sectors

The CQC publication Celebrating good care, championing outstanding care covers equality and human rights topics – especially in the caring and responsive sections.

Adult Social Care

- The CQC report, A Different Ending looks at the importance of addressing inequality in end of life care. Some hospices are providing outstanding care which takes equality into account and has a focus on human rights – including Trinity Hospice and Palliative care in Blackpool, St Luke's Hospice in Sheffield and East Lancashire Hospice

- Care By Us, a large homecare agency in North London and West Hertfordshire has adopted seven outcomes from the Hertfordshire "Ageing Well strategy". These include human rights principles around independence, dignity and respect, choice and control. The agency have used these principles to provide outstanding care.

- Waterside, an Anchor Trust care home in London, participated in a Middlesex University project to develop more inclusive services for lesbian, gay, bisexual and transgender people. This contributed towards the care home receiving an outstanding rating in the responsive key question.

- **Skills for Care** have published a Good and Outstanding Care Guide along with some video examples. The guide is arranged by the 5 key questions that CQC uses and covers many equality and human rights topics – with advice and examples from many good and outstanding services.

- The **Driving Up Quality Alliance** is made up of national bodies with a focus on improving the quality of care for people with a learning disability. They are funded by the Department of Health. The Driving Up Quality Code is "not intended as a quality measurement tool or to replace other codes and frameworks, but is a process that can enable organisations to think more deeply about what they are trying to achieve and how their behaviour impacts on this". Their website contains many good practice examples related to equality and human rights.

Hospitals

- Driving Improvement: case studies from 8 NHS Trusts focusses on Trusts which have moved from Inadequate or Requires Improvement to Good or Outstanding. We asked all trusts about their work on equality and human rights as part of this. The case studies of Leeds Teaching Hospitals NHS Trust, Cambridge University Hospitals NHS FT and University Hospitals Morecambe Bay NHS FT are particularly strong on how they used equality and human rights in their improvement journey.

- Our report The State of care in NHS Acute Hospitals 2014 – 2016 brings together the key learning from our first comprehensive programme of all 136 NHS acute and 17 NHS specialist trusts. This includes learning about equality and human rights for people using services – under the caring and responsive questions – and equality for staff – under "well led".

- Because of the nature of compulsory detention under the Mental Health Act, there is a history of looking at human rights in mental health care. Mersey Care NHS Foundation Trust has been a leading trust in developing human-rights based projects and approaches to work. Some examples are given in their October 2015 inspection report.

- Some outstanding independent hospitals are developing strong work around equality, for example Peninsula NHS treatment centre in Plymouth.

Primary medical care

We have compiled a large number of examples of outstanding practice for GPs, arranged by the 5 key questions that CQC uses. Many examples – especially but not exclusively in the caring and responsive sections - cover good practice around equality and human rights

Dental care

Our examples of notable practice for dentists include practices that have taken action to ensure equal access for patients and to improve health outcomes for particular groups – especially those practices listed under "responsive to people's needs".

Acknowledgements

About CQC

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.

- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.

- We use our legal powers to take action where we identify poor care.

- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation.
Caring – treating everyone with dignity and respect.
Integrity – doing the right thing.
Teamwork – learning from each other to be the best we can.

How to contact us

Call us on **03000 616161**
Email us at **enquiries@cqc.org.uk**
Look at our website **www.cqc.org.uk**

Write to us at **Care Quality Commission Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA**

Follow us on Twitter **@CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk/ourstrategy**

Please contact us if you would like this report in another language or format.

CQC-384-092017

REPORT TO Trust Board

Enclosure No:13

Date of Meeting:	09/11/2017		
Title of Report:	Finance Position Month 6		
Presented by:	Executive Director of Finance		
Author:	Assistant Director of Finance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
The report summarises the finance position at month 6 (September 2017)		Approval	☒
		Information	☐
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☐ Execs x☐ 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	None applicable		
Resource Implications: Funding Source:	None directly from the report None applicable		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on the protected characteristics as part of the completion of this report.		
Recommendations:	<u>Note:</u> • The reported surplus of £367k against a planned surplus of £176k. This is a favourable variance to plan of £191k. • The M6 CIP achievement: YTD achievement of £638k (56%); an adverse variance of £495k;		

	o 2017/18 forecast CIP delivery of £2,408k (75%) based on schemes identified so far; an adverse variance of £789k to plan;
	o The recurrent forecast delivery at month 6 of £2,722k representing a recurrent variance to plan of £475k.
	• The cash position of the Trust as at 30th September 2017 with a balance of £6,603k; £1,222k better than plan
	• Agency forecast is currently £286k above ceiling (£2,068k)
	• Year to date Capital receipts for 2017/18 is (£119k) compared to a net planned capital expenditure of £351k;
	o The original operating plan submitted to NHSI in December 2017 planned net capital expenditure of £1,474k by Month 6.
	• Use of resource rating of 2.
	<u>**Approve:**</u>
	• The month 6 position reported to NHSI.
	• Approve the forecast Agency Ceiling breach of £286k.
	.

Financial Overview as at 30th September 2017

Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(176)	(367)	(191)	(109)	G
FOT	(1,400)	(1,400)	0	(0)	G

Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	351	(119)	(470)	(34)	G
FOT	2,979	2,312	(667)	78	G

Retained (Surplus) / Deficit Run Rate 2017/18

Net Capital Expenditure - Plan / Forecast 2017/18

Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	5,381	6,603	1,222	19	G

Cash Balances - Actual/Forecast against Plan 2017/18
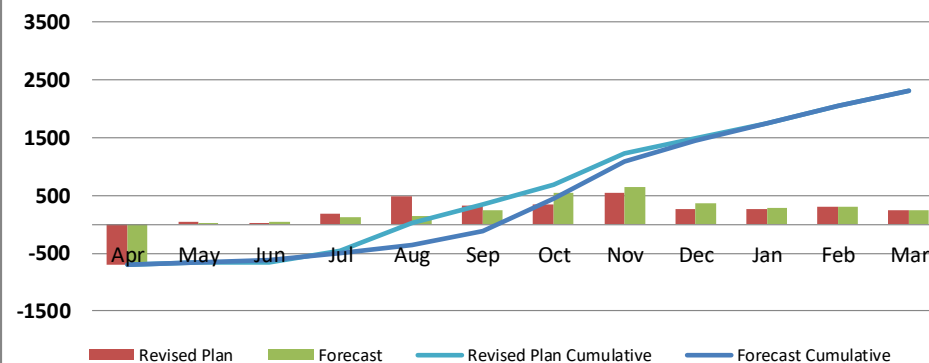
Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	903	558	(345)	(38)	(760)	R
Corporate	230	80	(150)	(65)	285	G
Total	1,133	638	(495)	(44)	(475)	R

Use of Resource

	Plan	Actual
Overall Risk Rating	2	2
Liquidity Ratio	1	1
Capital Servicing Capacity	3	3
I& E Margin	2	2
I&E Margin Variance to Plan	1	1
Agency Spend	1	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 6, the trust had an in month trading position of £118k surplus against a plan of £118k surplus; **showing a breakeven position**. Sustainability and Transformation funding has been assumed at £34k for month 6, bringing the overall trust control to a £152k surplus against plan of £152k; **showing a breakeven position**.

➢ The trust has a year to date trading position of £192k surplus against a plan of £1k surplus; **a favourable variance to plan of £191k**. After Sustainability and transformation funding (£175k), the trust has a Control Total surplus of £367k against a planned surplus of £176k; **a favourable variance to plan of £191k**.

➢ 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 where possible. There is a benefit to the financial position of £180k YTD through not backfilling these posts during implementation. This non-recurrent benefit accounts for the majority of the YTD surplus.

Table 1: Summary Performance	Annual Budget £'000	Month 6			Year-to-Date			Forecast		
		Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Income	(82,276)	(6,854)	(6,845)	9	(41,475)	(41,423)	51	(81,891)	(81,621)	269
Pay	61,947	5,192	4,749	(443)	31,691	29,847	(1,844)	62,091	59,554	(2,537)
Non Pay	16,765	1,316	1,739	423	8,417	10,008	1,591	16,236	18,439	2,203
EBITDA	**(3,563)**	**(346)**	**(357)**	**(11)**	**(1,366)**	**(1,568)**	**(202)**	**(3,564)**	**(3,628)**	**(65)**
Other Non-Op Costs	2,664	228	238	11	1,366	1,376	10	2,664	2,729	65
Trading Surplus	**(900)**	**(118)**	**(118)**	**(0)**	**(1)**	**(192)**	**(191)**	**(900)**	**(900)**	**0**
Sustainability & Transformational Funding	(500)	(34)	(34)	0	(175)	(175)	0	(500)	(500)	0
Control Total	**(1,400)**	**(152)**	**(152)**	**(0)**	**(176)**	**(367)**	**(191)**	**(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 £42k year to date on Stoke-on-Trent CCG's, relating partly to invoice disputes for 2016/17;

➢ £94k under recovery on Out of Area Treatments (OATs) due to an underperformance of actual activity compared to planned activity levels; £65k of this is due to the underperformance of the sale of substance misuse beds;

➢ Stoke on Trent Public Health is under performing by £25k due to a reduction in referrals from community service provided by Lifeline to Substance Misuse Inpatients in the first part of this year. Whilst referrals have improved there is still a YTD underperformance compared to plan.

➢ 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. **£175k is reflected at month 6**.

Table 2: Income	Annual Budget £'000	Month 6			Year-to-Date			Forecast		
		Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
NHS Stoke-on-Trent CCG	(35,710)	(2,959)	(2,959)	(0)	(17,781)	(17,739)	42	(35,570)	(35,528)	42
NHS North Staffordshire CCG	(24,412)	(2,016)	(2,016)	(0)	(12,086)	(12,086)	(0)	(24,252)	(24,252)	(0)
Specialised Services	(3,051)	(235)	(235)	(0)	(1,526)	(1,568)	(42)	(3,051)	(3,034)	18
Stoke-on-Trent CC s75	(3,947)	(329)	(329)	0	(1,974)	(1,974)	(0)	(3,947)	(3,947)	(0)
Staffordshire CC s75	(1,056)	(88)	(88)	0	(528)	(528)	0	(880)	(880)	0
Stoke-on-Trent Public Health	(1,392)	(134)	(158)	(25)	(590)	(565)	25	(1,392)	(1,348)	44
Staffordshire Public Health	(613)	(51)	(51)	0	(307)	(307)	0	(613)	(613)	0
ADS/One Recovery	(1,497)	(125)	(125)	0	(748)	(748)	0	(1,497)	(1,497)	0
Associates	(756)	(63)	(59)	4	(378)	(346)	32	(756)	(701)	55
OATS	(760)	(63)	(38)	26	(380)	(286)	94	(760)	(567)	193
Total Clinical Income	**(73,195)**	**(6,063)**	**(6,058)**	**5**	**(36,297)**	**(36,147)**	**150**	**(72,719)**	**(72,366)**	**353**
Other Income	(9,081)	(791)	(786)	4	(5,177)	(5,276)	(99)	(9,172)	(9,255)	(83)
Total Income	**(82,276)**	**(6,854)**	**(6,845)**	**9**	**(41,475)**	**(41,423)**	**51**	**(81,891)**	**(81,621)**	**269**
Sustainability Transformation Funding	(500)	(34)	(34)	0	(175)	(175)	0	(500)	(500)	0
Total Income Incl. STF	**(82,776)**	**(6,888)**	**(6,879)**	**9**	**(41,650)**	**(41,598)**	**51**	**(82,391)**	**(82,121)**	**269**

4. Expenditure

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

Table 3: Expenditure	Annual Budget £'000	Month 6			Year-to-Date			Forecast		
		Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Medical	7,488	641	539	(102)	3,766	3,301	(465)	7,488	6,684	(805)
Nursing	28,003	2,369	2,278	(91)	14,150	13,633	(517)	28,226	27,370	(855)
Other Clinical	14,684	1,227	1,025	(201)	7,383	6,329	(1,053)	14,624	13,106	(1,518)
Non-Clinical	10,818	921	819	(102)	5,484	4,957	(528)	10,799	10,040	(759)
Non-NHS	954	34	87	53	908	1,627	720	954	2,354	1,400
Total Pay	**61,947**	**5,192**	**4,749**	**(443)**	**31,691**	**29,847**	**(1,844)**	**62,091**	**59,554**	**(2,537)**
Drugs & Clinical Supplies	2,384	206	187	(19)	1,182	1,114	(68)	2,384	2,370	(14)
Establishment Costs	1,758	152	124	(29)	876	730	(145)	1,740	1,569	(171)
Information Technology	523	44	56	12	273	413	140	523	588	65
Premises Costs	2,101	177	160	(17)	1,050	1,013	(37)	2,101	2,187	85
Private Finance Initiative	4,087	341	354	13	2,043	2,128	84	4,087	4,249	162
Services Received	3,319	268	269	1	1,692	1,653	(39)	3,319	3,401	83
Residential Payments	1,708	142	251	108	854	1,070	215	1,708	1,966	257
Consultancy & Prof Fees	255	21	149	128	127	389	262	255	550	295
Unacheived CIP	(1,713)	(138)	0	138	(495)	0	495	(789)	0	789
Other	2,343	102	189	87	815	1,498	683	908	1,560	652
Total Non-Pay	**16,765**	**1,316**	**1,739**	**423**	**8,417**	**10,008**	**1,591**	**16,236**	**18,439**	**2,203**
Finance Costs	1,293	108	108	0	647	647	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	57	11	281	290	10	561	600	39
Investment Revenue	(14)	(1)	(1)	0	(7)	(5)	2	(14)	(10)	4
Fixed Asset Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	824	74	74	(0)	446	444	(1)	824	845	21
Total Non-op. Costs	**2,664**	**228**	**238**	**11**	**1,366**	**1,376**	**10**	**2,664**	**2,729**	**65**
Total Expenditure	**81,376**	**6,736**	**6,726**	**(9)**	**41,474**	**41,231**	**(243)**	**80,991**	**80,722**	**(269)**

Pay

➤ There is a net underspend on pay of £1,844k year to date due to a number of factors including vacancies across the trust, particularly Other Clinical (£1,053k), Nursing (£517k) and Medical (£465k) being backfilled with agency, bank and overtime where appropriate.

➤ Agency expenditure is £1,627k year to date, with £791k being attributable to implementation of ROSE (49%).
  o M6 YTD agency is £311k above the agency ceiling.
  o This is mainly driven by agency expenditure for the implementation of ROSE, which is £143k above the planned spend, but within the overall project envelope and locums expenditure which is £162k above plan.

➤ There are non-recurrent benefits included in the year to date position for not backfilling staff that are transferred onto the ROSE project, this equates to an indicative saving of £180k.

➤ The Agency forecast is currently £286k above ceiling (£2,068k). The trust is currently liaising with NHSi around the classification of expenditure. The NHSi returns are currently forecasting achievement of ceiling.

Non Pay

➤ Residential payments are overspent by £215k in year to date. NSCHT and City Council are jointly reviewing to establish further assurance around the accuracy of the charges.

➤ IT is overspent by £140k year to date. This is mainly due to:
  o Over-recovery of 2016/17 VAT through a HMRC inspection (£53k.)
  o £27k relates to costs for a Virtual Server

➤ Consultancy and Professional Fees are overspent by £262k year to date on Trust Board, PMO and Clinical systems. This is mainly for Consultancy Services around EPR (153k), AQUA (£33k) and the Digital STP work stream (£66k). EPR and STP are mostly funded by external recharges to the STP and NHS Digital.

4. Directorate Summary

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

Table 4: YTD Expenditure	Pay			Non Pay			Income			Total		
	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	8,793	7,940	(853)	2,179	2,408	229	(1,138)	(1,139)	(2)	9,834	9,209	(626)
AMH Inpatients	3,223	3,271	48	76	196	120	(63)	(65)	(3)	3,236	3,401	165
Children's Services	3,192	2,822	(370)	317	357	39	(329)	(294)	35	3,180	2,885	(295)
Substance Misuse	1,381	1,337	(44)	456	401	(55)	(236)	(178)	57	1,601	1,560	(42)
Learning Disabilities	2,689	2,434	(255)	188	159	(29)	(28)	(28)	(0)	2,849	2,565	(284)
Neuro & Old Age Psychiatry	5,449	5,362	(87)	408	302	(105)	(474)	(523)	(49)	5,382	5,141	(241)
Corporate	6,965	6,682	(283)	6,159	7,561	1,402	(39,382)	(39,370)	12	(26,259)	(25,128)	1,132
Total	**31,691**	**29,847**	**(1,844)**	**9,783**	**11,384**	**1,601**	**(41,650)**	**(41,598)**	**51**	**(176)**	**(367)**	**(191)**

➢ AMH Community is underspent on pay due to a vacancies not fully covered by Agency and Bank. The adverse variance on Non Pay results from under delivery of CIP against the target and overspends against residential payments.

➢ AMH Inpatient is overspent on pay mainly due to vacancies on medics being covered by Agency at a premium cost. Overspends on Non Pay are driven by under achievement of CIP against the plan.

➢ Other Directorates are underspent, mainly due to the level of trust vacancies.

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 M6. The Trust wide CIP achievement is 56% at M6 compared to plan.

CIP Delivery	Annual CIP Target 2017/18	YTD M6			Forecast					Recurrent Transacted	Recurrent Forecast
		Plan	Transacted	(Under)/Over Achievement	Plan	Total Schemes	(Under)/Over Achievement	RAG			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000			£'000	£'000
Clinical											
AMH Community	1,084	384	171	(214)	1,084	637	(447)	59%		405	613
AMH Inpatients	379	134	4	(130)	379	51	(328)	13%		24	44
Children's Services	333	118	74	(44)	333	264	(69)	79%		218	312
Learning Disabilities	256	91	116	26	256	257	1	100%		258	258
NOAP	495	175	193	18	495	474	(21)	96%		460	560
Total Clinical	**2,547**	**903**	**558**	**(344)**	**2,547**	**1,683**	**(864)**	**66%**		**1,365**	**1,787**
Corporate											
CEO	49	17	4	(13)	49	13	(36)	27%		8	23
Finance, Performance & Digital	61	22	33	11	61	69	8	112%		71	71
MACE	62	22	9	(13)	62	19	(43)	31%		20	20
Operations	29	10	16	6	29	33	4	115%		35	35
Quality & Nursing	13	5	5	0	13	13	0	100%		13	13
Strategy (Core)	10	4	7	3	10	17	7	168%		20	20
Trustwide	365	129	0	(129)	365	484	119	133%		0	673
Workforce & OD	61	22	7	(15)	61	77	16	126%		20	80
Total Corporate	**650**	**230**	**80**	**(150)**	**650**	**725**	**75**	**111%**		**187**	**935**
Total	**3,197**	**1,133**	**638**	**(495)**	**3,197**	**2,408**	**(789)**	**75%**		**1,552**	**2,722**

Below 75%	
Below 90%	

Target	3,197
Variance	(475)

➢ The 2017/18 year to date CIP achieved stands at £638k against a plan of £1,133k (56%)

➢ The **recurrent value** of schemes transacted is **£1,552k** against £3.2m target. The **recurrent forecast** as at M6 is £2.722m (85%); this represents a recurrent shortfall against the target of **£475k** (15%).

6. Statement of Financial Position

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

Table 6: SOFP	31/03/2017 £'000	31/07/2017 £'000	31/08/2017 £'000	30/09/2017 £'000
Non-Current Assets				
Property, Plant and Equipment	28,037	27,942	27,997	28,156
Intangible Assets	222	240	247	252
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**	**30,505**	**30,566**	**30,732**
Current Assets				
Inventories	88	81	77	88
Trade and Other Receivables	5,146	5,843	6,596	5,952
Cash and Cash Equivalents	6,964	6,636	6,243	6,602
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**12,198**	**12,560**	**12,917**	**12,641**
Total Assets	**42,780**	**43,065**	**43,483**	**43,373**
Current Liabilities				
Trade and Other Payables	(7,472)	(7,891)	(8,205)	(7,999)
Provisions	(333)	(302)	(278)	(259)
Borrowings	(457)	(633)	(633)	(633)
Total Current Liabilities	**(8,262)**	**(8,825)**	**(9,116)**	**(8,891)**
Net Current Assets / (Liabilities)	**3,937**	**3,734**	**3,801**	**3,750**
Total Assets less Current Liabilities	**34,518**	**34,240**	**34,367**	**34,482**
Non Current Liabilities				
Provisions	(474)	(474)	(474)	(474)
Borrowings	(12,189)	(11,861)	(11,823)	(11,785)
Total Non-Current Liabilities	**(12,663)**	**(12,335)**	**(12,297)**	**(12,259)**
Total Assets Employed	**21,855**	**21,905**	**22,071**	**22,223**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,648	7,648	7,648
Retained Earnings reserve	3,987	4,036	4,202	4,354
Revaluation Reserve	9,323	9,323	9,323	9,323
Other Reserves	897	897	897	897
Total Taxpayers' Equity	**21,855**	**21,905**	**22,071**	**22,223**

Current receivables are £5,952k, of which:

- £2,817k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter.
- £3,135k in awaiting payment on invoice. (£1,544k within terms)

£1,166k 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;
- £1,142k has not been formally disputed and full payment is anticipated.

Table 6.1 Aged Receivables/Payables	Within Term £'000	Days Overdue				Total £'000
		1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	
Receivables Non NHS	536	86	424	11	52	1,109
Receivables NHS	1,007	340	335	108	236	2,026
Payables Non NHS	723	70	22	3	89	907
Payables NHS	457	118	69	45	95	784

Aged Receivables M6

Legend:
- Within Term
- 1-30 days
- 31-60 days
- 61-90 days
- 91+ days

(4%, 9%, 49%, 14%, 24%)
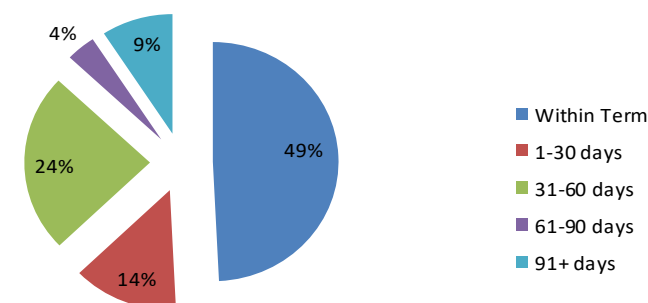
7. Cash Flow Statement

The cash balance at 30th September 2017 has increased to **£6.603m** due to a decrease in the value of receivables and a reduction in the payables; the Trust cash position at 30th September 2017 is **£1,222k higher than planned** due to slippage in capital expenditure. The Trust anticipates be on plan by March 2018.

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	Aug-16 £'000	Sep-16 £'000
Net Inflows/(Outflow) from Operating Activities	(2,674)	1,184	116	702	(221)	635
Net Inflows/(Outflow) from Investing Activities	692	(31)	(45)	(120)	(134)	(237)
Net Inflows/(Outflow) from Financing Activities	(38)	(38)	(38)	(38)	(38)	(38)
Net Increase/(Decrease)	**(2,019)**	**1,115**	**32**	**544**	**(393)**	**360**
Opening Cash & Cash Equivalents	**6,964**	**4,945**	**6,059**	**6,092**	**6,636**	**6,243**
Closing Cash & Cash Equivalents	**4,945**	**6,059**	**6,092**	**6,636**	**6,243**	**6,603**
Plan	7,064	6,964	6,164	5,889	5,517	5,381
Variance	**2,119**	**905**	**72**	**(747)**	**(726)**	**(1,222)**

Cash Balances - Actual/Forecast against Plan 2017/18
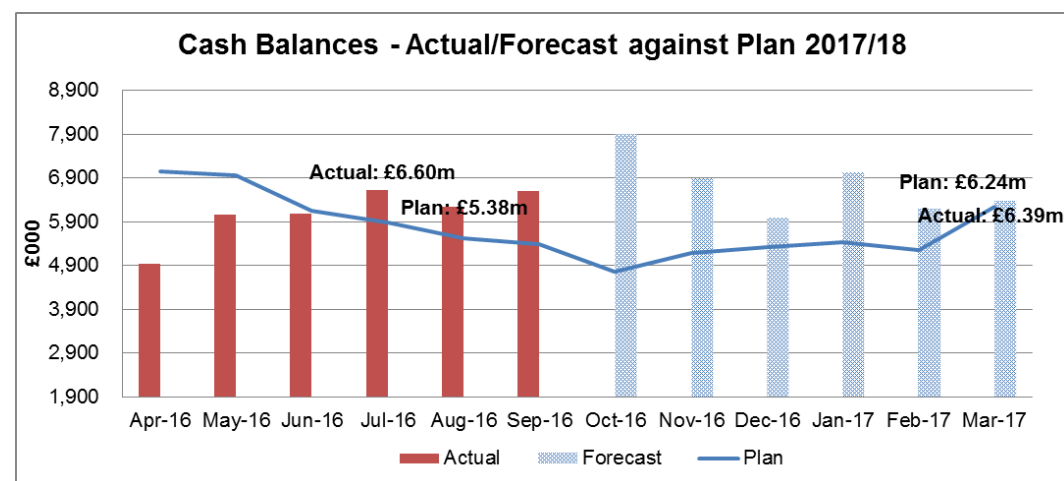
Summary of Outstanding Income		
Receivables	**£'000**	**RAG**
Invoices		
NHS Digital	203	
Stoke CCG	259	
SSSFT	598	
SSOTP	299	
West Cheshire CCG	155	
Other NHS Providers	512	
ADS	374	
Other Non NHS Providers	184	
Accruals		
STF	100	
TOTAL	**2,684**	

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.

Capital Expenditure	Original Annual Plan £'000	Year to Date			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Affordability Plan £'000	Actual £'000	Variance £'000
A&T Refurbishment	400	0	0	0	0	0	0
Hazelhurst Unit Development	325	0	0	0	0	0	0
Substance Misuse Additional Beds	125	0	0	0	0	0	0
Place of Safety	0	0	12	12	100	100	0
Temporary Place of Safety	0	83	2	(82)	94	94	0
Psychiatric Intensive Care Unit	2,120	586	440	(146)	2,153	2,149	4
E-rostering	102	62	66	4	102	102	0
Information Technology	50	235	6	(229)	235	235	0
Environmental Improvements (backlog)	120	25	28	3	120	120	0
Reduced Ligature Risks	300	7	7	(0)	200	200	0
Equipment	50	0	0	0	0	0	0
Darwin	0	0	39	39	26	39	(13)
Ward 4 - Environmental	0	30	0	(30)	30	30	0
Lymebrook MHRC	0	36	0	(36)	43	43	0
NOAP Airlock	0	0	0	0	27	27	0
VAT Recovery on 2016/17 Schemes	0	0	(7)	(7)	(9)	(9)	0
Contingency	100	0	0	0	9	0	9
Total Gross Capital Expenditure	**3,692**	**1,064**	**594**	**(470)**	**3,130**	**3,130**	**0**
Bucknall Hospital (Part)	(713)	(713)	(713)	0	(818)	(818)	0
Total Capital Receipts	**(713)**	**(713)**	**(713)**	**0**	**(818)**	**(818)**	**0**
Total Charge Against CRL	**2,979**	**351**	**(119)**	**(470)**	**2,312**	**2,312**	**0**

➢ The **Operating Plan** as reported to NHSI forecast there would be a total charge against the CRL of £1,474k by month 6, including (£713k) Capital Receipts for the sale of Bucknall Hospital and £2,187k Capital Expenditure.

➢ **Actual Capital Expenditure** as at month 6 is £594k against an updated Capital Expenditure plan of £1,064k

➢ A request has been made to NHSi to reduce the Capital plan to £2,312k from £2,979k; a reduction of £667k. Based on the NHSi plan the forecast underspend would be £667k.

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 Plan	Year to Date Actual	RAG Rating
Liquidity Ratio (days)			
Working Capital Balance (£000)		3,663	
Annual Operating Expenses (£000)		39,854	
Liquidity Ratio days		17	
Liquidity Ratio Metric	1	1	🟩
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		1,748	
Annual Debt Service (£000)		1,165	
Capital Servicing Capacity (times)		1.5	
Capital Servicing Capacity Metric	3	3	🟧
I&E Margin			
Normalised Surplus/(Deficit) (£000)		367	
Total Income (£000)		41,597	
I&E Margin		0.9%	
I&E Margin Rating	2	2	🟧
I&E Margin Variance from Plan			
I&E Margin Variance		0.45	
I&E Margin Variance From Plan	1	1	🟩
Agency Spend			
Providers Cap (£000)		1,348	
Agency Spend (£000)		1,627	
Agency %		21	
Agency Spend Metric	1	2	🟧
Use of Resource	2	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

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 6, the Trust has under-performed against this target for the number of invoices, having paid 86% of the total number of invoices, and paid 84% based on the value of invoices

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

Table 10: Better Payment Practice Code	2016/17			2017/18 Month 6			2017/18 YTD		
	NHS	Non-NHS	Total	NHS	Non-NHS	Total	NHS	Non-NHS	Total
Number of Invoices									
Total Paid	508	13,183	13,691	39	655	694	311	5,093	5,404
Total Paid within Target	459	11,610	12,069	23	560	583	257	4,414	4,671
% Number of Invoices Paid	90%	88%	88%	59%	85%	84%	83%	87%	86%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	-4.6%	-6.9%	-6.8%	-36.0%	-9.5%	-11.0%	-12.4%	-8.3%	-8.6%
Value of Invoices									
Total Value Paid (£000s)	6,860	29,380	36,240	550	2,793	3,343	3,556	15,519	19,075
Total Value Paid within Target (£000s)	6,385	27,914	34,299	346	2,754	3,100	3,232	14,523	17,755
% Value of Invoices Paid	93%	95%	95%	63%	99%	93%	91%	94%	93%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	-1.9%	0.0%	-0.4%	-32.1%	3.6%	-2.3%	-4.1%	-1.4%	-1.9%

11. Recommendations

The Trust Board is asked to:

Note:

- The reported surplus of **£367k against a planned surplus of £176k**. This is a favourable variance to plan of £191k.

- The M6 CIP achievement:
    - YTD achievement of £638k (56%); **an adverse variance of £495k**;
    - 2017/18 forecast CIP delivery of £2,408k (75%) based on schemes identified so far; an adverse variance of £789k to plan;
    - The recurrent forecast delivery at month 6 of £2,722k representing a **recurrent variance to plan of £475k**.

- The cash position of the Trust as at 30th September 2017 with a **balance of £6,603k**; £1,222k better than plan

- Agency forecast is currently £286k above ceiling (£2,068k)

- Year to date Capital receipts for 2017/18 is (£119k) compared to a net planned capital expenditure of £351k;
    - The original operating plan submitted to NHSI in December 2017 planned net capital expenditure of £1,474k by Month 6.
    - Based on the NHSi plan the forecast underspend would be £667k.

- A request has been made to NHSi to reduce the Capital plan to £2,312k from £2,979k; a reduction of £667k.

- Use of resource rating of **2**.

Approve:

- The month 6 position reported to NHSI.

- Approve the forecast Agency Ceiling breach of £286k.

REPORT TO Public Trust Board

Enclosure No:14

Date of Meeting:	9th November 2017		
Title of Report:	Finance & Performance Committee Assurance Report		
Presented by:	Chair of Finance & Performance Committee		
Author:	Deputy Director of Finance		
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 2nd November 2017. The meeting was quorate with minutes approved from the previous meeting on the 28th September 2017. Progress was reviewed and actions confirmed taken from previous meetings.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs X 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 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.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Oversees the risk relevant to the Finance & Performance Committee 932, 807, 970, 916, 931, 991, 992		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
Recommendations:	The Trust 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, 9th November 2017

Finance, Performance and Digital Committee Report to the Trust Board – 2nd November 2017

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 2nd November 2017. The meeting was quorate with minutes approved from the previous meeting on the 5th October 2017. Progress was reviewed and actions confirmed from previous meetings.

Executive Director of Finance Update

The following updates were given by the Executive Director of Finance, Performance and Digital;

- A Finance Deep Dive at Q2, highlighting key risks and mitigations to the 2017/18 financial forecast and recurrent position. A sensitivity analysis around the 2017/18 forecast was presented, showing different scenarios of risks and mitigations; the most likely case being slightly better than plan.

  CIP identification and delivery are a key risk to the Trust recurrent position. Mitigations in the 2017/18 forecast are mainly non recurrent (vacancies) and therefore not sustainable unless CIP is delivered recurrently.

- An update on national discussions taking place around Public Sector pay caps and a reflection on impact to the Trust. NSCHT would find it difficult to fund internally, without increasing CIP.

- The "Towards Effective NHS Payment System: 8 Principals" publication, which the Executive Director of Finance and Medical Director input into the content.

- An update on the PLICs in 2017/18 work programme to improve system quality, data quality and engagement. The Trust has engaged in a number of national projects including an early implementer of PLICs; one of only 3 Mental Health Trusts in the country.

- The current utilisation of the 2017/18 Apprenticeship Levy. Based on the expected number of apprentices to be appointed, the trust is expecting to utilise 23% of the 2017/18 levy of £233k.

- The Use of Resources framework assessments, which have now gone live.

Finance

- **Monthly Finance Report – Month 6**

The Finance position was presented showing a position that is £191k better than plan. This is supported non-recurrently through benefits associated with ROSE implementation. The Trust is forecasting to meet its agreed control surplus.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for month 6 and were concerned that the total identified was still significantly short of the target. £2.722m is currently forecast to be recurrently delivered against the £3.197m target. This is a recurrent shortfall of £475k. A number of schemes in the CIP forecast not transacted, are higher value schemes which are expected to be realised before the end of the year.

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.

- **Agency Utilisation Report**

The Committee were presented with the Agency utilisation report at M6 which showed a forecast breach of the Agency ceiling by £286k, mainly due to Medics and ROSE. The committee acknowledged the national shortage of medical locums but were assured that the trust was doing everything possible to recruit substantive posts. It was also noted that expenditure on ROSE agency was non recurrent.

The committee noted the significant reduction since April 2016 and was confident the Trust would deliver against the 2018/19 ceiling. It was also noted that the percentage Agency nursing as a % of total nurse pay was exceptionally low at 1.3%. The committee approved forecast breach to be reported externally.

- **Capital Spend and Forecast**

The M6 Capital forecast was provided, which included a Q2 update on affordability. The committee approved the 2017/18 Capital Plan which required a maximum Capital expenditure of £3,130k based on affordability.

Performance:

- **Activity Report**

The report detailed M6 activity against plan using traditional reporting methods and clustering. An action plan was provided to address the Cluster 99 activity, which has increased month on month since the implementation of Lorenzo. The Committee is not able to give any assurance around the activity reported and noted the lack of progress being made, particularly around the use of Care Clusters, due to issues with the quality of recording by operational staff.

A comprehensive Deep Dive has been requested to be provided to the next Committee.

- **Performance Report (PQMF)**

The report provides the Committee with a summary of performance to the end of Month 6 (September 2017)

Care Plan Compliance remains an issue in respect of 12 month reviews undertaken, with performance dipping at month 6. Assurance was given that the issues with performance were due to user error rather than reporting errors. Guidance has been embedded to encourage staff to use quick reference guides which is expected to reduce the number of errors.

Delayed Transfers of Care has improved in month for NOAP but worsened for AMH Inpatients, mainly due a market shortage of Care home placements. The work on a system wide level for NOAP on Red to Green, as well as escalation to Social Care, has been widely successful in driving improved performance.

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 which is expected to improve recruitment, once embedded.

Digital:

- **Digital Maturity Assessment**

The Digital Maturity Self-Assessment measures the extent to which NHS organisations effectively use technology. Since the last review in 2015/16, the Trust has increased its digital capability by 62% as a result of implementing Lorenzo, E Rostering and E Prescribing. The Committee note that the increased capability is likely to support the Digital Exemplar bid, through demonstrating that significant progress has been made around IT infrastructure.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Q2 Partnerships and Contracted activity.
- Information Plan
- Asset Management Policy
- Finance, Performance and Digital Risk Register
- Business Opportunities update
- Board Assurance Framework Q2
- Q2 Cash and Treasury Update
- Rectification plan for Agency

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, Performance and Digital Committee

REPORT TO: Trust Board

Enclosure No:15

Date of Meeting:	9th November 2017
Title of Report:	Assurance Report from the Quality Committee
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 work of the committee during October 2017 and request for the Trust Board to ratifiy policies and endorse recommendations in the report.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	Approved by Chair of Quality Committee and Executive Lead	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. 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:	To note policy approval		

**Key points from the Quality Committee meeting held on 26 October 2017
for the Trust Board meeting on 9 November 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 from the Trust's Outreach Team, Neuro and Old Age
      Psychiatry Directorate (NOAP). The presentation described a patient's journey following
      emergency admission to A&E and subsequent review by the Outreach Team. The ethos of the
      Outreach Team is to ensure that patients are reviewed in a timely way and receive assessment
      and on-going support in the most appropriate setting to meet their needs. It was highlighted that
      without the support of the Outreach Team it was likely the patient would have been transferred
      for EMI assessment with a view to 24 hour care. With the involvement of the Outreach Team
      the patient was able to return home with the support she required within 72 hours.

      It was noted that this was a really positive outcome and experience for the patient in this case.
      The presentation also described the on-going work to embed "Home First" principles with
      partners. This was a powerful story in terms of what can be achieved for the benefit of patients
      and was well received by the committee.

3.   **Meridian Tool - Community Case Load presentation**
      The committee received a presentation on the tool being used in community mental health
      teams. Members were shown how this capacity tool has been helping with job planning and
      skill mix to ensure best patient outcomes. Standards of care are agreed including expectations
      of assessment, intervention, visit length and frequency. While the tool is still being embedded,
      it was noted to be positive and has helped address some of the myths with regards to capacity
      planning tools. Members welcomed the presentation and the NOAP representative asked for
      this to be presented to the NOAP Directorate.

4.   **Safer Staffing monthly reports**
      The Committee received the latest safer staffing report. Reporting of Registered Nurse (R/N)
      and non-registered nurse staffing levels is a key requirement to ensure the Trust complies with
      National Quality Board standards. During August 2017, a fill rate of 82% for R/N staff and 94%
      for care staff on day shifts was achieved, with 84% and 105% respectively on night shifts.
      Taking skill mix into account, an overall 91% fill rate was achieved.

      The report indicates a challenge in staffing wards with vacancies contributing to this. It was
      noted that a significant number of R/N vacancies will be filled by October 2017 when new
      qualified R/Ns graduate. The committee also noted the further challenges associated with the
      temporary increase of beds on Ward 4 in response to winter pressures in the health economy.

      The November staffing report to the Trust Board will make recommendations following the 6
      month staffing review. It was also noted that the Trust has been invited to participate in the
      NHSI Retention Support Programme which will be pursued as it provides an opportunity to
      learn from other Trusts and gain support.

5. Performance & Quality Management Framework Month 5 2017/18

Committee members discussed performance by exception and the rectification plans in place. Month 5 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:

- Readmissions have significantly reduced from 15% in April to 4.7% in August.
- 100% of IAPT service users were treated within 6 weeks of referral.
- 97.8% of inpatient admissions were gate kept by the crisis team.

The following targets rated as red with mitigation plans for improvement noted:
- Delayed transfers of care.
- Care plans.
- Contracted vacancy rate.
- Clinical Supervision.

6. Reports received for Assurance

6a   Director of Quality Report

The Committee received the Director of Quality Report under the SPAR qualities priorities with notable items as follows:

Safe:
- **Health Service Safety Investigations Bill.** In September 2017 a draft Health Service Safety Investigations Bill was published. It will create a Statutory Health Service Safety Investigations Body, described by the Health Secretary as a landmark moment for patient safety across the NHS.

Personalised:
- **CQC Reporting on Deprivation of Liberty Safeguards.** The CQC has published its latest State of Care report setting out it assessments of health and social care across England and various sectors. Of particular note was delays being a continuous problem for local authorities in the processing of DOLS applications and actions to try and address this.

Accessible and Recovery Focussed:
- **Mental Health Act Reform.** In October 2017, the Prime Minister announced an independent review of the Mental Health Act so that longstanding injustice of discrimination in the mental health system can be tackled. More information will be provided as this work develops.

6b   Reports received for review, information and/or approval

- ✓ *NICE Report Q2 2017/18* (providing assurance with regards to the processes and procedures in place for the dissemination, implementation and monitoring of NICE guidance).

- ✓ *Data Quality Forum Update* (the committee received minutes from the August and September 2017 Data Quality Forum, providing information on the business discussed by the group.

- ✓ **Clinical Effectiveness Report** (noting outputs of the work of Mental Health Law Governance Group, Medicines Optimisation, Clinical Records and System Design Group, Research and Innovation Steering Group and the Clinical Effectiveness Group.

- ✓ **Unexpected deaths – audit on incident management** (RSN auditors commended the Trust on its processes and procedures concluding they are robust and well established in respect to incident management. While no learning was identified from this audit, it was highlighted that the team are not complacent and will continue to keep arrangements under review, developing systems and processes accordingly. The excellent report in this regard was noted by the committee.

- ✓ **Diversity and Inclusion – Workforce Race Equality Standards, report and action plan 2017/18**. The committee noted the report and action plan with further reports on progress planned.

- ✓ **Patient Led Assessment of the Care Environment (PLACE) 2017** – This report noted that all assessments had been completed in accordance with guidance and with patient representation. Scores were well above the national average and it was noted that all areas received very positive feedback from the patient assessors.

- ✓ **Sepsis report and action plan** – a verbal update was provided to give assurance about the important work that is on-going in this area. The full action plan, which remains on target, will be presented at the next meeting of the committee.

- ✓ **Suicide Prevention Strategy – work plan update.** Following the Trust Board approving the Suicide Prevention Strategy in March 17, the committee were provided with an update against the action plan with further reports to the committee planned in due course.

- ✓ **Update on Lampard Recommendations.** Following publication of recommendations relating to themes and lessons learnt from NHS investigations into Matters Relating to Jimmy Savile (2015) an action plan was submitted to the Trust Development Authority. The committee received an updated plan, which indicates that the action plan is now complete.

- ✓ **Environmental Works as part of a Risk Based Approach to Capital Spend** The committee received a detailed report setting out the process for risk prioritisation, including confirmation that the environmental ligature risk assessments had been completed for all in-patient and community facilities. The report provided assurance that the process had been followed regarding the capital programme with a further update planned for February 2018.

- ✓ **NCISH Annual Report 2017.** This report provided a summary of the 2017 annual report including current trust position in relation to recommendations contained within the report.

- ✓ **Q1 report on Safeguarding Activity.** This detailed report provided information to the committee on current case reviews, themes and trends in Safeguarding and pertinent issues from the Trust's Safeguarding Team.

✓ ***Draft Restraint Reduction Strategy and 2017/18 work plan***
The committee received and endorsed the proposed strategy and annual work plan. It was noted that this had also been presented to the Service User and Carer Council.

6c **Policy report** – the recommendations supported by the Committee for ratification of policies by the Trust Board (for extension to the 31 March 2018 or otherwise stated as follows):

- ✓ 5.0 Health & Safety Policy – approve 3 years
- ✓ 5.08 First Aid at Work – approve 3 years
- ✓ 5.06 Waste Policy
- ✓ 5.09 Environment Policy
- ✓ 5.18 Risk Markers Policy
- ✓ R01 Policy on the use of restricted interventions – approve 3 years
- ✓ R03 Restrictive Holdings
- ✓ R07 CS Gas Policy
- ✓ 1.15 Dress and Appearance
- ✓ 5.14 Outdoor Activities
- ✓ 5.41 Lone Worker Policy
- ✓ 5.25 New Mothers Risk Assessment
- ✓ 1.19 Chaperoning Policy
- ✓ 4.32 Privacy and Dignity
- ✓ 4.33 Clinical Photography
- ✓ 4.41 Responding to Patient Opinion
- ✓ R02 Safe Use of Bedrails
- ✓ 1.81 Access to Services, waiting times and discharge – approve 3 years
- ✓ R10 – Teaching Physical Interventions to Carers
- ✓ 7.13 Data Quality Policy – approve 3 years
- ✓ 7.14 Safe Haven Policy – approve 3 years
- ✓ 7.17a Health Records Management – approve 3 years
- ✓ MHA27 Non-Medical Approved Clinician – approve 3 years
- ✓ MHA15 – Patient Rights S132 – approve 3 years
- ✓ 4.26 – Listening and Responding (PALS & Complaints) – approve 3 years

7. **Learning from Experience Report August /September 2017**
The Committee received this bi-monthly learning from experience report detailing emerging issues, including learning and action taken following the feedback from Trust services. The following points were noted:
- Similar number of incidents reported in comparison to previous two months
- Decrease in the number of falls. Falls incidents are reviewed by the Physical Health Group. However, the Director of Nursing is leading a time limited Rapid Improvement Programme and will provide updates the Committee accordingly.
- No pressure ulcer incidents in this reporting period.
- Significant increase in compliments via PALS.
- High number of Friends and Family Test responses and positive feedback in September.
- Feedback from the Service User and Carer Council and their involvement in an array of Trust activities noted.

8. Serious Incident Report Q2

The committee received a report detailing trend data for Q1 and Q2 2017/18, noting themes, learning and change. The report also provided a quarterly update on Duty of Candour and a quarterly update on Mortality Surveillance

9. Complaints Update

Following review of the complaints process via an audit in May 2017, the number of complaints responded to within timescale was noted to have improved. The quality of report writing needs to be embedded and training and support is being provided in this regard. The complaints and PALS policy (Listening and Responding) was also reviewed and updated.

10. Directorate Performance Reports

Each Directorate presented in detail their performance as part of the new reporting arrangements to the Committee. Committee members continue to feel that this new style of reporting, capturing information from performance reviews enables a much more focussed discussion around cross cutting issues. The focus of the discussion centred on good practice and achievements, new developments and innovations, current and potential challenges.

11. Physical Health Strategic Plan 2017-2020

The committee received and approved the proposed strategy for physical healthcare. The document sets out from 2017-2020 the Trust's commitment to patients, carers and staff, zero tolerance to preventing ill health, and embraces the priorities for integrating physical and mental health. The committee commended its presentation (strategy on a page).

12. Draft Quality Improvement Development Strategic Work plan Programme for 2017/18

The Director of Nursing & Quality invited members to discuss with her the proposed projects in the draft work plan. This was approved in principle with further updates planned to the committee in due course.

13. Board Assurance Framework Q2 2017/18

The Committee received progress against the quality objectives that have oversight by the Committee. This report provided information and assurance on progress being made

14. Unannounced Assurance Visits Report – Q2 2017/18

The Committee received a detailed report of the findings from assurance visits; key themes and progress to date were discussed and reviewed.

15. Quality Impact Assessment of Cost Improvement Schemes (CIP)

Following on from the paper presented to the last meeting of the committee, it was noted that there were no issues to report by exception. There is monitoring in place for those schemes approved with key performance indicators in place that monitors closely for any negative impact on quality of service.

16. Mental Health Act Compliance – Overarching CQC report and learning outcomes

Over the last few months the CQC has carried out 7 unannounced visits to Trust services. This detailed report provided an overview of the services visited, highlighting the learning from those visits and actions taken to date to further improve compliance with the Mental Health Act.

17. Trust Risks to Quality Committee
Committee members considered the report for quality risks and how they interrelate to Directorate risks. Risk treatment plans and actions being taken were noted**.**

18. Next meeting:
Thursday 21 December2017 2pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director Medical and Clinical Effectiveness

30 October 2017