North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON Thursday 21st June 2018, 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.	**MINUTES OF THE OPEN AGENDA – 24th May 2018** *To APPROVE the minutes of the meeting held on 24th May 2018*	Approve Enclosure 2
4.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
5.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**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
8.	**REACH RECOGNITION INDIVIDUAL AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Individual Award to Jacquie Shenton, Consultant Nurse, Learning Disability Services* To be introduced by the Chief Executive and presented by the Chair	Verbal

9	**PATIENT STORY – VASCULAR WELLBEING SERVICE - THE WALKING FOOTBALL INITIATIVE** *To RECEIVE a Patient Story from Phillip Johnson, Service User and his wife Jill Johnson to be introduced by Maria Nelligan, Executive Director of Nursing & Quality*	Verbal / Short film
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
10	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
11	**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	
12	**TOWARDS OUTSTANDING INNOVATIVE PRACTICE** *To RECEIVE a briefing re: Towards Outstanding Innovative Practice from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 6
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
13.	**NURSE STAFFING MONTHLY REPORT - APRIL 2018** *To RECEIVE the Nurse Staffing Monthly Report from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 7
14	**SERIOUS INCIDENTS ANNUAL REPORT** *To RECEIVE the Serious Incidents Annual Report for assurance from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 8
15	**QUALITY ACCOUNT 2017/18** *To RECEIVE the Quality Account 2017/18 for assurance from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 9
16	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 1** *To RECEIVE the Month 1 Performance Report from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 10

	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
17.	**NATIONAL MENTAL HEALTH SURVEY ACTION PLAN** *To RECEIVE the National Mental Health Survey Action Plan from Jonathan O'Brien, Director of Operations*	Approval Enclosure 11
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
18.	**FINANCE REPORT – MONTH 1 (2018/19)** *To RECEIVE for discussion the Month 1 Financial position from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 12
19.	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** *To RECEIVE the Finance, Performance & Digital Committee Assurance report from the meetings held 7th June 2018 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 13
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
20	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from the meeting held 25th May 2018 from Gan Mahadea, Non-Executive Director*	Assurance Enclosure 14
21	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 7th June 2018 from Patrick Sullivan, Non-Executive Director*	Assurance Enclosure 15
22	**FREEDOM TO SPEAK UP** *To RECEIVE for approval the Freedom to Speak Up paper from Alex Brett, Director of Workforce, Organisational development and Communications*	Approval Enclosure 16
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
23	**LOCALITY WORKING / RESTRUCTURE** *To RECEIVE an update regarding Locality Working / Restructure from Jonathan O'Brien, Director of Operations*	Assurance Enclosure 17
	ANY OTHER BUSINESS	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 20th July 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 24th May 2018 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

David Rogers
Chairman

Directors:

Caroline Donovan
Chief Executive

Dr Buki Adeyemo
Medical Director

Maria Nelligan
Executive Director of Nursing and Quality

Lorien Barber
Non-Executive Director

Alex Brett
Executive Director of Workforce, Organisational Development and Communications

Suzanne Robinson
Director of Finance, Performance and Digital [part]

Ganeshan Mahadea
Non-Executive Director

Jonathan O'Brien
Director of Operations

Dr Keith Tattum
GP Associate

Patrick Sullivan
Non-Executive Director

Tony Gadsby
Non-Executive Director

In attendance:

Laurie Wrench
Associate Director of Governance

Lisa Wilkinson
Corporate Governance Manager (minutes)

Karen Armistead [part]
Head of Portfolio Management and Data Protection Officer

Wendy Dutton
Chair of Service User and Carer Council

Joe McCrea
Associate Director of Communications

Members of the public:
Kate Dacosta - Janssen

Retirees
Andy Bough – Workforce Safety Advisor
Barbara Britton – Mental Health Act Co-ordinator
Chris Landon – Healthcare Support Worker supported by Jane Aaron
Linda Simcock – Community Outreach Practitioner
Jackie Clowes – Modern Matron supported by Jackie Nolan and Suzanne Carr

REACH Team Recognition Award
Towards Outstanding Engagement Team
Jane Rook
Neil Clarke
Marie Barley
Di Harrison

The meeting commenced at 10:05am.

103/2018	**Apologies for Absence** Joan Walley, Non-Executive Director	**Action**
104/2018	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items. David declared he has been appointed as a Non-Executive Director of GGI (Good Governance Institution).	
105/2018	**Minutes of the Open Agenda – 18th April 2018** The minutes of the open session of the meeting held on 18th April 2018 were approved.	
106/2018	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***67/2018 – BAME Story – Staff Survey Results*** *– Deferred* ***76/2018*** *–* ***Dying to Work Campaign –*** *Draft has been shared with the Chair David Rogers. Joe McCrea confirmed there is an informal ongoing dialogue with MP John Ashworth.*	
107/2018	**Chief Executive's 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** Caroline attended a round table event for all Chief Executives nationally with the Secretary of State for Health and Social Care to discuss the NHS funding settlement. Discussions were had regarding Mental Health and particularly children's Mental Health Services and Home Treatment Services but also Public Health and the thought that needs to be given in the future for the public health grant. The Secretary of State felt that funding should be protected if a reduction comes out of Substance Misuse Services then this should be reinvested in other mental health services.	

Caroline felt that overall it was a positive event. The overall theme was a much stronger focus on prevention in mental health.

CELEBRATING OUR CQC RESULTS AND TEAMS

On May Day the Trust celebrated its journey of improvement to date and kept up the pace and trajectory towards outstanding that started over four years ago. The live celebration at Harplands Hospital of the Trusts fantastic CQC results was attended by staff, service users and stakeholders. Many thanks for all those who attended.

Hosted by Caroline Donovan and the Chairman, David Rogers - the event was livestreamed across social media and included links to our Outstanding Services - Adult Rehab Teams at Summers View and Florence House hosted by our Medical Director, Dr Buki Adeyemo. Also live streamed was Community CAMHS Team at Dragon Square hosted by our Director of Nursing and Quality, Maria Nelligan, celebrating that every one of their 5 CQC domains are rated Good. This is a fantastic achievement and gives confidence to our community on the quality of services provided.

The full proceedings and a highlights package of a great event - including a special CQC Celebration Film featuring staff and management talking about their achievement - have been made available via our YouTube channel, where they have received over 800 views to date.

TOWARDS OUTSTANDING ENGAGEMENT EVENT HIGHLIGHTS SUCCESSES OF ITS FIRST COHORT

On Tuesday 8 May the first cohort of staff went through our Towards Outstanding Engagement Programme. The event was shared across the Trust's social media channels and showed the fantastic achievement and dedication from our staff.

The event was attended by Chair, David Rogers, Non-Executive Directors Lorien Barber and Joan Walley chaired jointly by the Executive Director of Workforce, OD and Communications Alex Brett and Executive Director of Operations, Jonathan O'Brien. It shows the strong commitment of our senior leadership team to the programme.

The Towards Outstanding Engagement Programme is carefully designed and structured to allow teams across the Trust to really understand and own their own improvement in a robust and planned way. By assessing their own strengths and development areas both at the outset of their journey and at its completion, they are able to plan a tailored improvement journey that really means something to them and is built on their own reality.

The average increase in engagement scores across the teams was 5.6%, with some teams seeing improvements as large as 12.8%. Each team is at a different stage and are all being supported to continue their work to improve staff engagement - it's clear that the programme is being owned, valued and embraced by the full range of services and operations we provide, with some amazing results that were shared and celebrated.

STP DIGITAL WORKSTREAM GATHERS PACE

A full day meeting took place with the four potential suppliers who may be providing our new Integrated Care Record as part of our STP Digital Programme. It was a really positive day with many people including clinicians attending to hear from the suppliers about how they would work with us and what they could do. This will really progress our plans for clinical information to be able to be shared across organisations.

The really exciting thing for the Trust was the potential for patients to be in control of their record and having access to their own information and in some instances being able to choose which professionals/ organisations would have access to their information. This would have the potential to change the balance of power between the professional and the patient and enable a stronger focus on people taking responsibility for their own health.

The day was only part of the procurement process which will also include some site visits and detailed analysis of the business cases submitted. The site visits will take place during May and the plan is to have a supplier in place by July.

The workstream also held a celebratory and sharing event to recognise the great achievements of the range of healthcare teams who have deployed technology enabled care. The event had a packed agenda, focusing on people's experience of telehealth, video consultation, mobile apps, Patient Online and online clinical consultation triage.

An afternoon session looked a variety of uses of Facebook- whether in public settings or closed groups for example in UHNM. It also looked at social media use in GP practices, Patient Participation Groups, as part of screening and within maternity services.

Almost 100 people across the day saw a range of presenters, and there was lots of interest and discussion and reflections on how others can adopt and share the learning; a massive thank-you and well done to Dr Ruth Chambers - Chair of Stoke-on -Trent CCG and lead for Technology Enabled Care workstream as part of our Digital STP Programme.

LISTENING INTO ACTION EVENT FOCUSES ON DEVELOPING OUR SUPPORT FOR BAME STAFF

Caroline Donovan led a special Listening into Action event this month, particularly focusing on continuing efforts to support and develop Black, Asian, Minority Ethnic (BAME) staff. Lots of BAME staff attended as did Medical Director Dr Buki Adeyemo, Executive Director of Nursing and Quality, Maria Nelligan, Director of Workforce Organisational Development and Communications, Alex Brett, and Non-Executive Director Gan Mahadea. It was great to hear the personal stories from staff about their experiences, but the Trust's WRES scores also indicate that we have more to do. The LIA event produced some great ideas on what would make a difference, which will be taken forward with support from our great staff.

PREPARATIONS FOR PICU

The Trusts new Psychiatric Intensive Care Unit (PICU) building is now complete which will be a pleasant well designed environment for service users and carers. Massive thanks to Andrew Hughes, Geoff Neild and Ian Ball for their work on overseeing the design and build of the unit. Also a big thank you to Carol Sylvester, Natalie Larvin, Maxine Tilstone, Jackie Clowes and all clinical staff who have done a superb job working with service users and staff to ensure the clinical plans are fit for purpose

The biggest challenge now is being able to recruit registered nurses. The Trust has a scheme running whereby anyone introducing a doctor or trained nurse in a patient facing role at the Trust can be awarded an Amazon voucher. There is also another series of One Stop Shops to quickly recruit nurses in where staff can walk away on the same day with a job offer - subject to ID and other appropriate checks.

This will be the first time ever that our local communities will have access to such a facility preventing people from having to travel out of area to receive treatment.

A team from across HR and Comms have produced a series of films on the Trusts social media as part of a rolling series, including a walk-around of the new PICU featuring Natalie Larvin and Maxine Tilstone which has received over 500 views on YouTube, as well as other communications products including leaflets, job adverts and media promotion and advertising widely in various newspapers and publications.

CQC SYSTEM IMPROVEMENT AND STP

The Trust has been working together as a system for some months on its improvement plan for the STP and some really great improvements are now being delivered. The Stoke Council Delayed Transfers of Care have reduced significantly and the Council's ranking in the country has gone from close to the bottom to the top third. The innovative collaborative care homes project led by the GP Federation in partnership with SSOTP, Combined and Douglas Macmillan hospice is showing a 16% reduction in attendances to A&E.

As part of the Staffordshire STP, OD and System Leadership workstream chaired by Caroline Donovan a Primary Care Leadership Development Programme was commissioned . This was facilitated externally with input from a range of Combined staff, including Neil Clarke and Jane Rook from our OD team.

The programme is aimed at developing leadership capability amongst primary care across the whole of Staffordshire and Stoke-on-Trent, with a particular emphasis on developing new models of care.

Caroline attended the final workshop of the first Cohort on the programme involving a range of colleagues from across primary care, together with our Director of Workforce, OD and Communications, Alex Brett and the STP Director Simon Whitehouse. It was a great event, with lots of debate and

insight into the innovations, improved ways of working and development of effective working relationships that are catalysing change and improvement across Staffordshire. Each participant had led the development of a project which was really impressive – collectively there has been such improvement.

Caroline chaired the Midlands and East STP Board this month which had a real focus on growing the workforce, which will be one of the biggest challenges facing us as we move to implement the STP vision.

CONTINUING TO ENGAGE AS WE MOVE TOWARDS LOCALITY WORKING

The Trusts plans to introduce new integrated locality-based structures within Combined Healthcare continue apace. There has been a series of engagement forums with staff groups and stakeholders, while members of the Executive team have been out and about meeting Trust teams to seek their views on the proposals.

The driving principle of this new way of working is to strengthen how our wider community teams work across primary care, social care and community services.

The Trust proposes to implement Integrated Locality Working in a phased approach.

• Phase 1 – Reconfiguration of Clinical Directors, Associate Directors (HODs), Deputy Director of Operations - Go Live 2 July 2018
• Phase 2 – Configuration of Trust-wide Professional Heads- Go Live 16 July 2018
• Phase 3 – Configuration of Associate Clinical Directors & Clinical Leads, and all Service, AHP and Psychology Leads and Matron/Quality Leads - Go Live 27 August 2018
• Phase 4 – Transformation and redesign of clinical teams - Go Live 3 September 2018

Corporate structures (e.g. Finance, HR) will be aligned by July in order to report in line with new Directorates.

These new proposals will enable the Trust to be even more responsive and effective in delivering compassionate care to our local service users, their carers and families. Further engagement forums will be held over the course of the next six to eight weeks and will continue to involve frontline staff and teams across the Trust.

NOMINATIONS FOR OUR REACH 2018 AWARDS DRAW TO A CLOSE

The Recognising Excellence and Achievement in Combined Healthcare (REACH) Awards are an annual celebration of Trust staff and teams who go above and beyond in delivering excellent services. To mark the NHS 70 celebrations, this year's REACH will take place on Thursday 5 July at the Stoke-on-Trent Moat House. Nominations will open on Monday 26 March and we are hoping to beat last year's record-breaking total of 290 nominations. This year's awards will recognise outstanding achievements in

	the following categories: 1. Leading with Compassion Award 2. Rising Star Award 3. Volunteer/Service User Representative of the Year Award 4. Innovation Award 5. Valuemaker Award 6. Developing People Award 7. Partnership Award 8. Service User and Carer Council Award (decided by the Service User and Carer Council) 9. Unsung Hero Award 10. Proud to CARE Award 11. Team of the Year Award 12. Chairman's Award (decided by the Chair) For more information about the awards, including how to nominate, please visit our REACH website www.reachawards.org/nscht. **FINALISTS IN NATIONAL PATIENT SAFETY AWARDS** Two of the Trusts teams travelled to London to present their excellent work around Patient Safety. The Trust has been nominated twice in the category of Mental Health and Learning Disabilities in the national Patient Safety Awards. The Learning Disabilities team presented to a judging panel of eight national experts on the programme of medication reduction in the Learning Disability Inpatient Service, whilst a second team presented on the work of the High Volume User Service, which operates in collaboration with the British Red Cross and University Hospitals of North Midlands in supporting people who use services intensively. Congratulations to both teams for their efforts and for representing Combined Healthcare and the North Staffordshire System at these prestigious awards the Trust looks forward to hearing the outcome from the awards celebrations, which are being held for finalists in Manchester on 9 July 2018. **TOWARDS SMOKEFREE** Significant steps have been made collaboratively in stopping smoking across wards and gardens, as part of the overall ambition to become smoke free this year, the Trust is offering smoking cessation advice and Nicotine Replacement Therapy to anyone who needs it. Thank you to all our patients, visitors and staff that have worked tremendously hard in supporting our journey. It has been recognised that patients are leaving the wards at Harplands to smoke, and congregating outside reception. The signs at key points at Harplands will be reinforced and revised reminding patients and visitors that we are now a smoke free site. It will also sign post where to get advice and support with regards to stopping smoking. Staff are also asking visitors and patients to move away from the area to smoke and we all have a part to play in this.	

The Trust is committed to making its hospital and grounds a pleasant and healthier environment, and ask that staff, patients and visitors are tolerant as we move forward with this significant change.

FLYING THE FLAG FOR COMBINED AT THE POSITIVE PRACTICE MENTAL HEALTH COLLABORATIVE

Caroline recently attended the Positive Practice CEO dinner and national conference with our Director of Nursing and Quality, Maria Nelligan. The National Positive Practice Mental Health Collaborative is a user-led, multi-agency collaborative of 75 organisations, including NHS Trusts, CCGs, Police Forces, third sector providers, front line charities and service user groups. Its aim is to identify and disseminate positive practice in mental health services by working together across organisations and sectors, to facilitate shared learning and to raise the profile of mental health with politicians and policy makers.

We're strong supporters and active members of the Collaborative, and it was great to be able to attend the first ever Collaborative Convention and Learn and share with other mental health organisations. We have been asked to start a national substance misuse collaborative which Dr Derrett Watts our Clinical Director for substance misuse will be leading. Some of the Executive Team have also been asked to be on the judging panel for the positive practice awards.

LEADERSHIP ACADEMY FOCUSES ON APPRENTICESHIPS

Our latest Leadership Academy featured an interactive and informative session, updating knowledge, understanding and perceptions about apprenticeships in a bid to encourage our senior managers to think differently about how to access and utilise the apprenticeship levy in developing our future workforce. We also had a guest speaker, Anne Longbottom, Development Manager from Staffordshire University discuss updates and opportunities for higher level apprenticeships.

The Trust offers a range of apprenticeships and apprentice qualifications at different levels to enhance skills with the Trust, support talent management and draw maximum benefit from the funding available. We understand our current staff qualification levels to further enhance the skills of the workforce through apprentice qualifications and are developing new roles and pathways to enable staff to progress their career.

WOLVERHAMPTON UNIVERSITY

Our Medical Director Dr Buki Adeyemo has been invited to sit on the board of the University of Wolverhampton as an independent governor. This is great news for the Medical Director and the Trust and further enhances our growing relationships with our education partners.

HEALTH AND WELLBEING BOARD

On 18 April 2018 the Stoke-on-Trent Health and Well-Being Board met for the first time in its reconstituted form following the Stoke-on-Trent CQC System Review. The Board agreed a shared determination to provide

	system leadership as described in the CQC report. As a first demonstration of this commitment, the Board approved the Joint Commissioning Strategy prepared by the CCGs on behalf of health, social care and public health commissioners Jenny Harvey highlighted Staffordshire has seen the biggest cuts to services i.e. Lifestyle Services and queried if political control over mental health budgets is now in the hands of the councils. Caroline agreed and advised the Trust needs to give some consideration around how and if we should respond to the Secretary of State. Jenny also added that she had not seen anything around diversity and inclusion in employment and felt that as a Trust we are ahead of any other Trust in Staffordshire and suggested this is something that the Trust can take a lead on. Caroline talked about Yvonne Coghill, OBE, Director of the WRES Implementation Team for NHS England who is helping us to grow our leaders. Alex Brett and Caroline have been working on getting funding for leadership development across Staffordshire. We need to get at a strategic level Chairs and the Board signed up to this. Following conversations with Sir Neil MacKay this month we are going to have an inclusive Staffordshire wide conference that will launch the Leadership Programme. Dr Adeyemo added as an observation that there is still a lot of work to be undertaken with the medical workforce in understanding the true meaning of diversity. **Received**	
108/2018	**Chair's Report** David Rogers, Chairman provided an update. There is a lot of discussion currently around future funding of health services and social care and the obvious need to have a longer term solution to funding rather than short term handouts. There is a move to a longer term solution away from fire-fighting and there is some evidence that this is happening. A report recently published by the NHS Confederation looks at the scale of the funding pressures on the NHS and Social Care and the long term solution to this. Andrew Hughes added that the boundaries between value added and core business are becoming increasingly blurred that is clearly a financially driven issue. People are starting to look ahead 10-15 years and there has been talk of a 3-5% increase from the cabinet which is a substantial amount of money to fund improvements and changes for the better. The debate is now in the open which is positive. The Citizens Jury has the potential for looking at good things across	

	Staffordshire and they have just completed a report on access to mental health care which contains many stories from individuals some good and not so good and although they did not discuss these with the Trust (which is a missed opportunity) it will create a dialogue which will help us to improve services. Maria Nelligan advised this has been discussed at Clinical Quality Review Meeting (CQRM) and we are going to be working closely with the Service Users Carer Council (SUCC) taking forward recommendations where appropriate. We have made a commitment with the Clinical Commissioning Group (CCG) to work closer than we have so far. Ann James who is responsible for public health and social care for stoke City Council has become the leader of the Council but is still maintaining her responsibility for public health. The Trust has an excellent relationship with Ann and her promotion will be positive for the work we undertake in Stoke. ***Noted***	
109/2018	**Staff Retirements** **Andy Bough – Workforce Safety Advisor** Andy started his general nurse training in May 1986 at the City General Hospital, qualifying as a staff nurse in 1989. His first staff nurse role was at Bradwell Hospital where he worked in "Continuing Care" until 1991 when he was seconded to Ward 84 City General Hospital where he worked on "older person's admissions". He continued to work in this area until 1994 when he moved to the community and worked as a district nurse at several health centres around the city. It was during this time (2002) that Andy undertook the MAPA© Trainer's Course and in addition to his role as a district nurse, he began to teach "breakaway" courses to the PCT community staff. In 2005 an opportunity arose for Andy to move to Combined Healthcare as a fulltime MAPA© trainer and Andy has remained instrumental to the delivery of MAPA training ever since. During his long association with Combined Healthcare Andy has extended his training portfolio to also be involved in the delivery of Conflict Resolution Training, Basic Life Support training, In Hospital Resuscitation Training, Manual Handling training, Search Training and more recently Connect 5 training. Over the years Andy must have delivered training to hundreds of Trust staff and is therefore very well-known across the organisation. In recent years he has also contributed to the Trust flu vaccination programme by becoming a vaccinator himself and always presenting the positives regarding being vaccinated. As a trainer, he is renowned for his values, diligence, professionalism and ability to always make training interesting and meaningful. In recent years Andy has also contributed to the development of a number of less experienced trainers, always available to offer support, guidance and a wealth of experience to colleagues entering the world of training delivery. Andy has also had a key role in working alongside health professionals in the community L/D CAMHS service to provide parents and carers with advice and support in relation to children who exhibit risk behaviours, whilst	

always being available, when called upon, to support Harplands staff with the management of people who present behaviours that challenge.

If Andy were retiring from the Trust completely he would leave some very large shoes to fill and we would miss him greatly due to the high esteem in which he is held. We are therefore extremely delighted that after a short break he will be returning to the Trust to work in a part time capacity, sharing his in depth knowledge and skills with participants on training courses, hopefully for some years to come!
Hopefully, semi-retirement will enable him to spend more time with his grandchildren and following his beloved Chelsea FC!!

Barbara Britton – Mental Health Act Co-ordinator
For the first 18 months working in the Trust Barbara was employed by Spring Personnel, eventually taking up a substantive post with NSCHCT from July 1999 working as a clerical assistant on the psychiatric unit at the City General Hospital.

In June 2001 Barbara moved to St Edwards Hospital Clinical Information Department as Mental Health Law Secretary. Then from April 2002 to the present day she has worked as Mental Health Act Co-ordinator, now based at Harplands Hospital.

From 2006 – 2007 she undertook a short 12 month secondment as Clinical Risk Management Training Initiative- Coordinator.

Barbara is a very much valued and respected member of the mental health law team, not only by her day to day colleagues but also colleagues in teams across all directorates Trust wide. The Mental Health Act Team have been very stable for many years so we will all be adjusting over the coming months. We hope you enjoy everything you have planned with family and we would like to say thank you for all your hard work and dedication over the past 19 years and we wish you a long, healthy and happy retirement.

Chris Landon – Healthcare Support Worker
Chris retires form the NOAP Directorate following 29 years of dedicated service.

Initially Chris started his career within Neuro Psychiatry on Ward 14 he went on to work within Neuro Day Services both at Harplands, Bucknall Hospital and eventually at Bradwell Hospital.

Since the closure of day services at Bradwell Hospital Chris has remained a vital member of the Memory Clinic Service supporting service users upon their arrival to clinic, supporting with cognitive assessments, venepuncture and ECGS.

Over a number of years Chris has received praise and support from our service users and carers who often note his happy, warm and welcoming manner. Chris is our in house artist and over the years has often been noted

for his fancy dress and money raising initiatives for Huntington Disease, Dementia and Red Nose Day.

Fortunately for us Chris has agreed to retire and return to his team on a part time basis and so we look forward to welcoming him back again soon.

Linda Simcock – Community Outreach Practitioner
Linda started her career at Saint Edwards Hospital in April 1982 as a Nursing Assistant, and went on to start training at the School of Nursing at Saint Edwards Hospital in November 1982.

She qualified in January 1986 and started work at Wilkins house as Staff Nurse. In 1988 started work as a CPN, covering Kidsgrove, Tunstall, Longton area and finally Leek Moorlands, with Old Age services.

Linda has been integral in the development of the Care Home Liaison Team initially with Dave Jefferson in April 2008 and has worked hard to support the developments within this team until 2017.

Over the years Linda has developed the Trust Dementia Care Training and has been delivering the training within the Trust and in care homes for several years.

Linda has shown throughout her career her commitment and dedication not only to her service users group but the team and the carers she has supported over the years. We are very lucky within our team that Linda has agreed to retire and return to us once she has enjoyed a long holiday travelling.

Patrick Sullivan added that he also worked at St Edwards Hospital and Wilkins House with Linda which was a pleasure. Linda is a team player and very committed. Patrick referred to a previous presentation at Trust Board where a service user talked highly and positively of Linda and Dave Jefferson and the support they had received. On a personal level Patrick wished to thank all of the retirees today for their commitment.

Jackie Clowes – Modern Matron
Jackie commenced at St Edwards on the 5th September 1977 as a cadet nurse and began her nurse training in September 1979 qualifying as an RMN in September 1982.

Once qualified Jackie was a staff nurse on the acute admission ward until 1985 when she moved to be a CPN in the adult and older persons service for a year.

In 1986 Jackie returned to acute inpatient services as staff nurse on Menzies House, St Edward's and in 1987 was promoted to Ward Sister.

Jackie became the centre manager at the Sutherland Centre in 1991 and along with Lewis Chingono at Lymebrook she helped to establish the first two community mental health resource centres with inpatient facilities. The

	function of the beds at this time was prevention, intervention and respite. In 2002 Jackie took on the role of CPN caseload manager at Newcastle North CMHT until she was promoted in 2004 to Senior Team Leader for Moorlands North Integrated Mental Health and Social Care Team. She has worked closely with colleagues in South Staffordshire to establish an integrated approach to delivering community mental health services. This was the first time that health and social care staff had been co-located to deliver a service. Patrick Sullivan added in 2008 Jackie was successfully appointed as Matron for acute inpatient services, ECT and Acute Home Treatment team. Her motto being – 'never ask people to do anything you wouldn't be prepared to do yourself.' Towards the end of Jackie's career she worked as the Modern Matron for Adult Inpatient Services. All staff that Jackie has managed have found her to be extremely approachable, friendly, consistent and dedicated to excellent patient care. Jackie has been influential in the new PICU Development which is a significant achievement that will lead to improved patient care. Jackie is a valued member of the management team and is highly respected by patients, staff and other managers, she has fantastic leadership skills and is able to motivate others, inspire, listen and support other people. Jackie will be sadly missed by the Directorate but we wish her all the best in her retirement. Patrick Sullivan wished to add that had worked at St Edwards with Jackie. Patrick wished to echo what has been said today and added that staff have asked Patrick to say that the morning meetings that Jackie undertakes increase morale for the team and will be missed. Patrick thanked Jackie for her professionalism, calmness the way she is with staff and patients adding the amount of time she has worked for the Trust which is over 40 years of working life for the same organisation is an incredible achievement. Patrick wished to give personal thanks stating it brings back very fond memories and wished Jackie all the best. ***Received***	
110/2018	**REACH Team Recognition Award May 2018** Caroline Donovan presented the REACH Team Recognition Award to the Organisational Development Team. As we journey towards our goal of becoming Outstanding, we aim to give our teams the ability to assess and develop their strengths in a way that really means something to them. Our Organisational Development Team and mentors led our inaugural Towards Outstanding Engagement Programme, with the first cohort of 16 teams starting in June 2017. The programme was structured to allow teams across the Trust to really	

understand and own their own improvement in a robust and planned way. By assessing their own strengths and development areas both at the outset of their journey and at its completion, teams were able to plan a tailored improvement journey.

Teams from both clinical and corporate areas took part and produced some extraordinary results, with the average increase in engagement scores across the teams at 5.7%, with some teams seeing improvements as large as a 16.6% increase. Each team is at a different stage and are all being supported to continue their work to improve staff engagement - it's clear that the programme is being owned, valued and embraced by the full range of services and operations we provide.

A huge well done to our Organisational Development Team and mentors on all their hard work in delivering our Towards Outstanding Programme. The team truly demonstrated our Proud to CARE values. They provided compassionate support to teams across the Trust, whilst also ensuring they were approachable – so that teams felt able to discuss their engagement needs and ways of improving. They also take responsibility in delivering a high performing and excellent programme that delivers great results.

However, none of this would be possible without the hard-work and dedication of the teams involved in the programme.

- Access and Home Treatment
- Community Learning Disability
- Darwin Centre
- CYP
- Estates
- Finance
- Greenfields
- Lymebrook
- County Older Persons CMHT
- County Memory Service.
- Performance
- Pharmacy
- Ward 1
- Ward 6
- North Staffs Community
- North Staffs CAMHS
- North Stoke CAMHS
- Organisational Development & Learning

Some examples include Ward 1, who improved by 10.7% at an already challenging time with building work taking place for our new PICU. Our North Stoke CAMHS Team, who introduced Communication Cells, transforming handovers to become more person-centred and adhering to our Trust values.

Our fantastic Estates Team, who have made such vast improvements since

	the first survey and have taken wonderful steps to engage and involve staff and despite currently going through a large period of change – despite this, the team increased by 9.3% in overall engagement scores and are now the 5th most improved team. A wonderful achievement by all involved, our Towards Outstanding Programme continues its journey, building further on successes of Cohort 1 with mentor support. The next Cohort will be launched following structural changes to locality based model. Jane Rook, Associate Director of Organisational Development delivered a presentation which focussed on the teams shared purpose and the North Staffs Combined Engagement journey. Jane thanked the teams who took part in the journey, the Organisational Development Team for their hard work and also wished to thank Paul Draycott and Rob Cragg agreeing to start the journey. Patrick Sullivan asked if there was anything the Board could be doing differently to help teams. Jane added that teams have thought it not important to do things for the team and for their staff it has always been on the back burner due to working pressures. If we do not invest in the people we are paying to do the great work they are doing by valuing and recognising everyone within the team then we are missing a trick. Alex Brett added that maintenance is key. We need to invest in how we wrap around these teams to ensure they have time to reflect and think and empowering them to make the changes they want to make. For this team particularly getting this award today is really well deserved there is real energy, commitment and skill with a can do attitude. The work undertaken is amazing and on celebration day we saw the energy and enthusiasm of the teams which was exceptional. **Received**	
111/2018	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no questions / comments from the public.	
112/2018	**SERVICE USER AND CARER COUNCIL** Wendy Dutton, Chair of the Service User Carer Council provided an update. **Workshop 25th April 2018** The workshop saw the trial of an alternative time to 5pm and venue to support attendance from the Young People Council and Volunteers and specific invites and reminders have been sent. 1 additional volunteer attended and agreed to trial 2 further workshops. There was a lively debate on person centredness which resulted in good ideas and thoughts for progressing this work. Notes will be collated and	

	shared with those at the workshop before being forwarded to the remainder of the Service User & Carer Council membership. **Citizens Jury Update** Several members of Service User & Carer Council attended the Citizens Jury review of Mental Health Services. There was a disappointing and obvious lack of involvement from 3rd sector workers and current Mental Health service providers. The next step is to develop an action plan to review recommendations and their possible implementation. This is on the agenda for the next Service User & Carer Council Business meeting on 30 May 2018. Wendy advised that she has continued to attend the CCG meeting. There is continued Service User & Carer Council membership involvement in the following meetings: • Trust Board meetings • Interviews • PLACE Assessment • SUEEG Meetings • Business Meetings • People and Development • Inductions • Access Meetings • Adult In-patient meetings • Ward and Admin Volunteers and more! Maria Nelligan wanted to echo the hard work being undertaken by the Service Users Carer Council, their involvement in the above meetings, recruitment and attendance at external meetings. Andrew Hughes also wished to thank Wendy for her involvement in the work around PICU. ***Received***	
113/2018	**INTERNATIONAL NURSING DAY- LEADING CHANGE ADDING VALUE CONFERENCE** Maria Nelligan, Executive Director of Nursing and Quality provided a verbal update Caroline Donovan opened the celebrations of Nurses Day with a second Annual Nursing Conference. It is a celebration of everything our nurses do and what they achieve. The Trust welcomed Siobhan Heathfield, Regional Nurse for NHS Improvement and the inspirational Tommy Whitelaw, who is a great friend to the Trust and a national champion for Dementia.	

	The day featured workshops on such diverse topics as suicide awareness, understanding health inequalities and asylum-seeking. It also gave teams across the Trust the opportunity to showcase a range of Pledge Trees produced to show what they have done to date and what they commit to do in the coming year. The event was live streamed which can be watched via the Trusts Facebook page. The day was rounded off by every one of the attendees being presented with a Combined Nursing Badge and delivering a Happy Nurses Day message via Twitter to their colleagues across the NHS. Maria talked about the Positive Behaviour Support Clinic led by Learning Disability Registered Nurses looking at reducing the use of medication for people with a learning disability and supporting their carers and families. (STOMP). This is a national piece of work and we have signed the pledge to be part of this we were the first Trust to do so. Maria also talked about the Care Home Liaison Team and Care Home Coordination Centre. Nurses are at the forefront of the planning and intervention and actual work coordinating that. This is evolving and demonstrating how on the front line we can do things in a different way. Patrick Sullivan asked if any of the staff involved had tried to publish anything. Maria advised this is the next step. There will be a booklet of all the areas of good practice and we will support them to write up. Dr Adeyemo confirmed the Trust is promoting this sort of innovation via the Research & Development Team who will be working closely across all services where there is innovative practice to support publication in health magazines. ***Received***	
114/2018	**NURSE STAFFING MONTHLY REPORT – MARCH 2018** Maria 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 March 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during 2018 was 83% for registered staff and 96% or care staff on day shifts and 83% and 105% respectively on night shifts. Overall a 93% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. The trend is slightly improving but still challenging. As the Trust enters the	

summer period this will become even more challenging. The teams are working very hard in terms of planning using tools available to them i.e. E-Roster and the temporary staffing team to ensure cover.

The biggest impact in terms of staffing will be the October Keele students. Last year we employed 36 Keele students and still have 35 so we are undertaking a lot of work to ensure we gain all those student nurses supporting them to work on the bank or in any capacity they can over the holiday period.

Maria met recently with Staffordshire University to reaffirm our commitment to provide conditional offers and professional development to their students.

Safe staffing reporting indicated challenges in staffing wards during March 2018. A significant number of RN vacancies have been filled by newly qualified RNs during October 2017; these nurses are coming to the end of their period of preceptorship. 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. During 2018 it is anticipated that challenges will also be experienced with the planned opening of PICU, therefore the 2017 annual nurse 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.

The Trust have joined the NHSI Retention Support Programme. A project team is being identified to deliver this programme and a visit from NHSI is being arranged.

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

Jenny Harvey asked if the Trust is expecting the new working patterns to assist the problems we have. Maria confirmed the impact of the shifts will make an impact in terms of staffing but are offset at the moment with the number of vacancies.

Jenny asked where staff breaks have been cancelled were they taken later or are they shifts where staff did not receive a break at all. Maria advised it varies each every month in terms of times but it is taken back later sometimes on a shift or another day which is not an ideal situation to have.

Patrick asked with regards to the fill rate over 12 months are we doing

	absolutely everything we can. Maria confirmed there are real peaks and troughs through the year for holidays especially March when people are trying to fit their holidays in before end of year. The Trust allows in the E-Roster 17% for leave at any one time. But there are times of the year i.e. school holidays when everyone wants time off. Matrons receive regular reports on how well Ward Managers are rostering to enable them to manage from a performance point of view. We are planning now for July and August so we can plan for bank staff. Tony Gadsby asked if there could be any assurance given around PICU opening at the end of July as we have already referred to challenges for holidays over that period and how confident we are that we can open PICU with staffing that is appropriate and is not going to have an impact on these figures. Maria confirmed that opening PICU in July did not look positive but we are looking at alternatives we can do in terms of modelling to see if we can get the stretch to open that unit. We have looked at 10 different ideas to address this but it is unlikely we will be able to staff the unit in July. Patrick commented that he could not see at the moment any way of opening in July without compromising staff, destabilising units and wards and creating major safety issues. Maria confirmed there is a national shortage of staff we have a peak in our opportunity to recruit when students leave university. Directorates are working hard doing one stop shops with support of other teams. The Trust needs to look at its unique selling points and encourage people to come and work for us as a preferred employer within Staffordshire. Maria confirmed a meeting has taken place with NHSI to look at what we are doing in terms of recruitment and retention against the national profile, NHSI felt we were doing well in terms of the initiatives we have in place. Jonathan highlighted the need to ensure employment checks and ID checks are done and ready to go. Maria advised some of this work has commenced, all have a buddy and getting them into work over the summer is key. Alex Brett confirmed a Recruitment Lead will commence post next week to ensure systems and processes are as streamlined as much as possible. This post will be key to some of this work. Maria advised an application has been submitted to NHSE to develop 195 Nursing Associates 12 of which will be ours. This has been approved. This will give us an opportunity to look at skill mix again.	

	David Rogers referred to the low fill rate on Darwin low fill rate and asked if there had been any improvement since March. Maria confirmed she will undertake a deep dive. ***Received***	**MN**
115/2018	**QUARTER 4 SERIOUS INCIDENT REPORT** Dr Buki Adeyemo, Executive Medical Director presented the report and highlighted the following: The report covers the period from 1st January 2018 to 31st March 2018 (Quarter 4, 2017/18) and details the following: • The status of SIs currently open and trend data for Q3 2017/18 and Q4 2017/18. • Serious Incidents by category reported by quarter. • Themes learning and change arising from Serious Incident investigations. • The quarterly Duty of Candour report. The increase in reported SIs between 2016/17 and 2017/18, will be analysed within the Annual SI report, which will be submitted to Quality Committee in June 2018 SIs arising from slips, trips and falls are showing an increasing trend over the last 12 months however in Q3 and in Q4 there has been a reduction in the number of falls meeting SI criteria. Actions to address issues relating to falls from the falls rapid improvement group and the AQuA (Advancing Quality Alliance) initiatives are ongoing and under current review. During Q4, 23 incidents were reported onto StEIS and have undergone or are in the process of undergoing SI investigation. The main points to note are: • There were 7 unexpected deaths in the Substance Misuse Directorate. • In the Adult Mental Health-Community Directorate there were 8 unexpected deaths and 1 incident of violence and aggression (abuse) against community staff which will be investigated as a Serious Incident. • In the NOAP Directorate, there were 2 incidents of fractures caused through falling, 1 incident of a lapsed section/illegal detention and 1 suspected suicide within the directorate. • Within the Adult In-Patient Directorate, there were 2 incidents of patients inflicting serious self-harm, sadly one of these incidents later resulted in the person's death. One person also suffered a fracture following a fall.	

There were 7 deaths in the Substance Misuse Services however throughout the quarter; substance misuse was suspected as a contributory factor in 12 of the 17 deaths.

As previously reported, the addition of Stoke Community Drug and Alcohol Services (CDAS) has made an impact on the number of SIs reported from substance misuse services. During Q4, CDAS deaths account for 40% of deaths since this services was acquired by directorate.

In this quarter, there were 2 incidents of serious self-harm which occurred in the in-patient wards. One incident resulted in the person requiring surgical repair of the wound inflicted. The investigation into this incident is ongoing but the initial findings indicate that the incident could not have been foreseen and there were reasonable measures in place to prevent access to items which may be used to self-harm.

As previously reported, the outcome of the second incident of serious self-harm was the death of the person, following a period in medical intensive care. This incident is currently undergoing investigation utilising a new approach for the Trust; that of a review panel which includes an external panel member from another NHS Trust. This approach is being piloted in recognition that external scrutiny and challenge assists the Trust in identifying and learning lessons. Additionally, it is recognised that the RCA approach (Root, Cause Analysis) can cause significant distress to staff. The aim of investigating SIs and other incidents is to learn from these to decrease the likelihood of future occurrences. Therefore an approach that supports a culture of openness and learning, allowing staff to speak up when things go wrong, is essential. It is anticipated that the review panel approach will mitigate against any potential feeling amongst the staff of a 'blame culture' and also bring a greater depth to investigations through the promotion of a group/team reflective approach.

Recommendations and learning from investigations are disseminated on completion of the SI investigation. The learning that was found from the previous quarter and early Q4 investigations was:

- A need to improve the documentation around mental capacity assessments and the person's capacity to participate in decision making was noted. This is being monitored through case supervision and management processes. This work is also part of the ongoing Lorenzo development activity and will be monitored through the Inpatient and Community Safety Matrices
- Staff knowledge regarding the use of the Threshold Assessment Grid (TAG) has been strengthened through ongoing discussions/feedback and is currently being monitored by caseload supervision, management and audit.
- Training will be provided to all regular bank staff on the NOAP wards in relation to the falls risk assessments and the post falls assessment process. This is in order to ensure that all falls assessments are accurately documented and that action to support

people post falls is completed in a timely manner. Furthermore falls awareness relating to policy and process will be included in local induction.

There were a number of investigations where no recommendations for practice were made. However areas of good practice were identified, these include:

- Examples of good communication between community mental health and prison services and between substance misuse and prison services

During Q4, the Patient and Organisational Safety Team (P+OS Team) have worked with the Governance Leads to strengthen the Trust ability to demonstrate that the implementation of learning from investigations is embedded into practice and that changes can be evidenced. A new database has been produced, which allows the P+OS Team and the directorate governance leads to see at a glance all of the current action plans, progress made against completion of the action plans and evidence of progress made/maintained at the following 6 and 12 month periods. The progress made against these action plans will be monitored through quarterly reports to the Clinical Safety Improvement Group (CSIG) and onwards to CQRM

The Duty of Candour incident in January was in relation to a tissue viability incident. This incident was investigated and at the time of this upon review the damage was thought to have been avoidable and therefore meets the DoC criteria. The ward manager has met with the person and apologised for the lapse in care provided. In line with the DoC requirements, a written response to the patient was also provided.

- The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- It is noted that the number of SIs within this quarter has increased. The initial findings of investigations do not show any causal or contributory link beyond an increase in the number of incidents where drugs or alcohol were taken prior to the death of the person.

Lorien Barber asked if the Trust is doing enough around the dangers of alcohol. Dr Adeyemo confirmed she led a dual diagnosis listening event recently where there were a number of actions identified about how we can actually improve and how we can work closely together with services users and Substance Misuse Service Directorate. Dual Diagnosis is one of the key priorities on the BAF this year. Secondly, a CQUIN is being monitored continuously around advice we are giving to people prevention is key and we are trying to build into our processes.

Andrew Hughes highlighted the discussions we had with MP John Ashworth recently. Substance Misuse was something he wanted to pick up. Andrew advised he spoke to the Police Crime Commissioner he is keen to be part of

	these discussions. The tender for Stoke Community and Inpatient has been issued and there is a 25% reduction in funding and expectation of more activity in the community. We are currently reflecting with partners how we can respond to this. Our role as an organisation is clear but our role as an advocate must be just as strong. Patrick Sullivan highlighted the approach to commissioning is questionable. Effectively we enabled a service to continue for the right reasons now we are in a position where it is difficult and presenting challenges to apply for that tender. If we are not in a position to provide that service no one else will be able to. Jenny Harvey highlighted that the Trust voluntary groups will respond to this but this is something Stoke needs to own as this will affect the whole economy of the city. There is a wider engagement needed from Stoke-on - Trent cutting these sorts of services will only exacerbate problems. ***Received***	
116/2018	**LEARNING FROM DEATHS QUARTERLY REPORT** Dr Buki Adeyemo, Executive Medical Director presented the report and highlighted the following: This report provides a review of the unexpected deaths from Serious Incident Investigations and 'natural cause' deaths of service users which occurred during January to March 2018 and also provides an overview of the development of the process and incidents reported since the publication of Learning from Deaths (March 2017). This report has previously been included in the Serious Incident quarterly reports but in response to the national Learning from Deaths guidance, this analysis is now provided as a separate report. Natural cause deaths of patients (where the person is open to services at the time of death) as identified by HM Coroner, do not meet the requirement for SI investigation. The Trust undertakes local investigations as set out in 'Learning, candour and accountability' in order to ensure that there are no gaps/omissions in service delivery or missed opportunities for learning. These investigations include those people whose deaths are related to excessive alcohol use During this reporting timeframe 6 unexpected deaths have been reviewed by the MS group. These were the deaths of people in our patient population which were cleared as natural cause deaths and did not meet the criteria for investigation under the SI policy. Mortality review reports have been requested for all deaths meeting the set criteria. Some of the reports are yet to be reviewed due to the timings of the deaths. Of the 6 deaths investigated, issues related to drugs or alcohol featured in the deaths of 4 people. The causes of death included lung cancer, sudden cardiac arrest and respiratory disorders. When considering the 'on balance'	

	question of whether or not the death occurred as a result of problems in healthcare, the MS group concluded that none of the people died as a result of problems in mental healthcare. In all of the cases reviewed the care provided by our clinical teams was felt to be adequate to excellent. It was provided in a timely manner and appropriate for the mental health care of the person. The group also reviewed the care of 6 people whose deaths had been reported and investigated under the SI framework. This was to provide completeness with regards to the Trust understanding of the 'on balance' question. The Trust has established a process to undertake mortality surveillance in line with national guidance. Deaths which meet the criteria for SI investigation and natural cause deaths are identified and processes are in place to monitor the care provided by the Trust clinical teams. It is recognised that the input and effectiveness of primary and secondary physical health care provision is not available to the reviewers but as far as is practicable, the mortality surveillance group identify the physical health aspects of care required and determine if the support offered by our clinical teams is person-centred and holistic in its approach. There were 12 deaths examined by the MS Group during quarter 4 (6 natural cause and 6 subject to SI Investigation). It was concluded that issues related to mental health care did not contribute to any of these deaths. Therefore the Trust is asked to accept this report as assurance that mortality surveillance processes are in place. Caroline Donovan highlighted the need to identify where learning / improvements are being made and add to future reports. Dr Adeyemo to action going forward ***Received***	**BA**
117/2018	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 12** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. The following performance highlights should be noted: - 93.6% of patients have received treatment within 18 weeks of referral against a target of 92% - 100% of inpatient admissions have been gate kept by the crisis resolution/home treatment team against a target of 95% - 96.1% of people on a care programme approach have been followed up within 7 days after discharge (target 95%) In Month 12 there are 2 targets related metrics rated as Red and 1 target related metrics rated as Amber	

	MH Liaison: Response to AE referrals within 1 hour 94.0% at M12 from 97.0% at M11 In Month 12 there was an increase in referrals which has had an impact on achieving the 1 hour standard in month. Increase in referrals in March had investment in the service to develop to CORE 24 standards. Bed occupancy: Bed occupancy across all wards is 85% (excluding Adult inpatient which has a 90% target) is 92.6% in Month 12 from 92.5% in Month 11. The highest occupancy rates are on Darwin Ward (CY&P) and NOAP ward, whilst LD remains below target. High bed occupancy levels are impacted by the levels of admissions and may reflect pressures across the health and social care system. Agency Spend: 27.9% at M12 from 28.5% at M11 The annual agency ceiling is £2,068k against actual of £2,645k - £577k worse than plan (27.9%) The main drivers of the negative variances 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. The use of agency has now ceased on this project. - Medical Locums - £363k. This reflects the national shortage of medics. A paper was presented to the March Board which reported a number of initiatives that the Trust is exploring to attract and retain Medical Bank. Additionally the Trust is working to expand the medical bank. Lorien Barber asked in relation to agency spend if this was a position the Trust was anticipating. Suzanne Robinson confirmed this was not a 0 agency spend target it's a zero tolerance. The Trust did attempt to make a case to have the ceiling lifted unfortunately it was not supported. The outturn end of year is what was anticipated particularly looking at our nursing agency which is now comparative to the rest of the country. Our challenges as previously discussed is around medical agency spend. ***Received / Approved***	
118/2018	**FINANCE REPORT MONTH 12 (2017/18)** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. The Trust's 2017/18 financial plan was to deliver a trading position of £0.9m surplus. The Trust accepted the Control Total from NHS Improvement (NHSI) of £1.4m surplus which included £0.5m from the Sustainability & Transformation Fund. For 2017/18 the Trust had a Control Total surplus of £3,683k against the original plan of £1.4m; a £2,283k over performance	

against control.

Trusts that overachieved against control also receive a share of any remaining national STF funding at the end of the financial year. In 2017/18 NSCHT received £1,671k of the bonus STF Incentive Scheme.

CIP - The Trust target for the year is £3.197m, as reported to NHSI. This takes into account the requirement to deliver a £1.4m control surplus for 2017/18. The Trust wide CIP achievement is 100% at M12 compared to plan

The cash balance at 31st March 2018 has increased by £1,109k to £6,633k, mainly due to cash receipts from Health Education England at £982k and Local Authority quarterly receipts £581k, partly offset by an increase in capital expenditure in March. The Trust cash position at 31st March 2018 is £390k higher than planned as a result of slippage on the Trust's capital plan.

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £3,130k.

Trust Board were asked to note:

- The reported 2017/18 adjusted retained surplus of £3,683k against a planned surplus of £1,400k. This is a favourable variance to plan of £2,283k.
- The M12 CIP achievement of £3,206k (100%), a favourable variance of £9k; (this includes £1,223k Non Recurrent CIP Recognised in Month 12)
- The recurrent CIP delivery of £2,311k representing a recurrent adverse variance to plan of £886k.
- The cash position of the Trust as at 31st March 2018 with a balance of £6,633k; £390k better than plan
- Total Agency for 2017/18 is £577k above ceiling (£2,068k)
- Capital payments for 2017/18 of £2,995k compared to planned capital expenditure of £3,130k
- Use of resource rating of **1** against a plan of 2.

Received

The Trust Board is asked to approve:
- The month 12 position reported to NHSI
- The forecast Agency Ceiling breach of £577k.

Approved

Caroline Donovan highlighted this is a great position to be in and offered huge thanks to everyone, the Finance team and clinical teams in helping to deliver this position. Its good news the Trust is delivering according to plan but the key messages this year are to get the CIP in a higher occurring position.

119/2018	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** Tony Gadsby Non-Executive Director and Chair of the Finance, Performance and Digital Committee presented the report for assurance from the meeting that took place on 10th May 2018. The Committee received an update around North Staffordshire Combined 2018/19 contribution to the STP. Given the level of resource in kind put forward to work on STP work streams; it will result in a net repayment to the Trust. An update around the construction of the Trust Psychiatric Intensive Care Unit, outlining agreed funding, cost and workforce implications, as well as an update around the final Capital expenditure. The committee requested a more detailed review to be provided at the June FPD Committee A report will come to a future Trust Board. Congratulations to Andrew Hughes team for bringing in under budget. The Committee expressed concern around the pace of improvement around reporting Cluster 99s. A task and finish group, chaired by the Executive Director of Finance, Performance and Digital, meets monthly to provide a targeted approach to address issues around data quality and recording with clinical colleagues. This is expected to support improvement. The Finance position was presented, showing £2.3m better than plan. This includes £0.4m surplus improvement and £1.671m additional share of Sustainability and Transformation funding. CIP was fully delivered in the year through transacting non recurrent schemes in M12. The recurrent shortfall on CIP carried into 2018/19 targets is £486k. Due to concerns raised previously by the Committee around the fluctuating in performance against CAMHS waiting list targets; an update report was presented in M12. Following the presentation of the report and action plan, assertions from the Director of Operations and assurance that dedicated resource was being allocated to support; the committee are assured that sufficient focus is being placed on CAMHs waits to deliver recovery trajectories. The Committee requested an update report tracking progress against recovery trajectories to be presented at the end of Q1. The action plan was presented updating on the progress in delivering GDPR standards by 25th May 2018. The committee are assured that enough progress has been made to satisfy the requirements of the Information Commissioners Office (ICO.) The Chief Information Office presented headline slides summarising the outline business case for the Lorenzo Digital Exemplar (LDE.) The committee agreed in principal, however have requested further	

	information around resources, functionality and efficiencies at the next committee. Assurance on Key Systems, Reporting and Finance - The report outlined the impact of the restructure on Trust systems, reporting and finances. In addition, the report outlined the timeframes, the role of the corporate task and finish group and provided an assessment of the trust capability to report in line with each of the project phases. The committee were assured that the Trust will be able to report on the new structure and meet external reporting requirements from 1st July 2018. Further detail around the financial impact was requested and will be included in the June committee. ***Received***	
120/2018	**SELF CERTIFICATION G6 & FT4 (PROVIDER LICENSE)** Laurie Wrench, Associate Director of Governance presented the report. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions. NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition G6 by 31st May 2018 Trust Board confirmed compliance and agreed to sign today. ***Approved / Received***	
121/2018	**GENERAL DATA PROTECTION REGULATIONS UPDATE** Karen Armistead, Head of Portfolio Management and Data Protection Officer attended for the meeting for this item only and presented the report. General Data Protection Regulation (GDPR) was approved by the EU in April 2016; and will apply in the UK from 25 May 2018. The main legislation that previously regulated the use of personal data was the Data Protection Act 1998 and the Privacy and Electronic Communications Regulations 2003. RSM were commissioned in 2017/18 to produce a gap analysis around the	

	Trusts compliance with the new GDPR regulations. The purpose of this report is provide assurance around the trust progress around resolving areas of non-compliance. The audit report identified 10 areas of non-compliance which the trust is working towards implementing prior to the introduction of GDPR. The Trust is anticipating it will be compliant in all areas before the introduction of GDPR. A full action plan has been developed and is included within the report. Those who need to opt in are those who are not being looked at under Direct Care this is known as implied consent. In terms of research and surveys we would have to contact people in some way to ask for explicit consent. It is suggested this will be included in the Lorenzo system under initial assessment and link to a consent form. Looking at privacy impact assessments this is now crucial for any project included in the business cases. All policies have been updated and the compliance deadline will be met tomorrow. Lorien Barber asked how frequently consent will be revisited. Karen confirmed it can be at discharge but will always be judged by the clinician. Dr Adeyemo advised that it has been raised as a concern that this is more work for clinicians but consent is part of what clinicians are expected to do. Joe McCrea updated the Board in terms of our core GDPR updated privacy notice from general communications and how the Trust will communicate with Stakeholders and Press. There was a discussion around legitimate interest where there is no need to actively seek consent if there is a legitimate interest in contacting someone as an organisation we have a legal duty to promote health. Everyone has been e-mailed on the Trusts Stakeholder list. ***Received***	
122/2018	**ASSURANCE REPORT FROM THE AUDIT COMMIMTTEE** Gan Mahadea Non-Executive Director and Chair of the Audit Committee presented the report for assurance from the meeting that took place on the 23rd April 2018. Going Concern is a fundamental principle in the preparation of the financial statements. Members recommended that the Trust is a going concern which requires ratification by the Trust Board. ***Ratified***	

	Draft Annual Accounts - It was noted that this is the Trust's 19th Consecutive year of achieving financial balance and is the highest in year position of the last 9 years. Members of the Audit Committee approved the draft Annual Accounts for submission following delegated authority from the Trust Board The Audit Committee request delegated authority from the Trust Board to submit the Final Annual Accounts 29th May 2018 ***Approved*** **2018-19 Internal Audit Strategic and Operational Plan** Andrew Bostock, Head of Internal Audit, KPMG, presented the plan which had been agreed and discussed by the Executive Team and subsequently approved by the Audit Committee. There has been an additional item included; HR Governance Review. **Draft Annual Governance Statement** Laurie Wrench, Associate Director of Governance, presented the draft Annual Governance Statement 2017/18 which is a statement about the system of integrated governance, risk management and internal control, across the whole of the Trust's activities. The Trust is obliged to declare any significant internal control issues in its disclosure statement. Audit Committee will meet tomorrow to sign of Annual Accounts	
123/2018	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** Lorien Barber Non-Executive Director and Chair of the People and Culture Development Committee presented the report for assurance from the meeting that took place on 14th May 2018. **Staff Story** The Committee received a presentation from a staff member who had experienced over four months of severe and debilitating back pain. After personally funded visits to a chiropractor and a decline in motivation, positivity and work output, a chance remark from a work colleague started a journey of Trust support. This support in the form of 16 physiotherapy appointments; a workplace assessment, new chair, new table and weekly Pilates sessions, ensured that the staff member had maintained their attendance at work, and was again motivated and positive. Whilst the Trust does have a wealth of staff support on offer it was noted that this is not always well publicised and this will be addressed, a roadshow will also be going out to areas shortly, predominately the community areas to illustrate what can be put in place to support staff health and wellbeing. **Refreshed Terms of Reference and Cycle of Business** Following the AQuA Well-Led Development review late last year the Terms of Reference and Cycle of Business had been refreshed and revised. The Committee approved the refresh subject to a couple of changes to the cycle of business.	

Locality Working
The Committee was informed that the Locality Working Phase 1 Management of Change involving both Heads of Directorate and Clinical Directors had been launched, and would close on May 30th. Staff-side has been engaged in the discussions, and will continue to support staff as required. The Trust has initiated a publically accessible web-site to guide staff through the process. The Committee will continue to monitor the Management of Change as a standing agenda item.

Board Assurance Framework
The Committee reviewed the performance against the 2017/18 BAF at Quarter 4 and the new 2018/19 metrics.

The 2017/18 Q4 BAF was approved by the Committee as they noted:
There remain some challenges on delivery at Quarter 4 for apprentices and engaging and retaining staff. Work continues to embed and strengthen the values and behaviours framework, and favourable progress has been made with social media engagement. The Values and Behaviours framework has altered from green to amber as the Trust is not assured that these are fully embedded in practice. Apprenticeships has also moved to amber as the target of 33 apprentices has not been met, with only 15 commencing with the Trust; a robust plan around apprentices is in place to meet the levy. Attraction and Retention remains at red, and whilst the workforce plans are in place these are not currently competency-based. The D&I inclusion rate had altered to red to reflect the recent WRES findings. Turnover continues to be a challenge. The Communications Plan is amber as it was delayed being approved at Board to meet the assurance timescales; and there is a medical leadership programme planned for next year. Staff survey results are amber as there is steady state in results with the WRES scores deteriorating. Talent Management remains red; however there are plans to address this moving forward.

Workforce & OD Risks
A number of risks are monitored and reviewed through the Committee. The current risks have been identified and mitigation plans are in place.

The following new risk has been added:
Risk 1111 – There is a risk that staff engagement scores, turnover and retention for the Trust will be impacted on as a result of the change and transition to implement the integrated locality working structure. Risk rating 12.

The Committee also agreed the addition of a separate risk on clinical supervision reporting which was currently proving an issue with the onus on individuals to record this.

Workforce Metrics
The Committee was updated by exception.
For the last seven months we have had more starters than leavers, and work has been undertaken to reduce the time to recruit. The Trust is

	looking at retention initiatives as a lot of staff will be due to retire over the next few years. Nursing-wise there will be trigger points in the next few years; there remain challenges locally as the Universities are providing LD training, and few Universities support return to practice courses. There is also a large amount of medics due to retire over the next few years. The Trust has managed to retain a large proportion of student nurses, and is looking to work with areas further afield, Manchester and London have been tried, but incentives with other Trusts are substantially more than we currently offer. The market remains tight and we need to think creatively in order to attract staff. . **Being Open** It was noted that the Trust is currently out to advert for a new Freedom to Speak Up Guardian the role would be revised to one day per week and be aimed at those band 8A and above. **Policies** The following policies were approved by the Committee and the Trust Board are requested to ratify them: • Dress Code Policy • Job Evaluation Policy The following policy was agreed an extension to July 9th 2018: • Learning & Development Review Policy The following policies were agreed a six-month extension: • Personal Relationships at Work • Performance Improvement Policy • PDR Policy ***Ratified*** Tony Gadsby made reference to the risk for the Health and Wellbeing CQUIN and asked if the Trust is looking to mitigate to achieve the £62K. Alex Brett advised this is an historical risk we have achieved the CQUIN but this is a rolling risk around the capacity to achieve the CQUIN.	
124/18	**WORK PROGRAMME FOR ALLIANCE BOARD** Andrew Hughes, Joint Director of Strategy, Development presented the report. It was agreed the presentation Andrew had provided for the report would not be delivered today due to timing but Lisa Wilkinson would circulate to Trust board members. Andrew Hughes highlighted the following: - Membership continues to grow - Governed by an Alliance Board of stakeholders; driven by an Executive Team representing seven members. - Work programme - integrated locality working supported by digital	**LW**

	initiatives, estate reconfiguration and workforce development Tony Gadsby asked if SSSFT were engaged in the Alliance Board Andrew advised they have put forward two names to sit on the executive team. *Received*	
125/18	**CONSENT AGENDA ITEM** **Cyber Security Update** Suzanne Robinson, Executive Director of Finance, Performance and digital presented the report to the Board for information only. . To improve data security and protection for health and care organisations, the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards called the 2017/18 data security protection requirements (DSPR) that all providers of health and care must comply with. The 2017/18 DSPR standards are based on recommendations by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care and confirmed by the government in July 2017. Tony Gadsby asked if the Trust had insurance against an attack. Suzanne Robinson confirmed the Trust does have insurance but she would have to check if this covered cybersecurity.	**SR**
126/2018	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 21st June 2018 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
127/2018	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 1.15pm

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
24-May-18	114/2018	Nurse Staffing Monthly Report - March 2018 - Maria to undertake a deep dive into Darwin data (low fill rate)	Maria Nelligan	21-Jun-18	Information included in April Safer Staffing Report - Agenda item today
24-May-18	116/2018	Learning From Deaths Quarterly Report - In all of the cases reviewed the care provided by our clinical teams was felt to be adequate to excellent. Caroline Donovan highlighted the need to identify where learning / improvements are being made and add to future reports.	Dr Buki Adeyemo	20-Sep-18	
24-May-18	124/2018	Work Programme for Alliance Board - Slides were not presented at the meeting therefore Lisa Wilkinson will circulate to all board members.	Lisa Wilkinson	21-Jun-18	Actioned
24-May-18	125/2018	Cybersecurity - Suzanne Robinson to confirm if Trust are insured against a Cybersecurity attack.	Suzanne Robinson	21-Jun-18	Verbal update

REPORT TO TRUST BOARD

Enclosure No: 4

Date of Meeting:	21st June 2018		
Title of Report:	CEO Board Report		
Presented by:	Caroline Donovan, Chief Executive		
Author:	Caroline Donovan, Chief Executive		
Executive Lead Name:	Caroline Donovan, Chief Executive	**Approved by Exec**	☐

Executive Summary:		**Purpose of report**	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.		**Approval**	☐
		Information	☒
		Discussion	☒
		Assurance	☐
Seen at:	SLT Execs 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	N/A		

Resource Implications: Funding Source:	N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A
Recommendations:	1. To receive for information

Chief Executive's Report to the Trust Board
21st June 2018

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. BOARD DEVELOPMENT FOCUSSES ON TEAM WORKING AND FURTHER COMMUNICATING "TOWARDS OUTSTANDING" VISION.

Our recent board development session focused on reviewing our Organisational Development strategy considering how we wanted to strengthen it to align with our ambition "To be outstanding - in all we do and how we do it." When we updated this following the publication of our latest CQC results, we took the opportunity to refresh our supporting statement from "We're on a journey" to "Our journey continues..."

Our ambition of being "Outstanding in all we do" goes beyond simply achieving CQC Outstanding ratings - great as that is and not in any way lessening our admiration for the achievement of our teams in securing them. When we say we want to be Outstanding in all we do, we literally mean "all we do".

Our vision also is designed to emphasise the equal importance we attach to being outstanding:

- **"In all we do**".... via our SPAR quality priorities, delivering services that are Safe, Personalised, Accessible and Recovery-focused; and
- **"how we do it"...** via our Proud to CARE values, being Compassionate, Approachable, Responsible and Excellent

One way we can make this even more apparent is to align all of the excellent initiatives underway across the Trust under an overall 'Towards Outstanding" banner. We will be working this up over the next period, developing:

- *Towards Outstanding People* - bringing together our OD, workforce development, skills, recruitment and retention strategies and initiatives
- *Towards Outstanding Engagement* - bringing together Listening into Action, GoEngage and engagement strands of our communications activities
- *Towards Outstanding Value* - bringing together our fantastic Valuemakers initiative with our cost improvement programme, emphasising all the time our commitment to delivering value, not simply cost cutting
- *Towards Outstanding Ideas* - bringing together our fantastic efforts and achievements in research and innovation
- Tow*ards Outstanding Quality* - bringing together our quality and performance strategies
- *Towards Outstanding Partnerships* - bringing together our partnership working, our support for the North Staffordshire and Stoke-on-Trent Alliance Board.

We also spent time as a Board particularly discussing how we need to build on the improvement work we have done to date to ensure this spreads and is sustainable. Towards Outstanding Improvement will enable our staff and service users and carers to work together on using common improvement methodologies to improve services to deliver better outcomes. Whilst we have started this journey in partnership with AQUA – we now need to invest in enabling people to be trained and supported to make continual improvements. We already have two of our staff who have been trained in advanced improvement skills another five are imminently starting their training and there will be more to come. We are really keen that we have people trained as part of our new organisational changes so we maximise the potential for transformation and improvement.

2. LOCALITIES UPDATE

Our progress towards implementing our new localities structures continues apace. Engagement sessions continue to be held with teams, which I know are proving welcome and valuable to frontline members of staff and this month we passed an important milestone as the consultation on the first phase of the Management of Change ended.

12 engagement sessions in total (2 per existing Directorate) have now been delivered, led by the project Clinical Lead and the current Heads of Directorate with support from the HR Team. These sessions have given a dedicated opportunity for clinical teams and staff within the directorates to give their valued contributions and comments to the transformation process. All feedback from these sessions has been collected and fed through into the Task and Finish Groups. Staff were welcomed to attend sessions outside of their own directorate to increase opportunities for engagement.

As requested by clinical staff during these sessions, further directorate engagement sessions will continue to be held throughout the process, giving teams timely updates on the transformation process and continuing to give them an opportunity to engage, feedback and comment.

We regularly remind staff that, if they have any questions about our plans, how they affect them and the opportunities it offers, they can use our dedicated webpage – including an FAQs page and a web form they can use to ask us anything they like and get an answer. They can, if they prefer, even ask a question or give us a comment anonymously.

It's really important that everyone feels involved and has the opportunity to have their say.

3. REACH 2018

We have had a fantastic result with this year's REACH Awards. At the close of nominations we had received over 300 nominations - the first time in the Trust's history we've had such a response. As always, I really enjoyed taking part in the judging panel - it really is one of the highlights of my year each year.

Everyone who has nominated a fellow staff member has received an invitation to the event, so it should be even more packed the rafters than normal. In line with suggestions from the national NHS 70 Team, we have brought the normal date for REACH forward to take place on the 5th July.

It should be a great way to celebrate the 70th Anniversary of the NHS.

4. OUR AWARDS SUCCESS CONTINUES

We have had another month of Awards success.

Our Finance Team scooped the award for Finance Team of the Year from the West Midlands Healthcare Financial Management Association. The work of the finance team has been a regular item in my blogs and Board Report over the year - whether it's delivering our 19th consecutive year of financial balance, our innovative animated AGM film presenting our financial results or the Valuemakers scheme. It's great to see them getting external recognition and praise from their professional colleagues in the region. They have won a variety of awards recently and this prestigious one showcases what a fabulous team they are - really well done.

Our Learning Disability Directorate was rewarded for their fantastic achievements at the national HSJ value awards, scooping the award for Pharmacy and Medicines Optimisation. The HSJ judges themselves said "this project has worked across organisational boundaries to stop over-prescribing of medicines and significantly improve quality of care for a vulnerable group of patients. We would love to see this approach everywhere.

It was also a significant achievement that three more of our teams made the final shortlist: our finance team jointly with our clinical teams in the category "Improving value through innovative financial management or procurement" - for our Valuemakers programme - and no less than 2 out of only 11 across the whole in the NHS the Meir project for the Meir Partnership Care Hub and our CAMHS in Schools team- for our CAMHS in Schools innovative project.

A brilliant achievement - how fabulous to have 4 teams shortlisted in the national awards - it was a great evening - one where I felt immensely proud!" been made in the last few months.

5. HEALTHY STAFFORDSHIRE SELECT COMMITTEE

One of our most important meetings each year is our session at the Healthy Staffordshire Select Committee. This gives locally elected representatives the opportunity to hear from us about our performance over the past year and our plans for the future. Their role is to scrutinise us and ensure we are providing good services for our local communities.

It was a pleasure to be able to present a strong and positive story - of our continuing journey towards outstanding, our strong clinical and financial performance, our engagement with staff, service users partners and our future plans for locality working.

It was an even greater pleasure to receive warm and enthusiastic support from the Committee about what we have done, what we are doing and what we plan to do in future.

I am due to return next month to present with colleagues in our mental health STP plans.

6. CQC SYSTEM REVIEW

I am pleased to report positive feedback from Ed Moses from the Department of Health on the CQC Local System Review Improvement Plan. The feedback to me and Dave Sidaway, City Director from Stoke-on-Trent Council was very positive on the progress we have made and the positive position we are in compared to many other health and social care economies that were reviewed by the CQC. Whilst this was good to hear, there is still much for us to do. Our two biggest priorities going forward are NHS delayed transfers of care and supporting care planning for people at the end of their lives. It is however really important to thank people for the progress that has been made in the last few months.

I am also really pleased that, following an interview process that I was part of, Paul Edmondson-Jones has been appointed as the new Director of Adult Social Care, Health Integration and Wellbeing at Stoke-on-Trent City Council.

Paul has spent considerable time in the armed forces leading medical operations in the Falklands, Yugoslavia (including Bosnia) and the Gulf wars. He was responsible for a number of adult social care and public health functions in York, Hartlepool and Redcar and Cleveland Councils. He has also worked extensively in the NHS, contributing to several white papers on public health, pharmacy and health and social care.

This is a great appointment for Stoke-on-Trent and I am, alongside many others, very much looking forward to working with Paul.

7. HEALTH AND CARE TRANSFORMATION BOARD

At the recent STP Health and Care Transformation Board, one of the items we discussed was the implementation model for the integrated community teams. Our Alliance will be working up the model for North Staffordshire and Stoke-on-Trent through our newly established Alliance Executive team. The integrated teams approach is a key pillar of the STP plan and will be part of the engagement and consultation process that the STP is currently planning.

The plans will be focused on the simplification of urgent and emergency care, including urgent treatment centres and how to support flow from A&E into our hospitals. It will also introduce the concept of integrated care teams (ICTs) and their potential urgent care offer, as well as integrating how we provide mental health services into primary and community teams.

The STP team is seeking clinicians to support public engagement events. These will be taking place in June and July, from 4 – 8pm. Training is being offered to anyone who volunteers to support the process. I have urged our staff to consider taking part via my CEO Blog.

8. TRUST CONFIRMED FOR LORENZO DIGITAL EXEMPLER MOBILISATION STAGE

It was great to hear confirmation that Combined Healthcare has passed a significant milestone by being chosen by NHS Digital as only one of four NHS Trusts selected for the mobilisation phase of the Lorenzo Digital Exemplar programme.

The Trust sees the Lorenzo Digital Exemplar programme as a great opportunity to improve our services for children in the community. Our exciting plans build on our reputation as a digital exemplar and will be an excellent opportunity to spread our learning to other Trusts across the country.

Combined Healthcare's plans centre on delivering a digital transformation programme with the Children and Young People (CYP) Directorate. We aim to deliver a future where young people and their families are empowered to use technology to revolutionise their care. We want to remodel the referral and assessment functions within our CYP service by increasing the proportion of children with the ability to self-care and self-refer into services. This self-referral approach improves recovery, and enables a person to seek prompt treatment at an early stage, and it also reduces the likelihood of lower degree problems becoming more severe.

We'll be working closely with local schools, helping us develop a vision of how technology can really change the lives of children, young people and their families. Well done to all the team continuing to develop our plans and congratulations on reaching this next stage.

9. LISTENING FINANCE TEAM AWARDED FUTURE FOCUSSED FINANCE ACCREDITATION

I was delighted to hear that the NHS Finance Leadership Council has agreed that North Staffordshire Combined Healthcare NHS Trust should be awarded Future-Focused Finance Accreditation, at level 1, with effect from Friday 11 May 2018. The overarching principle of Accreditation is that the organisation is fully signed up to Future-Focused Finance's aim of ensuring that everyone connected with NHS Finance can influence decision making in support of high quality patient services.

The national FFF programme is aimed at improving NHS finance for everyone. Whether we work in finance or not we all need access to the relevant finance skills, methods and opportunities to influence decisions affecting our services. This helps us then work together to produce high value services and reduce waste in NHS spending.

Our finance team are greatly valued and respected by the FFF programme, including for our fantastic Valuemakers Programme. It's great to see them getting this recognition for their work. Well done to our fantastic finance team and everyone across the Trust making a contribution through Valuemakers.

10. CONTINUED RELATIONSHIP BUILDING WITH POSITIVE PRACTICE MENTAL HEALTH COLLABORATIVE

Our relationship building with the Positive Practice Mental Health Collaborative continues. The Positive Practice MH Collaborative is a user led multi agency collaborative of seventy-five organisations, including NHS Trusts, CCG's, Police Forces, third sector providers, front line charities and service user groups. It identifies, and disseminates, positive practice in mental health services by working together across organisations and sectors, to facilitate shared learning, and to raise the profile of mental health with politicians and policy makers.

We submitted 10 entries this month for their annual positive practice awards. We have been asked to start a national substance misuse collaborative which Dr Derrett Watts our Clinical Director for substance misuse will be leading. Some of the Executive Team has also been asked to be on the judging panel for the positive practice awards.

11. SCHWARTZ ROUNDS

I am really pleased that we have recently introduced Schwartz Rounds to the Trust. Schwartz Rounds originated in America as the legacy of Ken Schwartz. In 1994, Ken, a health attorney, was diagnosed with terminal lung cancer. During his treatment, he found that what mattered to him most as a patient were the simple acts of kindness from health staff – both clinical and non-clinical- which he said made "the unbearable bearable." Before his death, he left a legacy for the establishment of the Schwartz Center in Boston, to help to foster compassion in healthcare. From there Schwartz Rounds emerged.

Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to examine the clinical aspects of patient care. Therefore rounds focus on the emotional and social aspects of our work.

Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work.
The Schwartz Rounds are being held monthly with 2 having been held to date.

12. CARE COORDINATION WORKSHOP

We are currently focusing on strengthening our approach across the Trust to care co-ordination. The Executive Director of Nursing & Quality is leading an improvement programme with the first workshop held this month. There was strong representation across the directorates and examples of both positive practice and also where there are challenges. The programme will work on improving areas where needed to provide consistent and high quality support to service users and carers

NATIONAL UPDATE

13. HEALTH SELECT COMMITTEE PUBLISHES REPORT INTO INTEGRATED CARE: ORGANISATIONS, PARTNERSHIPS AND SYSTEMS

The House of Commons Health Select Committee has published its report into "Integrated care: organisations, partnerships and systems." The Report notes that NHS and social care services are looking after a population which is living longer and with increasingly complex health and care needs, including multiple long-term conditions.

Services need to change to reflect that and to be better organised around patients. Rising demand and costs for health and care are taking place alongside an unprecedented and prolonged squeeze on resources. More joined-up, coordinated and person-centred care can provide a better experience for patients, particularly those with multiple long-term conditions. However, progress to achieving these benefits has been slow.

Transformation remains key to sustainability. The Committee says it has seen and heard of examples of local areas which have made excellent strides forward in difficult circumstances. What is now required is the dedicated national financial and leadership support to enable the NHS to transform at pace.

The Report includes a specific mention of Staffordshire and Stoke-on-Trent from oral evidence from Simon Whitehouse, saying:

"With Staffordshire and Stoke-on-Trent being one of the more challenged areas in terms of both performance and financial viability, we have a real challenge. We need some of the flexibilities that are being offered and talked about in the more successful parts of the patch to enable us to make the scale of changes we need to make, but the resource, effort and focus is going to areas that are doing really well; they are advanced and probably had strong and robust relationships in place previously to enable some of that to happen. I would make the case, and articulate really strongly, that while we understand that and we need to learn from those areas, if all of that resource and effort goes into the ones that are at the leading or cutting edge, we are creating an even greater gap in terms of what that looks like. "

An STP area, or areas within it, work more effectively where they are meaningful to partners, local health professionals and most importantly the public. STPs, particularly those with more complex geographical boundaries, should be encouraged and supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population

14. COMBINED HEALTHCARE PRAISED IN KEYNOTE ADDRESS AT NHS CONFEDERATION CONFERENCE 2018

The success of Combined Healthcare in developing partnerships through the Alliance, with successes in reducing DTOCs and the Meir Hub, as well as our success in having CQC rating all of our services as 'Good' or 'Outstanding' for the first time in our history were specifically singled out by Shadow Health Secretary Jon Ashworth MP in his keynote address delivered by video link to the NHS Confederation 2018 Conference.

REPORT TO: OPEN TRUST BOARD

Enclosure No: 5

Date of Meeting:	21st June 2018		
Title of Report:	Service User & Carer Council Report		
Presented by:	Wendy Dutton, Chair, Service User & Carer Council		
Author:	Wendy Dutton, 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 to Trust Board of the Service User & Carer Council since the last meeting.		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

NHS
North Staffordshire
Combined Healthcare
NHS Trust

SERVICE USER AND CARER COUNCIL UPDATE
FOR TRUST BOARD ON 21st June 2018

Firstly I would like to announce the resignation of the Vice Chair, Tess Tainton. Tess was successful in applying for a post within the 'Inspiring Change' team in Manchester, a project she had been involved with in a voluntary capacity. We wish to extend our thanks to Tess and wish her well in her future career.

Business Meeting 30th May 2018

- The Meir Hub was discussed with added information from Sam Mortimer
- Lisa Sharrock presented the innovative Beable app, currently in simplistic prototype form, the potential breadth of application was discussed and encouraged.
- Citizens jury is to enter an 'Action Plan' phase. This will we are assured involve service providers, 3rd sector workers as well as service users and carers. MN involved in this stage.
- Adult social care was discussed, supported by Samantha Mortimer, several challenging issues were raised.
- 'Life Works' which supports Carers and |Service users living with ASD was discussed.
- This discussion then linked in to the recent changes within advocacy services, now Voicability / Voice Staffordshire, based at Stafford with a 5yr contract. While Sue Carson, are Advocacy member said there were exciting prospects some gaps had been identified. One of these gaps was highlighted in reference to Lifeworks were carer support / assessment inefficiency could be flagged with the support of Voicability no current contract for carers was present.
- Concerns were again raised by Carer's regarding the renewed 18month contract to the current provider despite concern at the lack of clarity of function / expenditure. This will again be taken back to Healthwatch and if possible a copy of the original review report will be attained
- Mental Health Survey Action plan, on reviewing this SM highlighted that already local service user/carer focus groups were being set up to look at the continuing issues around CPAs and then back into SUCC
- Towards Smoke Free, again a challenging discussion was had, in particular related to the Edward Myers Unit. Following frank discussion it was agreed that AM would be happy to arrange a meeting with service users to listen to and respond to their concerns. Work done so far within the Trust had its problems but less so than anticipated. A look for supportive suggestions and language was encouraged

Workshop 25th April 2018

It was agreed to continue with the trial if a new venue, Academic 1%2 at the Harplands and time, 5-7pm for a further 2 workshops.

Continued Service User & Carer Council membership involvement

- Trust Board meetings
- Interviews
- PLACE Assessment
- SUEEG Meetings
- Business Meetings
- People and Development
- Inductions

- Access Meetings
- Adult In-patient meetings
- Ward and Admin Volunteers and more!

Wendy Dutton
Chair, Service User & Carer Council
11th June 2018

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No:6

Date of Meeting:	21st June 2018		
Title of Report:	Towards Outstanding Innovative Practice		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Kerri Mason, Clinical Studies Officer		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report details two examples of innovative practice both shortlisted for National awards. 1. High Volume Users - The High Volume User Service (HVUS) work with patients associated with persistent A&E attendances, offering help and direction of more appropriate health and social care services. The aim of the HVUS is to directly engage the High Volume User population, defined as 12 or more attendances a month, in: devising a safe, personalised, recovery focused care place and reducing attendances and admissions for cohort by 30%. The service has demonstrated high quality care for High Volume Users, with a safe and accessible service to identify need, including 47% reduction in A&E attendance and financial savings of attendances and admissions. 2. STOMP - In 2015, 35,000 people with a Learning Disability were prescribed antipsychotic medication without any clinical justification. (NICE 2017). As a local solution to a national issue, Combined's adopted the Stopping the Over-Medication of People with a Learning Disability (STOMP) campaign. Combined's approach to STOMP has demonstrated value, a high level of service user and family involvement and improved health outcomes including reduction in medication, intelligent use of staffing and reduction in length of stay.	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	None
Resource Implications: Funding Source:	None N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	
Recommendations:	To receive for assurance

High Volume User Service - Presentation Summary

High Volume User Service Development

As one of, if not the, most challenged urgent care systems in country the High Volume User Service (HVUS) work with patients associated with persistent A&E attendances, offering help and direction of more appropriate health and social care services. The aim of the HVUS is to directly engage the High Volume User population, defined as 12 or more attendances a month, in:

- Devising a safe, personalised, recovery focused care plan;
- Reducing attendances and admissions for cohort by 30%.

To deliver the biggest impact, the HVSU demonstrate a high level of partnership and integrated working, involving clinicians and team from a variety of health and social care setting and services including, but not limited to A&E, West Midlands Ambulance Service and Local Authorities.

Outcomes

Over the last 24 months, during the Pilot and Embedding cohorts, the HVUS, has supported 204 service users. The service has demonstrated high quality care for High Volume Users, with a safe and accessible service to identify need, linked to a 24 hours Access & Home Treatment team. The holistic support package, focused on recovery, has demonstrated value and received outstanding feedback from clinicians, service users and commissioners

Feedback

"Without you I would not have even got to rehab, never mind where I am now. Thank you for everything - you will always be in my mind and heart… acceptance is massive and I accept all the things I cannot change but start my new life alcohol free. The world is my oyster now, it's my life and what I make of it is up to me." ***Service User***

"The HVU team have a non-judgmental, friendly, supportive approach which establishes rapport and often results in revelations and disclosure which help us all to understand the patient's behaviour. It goes without saying that this is invaluable in keeping not only the patient safe, but staff as well." ***Emergency Department Consultant***

Value

- 47% reduction in A&E attendance and admissions, against a target of 30%, equating to 1,109 fewer attendances;
- Financial savings of attendances & admissions (PbR equivalent) £495, 689;
- Benefits for others patient i.e. reduced congestion and overcrowding.

Lessons Learnt

The following benefits and barriers highlight what the service has learnt so far, during the pilot and embedding cohorts

Benefits (Pro's)	Barriers (Cons)
• Intensive Patient centred 'one to one'; • Biopsychological approach improved patient safety; • Clear Recovery Focus goals & objectives; • Measureable personal outcomes for patients; • Inclusive and Flexible service • Equitable for all • Development of data sharing agreement and consent Proforma; • Measure financial and operational outcome to CCG and providers; • Opportunities for patients for provide their story	• Duplication of service objectives • Poor sharing of information • Limited access to shared data • Reactive approaches across organisations • Local configuration of Alcohol services • Referrals into services for ongoing care and support • Reluctance from some GP's to engage • Having to utilise last resort methods (ABC)

Next Steps

During 2018/19 the HVUS will aim to expand into the next Cohort, scaling up the project to expand into the next cohort, 8 or more attendances. The ambition is for the format to be replicated regionally and nationally and continue to learnt, refine and adapt to further develop links both within and across services, spanning the whole health economy.

Reduction in a the use of Medication in a Learning Disability Inpatient Service: Pharmacy and medicines optimisation - Presentation Summary

Combined's Approach to STOMP LD Campaign

In 2015, 35,000 people with a Learning Disability were prescribed antipsychotic medication without any clinical justification. (NICE 2017). As a local solution to a national issue, Combined's adopted the STOMP campaign, which aimed to work with patients and families, utilising a Positive Behaviour Support (PBS) model. Combined's STOMP campaign followed least restrictive practice approach, sustainable on discharge.

A whole systems approach was adopted, to provide consistent support, and worked in partnership with colleagues from across the West Midlands to develop a PBS Organisational and Workforce Development Framework.

Outcomes

Combined's approach to supporting this complex patient group demonstrated a direct impact on reducing restrictive practices. STOMP demonstrated value, a high level of service user and family involvement and improved health outcomes; with the majority of patients having a reduction in antipsychotic medication without an increase in benzodiazepines, side effects, medication errors or appointments.

Service user and family involvement was integral to the success, with family and service user feedback received at local service user groups;

"I now believe that I can do things for myself"

"My daughter has improved so much since being at A&T"

Next Steps

Clearer objectives and vision for the STOMP campaign will support taking forward future plans and long-term sustainability; including the rollout of inter team and cross directorate working, workforce development and the development of the PBS clinics.

North Staffordshire Combined Healthcare NHS Trust

REPORT TO TRUST BOARD

Enclosure No:7

Date of Meeting:	21 June 2018		
Title of Report:	April 2018 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:	Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during April 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during 2018 was 85% for registered staff and 96% or care staff on day shifts and 69% and 117% respectively on night shifts. Overall a 94% 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:
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐	
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☒ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐	
Risk / legal implications: Risk Register Ref	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.	
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None	
Recommendations:	To receive the report for assurance and information	

Version	Name/group	Date issued
1	Maria Nelligan	08 June 2018
2	SLT Business	12 June 2018
6	Trust Board	13 June 2018

1 Introduction

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

2 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. A comprehensive annual report for 2017 was presented to April 2018 Board and the recommendations agreed. These are being progressed through the Safer Staffing Group.

3 Trust Performance

During April 2018 the Trust achieved a staffing fill rate of 85% for registered staff and 96% for care staff on day shifts and 69% and 117% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 94% fill 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 1. 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 monthly basis, the plan which sets out the actions and recommendations from staffing reviews.

4 Care Hours per Patient Day (CHPPD)

The Trust is now required to report CHPPD on a monthly basis. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours. The CHPPD metric has been developed by NHSI to provide a consistent way of recording and reporting deployment of staff providing care in inpatient untis. The aim being to eliminate unwarranted variation in nursing and care staff distribution across and within the NHS provider sector by providing a single means of consistently recording, reporting and monitoring staff deployment. The CHPPD:

- gives a single figure that represents both staffing levels and patient numbers, unlike actual hours alone
- allows for comparisons between wards/units as CHPPD has been divided by the number of patients, the value doesn't increase due to the size of the unit – allowing comparisons between different units of different sizes
- splits registered nurses from care staff (healthcare support workers /assistants) to ensure skill mix and care need is reflected
- is a descriptor of workforce deployment that can be used at ward, service or aggregated to trust level
- is most useful at a clinical ward level where service leaders can consider workforce deployment over time compared with similar wards within a trust or at other trusts as part of a review of staff productivity alongside clinical quality and safety outcomes measures

The Trust will use CHPPD to benchmark between specialities within the organisation and once the information is available through the model hospital national benchmarking will help inform safer staffing reviews.

5 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.

5.1 Impact on Patient Safety

There were no incidents reported during April 2018 relating to patient safety and nurse staffing issues.

5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During April 2018 it was reported that no activities were cancelled or shortened (and not rearranged) due to nurse staffing levels.

5.3 Impact on Staff Experience

In order to maintain safer staffing the following actions were taken by the Ward Manager during April 2018:

- 76 staff breaks were cancelled (equivalent to approximately 1.6% of breaks)
- 10 staff breaks were shortened equivalent to approximately >1% of breaks)
- 43 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas).

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

5.4 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 178 RN shifts were covered by HCSW where RN temporary staffing was

unavailable. A total of 33 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.

5.5 RN Staffing

In line with the national picture RN recruitment is challenging. The RN fill-rate 12 month trend line is demonstrating a slight decreasing trend; this follows a slight increasing trend last month.

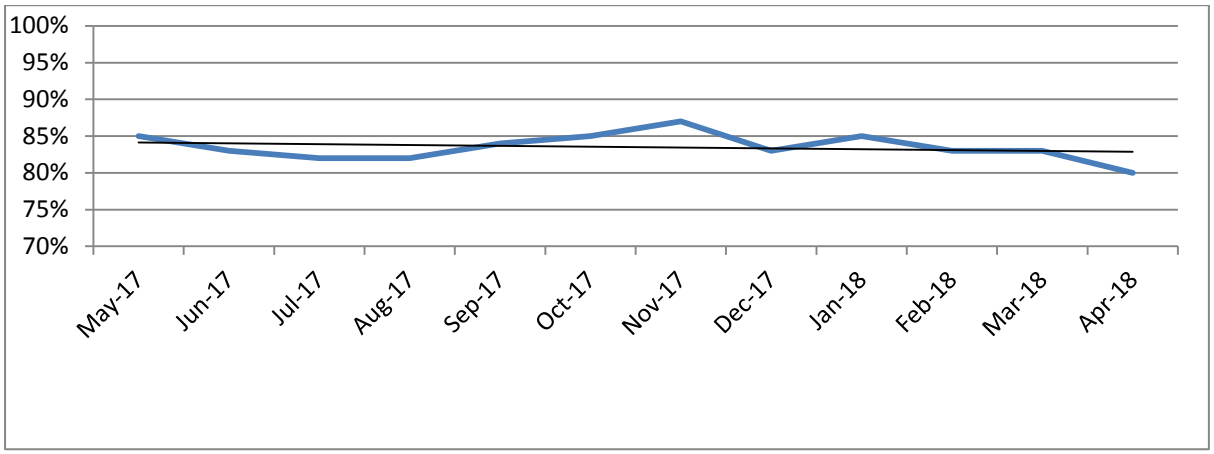


Figure 1 Twelve month RN fill rate trend line

The following actions have been taken to strengthen RN staffing:

- Twenty six third year Keele nursing students have accepted a conditional offer to commence with Trust in Oct 2018
- Shift patterns have been altered in response to staff feedback
- Recruitment opportunities for RNs continue to be advertised (including bank)
- The Trust has joined the NHSI MH recruitment and retention programme
- Recruitment campaign continues for PICU

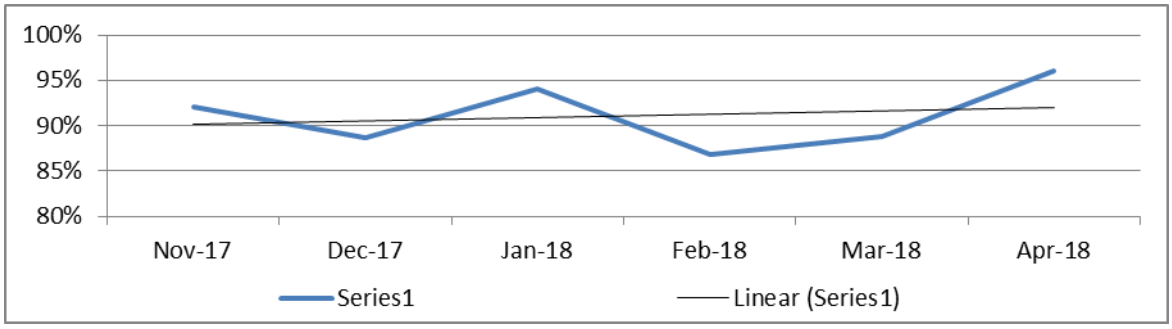
Additionally we are scoping the following:-

- Paying for retire & return RN's NMC registration fee
- Return to practice
- Reviewing potential to increase Band 6 practitioners
- Enhanced CPD offer
- Deputy Ward Manager leadership development programme

An action plan to increase RN recruitment in enclosed in Appendix 3.

6. Darwin staffing

Staffing on Darwin has been challenging over the past 6 months. The staffing fill-rate has fluctuated between 87% and 96% during this time period however overall the staffing fill-rate is on a slight upward trajectory as demonstrated in the graph below:



From November 2017 through to March 2018 there were service users who required additional support due to the complexities of their illness and this challenged the staffing on the ward. Throughout the last 6 months Darwin had reported that patient activities had been cancelled due to staffing issues however it is positive to note that during April 2018 there were no activities cancelled. Staffing fill-rate was above 95% for April for the first time in 6 months. Furthermore the Ward Manager reported to the WM T&F Group at the end of May 2018 that staffing is more positive, this has been sustained over the past 2 months.

Additionally it should be noted that there is provision for schooling provided whilst young people are on the unit. There are generally 6 young people at an appropriate stage in their recovery to attend school. Whilst the young people who are able to attend school are off the ward, this gives the opportunity for group and 1:1 work to carried out with the remaining young people.

The Safer Staffing Annual Report recommended an uplift for Darwin and although this has not yet been transacted the ward are staffing to the revised agreed staffing levels as a baseline through the use of Temporary Staff. Additionally further work is being undertaken with the Practice Education Team to attract newly qualified nurses to the unit and to increase student placements in order to ensure that a wider range of people are exposed to the unit to increase potential candidates for the future workforce. Work has also been undertaken with Temporary Staffing to widen the group of bank staff who are willing to work within CAMHS Tier 4.

7. Summary

Safe staffing reporting indicated challenges in staffing wards during April 2018. Over the past 2 years a significant number of RN vacancies have been filled by newly qualified RNs; a further 26 newly qualified nurses will be joining the Trust in October 2018. During 2018, in line with the national picture, it is anticipated that challenges will also be experienced with the planned opening of PICU and an enhanced recruitment campaign continues 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.

The Trust has joined the NHSI Retention Support Programme. A project team visit has been completed and learning shared.

8. 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 April 2018 Safer Staffing

Apr-18	Day						Night						DAY		NIGHT				
	RN			HCSW			RN			HCSW									
Ward name	Establishment hours	Clinically required hours	Total monthly actual hours	Establishment hours	Clinically required hours	Total monthly actual hours	Establishment hours	Clinically required	Total monthly actual hours	Establishment hours	Clinically required	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Overall RN fillrate	Overall HCSW fillrate	Overall fillrate
Ward 1	1369	1215	877	1369	1215	1288	651	677	362	651	666	973	72%	106%	53%	146%	65%	120%	93%
Ward 2	1369	1215	821	1369	1632	1656	651	677	472	651	1043	1152	68%	101%	70%	110%	68%	105%	90%
Ward 3	1369	1215	1127	1369	1559	1461	651	710	428	651	1028	1300	93%	94%	60%	126%	81%	107%	96%
Ward 4	1369	1215	1187	1369	1634	1579	285	682	545	856	1045	1097	98%	97%	80%	105%	91%	100%	96%
Ward 5	1141	1350	1043	913	1350	1490	285	683	352	571	842	1140	77%	110%	52%	135%	69%	120%	95%
Ward 6	1369	1215	1119	1141	1620	1667	285	677	377	856	1030	1309	92%	103%	56%	127%	79%	112%	98%
Ward 7	913	810	782	913	1377	1362	285	699	366	571	833	1162	97%	99%	52%	140%	76%	114%	99%
A&T	1369	810	805	1369	1620	1447	327	666	488	654	999	1096	99%	89%	73%	110%	88%	97%	94%
Edward Myers	913	952	757	913	1357	1412	325	355	348	651	666	666	79%	104%	98%	100%	85%	103%	96%
Darwin Centre	1369	817	801	913	810	733	327	333	333	654	677	666	98%	90%	100%	98%	99%	94%	96%
Summers View	913	474	503	456	900	465	325	322	322	651	322	311	106%	52%	100%	97%	104%	63%	79%
Florence House	456	900	572	913	900	782	325	322	322	325	643	611	64%	87%	100%	95%	73%	90%	83%
Trust total	**13916**	**12188**	**10393**	**13003**	**15974**	**15340**	**4724**	**6803**	**4716**	**7741**	**9793**	**11484**	**85%**	**96%**	**69%**	**117%**	**80%**	**104%**	**94%**

Apr-18	CHPPD							
Ward name	Total Actual Hours PD	Cumulative Count over the month of Patients @ 23:59	Care Hours Per Patient Day	Safe staffing was maintained by:	RN Vacancies	HCSW Vacancies	Bed occupancy	Movement
Ward 1	3498.95	409	8.55	Nursing staff working additional unplanned hours and altering skill mix	2.40	2.41	100%	↑
Ward 2	4101.14	630	6.51	Nursing staff working additional unplanned hours and altering skill mix	6.00	1.21	92%	↑
Ward 3	4316.22	530	8.14	Nursing staff working additional unplanned hours, cacnelling non direct care activities and altering skill mix	0.60	1.11	81%	↓
Ward 4	4407.6	561	7.86	Nursing staff working additional unplanned hours and altering skill mix	4.50	3.00	98%	↑
Ward 5	4025.43	292	13.79	Altering skill mix	1.50	-0.20	84%	↓
Ward 6	4472.6	374	11.96	Nursing staff working additional unplanned hours, multi-disciplinary team supporting and altering skill mix	3.30	2.35	88%	↓
Ward 7	3672.5	543	6.76	Nursing staff working additional unplanned hours	1.80	0.00	91%	↑
A&T	3837.02	140	27.41	Altering skill mix	3.63	3.88	78%	↑
Edward Myers	3183.16	355	8.97	Nursing staff working additional unplanned hours and altering skill mix, support was also given to other wards	3.30	0.88	91%	↑
Darwin Centre	2532.48	329	7.70	Nursing staff working additional unplanned hours and altering skill mix, support was also given to other wards	3.20	0.20	99%	↑
Summers View	1599.87	180	8.89	The MDT supported the nursing team	2.40	0.00	90%	↓
Florence House	2286	255	8.96	The MDT supported the nursing team	0.00	1.50	100%	↑
Trust total	41933	4598	9.12		32.63	16.34		

Appendix 2 Staffing Issues

- There have 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. An Advanced Nurse Practitioner has been recruited and will commence in May2018.

- There are currently 47.1 WTE RN vacancies in in-patients (32.6 WTE current in-patient wards and 14.5 WTE for PICU). Of the 32.6 WTE vacancies in current in-patient wards (ie excluding PICU), a significant number are in the recruitment process (including the newly qualified University of Keele nurses who are due to join the Trust in October 2018). We continue to advertise for the remainder and a series of one-stop-shops are planned over the next few months.

- There are currently 16 WTE HCSW vacancies reported within in-patient wards. The majority of these are in the recruitment process.

- Ward 2 and 4 have the highest RN vacancies of 6 and 4.5 WTE respectively; the majority of these have been recruited to. The remaining posts have been advertised externally and have been 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.

- 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) however the number of vacancies on these wards has made this challenging to achieve consistently.

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

Appendix 3 Recruitment Action Plan

	IDEAS	ACTION BY	WHEN
1	Reach out to retired RN and offer to pay for registration (£120) and support validation to work fixed term bank etc. (need to fast track application)	Maria Nelligan	30th June 2018
2	Return to practice contact HEE for support with a scheme locally	Julie-Anne Murray	Plan by end of June
3	Review skill mix on wards to identify increase in Band 6 practitioners (other roles) attracted externally	Julie-Anne Murray Maria Nelligan	End May 2018
4	Introduce a friend scheme for RNs and Consultants £150	Kerry Smith	30th June 2018
5	Transport provision to the Harplands for "out of area" RN include in advert	Kerry Smith	30th June 2018
6	Accommodation and relocation to be offered to oversees and "out of area" RN included in advert	Kerry Smith	30th June 2018
7	CPD offer to all RNs with individual career advice, included in advert	Kerry Smith Julie Anne Murray	30th June 2018
8	Weekly payroll for Bank staff explore option for substantive inpatient RN and e payslips (some costings done already £20k for 250 bank)	Julie-Anne Murray Mike Newton	Paper for Execs 18th June 2018
9	Temp staffing and e rostering ensure we utilise all available apps and apply to substantive staff where appropriate	Julie-Anne Murray	30th June 2018
10	Oversees recruitment scope current activity	Maria Nelligan Kerry Smith	30th June 2018
11	Student nurse on the bank offer on commencement of course with clear buddies identified to mentor through programme	Julie-Anne Murray	30th June 2018

	IDEAS	ACTION BY	WHEN
12	Preceptorship programme, highlight on recruitment and offer to all RN posts	Julie-Anne Murray	30th June 2018
13	Clear career structure from HCA to DON promoting Consultant Nurses and Advanced Practitioner roles	Julie Anne Murray Maria Nelligan	30th June 2018
14	Rotation to learn other specialties or specialising on one available as part of CPD and recruitment offer	Julie-Anne Murray Kerry Smith	Current
15	Scope the HCA interest and who will meet criteria for RN course now, some funding may become available from NHSE for LD	Julie-Anne Murray Maria Nelligan	Completed nursing assurance 30th June 2018
16	Revisit roles particularly the Ward manager role for PICU to consider hybrid of WM and Clinical Nurse Specialist to attract experienced PICU Ward Manager	Maria Nelligan Natalie Larvin	30th June 2018
17	Aspiring Ward Managers development programme to develop clinical leadership and resilience	Julie-Anne Murray Jane Rook	September 2018
18	Routine Recruitment pace, see how this can be streamlined and sped up	Kerry Smith	30th June 2018
19	Media Campaign- included incentives above “why best to work” @ Combined and local highlights	Joe McCrea	31st July 2018
20	“One Stop Shop” to be streamlined	Joe McCrea Kerry Smith	Current

Note above from discussion at Execs and from previous papers costings will need to be added, some already prepared

REPORT TO: OPEN TRUST BOARD

Enclosure No:8

Date of Meeting:	21st June 2018		
Title of Report:	Serious Incident Report 2017/18		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides analysis of Serious Incidents which occurred from April 2017 to March 2018. It is noted that the number of serious incidents in this reporting period. The provision of Substance Misuse Services in Stoke-on-Trent has only accounted for a small percentage of the increase in deaths in the last 12 months; it is noted that alcohol and drug misuse of people not known to SMS continues to be a factor in the deaths reported.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒	Date: May 2018	
	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	Nil identified		
Resource Implications: Funding Source:	Nil identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	No issues with regards to protected characteristics have been identified during the analysis of the Q4 SI data		
Recommendations:			

Version	Name/group	Date issued
1	Dr O Adeyemo	14/05/2018

1. Purpose of the report

This report provides assurance to the Quality committee of the Trust processes relating to Serious Incidents (SIs). The report covers the period from 1st April 2017 to 31st March 2018 and details the following:

- Serious Incidents by category reported by quarter.
- Themes learning and change arising from Serious Incident investigations.

2. Serious Incidents 2017/18

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. For comparison purposes, the table below illustrates the total number of SIs reported by quarter for the last two years, April 2016 to March 2018

Table 1.

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	3	3	**14**
Pending review – Unexpected/potentially avoidable death	0	10	7	6	**23**	4	10	8	11	**33**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	1	1	1	**3**	1	0	2	2	**5**
Disruptive, aggressive behaviour meeting SI criteria	1	0	0	0	**1**	0	0	0	0	**0**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (suspected suicide)	7	11	4	2	**24**	3	6	2	5	**16**
Unexpected/potentially avoidable injury causing harm	0	1	0	0	**1**	0	0	0	0	**0**
Apparent/actual abuse	0	0	0	0	**0**	0	1	2	2	**5**
Total	10	23	13	11	**57**	10	23	17	23	**73**

In 2017/18, a total of 80 incidents were reported onto the national database StEIS (Strategic Executive Information System). However after discussions with our commissioners, 8 incidents were downgraded; 7 were downgraded due to being natural cause deaths and therefore investigated as part of the Trust mortality surveillance process and 1 incident was downgraded as the SI was completed by SSSFT and Combined Healthcare contributed to this investigation.

The reporting period 2017/18 shows an increase of 22% more SIs than in 2016/17. Quarter 4 showed the biggest increase in SIs reported with an increase of 53% on quarter 4 in 2016/17. There were 49 deaths reported in the primary category of unexpected/potentially avoidable death. These incidents are then divided into two further subcategories: There were 33 deaths in the subcategory of 'pending review' and 16 deaths in the subcategory 'apparent/ actual/ self-inflicted harm meeting SI criteria'.

The category showing the largest increase was that of 'Pending review', this category is used when the circumstance around the death do not immediately give rise to a reasonable suspicion of death by suicide. The majority of deaths reported here relate to the deaths of people known to substance misuse services.

The table shows that one of the largest increases during 2017/18 was in the incidence of slips, trips and falls where a 65% increase was noted. The majority of the falls were reported from the NOAP wards, with ward 4 accounting for 50% of all falls meeting the SI criteria. In order to prevent falls resulting in harm a number of actions were taken across the Trust. These actions included the establishment of a falls rapid improvement task group, which reviewed the trust falls policy and developed a multi-factorial risk assessment which was later incorporated into the risk assessments available on Lorenzo. Also, working in collaboration with the Advancing Quality Alliance (AQuA), the Trust aimed to reduce the number of falls in our NOAP inpatient areas by initiating locally developed falls reduction projects.

The category of apparent/actual abuse was used by the Trust for the first time in 2017/18, when 5 incidents were reported under this category. Four incidents were reported following the identification of errors in MHA documentation which resulted in unlawful detention and one incident of a service user physically assaulting staff was also reported.

A checklist has been developed to help support positive practice. Progress will be monitored and reported through the Quality Committee.

Suicide prevention remains at the forefront of the Trust agenda and is one of the five priority areas for the Staffordshire and Stoke-on-Trent STP partnership. In 2017/18, there was a 33% reduction in the number of deaths where suicide was suspected. This is a positive position however the Trust has continued to develop our suicide prevention strategy. A suicide prevention action plan is ongoing and during this year, the Trust has developed and implemented learning for all staff. We have introduced mandatory suicide awareness sessions; an e-learning package for all staff in the Trust and face-to-face training for clinical staff. The feedback from staff attending this training has been positive however the staff have identified a further need for skills training in relation to therapeutic interventions. At present the Trust does not provide this aspect of training. Therefore it is suggested that the Trust takes the earliest opportunity to consider how training in practical suicide prevention interventions may be developed.

The Trust continues to work in partnership across the local health and social care economy. The Trust representatives contribute to the Staffordshire and Stoke-on-Trent Suicide Prevention group and action plan where the aim is to reduce suicides across the whole of the county.

Table 2 below illustrates Serious Incidents by team for the period April 2017 to March 2018.

Table 2

Access Team	3
Access/EDT	1
Acute Home Treatment	1
AHTT/Greenfield Centre	1
AHTT/Lymebrook	1
Ashcombe Centre	1
Ashcombe Centre/One Recovery	1
Assessment & Treatment	2
CDAS	6*
CJMHT	2
Criminal Justice MH Team	1
Darwin Centre	1

Early Intervention	1
Greenfield Centre	2
Healthy Minds/Access Team	1
ICMHT Brandon Centre	1
IOU, Edward Myers Centre	1
Lymebrook MHRC	1
One Recovery	2
One Recovery Burton	4
One Recovery Leek	2
One Recovery Newcastle	5
One Recovery Stafford	1
Outreach Team	1
RAID	1
Resettlement & Review	2
Stoke Substance Misuse	3
Sutherland Centre	5
Ward 2, Harplands Hospital	4
Ward 2/CDAS	1
Ward 3, Harplands Hospital	2
Ward 4 Harplands Hospital	1
Ward 4, Harplands Hospital	6
Ward 5, Harplands Hospital	2
Ward 6, Harplands Hospital	3
Grand Total	**73**

*Stoke Community Drug and Alcohol services (CDAS) is not a full year figure as this service did not commence until June 2017.

Table 3 below is an extract from table 2 and shows the number of serious incidents involving people known to Substance Misuse Services

Table 3

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	total
One Recovery East (Burton)		2		1	1					1		1	6
One Recovery North (Newcastle)				1					2	1		1	5
One Recovery North (Leek)				2									2
One Recovery (Stafford)										1			1
Stoke CDAS						2		1	3	2			8
Grand total		2		4	1	2		1	5	5		2	22

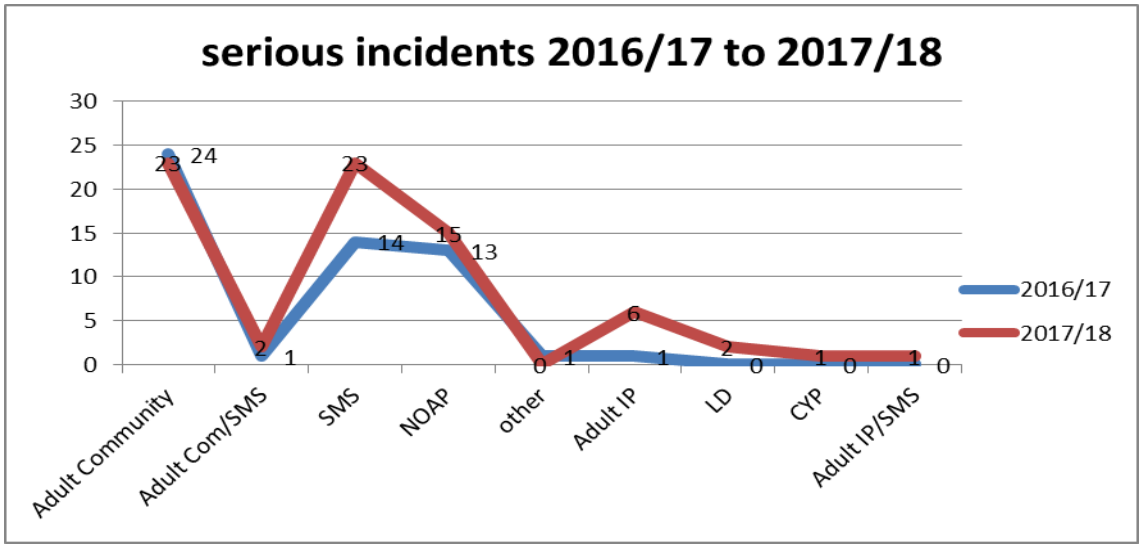
The Trust began delivering community substance misuse services in Stoke-on-Trent in June 2017 following the commissioning of Stoke Community Drug and Alcohol Services (CDAS). At year end, the number of deaths of people known to CDAS accounts for 36% of all deaths in substance misuse services.

The number of deaths reported for people known to One Recovery Services remains largely unchanged, with the deaths of 13 people in 2016/17 and 14 in 2017/18. Although there were significant changes to service delivery due to budget cuts in 2017/18, the full impact of these changes is not yet fully known. The Trust Substance Misuse services are holding a service SI analysis away day in June 2018 in order to review the findings of recent SIs and to explore the impact of changes to the service.

3. Themes and Trends

Graph 1 below shows the number of Serious Incidents reported monthly by directorate for 2016/17 and 2017/18.

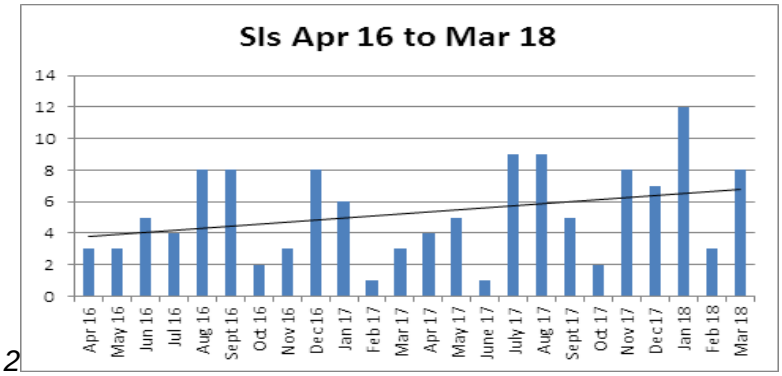
Graph 1



The Adult Community directorate reported the largest number of serious incidents. However there was no change in the total number of incidents by this directorate over the last 2 years, with 25 incidents reported in 2016/17 and again in 2017/18. Issues relating to the care of people with a dual diagnosis featured in a number of SI investigation reports. The reports into these incidents concluded that in these cases substance misuse tended not to be a problem of addiction but of binge and occasional use, which resulted in unpredictable and chaotic behaviours, including self-harm. However the need for improved communication between mental health and substance misuse services was identified by the directorate and incorporated into ongoing action plans.

Graph 2 below shows SIs per month for the period April 2016 to March 2018 with the trend line showing an increasing trend line. This is due to an increase in SIs in 2017/18.

Graph 2



4. Learning from Serious Incidents

Recommendations and learning from investigations are disseminated on completion of the SI investigation. However the Patient and Organisational Safety Team and the directorates ensure that any learning identified that requires immediate attention is shared with teams before the final reports are available. Throughout the year there have been a number of reports where no recommendations for practice were identified.

- Examples of the learning and actions taken in response to outcomes of investigations are outlined below: There were a number of recommendations around the theme of improving communication: areas for improvement included internal team-to-team communication and externally to other agencies. Actions taken included issuing a practice note and holding a Learning Lessons session. This session was used to explore how lapses in communication prevent up-to-date or accurate information reaching clinicians in a timely manner and therefore have the potential to impact on service delivery.
- Improvements in recording information also featured in several investigations. Clinicians were challenged around improving the recording of information in relation to risk assessments, care plans and mental capacity assessments. Care planning and risk assessment training sessions were developed and implemented and the outcomes of these actions are being monitored through the safety matrix audits, case supervision and management processes.
- A SOP was issued to the Access and Home Treatment Teams to strengthen their use of the Threshold Assessment Grid (TAG). This tool assists practitioners to provide evidence of their decision making when considering the next steps in care provision i.e. ongoing treatment or discontinuation of treatment. This is also being monitored through case supervision, reflective feedback sessions and practice observations.
- Prior to the introduction of the Meriden tool in the community teams, a number of serious incident investigations had revealed issues in the management of new referrals in relation to the allocation of care coordinators. Since the introduction of the tool and the use of robust caseload management there have been no serious incidents involving the non-allocation of new referrals.
- Several investigations demonstrated 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 importance of ensuring family/carer engagement. Discussions took place regarding the need to ensure that all parties (staff/service users and families) have clear and agreed understanding and expectations around the care to be provided during and
- post discharge.
- Improved knowledge around dual diagnosis remains an issue for some teams. This has been addressed through the development of substance misuse champions in some teams and the Trust held a listening event in October 2017, which aimed to support staff learning and development in dual diagnosis
- An increase in the number of incidents involving slips, trips and falls resulted in the Director of Nursing taking forward a falls rapid improvement group to explore the issues around the increase in falls and to ensure that the Trust processes were robustly implemented. The group reviewed and updated the falls policy and developed a new multifactorial risk assessment which was uploaded into Lorenzo as part of the overall falls risk assessment. In conjunction with the Advancing Quality Alliance (AQuA), the NOAP wards worked on a quality improvement project which aimed to reduce the number of falls experienced by inpatients in these areas. This project developed a number of initiatives aimed at improving patient independence with regards to mobility, strength and balance.
- Due to the number of incidents involving the management of MHA documentation, a checklist has been introduced, to be used at ward level and incorporated into the Inpatient Safety Matrix for auditing purposes however it is anticipated that additional measures will be determined once all the investigations are completed.

5. Conclusion

- The trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- There has been an increase in incidents relating to compliance with the Mental Health Act during this reporting timeframe. These reports and the findings of the 3 incidents reported between August 2017 and December 2017 will form the basis of an overarching action plan to address issues identified.
- The number of falls related SIs has reduced in this quarter. The quality improvement work for falls prevention is ongoing and the number and impact of all falls will be monitored by the NOAP senior clinicians and the patient safety team.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:9

Date of Meeting:	21st June 2018		
Title of Report:	Quality Account 2017/18		
Presented by:	Laurie Wrench, Associate Director of Governance		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Buki Adeyemo / Maria Nelligan	Approved by Exec	☒

Executive Summary:		Purpose of report	
The Quality Account is produced each year to provide assurance to the public and stakeholders on the arrangements for quality within the Trust. The QA is in draft form and is out for consultation with key stakeholders.		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	Legal requirement to publish a Quality Account by 30th June each year		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Trust Board is asked to give final approval to the content of the 2017/18 Quality Account noting that the final design will reflect the design of the annual report.		

North Staffordshire Combined Healthcare NHS Trust

Quality Account 2017/18

Contents

Message from the Chair and Chief Executive

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

Care Quality Commission

In February, we were really pleased that the Care Quality Commission rated every Combined Service as "Good" or "Outstanding".

The results mean that at the time of publication, Combined Healthcare was the highest rated mental health trust across the Midlands and East of England, and third highest in the whole country.

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

To be able to continue to improve upon last year's fantastic results is something quite remarkable. It is a tribute to the continuing sheer determination, talent, dedication and ability of our fantastic staff.

Particularly impressive was the improvement of our Community CAMHS services who in our first inspection were rated Inadequate and now have all five domains rated as Good. Our Adult Rehab services joined our Older Peoples Community services who are now rated as Outstanding.

But we are not complacent and our journey of improvement is continuing supported by our Towards Outstanding Engagement programme. We will be continuing our quality strategy to deliver Safe, Personalised, Accessible and Recovery focused services based on integrated locality working across North Staffordshire and Stoke-on-Trent.

We are also proud that we have been chosen by the CQC as a mental health exemplar and have been asked to share our journey of improvement with other organisations.

Our key achievements

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

- ✓ 91% of staff in NHS staff survey believe the organisation provides equal opportunities for career progression or promotion
- ✓ Finalist in no less than four 2018 HSJ Value Awards - including 2 out of only five finalists in mental health category
- ✓ Significant improvement in CAMHS waiting times - Two thirds of children and young people are seen for a first assessment within four weeks - no child waits more than

18 weeks, 97% of children and young people start their course of treatment within 18 weeks

- ✓ Among the very best performers in the country in Patient Led Assessment of the Care Environment (PLACE) results. Each of the six Trust sites inspected achieved 100% perfect scores in one or more areas.

- ✓ First mental health Trust in the country to host NHS Chief Executive Simon Stevens and the national NHS Executive Team for their Regional Meeting

- ✓ 19 consecutive years of financial balance

- ✓ Working closely with Keele University, achieving the highest conversion rates to psychiatry training of any medical school in England

- ✓ Average length of stay for new learning disability admissions cut by 60%.

- ✓ Proud to be able to be called a Keele University Teaching Trust

- ✓ Meir Partnership Care Hub winner of National Positive Practice in Mental Health Collaboration - a user led multi agency collaborative of 75 organisations, including NHS trusts, clinical commissioning groups, the police, third sector providers, frontline charities and service user groups.

Our key priorities

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

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

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

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

We hope you enjoy reading our Quality Account.

Introduction

Welcome to our trust.

North Staffordshire, Combined Health Care, NHS trust was established in 1994 and provides mental health and learning disability care to people predominantly living in the city of Stoke-On-Trent and in North Staffordshire.

We provide services to people of all ages with a wide range of mental health and learning disability needs. Sometimes our service users need to spend time in hospital, but much more often, we are able to provide care in outpatients, community resource settings and in people's own homes.

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

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

Our team of 1286 whole time equivalent (WTE) staff are committed to providing high standards of quality and safe services. We service a population of approximately 464,000 people from a variety of diverse communities across Northern Staffordshire.

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

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

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

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

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

Welcome to our Quality Account

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

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

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

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

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

Services Covered by this Account

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

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

1. Statement on Quality

1.1 Our Vision, Values and Objectives

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

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

Our Vision: 'To be outstanding'

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

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

Our values are:

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

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

Quality priorities

We are committed to providing the highest quality and safe mental health services. Safety and quality drive our agenda. Integral to this is our emphasis on four key quality priorities defined by the Board and embedded across the organization known as ‘SPAR’:

- Our services will be consistently **safe**
- Our care will be **personalised** to the individual needs of our service users
- Our processes and structures will guarantee **access** for service users and their carers
- Our focus will be on the **recovery** needs of those with mental illness

1.2 Trust Care Quality Commission

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

The CQC confirmed that the trust is the best rated mental health trust across the whole of the Midlands and East and the third highest in the whole country - only 1 of 3 with every core service rated at least ‘good’ and at least two core service rated as ‘outstanding.’

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

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

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

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

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

CQC highlighted several areas of ‘Outstanding’ practice including:

- **Acute Inpatient wards** cohesive and knowledgeable multidisciplinary team and the instigation of the acute care pathway ensured that a wide range of activities, therapies and interventions were available to actively engage patients and carers, which reduced the amount of time patients needed to stay in hospital.

- **Rehabilitation Inpatient units** introduction of a support time and recovery worker who normally worked within a community team to the units has enhanced the community programme offered to patients.

- **Adult Community Mental Health Services** - The early intervention team had worked with service users to develop a specific dual diagnosis pathway for people who used drugs and alcohol and experienced psychosis. They had developed a set of ‘change cards’ to assess where people were in the cycle of change so that they could assess the most suitable interventions for patients.

- **Specialist CAMHS Community Services** - the service recently launched a new mental health and wellbeing strategy in schools across Stoke-on-Trent.

- **Inpatient Wards for Older People** - The service manager had led on a project to identify causes of delayed transfers of care from the service alongside commissioners, local authority and NHS partners. An action plan had been in put in place that had reduced the numbers of patients delayed in their discharge. They had also linked local actions into a broader local health and social care effort to improve the care experience of older adults throughout Stoke and North Staffordshire.

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

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

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

The Trust is also proud to have been chosen by the CQC as a national mental health exemplar and is delighted to have the opportunity to share our journey of improvement with other organisations.

All core services have comprehensive improvement plans in place to address the areas noted in the CQC reports and to date significant progress has been made with many of the ‘must’ and ‘should’ do requirements being addressed and rated as ‘complete’ following a robust assurance process through our performance management arrangements.

Summary Rating Table:

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

Detailed Rating Table:

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

1.3 Quality of Services- Key achievements at a glance

Quality of Care

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

Under 'Safe' we have:

- ✓ In the 2017 CQC inspection all core services were rated as 'good' or 'outstanding'. Furthermore all 'must do' and 'should do' requirements from CQC from 2016 have been addressed. Additionally all core services have comprehensive improvement plans in place to address the areas identified in the 2017 CQC inspection and to date significant progress has been made with many of the 'must do' and 'should do' requirements being addressed and rated as complete. We will continue this robust assurance process through our performance management arrangements.
- ✓ In terms of improved physical health monitoring, clinical staff received physical health training including recognition of the deteriorating patient in relation to the onset of sepsis. The National Early Warning Scoring (NEWS) tool has also been implemented. Following these initiatives there has been a reduction in our inpatients being transferred to the local acute hospital.
- ✓ Commenced our journey towards being a smoke free organisation with in-patient areas going smoke-free from April 2018.
- ✓ For the second year running the flu vaccination campaign achieved the national target of at least 70% frontline staff receiving the vaccination.
- ✓ A rapid falls reduction programme was introduced and the policy, practice and training were all reviewed and updated to minimise avoidable falls. Avoidable falls have decreased as has harm from avoidable and unavoidable falls.
- ✓ Compliance with physical health monitoring and recording post rapid tranquilisation is monitored through monthly review of incidents and subsequent completion of physical health monitoring; the Inpatient Safety Matrix demonstrated 100% compliance in Q4
- ✓ The Trust Suicide Prevention Strategy was implemented during 2017/18. As part of this strategy we have worked in collaboration with Public Health with the aim of reducing suicides in the local area.
- ✓ Continued to facilitate the 'living well with risk group' to embed the Suicide Prevention strategy and ensure involvement of people with lived experience.
- ✓ Embedded unannounced assurance visits to in-patient wards with quarterly reporting to the Quality Committee and Trust Board.
- ✓ Agreed a plan for further investment in environmental ligature improvements in accordance with 2016/19 plan.
- ✓ We have introduced an acute care pathway on our adult inpatient wards the impact of which has seen a reduction in the length of stay
- ✓ Implementation of an assurance framework and strategy for Infection Prevention & Control (IPC) which is evaluated a minimum of bi-monthly. This forms part of the governance around IPC with quarterly and annual IPC reports.
- ✓ Additionally, falls prevalence and categorisation is reviewed a minimum of weekly. During 2017/18 there has been an intense Quality Improvement (QI) programme which has shown

rapid improvement in multi factorial risks assessments and care planning. This is supported by the multi-disciplinary team and our on-going commitment to Quality Improvement.

Under 'Personalised' we have:

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

Under 'Accessible' we have:

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

Under 'Recovery Focussed' we have:

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

1.4 Building Capacity and Capability.

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

The Board has a wide range of experience and skills to provide effective leadership. As part of our Board Development Programme we have undertaken a Board skills assessment and are currently reviewing the findings noting areas of strength and where there may be potential gaps in skill.

Our continuous cycle of board development acts as an opportunity for ongoing organisational development. A core component of the development programme is to ensure that all board members have a focus of continual improvement in order to deliver the highest quality, safe services for our community, within resources available. During 2017/18, the Trust strengthened its approach to Board Development, participating in the Advancing Quality Alliance programme (AQuA) and linking this through to leadership and quality development across the wider Trust through the Leadership Academy.

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

1.5 Workforce

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

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

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

We focus on:

Cultural Development

Towards Outstanding Engagement:

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

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

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

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

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

Health and Wellbeing:

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

the introduction of a Physio fast track service and Pilates sessions which staff are invited to attend.

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

Leading with Compassion:

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

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

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

Diversity & Inclusion:

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

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

- April 2017: Trust appointed as an NHS Employers Diversity and Inclusion Partners Programme Diversity Champion
- May 2017: We held our first Trust LGBT (Lesbian, Gay, Bi and Trans) Focus Groups for service users and staff facilitated by Abby Crawford from Stonewall and were also presented with an award from Deafvibe for the work of the Trust's Deaf Awareness Group in raising awareness, and developing access and experience for service users who are deaf or hearing impaired.
- May 2017: the Trust established links with the local Stoke Sikh Gurdwara and was presented with an award at the Vaisakhi celebrations; this has led to continued collaboration and partnership working throughout the year
- June 2017: We held our highly acclaimed Staffordshire Symphony of Hidden Voices inclusion conference that aimed to 'show not tell' people what inclusion is through the power of personal stories
- July 2017: The Trust's Diversity and Inclusion Group were runners up in the Trust REACH Awards for the Team of the Year Award

- September 2017: Trust spirituality garden opened with daily access for service users, carers, other visitors and staff – thanks to a generous grant of £12,000 from the Tesco Bags of Help fund.
- October 2017: We launched our Trust BAME Staff Network, led by Cherelle Laryea, Trainee Clinical Psychologist and held 'Afternoon Tea with the Director of Nursing' sessions held for BAME staff
- December 2017: Trust awarded £50,000 funding to deliver a Staffordshire NHS BAME Leadership Programme (programme will be delivered in 2018-19)
- February 2018: Trust established links with Stoke Central Mosque and agreement to work in collaboration going forwards and praised by the local Commissioning Support Unit (CSU) for the work the Trust has done in developing diversity and inclusion

Proactive stress management and resilience approach:

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

Leadership and management development:

Our People Management Programme is a modular scheme that develops our managers and aspiring managers in multiple aspects of their management competency. This programme has been extended to include new subject areas to support our managers and aspiring managers.

We have continued to work with our leaders through our Leadership Academy with the programme of events focussing on key strategic topics that are aligned to our Board Development Programme.

Recruitment and Retention:

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

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

Learning Management:

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

Apprenticeships and New Roles:

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

Staff Awards:

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

Listening to Staff:

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

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

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

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

1.6 Quality of services - key priorities 2018-2019

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

We will commit to building on our quality systems and learning from CQC inspections to ensure a continuous programme of improvement.

Following October's CQC inspection we have continued to review areas for improvement through the on-going development of comprehensive action plans and will work in partnership with the CQC, service users, carers and other key stakeholders to implement and sustain improvements.

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

- Our services will be consistently **S**AFE
- Our care will be **P**ERSONALISED to the individual needs of our service users
- Our processes and structures will guarantee **A**CCESS for service users and their carers
- Our focus will be on the **R**ECOVERY needs of those with mental health illnesses.

In summary our quality priorities for 2018/19 include:

Safe:

- Dual Diagnosis pathway
- Zero Suicide ambition
- Improve physical health by being a smoke-free Trust (year 2 of 2)
- 100% achievement of CQUIN schemes
- Transition between services
- SPAR wards accreditation framework
- Continued investment in environmental ligature improvements
- Auditing Sepsis compliance
- Falls prevention
- Flu vaccination campaign
- Improved medicines management
- Community Safety Matrix
- PLACE programme
- Audit prone restraint and benchmark nationally

Personalised:

- Implement Person Centredness Framework

- Implement restraint reduction strategy
- Patient control to access their own electronic patient record
- Mental Health Law
- Therapeutic observation Quality Improvement project

Accessible:

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

Recovery Focussed:

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

Further details are within Section 2.2

1.7 Trust Statement

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

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

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

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

Table of signatories of trust board members to be added.

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

Keith Tattum, GP Associate		21st June 2018
Wendy Dutton, Chair of Service User and Carer Council		21st June 2018

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

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

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

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

The directors confirm that, to the best of their knowledge and belief, they have complied with the above requirements in preparing the Quality Account

Caroline and David signature here

David Rogers	Caroline Donovan
Chair	Chief Executive

2.0 Priorities for improvement (looking forward) and statements of assurance from the board.

Plans for Improvement:

Engaging our partners and stakeholders

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

Performance Quality Monitoring Framework

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

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

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

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

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

2.2 Priorities for improvement and goals agreed with commissioners.

Key priorities for improvement

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

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

- Our services will be consistently **S**AFE
- Our care will be **P**ERSONALISED to the individual needs of our service users
- Our processes and structures will guarantee **A**CCESS for service users and their carers
- Our focus will be on the **R**ECOVERY needs of those with mental health illnesses.

Progress monitoring:

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

Key quality priorities for 2018/19:

Safe:

- Develop and implement a Trustwide standard operating procedure that reflects the needs of service users with Dual Diagnosis
- Collaborate with partners to reduce death by suicide within the Trust as part of our Zero Suicide ambition and as part of a countywide strategy
- Improve physical health by being a smoke-free Trust (year 2 of 2)
- Improve physical health monitoring for service users
- 100% achievement of CQUIN schemes
- Transition between services
- Implement SPAR wards accreditation framework to enhance the quality of care on in-patient wards
- Continue investment in environmental ligature improvements
- Continue to audit sepsis compliance against national standards
- Audit of falls to evidence reduction in avoidable falls following quality improvement programme
- Increase compliance with IPC audits from 85% to 90%

- Implement a Flu vaccination campaign with a target of 75%
- Improve medicines management including achieving 100% compliance with daily fridge temperature monitoring and correct labelling of topical medications
- Implement a standardised approach to safety through the Community Safety Matrix
- Maintain safer staffing in line with NQB and continue with 24/7 teams and introduce community teams
- Continue to implement PLACE programme and develop a strategy to be in the top performing quartile of trusts nationally
- Audit prone restraint and benchmark nationally

Personalised:

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

Accessible:

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

Recovery Focussed:

- Implement both a virtual and physical wellbeing academy to complement traditional rehabilitation approaches by providing people with education and learning experiences as a means of supporting personal and social recovery

- Develop and implement a Trustwide strategy to embed peer mentor, volunteers and employment opportunities for people with lived experience (develop at least 10 peer mentors)
- Identify quality priorities for 2019/20 in partnership with the SUCC who will collaborate in improvement initiatives
- Develop and implement a Towards Outstanding service user environments programme in collaboration with SUCC
- Implement unannounced assurance visits to Community Teams with priorities based on risk

2.3 Statement of Assurance from the Board

How progress will be measured and monitored

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

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

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

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

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

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

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

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

Payment by Results:

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

Measuring clinical performance

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

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

National Projects and Initiatives

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

Quality governance assurance framework

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

Litigation cases for 2017/18

The numbers have remained static for non-clinical claims received for 2017/18 with only two being registered for employee liability.

The expenditure on non-clinical claims has seen a 52% reduction from the previous year. The Trust has been able to successfully defend claims where we have been able to provide evidence that policies and procedures have been followed. We continue to work closely with NHS Resolution to use the intelligence learnt from these cases thereby ensuring quality improvements.

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

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

Learning lessons

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

2.4 Review of services

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

During the period from 1st April 2017 to the 31st of March 2018 North Staffordshire Combined Healthcare NHS trust provided eight NHS services. The trust has reviewed all the data available on the quality of care in all of the NHS services provided by the trust.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of the NHS services by North Staffordshire Combined Healthcare NHS Trusts for 2017/18.

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

22.5 Participation in Clinical Audit.

'Clinical audit is a quality improvement process that seeks to improve patient care and outcomes against specific criteria and the implementation of change.

Where indicated, changes are implemented at an individual team, or service level and further monitoring is used to confirm improvement in healthcare delivery. As such, clinical audit is an essential part of the quality assessment framework and a key element of clinical governance.'

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

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

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

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

TITLE	% of cases submitted	% of cases required to be submitted
Prescribing Observatory for Mental Health (POMH): prescribing topics in mental health services:		
• Prescribing valproate for bipolar disorder (topic 15b)	100%	100%[1]
• Use of depot / long-acting injections for relapse prevention (topic 17a)	12% NA – Data collection ongoing	100%[1] 100%[1]
• Rapid tranquillisation (topic 16b)	100%	100%[1]

National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	100%*	100%
• Early Intervention in Psychosis • National Clinical Audit of Psychosis • Young People's Mental Health (National Confidential Enquiry into Patient	100% 100% of required sample 100%	100% 100% of required sample 100%

** This data is collected centrally on a rolling basis as part of the NCI process*

[1] *Please note that for POMH audits there is no minimum requirement of cases to be submitted.*

For Topic 17a an adequate sample size was obtained without the need to submit 100% of cases relevant to the sample population, therefore the Trust still met the 100% requirement for POMH.

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

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

POMH 16a: Rapid tranquilisation	**Action completed**
• It was noted that due to ward round timings and weekends it may not be feasible for debrief to take place within 24 hours. To review with the Medical Director to agree whether 72 hours is an appropriate timeframe for debrief to take place.	✓
• Results to be fed back to Ward Managers for cascade to staff.	✓
• To discuss the possibility of providing injectable drugs training as part of the in-depth physical health training programme via the Physical Health meeting	✓
• Pharmacists will continue to highlight at-risk patients via prescription charts and to support the use of the HDAT monitoring form.	Ongoing

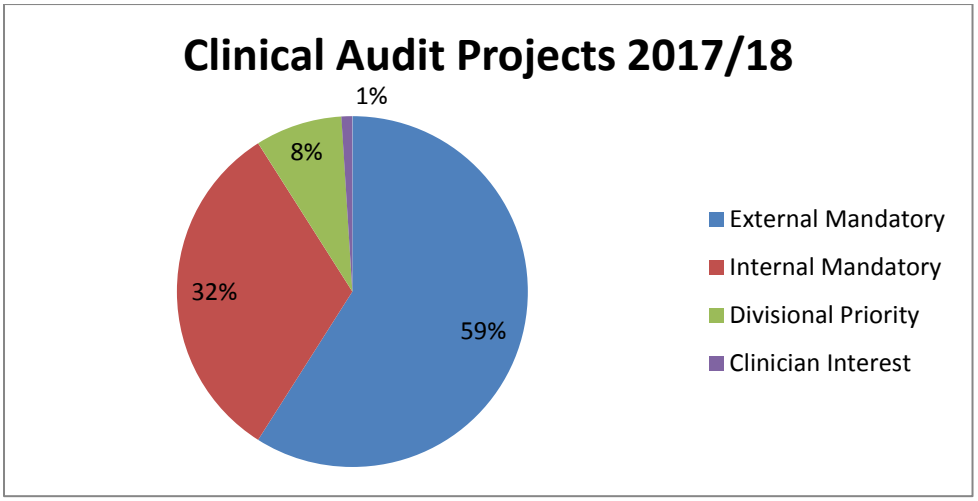
• To highlight areas where the HDAT monitoring form is not completed on a systematic basis via the Clinical Effectiveness Group for further action.	Ongoing
• To present the results as part of one of the trust's educational sessions, including: - The difference between maximum doses of IM and oral haloperidol - The importance of completing the HDAT monitoring tool - That intramuscular haloperidol should not be used as part of rapid tranquilisation in the absence of a recent ECG. - Recording of physical observations and cases where patients decline physical observations via the NEWS chart.	✓

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

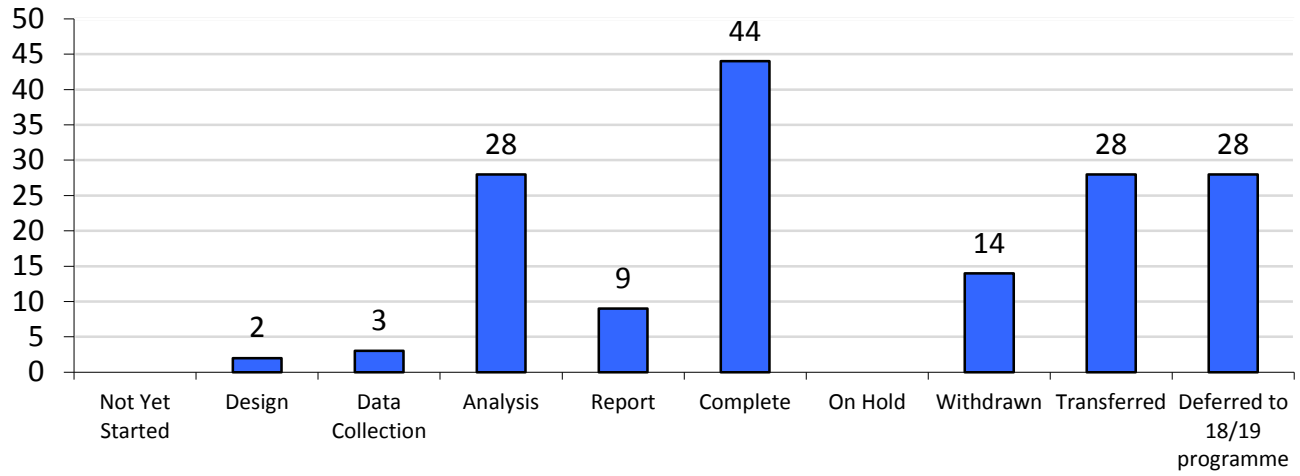
Local clinical audit programme 2017/18

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

The following chart reflects the total number of projects identified for 2017/18 split by the four priority areas:



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



Clinical Audit Programme 2017/18

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

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

2.6 Participation in Research

During 2017/18 the Research and Development (R&D) team has continued to contribute to NHS national research through the delivery of high quality portfolio and commercial research. During 2017/18 the Trust faced a significant challenge with regards to recruitment to NIHR portfolio studies; our initial recruitment target was revised in month

5 and increased by over 200%. This challenge inspired staff to consider innovative ways to respond meet the target. We had a prize of hamper for the highest number of referrals received, weekly communications to wider staff about research referrals. Our final recruitment figure of participants in research approved by an ethics committee is 110 and is in excess of our original target.

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

We recognise that for many individuals research offers an opportunity to take a more active role in care and make an active contribution to the development of new knowledge while at the same time experiencing an enhanced quality of care. We firmly believe that service user involvement is crucial to high quality research, not just at the point of implementing a protocol but all through the study design process. During 2017/18 we have engaged directly with groups of service users and carers both within the trust and the local community. We have received positive feedback from service users regarding their experiences of being involved in research and are committed to increasing the opportunities that our service users and carers have for helping to shape the future of research within the trust.

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

Research engagement

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

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

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

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

initiated work to look at the roles and expectations of the directorate representatives.

Student Research

During 2017/18, the R&D team continued to support staff at Combined who were undertaking research as part of a higher educational qualification e.g. professional doctorate, masters etc.

Twenty three students received support, with 13 completing the research approvals process. Of the 23, 20 were undertaking professional doctorates, and 3 were undertaking a masters qualification. See Table 1 below for a breakdown by directorate, and Table 2 for a breakdown by participant type.

Table 1 – Student Research / Directorates

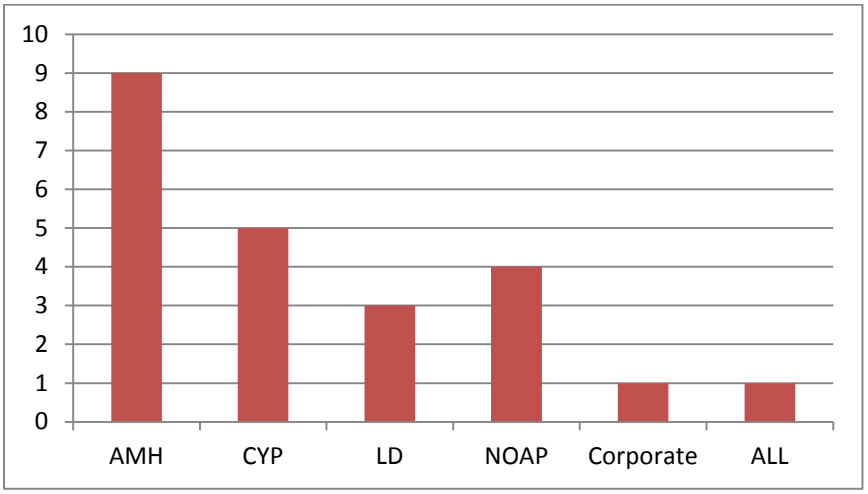
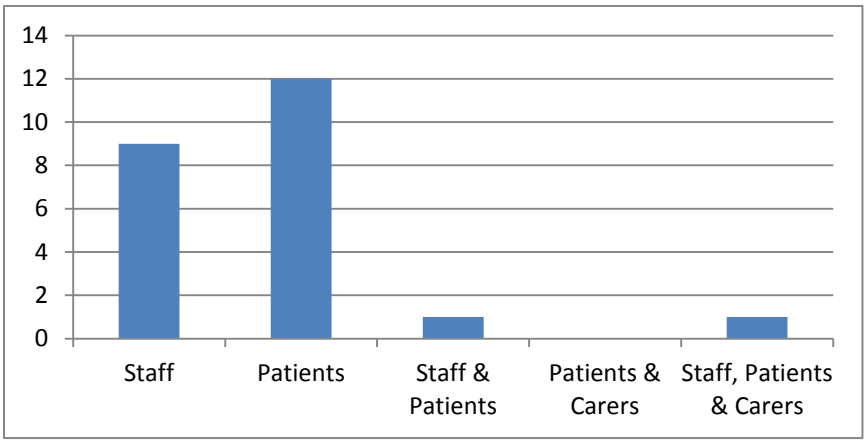


Table 2 – Student Research / Participant Type



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

The Trust have now signed a memorandum of understanding with Staffordshire University, and the R&D team hope to collaborate around support for students and streamlining of research approvals processes in the coming year.

Delivery of Clinical Trials of Medicinal Products (CTIMPS)

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

External Engagement

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

Key achievements during 2017/18

BeAble App Developments

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

Neurodegenerative Active Partnership (NOGAP) developments

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

2.7 Goals agreed with commissioners.

Commissioning for Quality and Innovation (CQUIN) Framework.

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

2.8 Statement from the Care Quality Commission.

Registration:

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

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

At the following locations:

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

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

CQC inspection:

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

CQC special reviews and investigations:

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

2.9 Statement on Data Quality

NHS Number and General Medical Practice Code Validity

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

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

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

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

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

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

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

Information Governance Toolkit attainment levels

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

External Clinical Coding Audit

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

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

The services reviewed in the sample were adult and older adult mental health, child & adolescent mental health and substance misuse.

The audit was undertaken by D&A Clinical Coding Consultancy Ltd, who are NHS Classifications Service approved auditors.

The Trust was commended for its excellent level of coding accuracy and commended on the strong commitment to coding. It was further noted that there is a strong clinical engagement across all specialties.

Relevance of data quality

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

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

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

Data Quality Metrics

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

Action to improve data quality

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

Other actions include:

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

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

Data Quality Forum - Data issue management

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

The Data Quality Forum comprises of representatives from corporate services and clinical directorates (data champions who take a leadership role in resolving data integrity issues). The Forum is responsible for data issue management and the process of reducing and removing the barriers that limit the effective use of data within the Trust. This includes identifying data quality issues, approving definitions, establishing quantification of issues, prioritizing data quality problems, tracking progress, and ultimately resolving the DQ issues.

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

The Data Quality Forum is concerned with policy development and compliance at the right level of granularity to make a difference. Reporting and monitoring are key components of data quality management. The Forum also ensures that staff are aware of their responsibilities surrounding excellent standards of data quality through continuous communication and promotion.

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

National Tools to support Data Quality

Data Quality Maturity Index (DQMI)

The DQMI is a quarterly publication intended to raise the profile and significance of data quality in the NHS by providing data submitters with timely and transparent information about their data quality.

The Trust’s DQMI was 97.4% in the latest published national data (September 2017).

3.0 Review of quality performance for 2017/18 (looking back) and statement from key partners

This section is in three parts:

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

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

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

3.1.1 Performance against 2017/18 key priorities

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

The following table identifies the CQUIN areas as identified

CQUIN area	Patient safety	Clinical Effectiveness	Patient Experience	Innovation	Achievement (%)	Financial value (£)
Staff Health and Well-being: (Initiatives 1a, b & c) Improvement of health and wellbeing of NHS staff, healthy food and drink for NHS staff, visitors and patients, and improving the uptake of flu vaccinations for frontline clinical staff.	✓			✓	**100%**	**£168,603**
Physical health 3a & b: Cardiometabolic assessment and treatment for patients with psychoses / Collaboration with primary care clinicians	✓	✓		✓	**96%**	**£168,604**
Improving Services for People who Present at A&E: Supporting people with a mental health need to reduce A&E attendances	✓	✓		✓	**100%**	**£168,603**
Transitions from CYPMHS to AMHS: Supporting young service users as they move from children's to adult services, or back into primary care	✓	✓	✓	✓	**97.5%**	**£168,603**
Preventing Ill Health by Risky behaviours: (Initiatives 9a, 9b, 9c, 9d and 9e)Improving the identification of inpatients who smoke or who drink above safe levels and ensuring that they receive appropriate interventions		✓			**81.5%**	**£168, 604**

Staff Health and Wellbeing: Improvement of health and wellbeing

SPAR priorities
Safe

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

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

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

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

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

SPAR priorities
Safe

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

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

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

What did we achieve?

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

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

SPAR priorities
Safe

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

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

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

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

Physical Health: Cardiometabolic assessment and treatment for people with psychoses

SPAR priorities
Safe

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

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

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

How did we monitor and report on progress?

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

What did we achieve?

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

Physical Health: Collaboration with Primary Care Clinicians

SPAR priorities

Safe, Personalised

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

Our goal

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

How did we monitor and report on progress?

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

What did we achieve?

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

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

SPAR priorities

Accessible; Personalised

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

Our goal

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

How did we monitor and report on progress?

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

What did we achieve?

Working together, NSCHT and UHNM have been able to demonstrate a reduction in attendances by the patients supported by this CQUIN of over 40%. This is a fantastic achievement and significantly exceeded the CQUIN requirement for a 20% reduction.

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

SPAR priorities

Accessible; Personalised

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

Our goal

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

How did we monitor and report on progress?

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

What did we achieve?

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

Preventing Ill Health by Risky Behaviour: Alcohol and tobacco

SPAR priorities
Personalised

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

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

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

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

3.1.2 Key Quality Priorities Achievements 2017/18

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

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

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

Priority: Improved physical health monitoring

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

Additionally we have achieved the following:

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

Priority: Implement our Suicide Prevention Strategy

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

Additionally we have:

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

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

Outcome: The Service User and Carer Council (SUCC) have engaged with the development of the Person Centredness Framework and we have representation

from service user and carer's across a range of trust business and activity; including interviewing new recruits, co-facilitating a wide range of events, attending various committees including People, Culture and Development, Quality, Finance, Performance and Digital and Business Development.

Additionally:

- The service user and engagement strategy has been refreshed in partnership with the SUCC.
- We have ensured that there is a service user and carer representative at the mental health sustainability and transformation plans (STP) board.
- There is service user and carer representation on our trust committees facilitated through the SUCC.
- Work has commenced in developing a network of peer support workers and peer support worker strategy is being developed.
- When preparing for the 2016/17 AGM, the finance team developed an animated video to present the accounts in a way that was easy to understand, which fully supported staff and service users to understand how we spend our money to deliver the best patient care. Many viewers said it was the first year they genuinely understood the numbers.
- To support personal and social recovery we have progressed the development of a well-being academy (recovery college) with plans in place for a virtual and physical resource.

Priority: Review of models of care and care pathways.

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

Additionally:

- We have introduced an acute care pathway on our adult inpatient wards
- A psychiatric intensive care unit (PICU) has been built and we are currently recruiting the staff team with a view to opening the unit in summer of 2018.

Outcomes from additional objectives for 2017/18:

Under Safe we have:

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

Agreed a plan for further investment in environmental ligature improvements in accordance with 2016/19 plan.

Under Personalised we have:

Agreed a contract for the extension of the FLO and autographed innovation to develop a self-managed integrated care pathway for dementia patients. This work is now being taken forward.

Implemented the diversity and inclusion plan and Workforce Race Equality Standard (WRES) awareness sessions have been delivered with staff, Board and Leadership Academy involvement. This work will continue during 2018/19.

Worked with Helen Sanderson Associates, our service users, carers and staff to develop a Person Centredness Framework; the overarching principles have been agreed and the framework will be implemented in 2018/19.

Under Accessible we have:

Achieved 92% compliance with national waiting times targets and 18 week waits for definitive treatment for all services.

Worked in collaboration with primary care and the University Hospital of North Midlands (UHNM) to become more accessible to patients through the use of video consultation in the Neuropsychiatry and Older Persons directorate. This will be carried forward in 2018/19 with pilots in 2 further directorates.

Progresses work through collaboration with the Service User and Carer Council and R&I Steering Group with a view to re-launching Dragons Den; this will be linked to the value-makers scheme. This will be carried forward in 2018/19.

Developed an allied health professional strategy which is proceeding through internal governance processes prior to implementation.

Worked with partners to develop an estates (building and land) optimisation strategy for North Staffordshire.

Under Recovery focussed we have:

Ensured recovery principles underpin our strategic priorities, policies, procedures, risk assessments and care plans.

Ensured care plans are completed with individuals and are wellbeing and recovery focussed.

Introduced and strengthened to develop evidence based psychological interventions in our adult acute wards.

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

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

The information is presented under the three main headings of:

- patient safety
- clinical effectiveness
- patient experience.

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

Patient safety

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

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

Cleanliness as assessed by the PLACE team 2017/18

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

Trust overall score	**99.61**%	**97.18** %	**96.33**%	**98.78**%	**93.63**%

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

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

Disability arrangements as assessed by the PLACE team 2017/18:

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

Incidents

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

The definitions of incidents used by the trust are listed below

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

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

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

Patient Safety Incident
The National Reporting and Learning System's definition for reportable incidents is as follows;

"A Patient Safety Incident (PSI) is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care".

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

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

	2015/16	2016/17	2017/18
General incidents	4,037	4,553	4330
Moderate	79	75	80
Major	6	3	9
Catastrophic	128	76	65
Total	4,250	4,750	4484
Incidents resulting in severe harm or death as a % of total	5.0%	3.2%	3.4%

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

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

Safety Improvement Initiatives

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

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

improvement methodology and to take forward QI projects.

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

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

The patient journey is often much wider than the services offered by Combined Healthcare and requires the need for our staff to be working in partnership across many health and social care agencies in order to provide the most appropriate care and support for the person at the right time. As part of this, the trust has worked with our partner agencies to promote good mental health and the reduction of stigma by participating in national events such as 'Brew Monday' with the Samaritans and the Parkinson's 'Get it on Time' campaign.

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

Area of performance	Incidents reported to the National Patient Safety Agency (NPSA)
Metric – method of calculating performance:	KPI Number of incidents reported to the National Patient Safety Agency
Performance:	There were 2,096 NRLS incidents reported during 2017/18 which is a slight reduction in the number of incidents reported from the previous year. As previously stated this was due to a small number of people with complex needs being responsible for a large number of incidents in 2016/17. Of these, the number of incidents resulting in severe harm or death (74) as a percentage of the total was 3.5%.

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

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

Never events

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

Serious incidents

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

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

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

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

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

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

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

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

External data and reports are shared with the monthly Clinical Quality Review Meeting chaired by Commissioners. Whilst the Directorates are members of the internal governance forums, the Directorate Governance Leads are also responsible for ensuring that service user safety is an agenda item at Directorate meetings.

Infection Prevention and Control

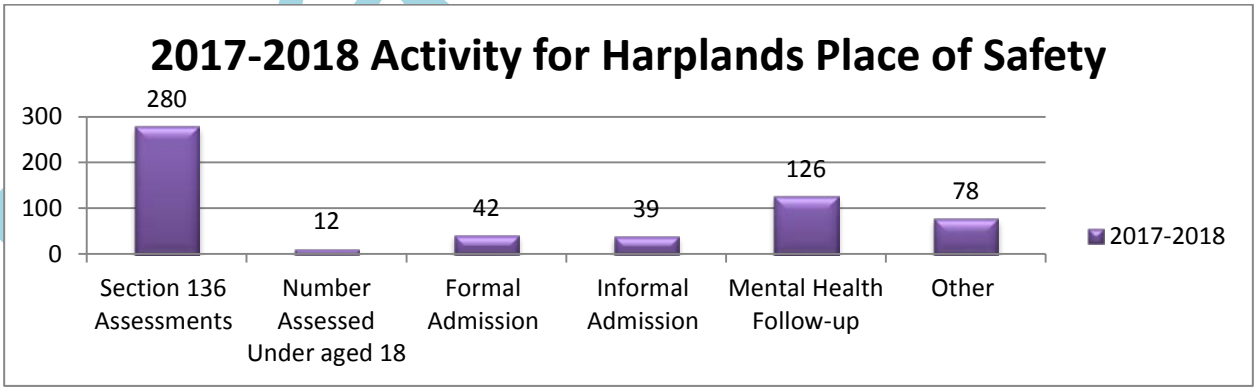
There have been no MRSA blood stream infections and no Methicillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections reported. MRSA screening compliance remains at 100% for all those admissions who fulfil the criteria for screening.

The Trust's target of zero avoidable HCAIs was therefore maintained.

Clinical effectiveness

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

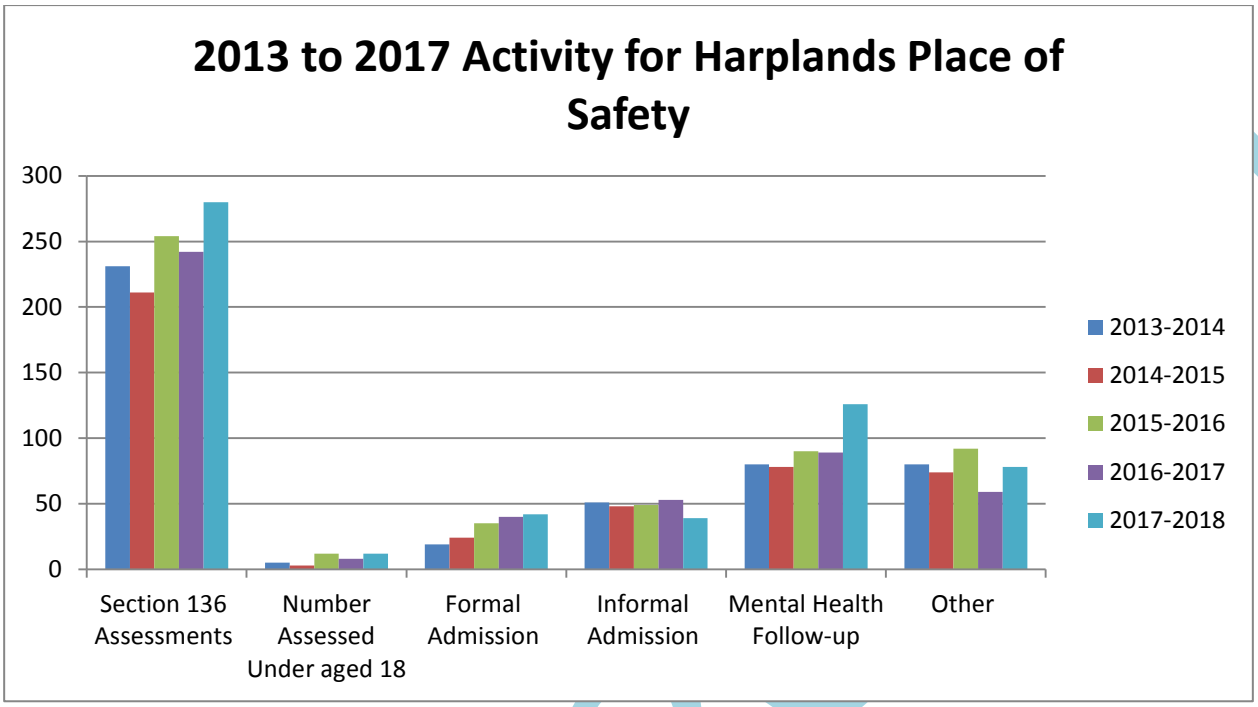
Number of Place of Safety assessments carried out under Section 136 of the Mental Health Act 2017/18



On occasions when the Harplands Place of Safety Suite is occupied, the Trust will seek to support the police to locate a vacant alternative health-based place of safety within Staffordshire to enable the completion of the assessment. The Police and Crime Act 2017 came into force on

11th December 2017 and where appropriate, Accident and Emergency Departments can be used as a health-based Place of Safety for completion of the assessment. No assessments have taken place in police custody since December 2017.

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



This data shows the outcome of the assessments completed at Harplands Hospital's place of safety, in terms of admission to hospital, and the number of cases where the person was under the age of 18 years, for the last five years

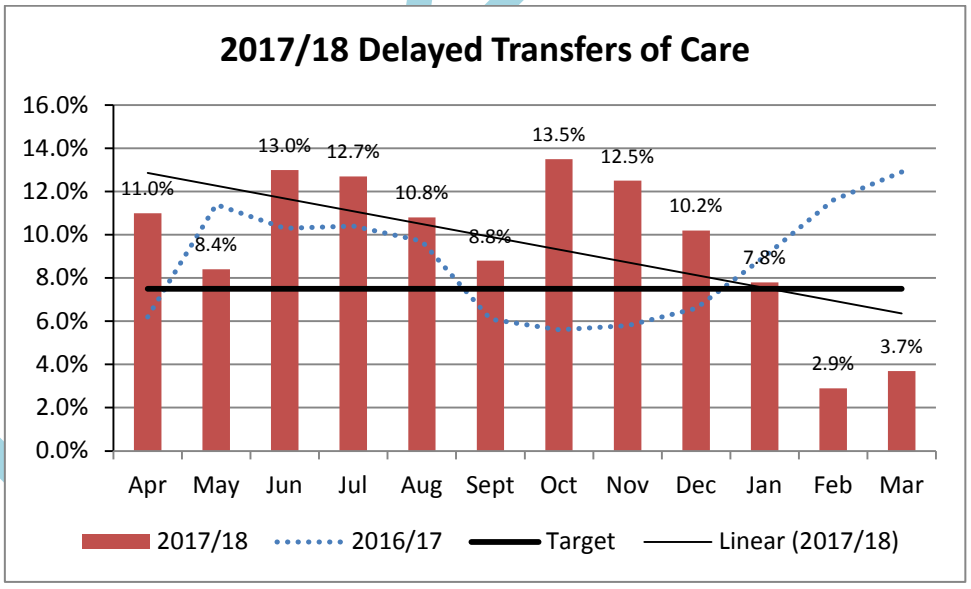
Area of performance	Delayed Transfers of Care
Metric – method of calculating performance:	**Delayed Transfers of Care**

Performance:

Overall, for 2017/18 the Trust's rate for delayed transfers of care is 9.6% for the year, against a target of less than 7.5%.

This reflects an increase from 5.76% reported for 2016/17 and is in line with the national position where there is an increase in whole system delays associated with high rates of bed occupancy and reduction in funding of social care that are resulting in extra pressures on the health economy. The Trust is in discussion with health and social care commissioners to ensure that every effort is made to ensure that service users are located in the most appropriate environment.

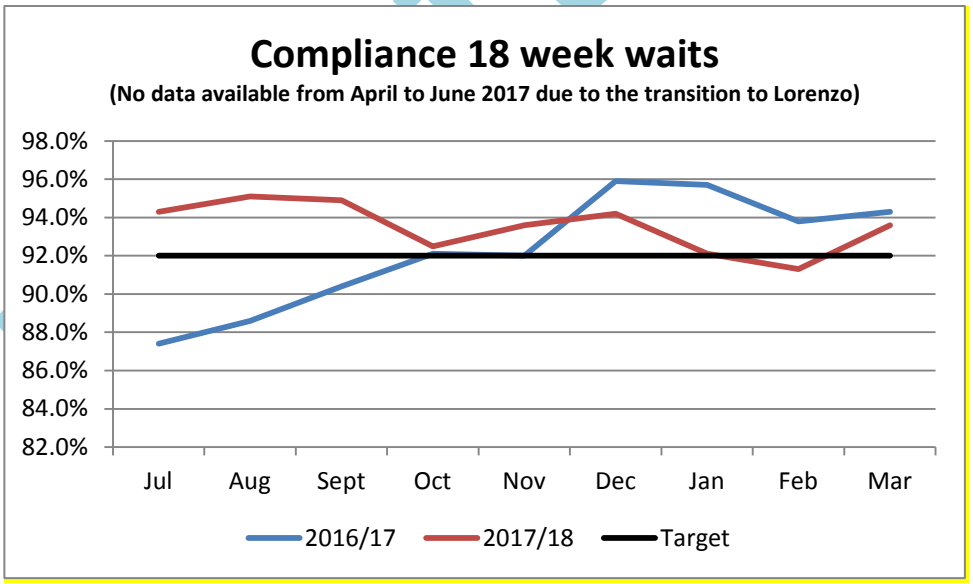
The Trust has been an early adopter of the RED and GREEN approach in mental Health. Developed by the Emergency Care Programme (ECIP), it focuses on eliminating patient time wasted in the pathway (Red days) and focussing on days which are of value to the patient (Green days. The Trust also worked with the A&E Delivery Board and has received support from partner agencies to improve processes, such as timely assessment and rapid approval to funding and progression on the Choice Protocol. The Trust will continue to focus on this as a quality priority for 2017/18.



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

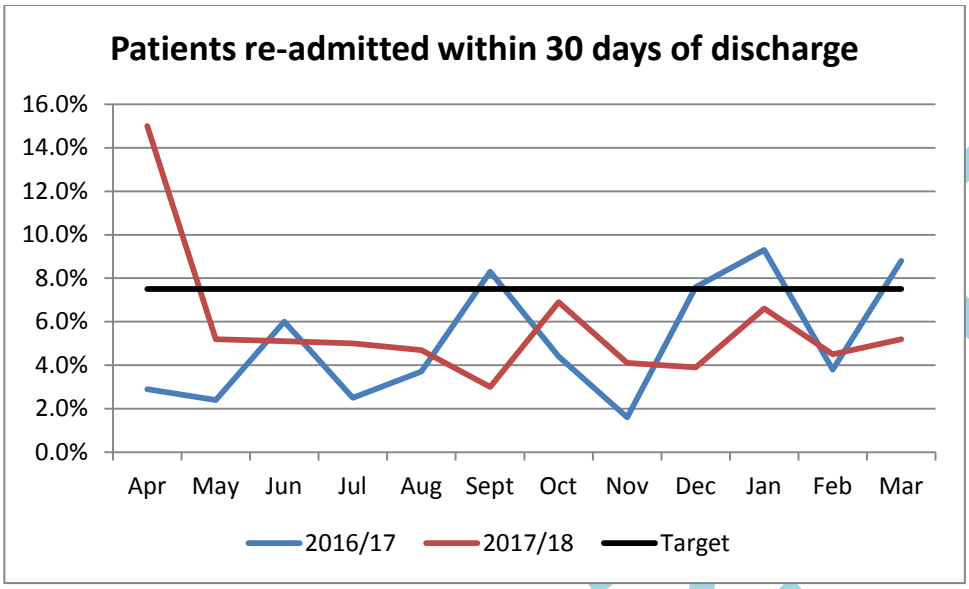
Area of Performance	Compliance 18 week waits
Metric – method of calculating performance:	18 week waiting time (Referral to Treatment)Target 92%
Performance:	Performance for 2017/18 is 92.5% at year end. The Trust monitors the waiting time from referral for all service users who have been waiting to ensure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

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	86.4%	87.2%	83.3%	87.4%	88.6%	90.4%	92.1%	92.0%	95.9%	95.7%	93.8%	94.3%
2017/18	93.5%	N/A	82.4%	94.3%	95.1%	94.9%	92.5%	93.6%	94.2%	92.1%	91.3%	93.6%



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

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



Area of performance	7 day follow up of Care Programme Approach (CPA) patients
Metric – method of calculating performance:	Follow up of CPA patients within seven days of discharge Target 95%

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

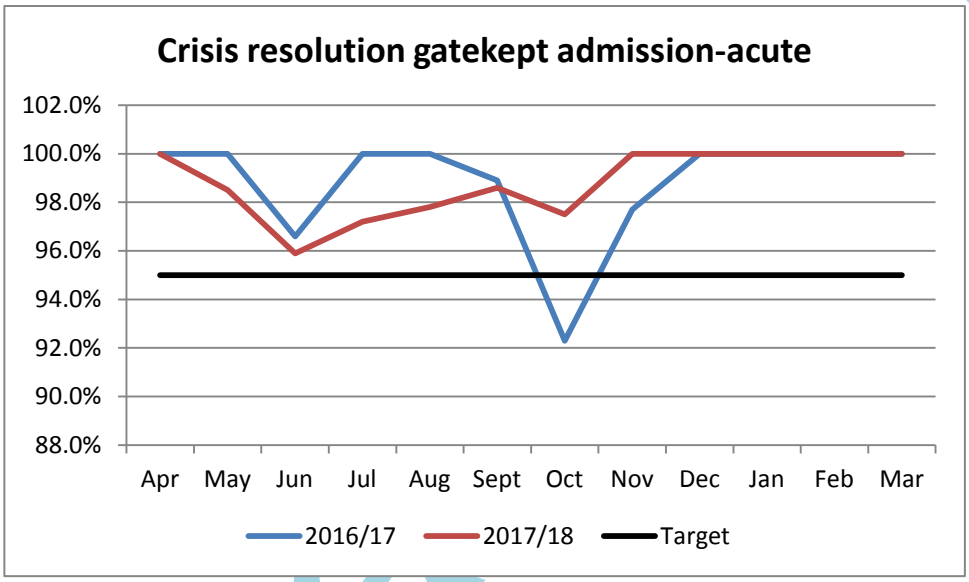
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	97.5%	96.8%	96.9%	97.9%	96.2%	97.9%	100%	92.3%	97.5%	95.8%	92.5%	91.0%
2017/18	100.0%	96.9%	94.1%	93.1%	86.7%	97.4%	92.9%	97.4%	90.9%	95.7%	93.9%	96.1%

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

Source: NHS England

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

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

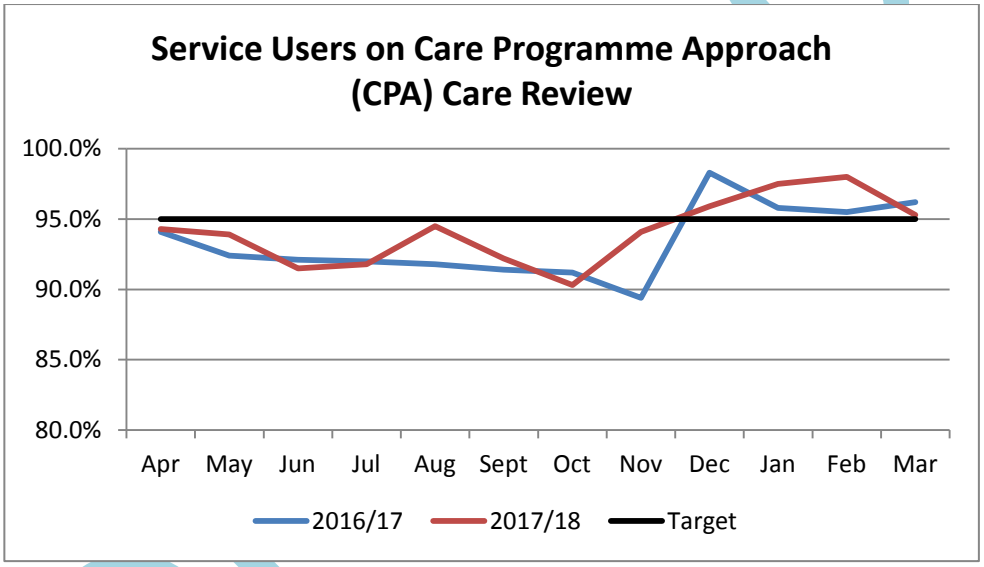


Most recent published benchmarking data:	Q4 2014/15 (%)	Q4 2015/16 (%)	Q4 2016/17 (%)	Q3 2017/18 (%)
Trust	99.0	99.5	100.0	100
National average	99.1	98.2	98.8	98.5
Highest	100	100	100	100
Lowest	59.5	84.3	90.0	90.0

Source: NHS England

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

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



Settled Accommodation and Employment

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

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

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

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	20.9%	20.3%	18.9%	17.3%	15.2%	13.1%	11.8%	14.7%	16.6%	17.0%	17.1%	17.9%

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

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	4.6%	4.4%	4.2%	3.6%	3.0%	2.7%	2.3%	2.1%	2.1%	1.9%	1.5%	1.3%

Staff Satisfaction

Towards Outstanding Engagement

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

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

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

- The average variance of engagement scores for teams going through cohort 1 shows an average increase of 5.7%
- 12 of the 16 teams saw an increase in their engagement scores
- Greatest improvements came from North Stoke CAMHS, increasing by 16.6%, They were the joint lowest scoring team in the 1st survey and the highest scoring team in the 2nd survey
- Greenfields saw similar results, being the second lowest scoring team in the 1st survey and being the second greatest improving team, with a 12.8% increase.
- The estates department were one of the lowest scoring teams in the first survey. They have taken major steps to engage and involve staff and despite currently going through a major management of change, they have increased their overall engagement score by 9.3% and are now the 5th most improved team
- 12 of the 16 teams in this cohort initially scored below our Trust's average engagement score, which shows they were ideal teams for the programme
- Out of these 12 teams, 9 improved their engagement scores, with 6 improving to above the Trust average

Staff Survey Results

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

	Your trust in 2017	Average (median)	Your trust in 2016
"I would recommend my organisation as a place to work"	53% ↑	57%	50%
Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	**3.62** ↑	**3.67**	**3.56**

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

Benchmarked data

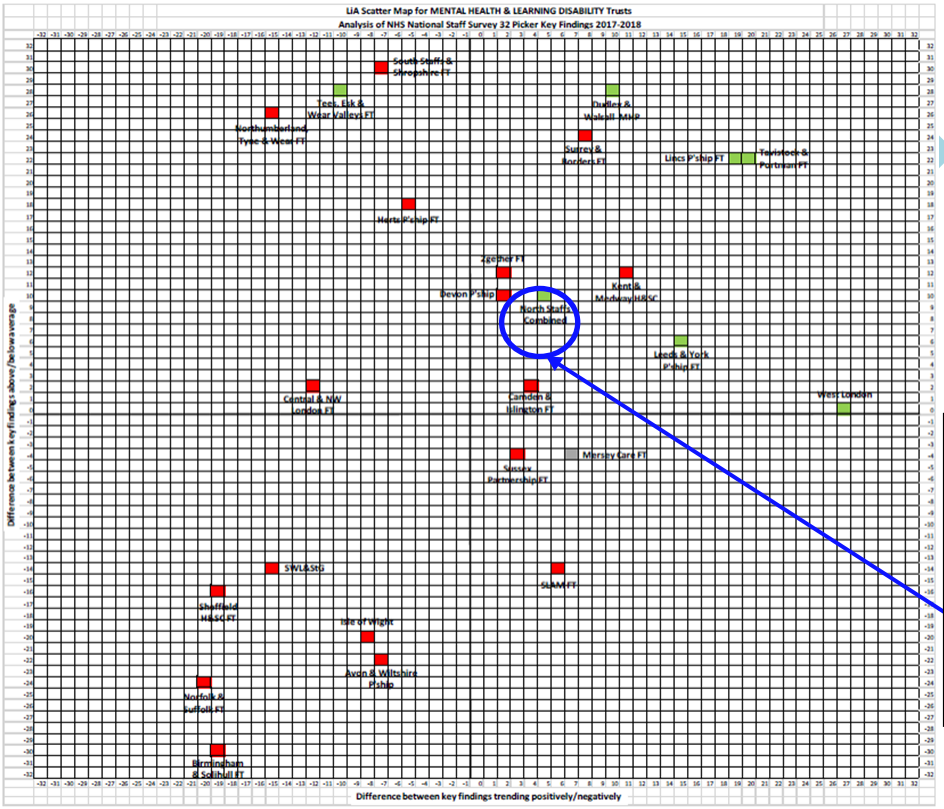
2017 (32 key findings)	2016 (27 key findings)

Above average	10	31%	**Above average**	9	33%
Average	15	47%	**Average**	10	44%

The scatter graph below has been developed by 'Optimise' (LiA) as part of Listening into Action (LiA) and benchmarks the Trust against all other comparable mental health trusts, showing positive improvements in our staff survey scores and that we are positioned in the top quartile nationally.

'Optimise' (LiA) have recognised the progress North Staffordshire Combined have made in their LiA Scatter Maps and associated league tables. In their commentary, they state North Staff Combined have "made good improvements."

LiA Scatter Map for Mental Health & Learning Disability Trusts
Analysis of NHS National Staff Survey 32 Picker Key Findings 2017-18



North Staffordshire Combined position

- Improvement on 2016 scores (Green)
- Top Right Quadrant represents above average performance and more positive trend year on year

From our staff survey results, we have prioritised the following areas, resulting in the creation of action plans for targeted and focussed activity across 2018/19;

1. Closing the gap in differences between experiences of white and BAME staff
2. Harassment, bullying or abuse from patients, relatives, public or colleagues
3. Staff ability to contribute towards improvements at work
4. Staff agreeing their role makes a difference to patients / service users
5. Staff confidence and security in reporting unsafe clinical practice
6. Increasing the quality of appraisals
    1.

Patient Experience

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

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

Friends and Family Test (FFT)

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

Service User and Carer Council

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

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

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

The Annual Mental Health Community Survey 2017

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

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

Area of performance	Patient experience

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

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

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

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

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

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

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

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

Questions relating to	Score out of 10	How this score compares with other trusts

Overall views of care and services	7.4	Worse	**About the same**	Better
Overall experience	7.1	Worse	**About the same**	Better

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

Complaints Received

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

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

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

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

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

Themes, Trends and Learning

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

Patient Advice and Liaison Service (PALS) contacts

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

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

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

Compliments

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

3.3 Engagement and statements from key partners.

Engaging our partners and stakeholders

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

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

Development Stage

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

Agreeing priorities

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

Sharing the draft Quality Account

In line with a Department of Health Guidance, we also produced a draft Quality Account and shared this with key partners as follows:

Local commissioners, Local Health watch organisations, Local Authority Overview and Scrutiny Committees.

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

Comments from key partners

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

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

The contract and service specifications with the Trust detail the level and standards of care expected and how these will be measured, monitored, reviewed and performance managed. As part of the contract monitoring process, North Staffordshire CCG and Stoke-on-Trent

CCG meet with the Trust on a bimonthly basis to monitor and seek assurance on the quality of services provided. In addition the CCGs work closely with the Trust and undertake continuous dialogue as issues arise to seek assurance, obtained through quality visits and attendance at Trust internal meetings.

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

Review of 2017/18

It is pleasing to note the Trust's commitment to improving quality as demonstrated by the following achievements:

- The CCGs recognise the considerable amount of work undertaken by NSCHT staff to achieve a "Good" or "Outstanding" rating in every Service and a 'Good' rating following the CQC inspection during October and November 2017 and acknowledge the significant achievement of been chosen as a mental health exemplar by CQC.
- It is pleasing to note during 2017/18, the Trust strengthened its approach to quality by participating in the Advancing Quality Alliance programme (AQuA) and linking this through their leadership development and the innovative approach to developing their falls reduction programme.
- Throughout 2017/18 the CCGs in partnership with the Trust's Governance Team, Staffordshire and Stoke-on-Trent Healthwatchs' have undertaken 14 announced quality visits which have provided 'real time' assurance on the quality of services provided by the Trust to the local community. The CCG would like to thank staff for their continued support and open approach to these visits. The 2018/19 quality visits programme has been agreed with the Trust.
- We are pleased to see the Trust's continued focus on Service User and Carer Experience and Engagement and notable improvements to the Family and Friends Test (FFT) response with NSCHT achieving the 5th highest rate of returns nationally in November 2017.
- The Trust has continued to participate in the delivery of the five national CQUIN schemes throughout the year and have provided reports detailing the successes and the substantial improvements made for service users as a result of these schemes.
- During 2017-18 the Trust attended the CCG's Joint Quality Committee in common and presented the improvements made to the Child and Adolescent Mental Health Services [CAMHS]. The CCG are pleased to see significant improvements in waiting times to access Services
- It is pleasing to note that the Trust is the best performing trust in England for IAPT recovery rates.

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

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

Priorities for 2018/19

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

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

Heather Johnstone

Director of Nursing & Quality

Health Watch Staffordshire

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

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

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

We would comment that some of the presentation of performance in charts and diagrams are not always clear to the lay reader of the account. Likewise, it where the results of the

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

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

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

Health Watch Stoke-On-Trent

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

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

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

General Comments

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

Statement on Quality

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

Priorities for improvement 2018/19

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

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

The committee were pleased to note the Trust's continued focus on waiting times for both referral to assessment and referral to treatment times for adult mental health services and CAMHS. However, they had previously been made aware of the concerns held by some partners about the quality of some assessments and also about the process for transition from children and young people's services to adult services, and sought assurances in this respect.

The committee were interested in the proposals for a 'Wellbeing Academy' and the work being undertaken with partners in this area and stated that this might be something that the committee might want it explore further at the appropriate time.

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

Review of Priorities 2017/18

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

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

There were several noteworthy areas of improved performance in 2017/18:

- North Stoke CAMHS had improved from being the joint lowest scoring team in the first Staff Satisfaction Survey to being the highest scoring team in the second survey, with Greenfields seeing similar results;
- The numbers of compliments received directly by the PALS service and via the Family and Friends Test (FFT) have increased by a truly significant amount from 244 in 2016/17 to 2,063 in 2017/18.

3.4 Statement of changes

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

You said:

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

Our response:

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

You said:

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

Our response:

XXX

You said:

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

Our response:

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

You said:

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

Our response:

Revised formatting completed

You said:

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

Our response:

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

3.5 Auditor statement of assurance

To be added

3.6 Glossary

AIMS- Accreditation for inpatient rehabilitation units.

ASD- Autistic spectrum disorder

ADHD- Attention deficit hyperactivity disorder

ASIST- Advocacy services in Staffordshire

CAMHS- Child & Adolescent mental health services

CCG- Clinical commissioning group (made up of local GPs, these groups replaced primary care trusts (PCTs) as commissioners of NHS services from 2013/14)

CLRN- Comprehensive local research network

CPA- Care programme approach

CPD- Continuing professional development

CPN- Community Psychiatric nurse

CQC- Care quality commission

DOH- Department of health

ECT- Electroconvulsive therapy

EngAGE- Stoke-on-Trent forum for people over 50 to give their views

Health watch- Local independent consumer champions, represents the views of the public.

HRG4- Health resource group (standard groupings of clinically similar treatments)

IAPT- Improving access to psychological therapies team

IM&T- information management and technology

IT- information technology

KPI- key performance indicator

Metric- method of calculating performance

Mind- Mental health charity network

MRSA- Methicillin-resistant staphylococcus Aureus

NDTI- National Development team for inclusion

NHSLA- NHS Litigation Authority

NICE- National Institute for health and clinical excellence

NIHR-National institute for health research

NPSA- National patient safety agency

NSCHT- North Staffordshire Combined Health Care NHS Trust

PALS- Patient advice and liaison service

PBR- Payments by results

PIP- Productivity improvement pathway programme.

POMH- Prescribing Observatory for mental health

QIPPP- Quality, innovation, productivity, partnership and prevention.

RAID- Rapid assessment interface and discharge

R&D- Research and development

REACH- Local advocacy project supporting people with learning disabilities

RETHINK- Mental health membership charity

SPA- Single point of access (to mental health services)

SUS-Secondary user's service

TDA- Trust development Authority

UHNM- University Hospital of North Midlands NHS Trust

The trust is committed to providing communication support for service users and carers whose first language is not English. This includes British sign language (BSL) This document can be made available in different languages and formats, including Easy Read, on request.

If you would like to receive this document in a different format, please call 0300 123 1535 ext. 4651 (Freephone 08000328 728) or write to our FREE POST address:

Freepost RTCT-YEHA-UTUU

Communications & Membership Team North Staffordshire Combined Health Care NHS,

Trust Trentham Business Centre, Bellringer Road, and Trentham Lakes South, Stoke-on-Trent, ST4 8HH.

Or email on: qualityaccount@northstaffs.nhs.uk

Visit our website: www.combined.nhs.uk

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:10

Date of Meeting:	21st June 2018		
Title of Report:	Performance & Quality Management Framework Month 1		
Presented by:	Suzanne Robinson, Director of Finance, Performance & Digital		
Author:	Vicky Boswell, Associate Director of Performance		
Executive Lead Name:	Suzanne Robinson, Director of Finance, Performance & Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report provides an overview of performance for April 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In Month 1 there is 1 target related metric rated as Red and 1 target related metric as Amber; all other indicators are within expected tolerances. 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.	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	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 or performance standards. There have been significant improvements in data completeness and data quality following Lorenzo implementation. There are plans to address remaining issues and to support further developments in the Data Quality Improvement Plan agreed with commissioners.		

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 committee is asked to • Receive the Trust reported performance, management action and committee oversight on the Month 1 position. • Note that the Trust will trust be under routine surveillance (rather than enhanced surveillance) by NHSE through the Shropshire & Staffordshire Quality Surveillance Group.

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD

Date of meeting:	21st June 2018
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 1 2018/19**
Executive Lead:	Suzanne Robinson, Director of Finance, Performance & Digital
Prepared by:	Vicky Boswell, Associate Director of Performance
Presented by:	Suzanne Robinson, Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for April 2018 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.

2 Shropshire & Staffordshire Quality Surveillance Group (QSG)

The Shropshire & Staffordshire QSG is a forum where partners review risks to quality across NHS commissioned services through sharing intelligence. It provides opportunities to coordinate actions to drive improvement, respecting statutory responsibilities and ongoing operational liaison between organisations.

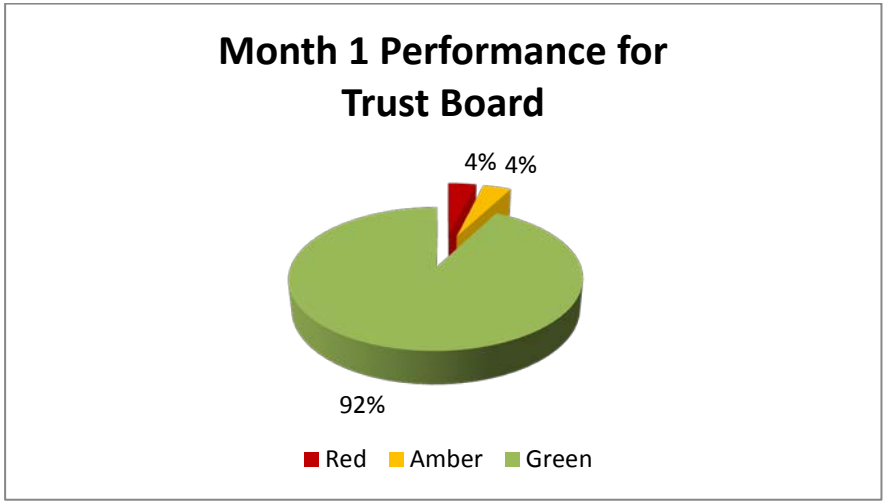
Under the terms of the QSG, there are two forms of surveillance that NHSE may apply to NHS providers: routine and enhanced. NHS England has determined that the trust will fall under routine surveillance rather than enhanced surveillance. This is positive news. It means that the Trust will no longer receive a formal notification letter; rather routine monitoring will form part of our ongoing commissioner and provider dialogue.

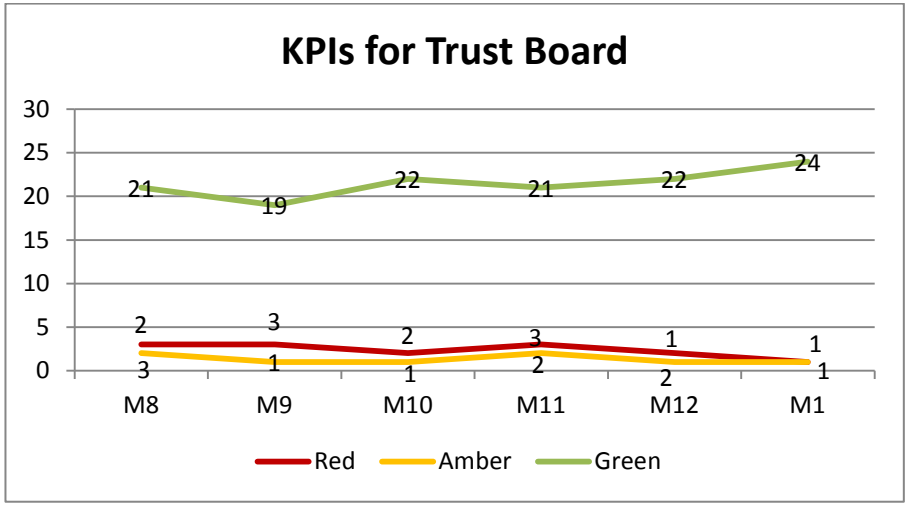
3 Executive Summary – Exception Reporting

The following performance highlights should be noted:

- 100% of patients on a care programme approach have received a follow up within 7 days of discharge
- 75.0% of Early Intervention in Psychosis patients have waited a maximum of 2 weeks from referral to treatment
- 100.0% of inpatient admissions have been gate kept by crisis resolution/home treatment team
- 100.0% of people seen for crisis assessment within 4 hours of referral
- Emergency readmissions have reduced to 6%

In Month 1 there is 1 target related metric rated as **Red** and 1 target related metric rated as **Amber**; all other indicators are within expected tolerances.



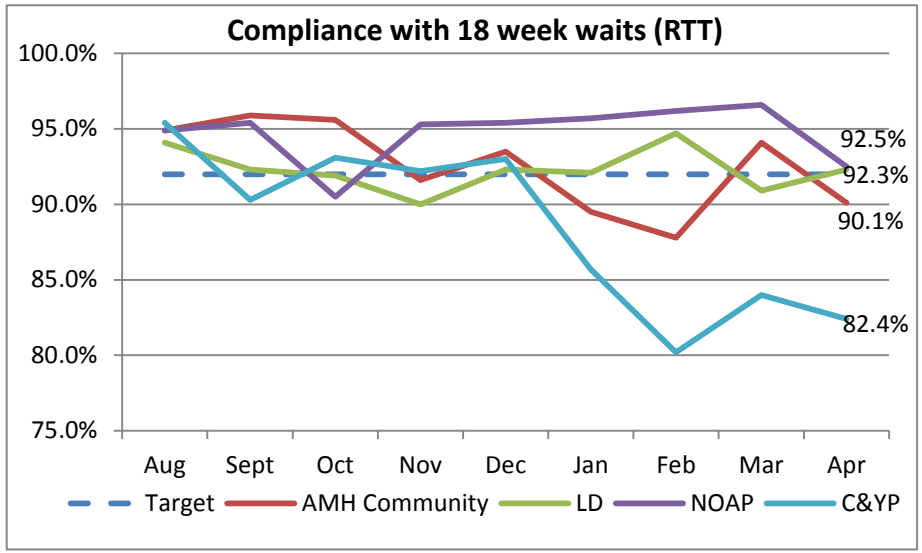


4 Updated metrics and targets

The following measures and targets have been updated for Month 1:

- Sickness Absence percentage figures for January confirmed, provisional data received for February, March and April 2018
- Memory Assessment Service 12 week waits metric has been added to the report in M1.

5 Exceptions - Month 1

KPI Classification	Metric	Exec/Op Lead	Target	M12	M1	Trend	Commentary
CCG	Waiting Times: Compliance with 18 week waits (Referral to Treatment or Intervention)	Exec Dir of Ops	92.0%	GREEN 93.6%	AMBER 90.5%	↘	90.5% at M1 from 93.6% at M12 AMH Community – 90.1% at M1 from 94.1% at M12 LD - 92.3% at M1 from 90.9% at M12 NOAP – 92.5% at M1 from 96.6% at M12 C&YP – 82.4% at M1 from 84.0% at M12 There has been a reduction in performance Trust-wide associated with the increased numbers of breaches in AMH Community, NOAP and CYP. For CYP the trust is reviewing demand as we believe that this has increased in some areas and addressing capacity by actively recruiting to vacant posts. All directorates have identified issues, are reviewing demand and capacity plans and are ensuring that recording reflects actual performance levels. Recovery Plans will be monitored through Performance Review meetings. 

KPI Classification	Metric	Exec/Op Lead	Target	M12	M1	Trend	Commentary
CCG	Admissions: Number of patients 16-17 year old admitted to Adult Psychiatric wards	Exec Dir of Ops	0.0	GREEN 0.0	RED 1.0	↗	1.0 in M1 from 0.0 in M12 A patient (17 ½ year old) was admitted to the Learning Disability A&T unit following a MHA Assessment on 11.4.18. A referral for a Tier 4 CAMHS bed would ordinarily be made but the clinical team and Local Authority commissioners agreed that due to the patient's age, presentation and potential vulnerability that a local A&T bed would be most suitable. The patient was admitted to A&T on 11.4.18 and remained in the bed at the end of the month.

6 Recommendations

The Trust Board are asked to;

- Receive the Trust reported performance, management action and committee oversight on the Month 1 position

Month: **April 2018/19**
1
Key:-

PQMF Report to Trust Board

North Staffordshire Combined Healthcare NHS Trust

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)

	Metric	Frequency	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
NHSI	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target-17/18-50%, 18/19-53%)	Monthly	53%	75.0%											
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention)	Monthly	92%	90.5%											
CCG	AMH Community	Monthly	92%	90.1%											
CCG	LD	Monthly	92%	92.3%											
CCG	NOAP	Monthly	92%	92.5%											
CCG	C&YP	Monthly	92%	82.4%											
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0											
CCG	MH Liaison Team response to A&E referrals within 1 hour	Monthly	95%	94.8%											
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%											
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%											
National	Percentage of inpatient admissions that have been gate kept by crisis resolution/ home treatment team	Monthly	95%	100.0%											
National/CCG	Overall safe staffing fill rate	Monthly	No Target	93.7%											
National	Mental health delayed transfers of care (target NHSI)	Monthly	7.5%	5.5%											
CCG	Emergency Readmission rate (30 days). Percentage of patients readmitted within 30 days of discharge.	Monthly	7.5%	6.0%											
NHSI	Total bed days patients have been Out of Area	Monthly	No target	4.0											
Trust Measure	Adult	Monthly	No target	4.0											
Trust Measure	Older Adult	Monthly	No target	0.0											
NHSI	Ratio of days Out of Area to baseline (Baseline set at M9 2017/18 figure of 150 bed days, as per SOF guidance, shown as 100%. The ratio of days each month to this baseline figure is then expressed as a percentage.)	Monthly	<100%	2.7%											
Trust Measure	Total patients Out of Area	Monthly	No target	2.0											
Trust Measure	Adult	Monthly	No target	2.0											
Trust Measure	Older Adult	Monthly	No target	0.0											
Trust Measure	Total bed days - PICU	Monthly	No target	252.0											
Trust Measure	Total patients - PICU	Monthly	No target	5.0											
SAFE															
CCG	Number of patients 16/17 years old admitted to Adult Psychiatric wards	Monthly	0.0	1.0											
NHSI	Admission to adult facilities of U16s	Monthly	0.0	0.0											
CCG	Bed Occupancy (Including Home Leave)	Monthly	85%	84.8%											
CCG	AMH IP	Monthly	90%	89.7%											
CCG	LD	Monthly	85%	79.7%											
CCG	Neuro	Monthly	85%	88.2%											
CCG	Old Age Psychiatry	Monthly	85%	91.5%											
CCG	C&YP	Monthly	85%	98.7%											
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%	1.48%											
NHSI / 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%	69.3%											
NHSI / 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%	100.0%											
NHSI / 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%											
CCG	S136 (Place of Safety) Assessments	Monthly	No Target	22.0											
National	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	95.3%											

	Metric	Frequency	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
NHSI	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	100.0%											
NHSI/CCG	Never Events	Monthly	0	0.0											
National	Patient Safety Alerts not completed by deadline	Monthly	0	0.0											
CCG	Mixed Sex Accommodation Breach	Monthly	0	0.0											
CARING															
National	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	90.8%											
National	Staff Friends and Family Test - % recommended - care	Quarterly	No Target												
National	Percentage of complaints responded to in line with timescale agreed with complainant	Monthly	95%	100.0%											
National	Written complaints rate	Quarterly	No Target												
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0											
ORGANISATIONAL HEALTH															
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%	-45.0%											
National	Sickness Absence Percentage: Days lost	Monthly	4.95%	2.8%											
National	Staff Turnover (% FTE)	Monthly	>10%	0.6%											

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REPORT TO: OPEN TRUST BOARD

Enclosure No: 11

Date of Meeting:	21 June 2018		
Title of Report:	Community Mental Health Survey Action Plan 2017/18		
Presented by:	Jonathan O'Brien, Director of Operations		
Author:	Samantha Mortimer, Head of Adult Mental Health Community Directorate		
Executive Lead Name:	Jonathan O`Brien, Executive Director of Operations	Approved by Exec	☒

Executive Summary:		Purpose of report	
The 2017 community survey results have been collated into the attached action plan which is monitored 3 monthly through directorate business meeting		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT x☐ Execs ☐ Date: 12th June 2018	Document Version No.	
Committee Approval / Review	• Quality Committee x☐ • 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.x☐ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	No risks		
Resource Implications: Funding Source:	No resource implications		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)			
Recommendations:	To receive this report for information		

Community Mental Health Survey Action Plan 2017/18

Improved score
About the same , remains in range
Lowest range

As a directorate we will review this action plan and update it on a three monthly basis at directorate meetings.

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
Section 1: Health and Social Care Workers										
Did the person or people you see listen carefully to you? Were you given enough time to discuss your needs and treatment? Did the person or people you saw understand how your mental health needs affect other areas of your life?	8.4 7.7 7.3	8.1 7.6 7.1	8.1 7.6 7.0	The Trust has strengthened the overall approach to care planning. Monthly audits are being undertaken following the introduction of a trust wide audit tool. Assurance is gained and actions agreed for improvement on a monthly basis. New recovery focused care plans have been implemented which form the basis of the monthly audit.	Sam Mortimer/ Jane Munton Davies Service Managers	Ongoing	Care planning training undertaken at preceptorship/ Trust Induction and as part of Mandatory Training and is monitored through directorate performance dashboard. The monthly audit is being completed by teams. The monthly audit is showing an upward trend and monitored through performance dashboard. Each team will individually have an action plan for their complaints which will incorporate team level action plan. An overarching plan will be held at Directorate level for senior review / sign off Open space events undertaken Person centeredness event	Care plan training compliance March 18: 86% **CSM audit average compliance** (March 18): **Care Management**: 76% **Risk assessment**: 75% **Care plan:** 51% **Complaints open** (March 18): 0 On 29th March 2017. 11th April 2018.		Reviewed and updated 3 monthly ✔

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
							NSCHCT service users focus group June 2018			✔
				Specialist Teams Celebration Event co-produced with service users	*Sam Mortimer/ Simon Wilson*	*19/10/2017*	*Successful Event 19th October 2017.*	19th October		✔
Section 2: Organising Care										
Have you been told who is in charge of organising your care and services? Do you know how to contact this person if you have a concern about your care? How well does this person organise the care and services you	7.4 9.6 8.6	7.4 9.8 8.2	7.5 9.8 8.3	**All care co-ordinators will ensure that service users are made aware of who is in charge of the care provided through documentation contained in the care plan with contact details as appropriate.**	Team Managers		Weekly performance will acknowledge progress. Records audit tool completed monthly. Monthly Case load management utilising demand and capacity tool *[used across four Community Mental Health Teams and Access/Home Treatment Team]*. Care coordination workshop	Care management policy operational. **CSM audit results** – See latest results above in Section 1. Example Inserted below: Caseload assurance data 13.04.18 GF.d		✔
				A SOP *has been* developed *and introduced* to ensure that	Team Managers		SOP completed by team managers.	**CHMT Care Coordinator Absence Procedure**		✔ ✔

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
need?				**service users have a negotiated nominated alternative contact in the absence of their care coordinator.**			To be reviewed weekly at CMHT managers assurance meeting.	SOP- CMHT Care Coordinator Absence Procedure- V2.zip Weekly monitoring Assurance document available		
				All service users are provided with a copy of their care plan and this will be recorded in the *Lorenzo* system for monitoring purposes	Team Managers		This is contained within the audit tool.	**CSM Audit results:**		
Section 3: Planning Care										
Have you agreed with someone from NHS mental health services what care you will receive? Were you involved as much as you wanted to be in agreeing what care you will receive? Does this agreement on what care you will receive take into account your personal	5.9 7.6 8.0	5.6 7.1 7.6	5.8 7.7 7.6	**Staff are required to evidence within the care plan that the service user has agreed and signed the care plan through co -production** **Trust wide service user focus group relating to choice and empowerment**	Team Managers		This is contained within the audit tool. *Focus group to determine what service users would like and what they get currently*	**CSM Audit results:** see above in section 1.		
				Recent care plan audits will be reviewed to ascertain trends	Audit team		*Care Plan and risk assessment audits are reviewed by Service Managers and submitted to Head of Directorate on a monthly basis.*	**CSM Audit results:** see above in section 1.		
				Care plans are devised to support health and social care needs	Team Managers		Section within care plan specific to social care needs. Also part of supervision. *The Trust approved risk*			

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
circumstances?							*assessment document takes into account personal circumstances and these are audited on a monthly basis by Teams.*			
Section 4: Reviewing Care										
In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?	7.4	6.9	7.4	**All service users will receive a formal review as a minimum every *9* months with the outcome being a jointly agreed, updated plan of care / care plan..** **Trust wide service user focus group**	Team Managers		*Weekly rectification plans for overdue CPA to be submitted to Head of Directorate* *CSM peer audits are completed monthly*	CSM , performance monitoring		
Were you involved as much as you wanted to be in discussing how your care is working?	7.9	7.8	7.4	**Frequency of reviews will be monitored through performance management data**	Team Managers		CPA review figures are above the required 95% Focus group discussion			
Did you feel the decisions were made together by you and the person you saw during this discussion?	8.0	7.8	7.7	**Content of the reviews will be agreed with service user and recorded within health records**	Team Managers		Record quality is audited on a monthly basis. This is done as part of the review. For discussion within focus group			
Section 5: Changes in who people see										

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
Were the reasons for this change explained to you at the time? What impact has this had on the care you receive?	7.4	5.4 7.0	5.2 7.4	**A SOP *has been* developed that clearly outlines the directorate expectations in ensuring service users are aware of who to contact in the absence of their care coordinator (adult)**	Team Managers		See earlier section on SOP [see earlier *section 2].*	**CHMT Care Coordinator Absence Procedure** SOP- CHMT Care Coordinator Absence Procedure- V2.zip		
Did you know who was in charge of organising your care while this change was taking place?	5.3	3.8	5.0				*Focus group*	**Assurance will be obtained through focus group**		
Section 6: Crisis care										
Do you know who to contact out of office hours if you have a crisis?	6.4 6.2	6.3 5.6	6.7 6.2	**All care plans will contain reference to what the service user is to do in a crisis, evidenced through supervision records and clinical audit**	Team Managers		Records audit tool – monthly basis To include SOP on alternative contact as well.			

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
When you tried to contact them, did you get the help you needed?				**A contact card / communications card will be introduced across all clinical areas. The card will display details including:** • Telephone number to contact in crisis • Name of Care Co-coordinator • Medication information details • (web addresses) – adult	Simon Wilson	June 2018	*Contact with communications team to establish what has been used. No record of previous card.* *New card to be designed and costed.* *Approval to be sought via Directorate Meeting.*			
Section 7: Treatments										
Were you involved as much as you wanted to be in the decisions about which medicines you receive?	7.4	7.0	6.8	**All care plans will contain evidence that the service user has been involved in decisions regarding medications**	*Clinical Lead*		*Nurse Practitioners to conduct* spot audit to ensure that service users receiving care under CPA are involved in discussion regarding their medication treatment.			
Were you given	7.4	7.2	7.0				*The Trust have invested in the*			

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
information about new medicine(s) in a way that you were able to understand? In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines? Were you involved as much as you wanted to be in deciding what treatment or therapies to use?	8.3 8.2	7.0 7.0	7.8 8.6				*Choice and Medication Website and all service users have access including patient information leaflets for medications.*			
				Re-audit of care plans containing evidence that the service user has been involved in decisions regarding medications to be completed.	Team managers		As above			
				Service users will be signposted to appropriate websites for information on the medication they take. Where the service user does not have access to the internet, hard copies of information will be printed by staff for service users to read. • Pharmacy support to be discussed at MoG • Hard copies of information provided at time of medication being prescribed.	*Karen Ware/Judith Donlon*	*Feb 2018*	Records audit to assure evidence of information having been provided.			
				Pathways to be reviewed to support the implementation of NICE guidance	Clinical Leads	April 2018	*Lithium monitoring.*			

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
Section 8: Other areas of life										
In the last 12 months, did NHS mental health workers give you any help or advice with finding support for your physical health needs?	5.4	4.6	4.2	The CQUIN for physical health care is operational for 2017/18. All teams have physical health care leads. **Clinical leads to support the process**	Clinical Leads	*October 2018*	*Risk for non-achievement in the Community Directorate, CMHTs will be required to hit over 65% for full payment and Early Intervention over 90% for full payment. Ensure for 2018 period that systems are in place to improve on part 1 performance.*			
				The CQUIN for physical health care will also be operational for the next quarter – clinical leads to support the process.	Clinical leads above					
In the last 12 months, did NHS mental health workers give you any help or advice with finding support for financial advice or benefits?	4.4	4.2	3.5	There is a bid currently in process for the Citizen Advice Bureau to work closely with CMHTs and specialist mental health teams. **This will be incorporated into the directorate operational policy**.	Simon Wilson	January 2018	*Service managers have been encouraged to formulate a business case to fund input from CAB if it will improve service user outcomes.*			

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
In the last 12 months, did NHS mental health workers give you any help or advice with finding support for finding or keeping work?	3.7	3.6	3.8	**The Step on/work4you employment teams will agree with CMHT's the frequency of attendance at the multi-disciplinary team meetings in CMHTs to improve visibility. A re-launch of the initiatives and advertising of the availability of these services will take place.** **Certificate in community mental health care is open to servicer users and carers.**	Simon Wilson	April 2018	This is being done through the employment specialists. The last agreement was that CMHTs would prefer allotted slots rather than them attending MDT. *NHS England are part of the five year forward review are looking to double access to IPS NSCHCT has a centre of excellence in Step On who are being targeted in wave one to further develop services. We are in current communications with CCG Commissioners to develop a bid for Wave 1 and Wave 2 across Staffordshire, this will be an STP Bid and will be signed off by the Executive officer.* *To promote referrals to employment at every opportunity.*	Bid Successful for the doubling of the IPS service		
Has someone from NHS mental health services supported you in taking part in an activity locally?	4.2	3.7	4.3	**A Directory of service is being developed corporately** **Trust new website will incorporate local services** **Cooperative working/ MCP project has commenced within the City**			Update required from Comms *The Award Winning MCP Project to be rolled out across Stoke* *Mini Growth point has now commenced*			

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
Have NHS mental health services involved a member of your family or someone close to you as much as you would have liked?	6.4	6.0	6.8	**Monthly audit undertaken** **New trust risk assessment has been developed that incorporates relatives and carers views**	Team Managers	Ongoing		**CSM Audit results** (See section 1 above) **CSM Audit results** (See section 1 above)		
Have NHS mental health services given you information about getting support from people with experience of the same mental health needs?	4.2	4.2	4.1	**The approach to publicising how service users can get involved in volunteering will be developed.**	Veronica Emlyn	May 2018	Awaiting response from Veronica			
				Since 2001 the trust has had citizens with lived experience working with us and employed as STR workers	Julie Richardson / Dave Smith					
Do the people you see through NHS mental health services help you feel hopeful about the things that are important	5.9	6.1	6.2	**The outcome of the LIA for recovery will be embedded as part of the trust wide approach and video used within the training of staff**	All team managers Communications		*Recovery college is being progressed.*			

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
to you?										
Section 9: Overall views of care and experience										
Overall, in the last 12 months, did you feel that you were treated with respect and dignity be NHS mental health services?	8.6	8.4	6.1	*It is anticipated that implementation of the actions described above will lead to maintaining and further improving the experience of services users accessing services*			*Fortnightly quality forum to focus on patient experience whereby report will be produced so Teams can reflect on feedback.* *NHS Choices* *Compliments* *Friends and Family Test* *PALS* *Complaints* *Service user focus groups*			
In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?		5.9	8.7	• *The agreement to provide a needs led service will be determined at the care planning stage* • *It is anticipated that the change in service provision may be a challenge for service users* • *Service expectations will be communicated to all service users at the point of first contact*			*Service user focus groups*			
Section 10: Overall experience										
Overall……..I had a very poor experience / I had a very good	7.3	6.9	7.1	*It is anticipated that Implementation of the actions described above will lead to maintaining*						

Question	2015 Score	2016 Score	2017 score	Action	Responsibility	Date	Comment / Progress	Assurance	RAG	Expected Completion date
experience.				*and further improving the experience of services users accessing services.*						

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REPORT TO Trust Board

Enclosure No:12

Date of Meeting:	21/06/2018		
Title of Report:	Finance Position Month 1		
Presented by:	Suzanne Robinson - Executive Director of Finance, Performance and Digital		
Author:	M Newton - Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson - Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report summarises the finance position at month 1 (April 2018)	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:	Trust Board is asked to: Note: The reported Month 1 2018/19 surplus of £60k against a planned surplus of £34k. This is a favourable variance to plan of £26k.

	The M1 CIP achievement: • YTD achievement of £4k (2%); an adverse variance of £165k; • 2018/19 forecast CIP delivery of £1,472k (53%) based on schemes identified; an adverse variance of £1,323k to plan; • The recurrent value of schemes transacted at £46k, 27% of target. The cash position of the Trust as at 30th April 2018 with a balance of £8,043k; £677k better than plan Capital payments for month 1 of £40k compared to planned capital expenditure of £100k; Use of resource rating of 2 against a plan of 2. Approve: The month 1 position reported to NHSI.

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Financial Overview as at 30th April 2018

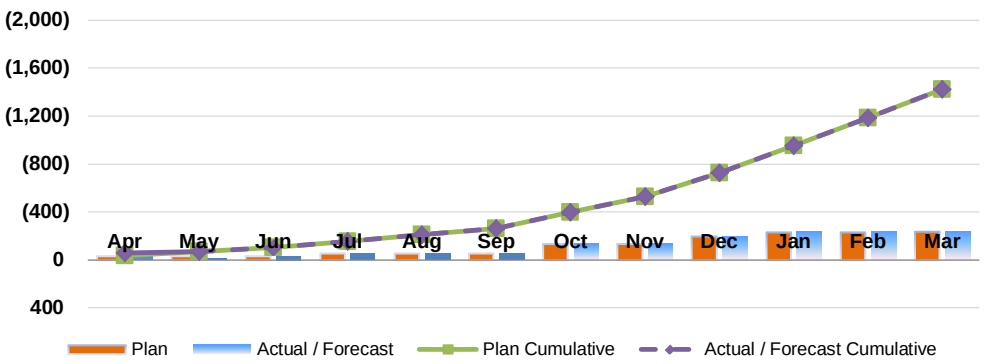
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(34)	(60)	(26)	(76)	G
FOT	(1,423)	(1,423)	0	0	G

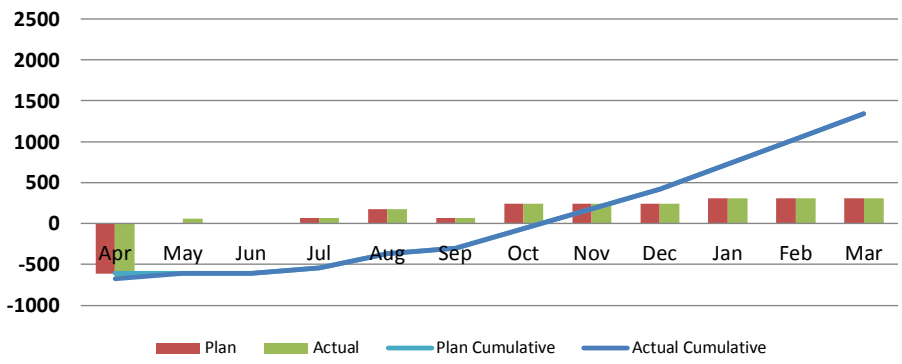
(Receipt)/Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	(613)	(673)	(60)	10	A
FOT	1,345	1,345	0	0	G

Retained (Surplus) / Deficit Run Rate 2018/19



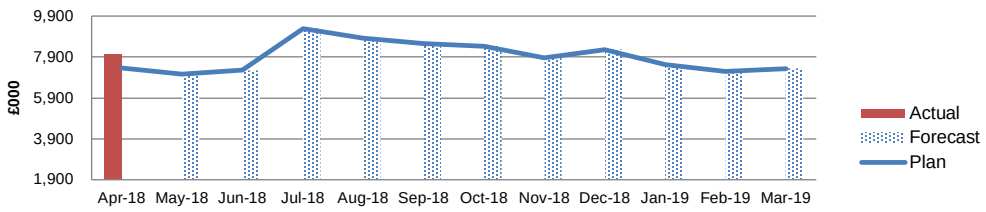
Net Capital Expenditure - Plan / Forecast 2018/19



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	7,366	8,043	677	9	G
FOT	7,339	0	(7,339)	(100)	G

Cash Balances - Actual/Forecast against Plan 2018/19



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	108	2	(106)	(98)	(776)	R
Corporate	61	2	(59)	(97)	205	G
Total	169	4	(165)	(98)	(570)	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	1

1. Introduction:

The Trust's 2018/19 financial plan is to deliver a trading position of £0.720m surplus. The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.423m surplus which includes £0.703m 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 1, the trust had an in month trading position of £25k surplus against a plan of £1k deficit; **showing a £26k improvement to plan**. Sustainability and Transformation funding has been assumed at £35k for month 1, bringing the overall trust control to a £60k surplus against plan of £34k; **showing £26k improvement to plan**.

- The Trust has not produced a detailed forecast at month 1, but expects to deliver in line with plan to give a trading surplus of £0.720m. Sustainability and Transformation funding is expected to be £0.703m in line with plan giving an overall Control Surplus of £1.423m.

		Month 1			Year to Date			Forecast		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(83,012)	(6,901)	(6,846)	54	(6,901)	(6,846)	54	(83,012)	(83,012)	0
Pay	61,404	5,184	5,023	(161)	5,184	5,023	(161)	61,404	61,404	0
Non Pay	18,155	1,490	1,567	77	1,424	1,567	143	18,155	18,155	0
EBITDA	**(3,453)**	**(227)**	**(257)**	**(30)**	**(293)**	**(257)**	**36**	**(3,453)**	**(3,453)**	**0**
Other Non-Op Costs	2,733	228	232	4	228	232	4	2,733	2,733	0
Trading Surplus	**(720)**	**1**	**(25)**	**(26)**	**(65)**	**(25)**	**40**	**(720)**	**(720)**	**0**
Sustainability & Transformational Funding	(703)	(35)	(35)	0	(35)	(35)	0	(703)	(703)	0
(Surplus)/Deficit for the year	**(1,423)**	**(34)**	**(60)**	**(26)**	**(100)**	**(60)**	**40**	**(1,423)**	**(1,423)**	**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.
- £48k under recovery on OATs at month 1, due to a catch up of invoices.
- Stoke on Trent Public Health under recovery of £12k due to the contract being renegotiated at a lower value than plan.
- STF for 2018/19 is £703k, assumed at 15% in quarter 1, 20% quarter 2, 30% quarter 3 and 35% in quarter 4.

Table 2: Income	Annual Budget £'000	Month 1		
		Budget £'000	Actual £'000	Variance £'000
NHS Stoke-on-Trent CCG	(37,374)	(3,084)	(3,084)	(0)
NHS North Staffordshire CCG	(25,503)	(2,093)	(2,093)	(0)
Specialised Services	(3,189)	(266)	(266)	(0)
Stoke-on-Trent CC s75	(3,947)	(329)	(329)	0
Staffordshire CC s75	(1,054)	(88)	(88)	(0)
Stoke-on-Trent Public Health	(1,293)	(135)	(123)	12
Staffordshire Public Health	(613)	(51)	(51)	0
ADS/One Recovery	(1,467)	(122)	(122)	0
Associates	(772)	(64)	(61)	4
OATS	(771)	(64)	(16)	48
Total Clinical Income	**(75,984)**	**(6,296)**	**(6,232)**	**64**
Other Income	(7,028)	(605)	(614)	(9)
Total Income	**(83,012)**	**(6,901)**	**(6,846)**	**54**
Sustainability Transformation Funding	(703)	(35)	(35)	0
Total Income Incl. STF	**(83,715)**	**(6,936)**	**(6,881)**	**54**

4. Expenditure

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

- Underspend of £161k at month 1 on pay is due to vacancies across the trust, partially covered by agency.
- Agency costs at month 1 are £96k, **£78k below the M1 agency ceiling of £174k.**

Table 3: Expenditure	Annual Budget £'000	Month 1		
		Budget £'000	Actual £'000	Variance £'000
Medical	7,595	639	679	40
Nursing	28,420	2,427	2,359	(68)
Other Clinical	15,293	1,277	1,060	(218)
Non-Clinical	9,874	823	811	(12)
Apprenticeship Levy	214	18	18	0
Non-NHS	8	0	96	96
Total Pay	**61,404**	**5,184**	**5,023**	**(161)**
Drugs & Clinical Supplies	2,303	196	196	0
Establishment Costs	1,669	141	119	(22)
Information Technology	626	52	61	8
Premises Costs	2,162	183	203	20
Private Finance Initiative	4,372	364	363	(1)
Services Received	3,067	256	267	11
Residential Payments	1,708	142	205	63
Consultancy & Prof Fees	52	4	22	17
External Audit Fees	65	5	5	(0)
Legal Fees	65	5	6	1
Unacheived CIP	(2,749)	(165)	0	165
Other	4,816	306	120	(186)
Total Non-Pay	**18,155**	**1,490**	**1,567**	**77**
Finance Costs	1,293	108	108	0
Local Government Pension Scheme	0	0	0	0
Unwinding of Discounts	0	0	0	0
Dividends Payable on PDC	561	47	47	0
Investment Revenue	(14)	(1)	(2)	(1)
Fixed Asset Impairment	0	0	0	0
Depreciation (excludes IFRIC 12)	893	74	80	5
Total Non-op. Costs	**2,733**	**228**	**232**	**4**
Total Expenditure	**82,292**	**6,902**	**6,821**	**(80)**

5. 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	1,504	1,385	(120)	338	472	134	(201)	(200)	1	1,641	1,656	15
AMH Inpatients	516	523	7	30	29	(1)	(0)	(0)	(0)	546	551	5
Children's Services	523	470	(54)	40	70	30	(49)	(51)	(2)	515	489	(26)
Substance Misuse	259	245	(14)	87	83	(4)	(40)	(28)	13	305	300	(5)
Learning Disabilities	443	397	(46)	(6)	29	35	(20)	(24)	(4)	417	402	(15)
Neuro & Old Age Psychiatry	1,034	944	(90)	38	56	18	(90)	(92)	(2)	982	909	(73)
Corporate	904	1,060	156	1,190	1,059	(131)	(6,535)	(6,487)	48	(4,440)	(4,368)	73
Total	**5,184**	**5,023**	**(161)**	**1,718**	**1,798**	**81**	**(6,936)**	**(6,881)**	**54**	**(34)**	**(60)**	**(26)**

- AMH Community is underspent on pay due to 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 on residential payments.
- AMH Inpatient is overspent on pay mainly due to increased bank nursing costs.
- Other Directorates are underspent, mainly due to the level of trust vacancies.

6. Cost Improvement Programme

The Trust target for the year is £2.795m, as reported to NHSI. This takes into account the requirement to deliver a £1.423m control surplus for 2018/19. The table below shows the achievement by Directorate towards individual targets at M1. The Trust wide CIP achievement is 2% at M1 compared to plan.

		YTD M1			Forecast					
CIP Delivery	Annual CIP Target 2018/19	Plan	Transacted	(Under)/Over Achievement	Plan	Total Schemes	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Clinical										
AMH Community	973	33	0	(33)	973	195.30	(778)	20%	0	421
AMH Inpatients	160	2	2	(1)	160	139.38	(20)	87%	20	175
Children's Services	296	13	0	(13)	296	201.37	(95)	68%	0	232
Learning Disabilities	234	31	1	(30)	234	218.59	(16)	93%	8	167
NOAP	551	29	0	(29)	551	315.34	(235)	57%	0	443
Total Clinical	**2,214**	**108**	**2**	**(106)**	**2,214**	**1,070**	**(1,144)**	**48%**	**28**	**1,438**
Corporate										
CEO	15	1	0	(1)	15	21	6	140%	0	21
Finance, Performance & Digital	43	4	0	(3)	43	60	17	140%	2	60
MACE	9	1	0	(1)	9	14	4	144%	0	14
Operations	6	0	0	(0)	6	6	0	100%	0	6
Quality & Nursing	41	3	0	(3)	41	42	2	104%	0	42
Strategy	11	1	0	(1)	11	11	0	100%	4	11
Trustwide	384	44	0	(44)	384	196	(188)	51%	0	580
Workforce & OD	72	6	1	(5)	72	53	(20)	73%	13	53
Total Corporate	**581**	**61**	**2**	**(59)**	**581**	**402**	**(179)**	**69%**	**18**	**786**
Total	**2,795**	**169**	**4**	**(165)**	**2,795**	**1,472**	**(1,323)**	**53%**	**46**	**2,225**

Below 75%	
Below 90%	

Target	**2,795**
Variance	**(570)**

- The forecast position at M1 for 2018/19 is £1,472m (53%), which represents an in year shortfall against the annual target of £1,323k.

7. Statement of Financial Position

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

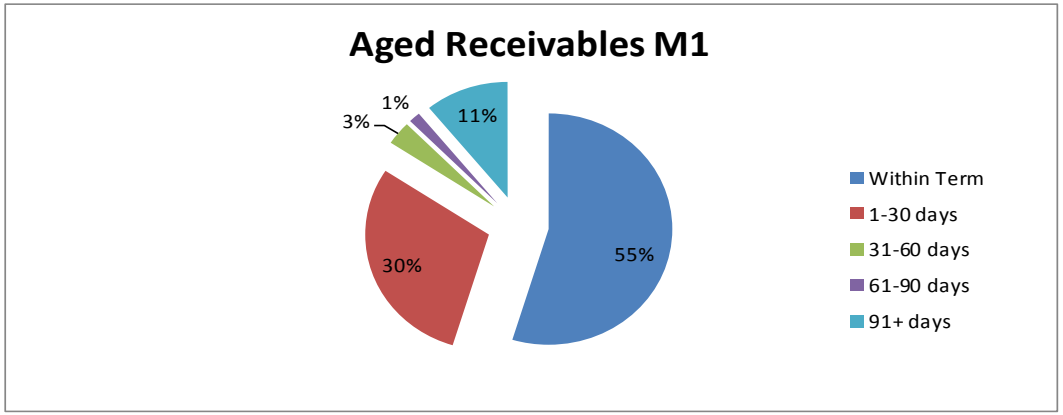
Table 6: SOFP	31/03/2018 £'000	30/04/2018 £'000
Non-Current Assets		
Property, Plant and Equipment	31,026	30,994
Intangible Assets	277	271
NCA Trade and Other Receivables	608	608
Other Financial Assets	1,089	1,089
Total Non-Current Assets	**33,000**	**32,962**
Current Assets		
Inventories	79	76
Trade and Other Receivables	7,347	5,571
Cash and Cash Equivalents	6,633	8,043
Non-Current Assets Held For Sale	0	0
Total Current Assets	**14,058**	**13,690**
Current Liabilities		
Trade and Other Payables	(7,166)	(6,740)
Provisions	(621)	(617)
Borrowings	(633)	(633)
Total Current Liabilities	**(8,420)**	**(7,991)**
Net Current Assets / (Liabilities)	**5,639**	**5,699**
Total Assets less Current Liabilities	**38,639**	**38,661**
Non Current Liabilities		
Provisions	(458)	(458)
Borrowings	(11,557)	(11,519)
Total Non-Current Liabilities	**(12,015)**	**(11,977)**
Total Assets Employed	**26,624**	**26,684**
Financed by Taxpayers' Equity		
Public Dividend Capital	7,648	7,648
Retained Earnings reserve	9,032	9,092
Revaluation Reserve	9,944	9,944
Total Taxpayers' Equity	**26,624**	**26,684**

Current receivables are £5,571k, of which:

- £3,777k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter. £2,046k relates to 2017/18 Sustainability and Transformation Funding
- £1,794k is awaiting payment of invoice. (£982k within terms)

£282k is overdue by 31 Days or more and therefore subject to routine credit control processes.

		Days Overdue				
Table 6.1 Aged Receivables/Payables	Within Term £'000	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	703	812	4	0	129	1,648
Receivables NHS	279	(282)	55	27	67	146
Payables Non NHS	692	65	27	7	33	824
Payables NHS	374	73	1	18	10	476

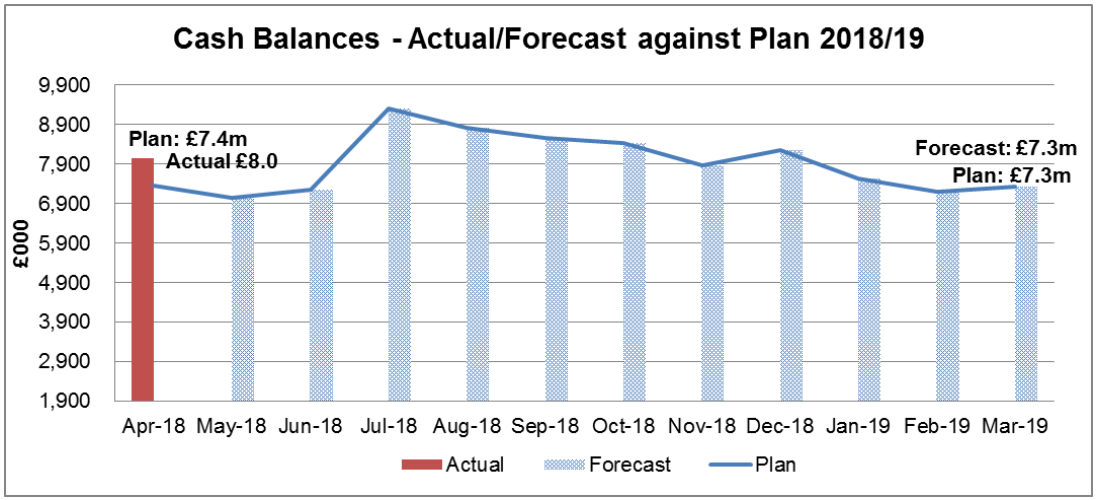


8. Cash Flow Statement

The cash balance at 30th April 2018 has increased by £1.410m to **£8.043m** due to a decrease in Non NHS and Local Authority debtors in April. As a consequence of this the Trust cash position at 30th April 2018 is **£0.677m higher than planned.** The Trust anticipates being in line with plan by March 2019.

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

Table 7: Statement of Cash Flows	Apr-18 £'000	May-18 £'000	Jun-18 £'000	Jul-18 £'000	Aug-18 £'000	Sep-18 £'000	Oct-18 £'000	Nov-18 £'000	Dec-18 £'000	Jan-19 £'000	Feb-19 £'000	Mar-19 £'000	Annual £'000
Net Inflows/(Outflow) from Operating Activities	773	(936)	251	2,171	(255)	(138)	170	(281)	682	(381)	41	497	**2,594**
Net Inflows/(Outflow) from Investing Activities	676	1	1	(66)	(174)	(65)	(240)	(240)	(240)	(306)	(307)	(309)	**(1,269)**
Net Inflows/(Outflow) from Financing Activities	(38)	(53)	(53)	(52)	(53)	(53)	(53)	(52)	(53)	(53)	(53)	(52)	**(618)**
Net Increase/(Decrease)	**1,410**	**(988)**	**199**	**2,053**	**(482)**	**(256)**	**(123)**	**(573)**	**389**	**(740)**	**(319)**	**136**	**706**
Opening Cash & Cash Equivalents	**6,633**	**8,043**	**7,055**	**7,254**	**9,307**	**8,825**	**8,569**	**8,446**	**7,873**	**8,262**	**7,522**	**7,203**	
Closing Cash & Cash Equivalents	**8,043**	**7,055**	**7,254**	**9,307**	**8,825**	**8,569**	**8,446**	**7,873**	**8,262**	**7,522**	**7,203**	**7,339**	
Plan	7,366	7,055	7,255	9,307	8,825	8,568	8,445	7,873	8,263	7,523	7,204	7,339	7,339
Variance	**(677)**	**(0)**	**1**	**(0)**	**(0)**	**(1)**	**(1)**	**(0)**	**1**	**1**	**1**	**(0)**	



9. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2,058k. Table 7 below shows the planned capital expenditure for 2018/19 as submitted to NHSI.

		Year to Date			Forecast		
Table 8: Capital Expenditure	Annual Plan £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Learning Disability Facilities	400	0	0	0	400	400	0
Hazelhurst incl Second Place of Safety	1,000	0	0	0	1,000	1,000	0
Information Technology Replacement Pr	108	0	0	0	108	108	0
Backlog Maintenance	150	0	0	0	150	150	0
Reduced Ligature Risks	250	0	0	0	250	250	0
Equipment Replacement Programme	50	0	0	0	50	50	0
Psychiatric Intensive Care Unit	100	100	34	(66)	100	95	(5)
Darwin	0	0	0	0	0	0	0
Generator	0	0	5	5	0	5	5
Total Gross Capital Expenditure	**2,058**	**100**	**40**	**(60)**	**2,058**	**2,058**	**0**
Bucknall Hospital (Part)	(713)	(713)	(713)	0	(713)	(713)	0
Total Capital Receipts	**(713)**	**(713)**	**(713)**	**0**	**(713)**	**(713)**	**0**
Total Charge Against CRL	**1,345**	**(613)**	**(673)**	**(60)**	**1,345**	**1,345**	**0**

- The **Operating Plan** as reported to NHSI forecast there would be a total charge against the CRL of (£613k) by month 1, including (£713k) Capital Receipts for the sale of Bucknall Hospital and £100k Capital Expenditure.
- **Actual Capital Expenditure** as at month 1 is (£673k) including £40k capital expenditure and (£713k) Capital Receipts for the sale of Bucknall Hospital.

10. 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)		5,624	
Annual Operating Expenses (£000)		6,589	
Liquidity Ratio days		26	
Liquidity Ratio Metric	1	1	
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		294	
Annual Debt Service (£000)		193	
Capital Servicing Capacity (times)		1.5	
Capital Servicing Capacity Metric	3	3	
I&E Margin			
Normalised Surplus/(Deficit) (£000)		60	
Total Income (£000)		6,881	
I&E Margin		0.9%	
I&E Margin Rating	2	2	
I&E Margin Variance from Plan			
I&E Margin Variance		0.4%	
I&E Margin Variance From Plan	1	1	
Agency Spend			
Providers Cap (£000)		174	
Agency Spend (£000)		96	
Agency %		(45)	
Agency Spend Metric	1	1	
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

11. 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 1, the Trust has under-performed against this target for the number of invoices and value, having paid 90% of the total number of invoices, and paid 94% based on the value of invoices. The majority of breaches in number of invoices relate to Agency, which invoiced by shift by individual. Work is ongoing with the Agencies to reduce invoices and streamline authorisation using E-Rostering.

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

	2017/18			2018/19 Month 1			2018/19 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	659	10,933	11,592	81	1,200	1,281	81	1,200	1,281
Total Paid within Target	575	9,527	10,102	77	1,071	1,148	77	1,071	1,148
% Number of Invoices Paid	87%	87%	87%	95%	89%	90%	95%	89%	90%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-8%**	**-8%**	**-8%**	**0%**	**-6%**	**-5%**	**0%**	**-6%**	**-5%**
Value of Invoices									
Total Value Paid (£000s)	7,164	33,211	40,375	705	3,037	3,742	705	3,037	3,742
Total Value Paid within Target (£000s)	6,258	31,653	37,911	668	2,835	3,503	668	2,835	3,503
% Value of Invoices Paid	87%	95%	94%	95%	93%	94%	95%	93%	94%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-8%**	**0%**	**-1%**	**0%**	**-2%**	**-1%**	**0%**	**-2%**	**-1%**

12. Recommendations

The Trust Board are asked to:

Note:

- The reported YTD surplus of **£60k against a planned surplus of £34k**. This is a favourable variance to plan of £26k.

- The M1 CIP achievement:
  - YTD achievement of £4k (2%); **an adverse variance of £165k**;
  - 2018/19 forecast CIP delivery of £1,472k (53%) based on schemes identified; an adverse variance of £1,323k to plan;
  - The recurrent value of schemes transacted at £46k, 27% of target.

- The cash position of the Trust as at 30th April 2018 with a **balance of £8,043k**; £677k better than plan

- Month 1 Capital receipts for 2018/19 at (£673k) compared to a net planned capital expenditure of (£613k);

- Use of resource rating of **2** against a plan of 2.

Approve:

- The month 1 position reported to NHSI.

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REPORT TO Public Trust Board

Enclosure No:13

Date of Meeting:	24TH MAY 2018		
Title of Report:	Finance, Performance and Digital Committee Assurance Report		
Presented by:	Chair of Finance, Performance and Digital Committee		
Author:	Mike Newton - Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson – Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 10TH May 2018. The meeting was quorate with minutes approved from the previous meeting on the 5th April 2018. Progress was reviewed and actions confirmed 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		
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 21st June 2018

Finance, Performance and Digital Committee Report to the Trust Board – 21st June 2018.

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 6th June 2018. The meeting was quorate with minutes approved from the previous meeting on the 10th May 2018. Progress was reviewed and actions confirmed from previous meetings.

Executive Director of Finance, Performance and Digital Update

The following updates were given by the Executive Director of Finance, Performance and Digital;

- **NHS Providers publication** – Aligning the work of NHSE and NHSI - The bringing together of the two regulators would provide more clarity for commissioners and providers and this was welcome.

- **Lord Carter Shortlist** – the Deputy Finance Director is representing the Trust in London today for the Hospital Innovations Conference for Lord Carter; where we have been shortlisted for an award for Innovation with the Combined Value makers Scheme.

- **HFMA and HSJ Shortlist -** The Trust is attending the HSJ Awards and West Midlands HFMA conference awards where the Trust have been shortlisted for Combined Value Makers Scheme and for Finance Team of the year.

- **Lord Carter Efficiency Report for Mental Health & Community Services** – This report was published recently following the acute sector report on unwarranted variation. There were a number of recommendations many of which focused on community services. This report would help the Trust to identify efficiency opportunities.

Finance

- **Monthly Finance Report – Month 1**

The Finance position was presented, showing £26k favourable variance to plan. Agency utilisation in M1 was £96k against a ceiling of £174k, giving a £78k favourable variance.

Use of resource rating of 2 against a plan of 2.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for month 1 and were concerned

that the total identified was significantly short of the target. CIP achievement in M1 was £4k, giving an adverse variance of £165k. A high level forecast at M1 shows CIP delivery of £1,472k, giving an adverse variance to plan of £1,323k.

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 2018/19 given the level of unidentified schemes.

Digital:

- **Lorenzo Digital Exemplar**

The Director of Finance, Performance & Digital presented detailed slides Lorenzo Digital Exemplar (LDE.) This highlighted information around resources, functionality and efficiencies. The committee noted that there had been engagement with the Youth Council and clinicians in the trust; providing vital clinical input.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Performance Report (PQMF)
- Finance, Performance and Digital Risk Register 2017/18
- Agency Utilisation M1 (*for information)*
- Business Opportunities *(for information)*
- FPD Monitoring Schedule (*for information*)
- Cycle of Business 2017/18 and 2018/19 (*for information*)

Recommendation

The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby
Chair of Finance, Performance and Digital Committee

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REPORT TO TRUST BOARD

Enclosure No:14

Date of Meeting:	21st June 2018		
Title of Report:	Summary of the Audit Committee held on 25th May 2018		
Presented by:	Gan Mahadea, Chair / Non Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a summary of the key headlines from the Audit Committee held on the 25th May 2018. The full papers are available as required to members.		Approval	☒
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Receive the report for assurance and note the approval of the Annual Governance Statement, Annual Accounts and Annual Report		

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Assurance Report of the Audit Committee

25th May 2018

Annual Governance Statement 2017/18

The Committee approved the Annual Governance Statement developed in accordance with NHSI guidance. No significant control issues were reported for the Trust in 2017/18 and the Head of Internal Audit opinion reported that the organisation has an adequate and effective framework for risk management, governance and internal control.

Quality Account 2017/18

The Committee received the draft Quality Account for assurance purposes and noted that the final version is due for submission on 30 June 2018 following approval by the Quality Committee on behalf of the Trust Board. It was noted that the document has been shared with our stakeholders and external auditors for comments for which feedback has been positive.

Ernst and Young confirmed that the content of the Quality Account was in line with relevant regulations and it is consistent with the other specified information.

Approval of Annual Report 2017/18 and Annual Accounts

The Committee approved the Annual Report 2017/18 for submission 29th May 2018.

The Committee had received a detailed presentation at the Extraordinary Audit Committee held on 23rd April 2018. The auditors presented their audit report of the accounts and did not highlight any areas of material concern. The Committee approved the annual accounts having been granted delegated authority by the Board in readiness for submission on 29th May 2018.

Audit Recommendations – Tracking Report

The Committee received an update on Internal Audit actions and their progress in terms of implementation as of 25 May 2018. Five actions were overdue for which extensions were approved. It was also noted that 36 actions had been implemented and 10 further actions were in progress.

ISA 260 Audit Memorandum

Ernst and Young, presented ISA 260 Audit Memorandum report in respect of the findings of the External Auditors 2017/18 statutory audit. The audit concluded the Financial Statements and Value for Money and gave an overall unqualified audit opinion.

Freedom of Information Report – Q4

The Committee noted that during Q4 the Trust saw a reduction in the number of FOIs compared to 2016/17. However, there is an overall increase in FOI requests. In Q4 there has been 61 requests, 7 of which were not applicable to the Trust.

The common themes were noted as follows:

- IT
- Estates
- Waiting times
- Number of referrals

Waivers over £20k Report – Q4 and Summary of Losses and Special Payments – 1 April 2017 – 31 March 2018

The Scheme of Delegation requires the Audit Committee to review all waivers over £20,000 and noted that during Q4, there were 7 waivers totalling £246,308. For the 12 month period the losses and special payments totalled £21k.

Additional Reports Received:

- Summary of the Quality Committee –5 April 2018
- Summary of the Finance, Performance and Digital Committee – 8 March, 5 April and 10 May 2018
- Summary of the People and Culture Development Committee - 12 March and 14 May 2018
- Summary of the Business Development Committee – 8 March and 10 May 2018
- Minutes of the Information Governance Steering Group – 5 March 2018
- Minutes of the Data Quality Forum 26 February, 26 March and 24 April 2018

Laurie Wrench, Associate Director of Governance
On behalf of
Gan Mahadea, Chair
13th June 2018

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: Trust Board

Enclosure No: 15

Date of Meeting:	21st June 2018		
Title of Report:	Assurance Report from the Quality Committee		
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee		
Author:			
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 April/May 2018 and request for the Trust Board to ratify 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		

North Staffordshire Combined Healthcare NHS Trust

Key points from the Quality Committee meeting held on 7 June 2018 for the Trust Board meeting on 21 June 2018

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. Performance & Quality Management Framework Month 1 2018/19

Committee members discussed performance by exception and the rectification plans in place. The following performance highlights should be noted;

- 100.0% of people on a care programme approach have received a follow up within 7days of discharge
- 95.4% of people on a care programme approach have received a follow up within 12 months
- Emergency readmissions have reduced to 6%

There was a detailed discussion regarding quality metrics.

3. Reports received for Assurance

4a Reports received for review, information and/or approval

- ✓ ***Safer Staffing Group Terms of Reference –*** Approved
- ✓ ***Clinical Audit Draft Programme 2018/19 –*** Approved
- ✓ ***Unannounced Quality Visits Annual Report 2017/18.*** This report summarises the findings of the Trust's Unannounced Assurance visits which have taken place during 2017/18. The protocol for visits for 2018/19 has been strengthened for tighter completion on the management of improvement action plans and with oversight from Performance.
- ✓ ***Announced Quality Visits CCG/Healthwatch Annual Report.*** This report summarises the findings from the announced quality visits which have jointly taken place between the Trust, CCG and Healthwatch during 2017/18. The Trust is reviewing next year's schedule with our commissioners to agree a stronger focus on best practice.
- ✓ ***Data Quality Forum Update.*** The Committee received minutes from the 24 April 2018 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.

- ✓ ***Environmental Ligature Risk Assessment and Investment Proposals.*** The Committee received a report regarding the programme to reduce the number of Ligature Anchor points; however there is a requirement for further consideration by the Executive Team and this is being dealt with as a matter of priority.

- ✓ ***Letter to CEO from Quality Surveliance.*** The Trust's surveillance rating remains on Routine, as there are no concerns about the Trust.

- ✓ **Ward 1 Appreciate Enquiry Progress Report.** The Committee received this action plan which details progress following a report detailing the findings of an Appreciative Inquiry report concerning Ward 1.

- ✓ ***SI Annual Report – 2017/18.*** The Committee noted the key categories and improvement programme in place to address these. The Committee also noted lessons learnt and notable practice.

- ✓ ***Self Harm Annual Report – 2017/18.*** The report provides an analysis of self harm events which occurred during the period from 1 April 2017 to 31 March 2018.

- ✓ ***Governance, Audit, FOI and Risk Annual Report 2017/18 –*** The Committee received the Annual Report which describes the work of the Governance, Audit, FOI and Risk department over the previous 12 months and forward plans for 2018/19.

- ✓ ***Safeguarding Report Q4 2017/18*** The detailed report provides information to the Committee on current case reviews, themes and trends in safeguarding and pertinent issues from the Trust`s Safeguarding Team.

- ✓ ***Community Mental Health Survey.*** The 2017 Community Survey results have been collated into an amalgamated action plan which is monitored on a 3 monthly basis through Directorate Business meetings.

- ✓ ***Director of Infection, Prevention and Control Report Q4 2017/18.*** The report provides assurance in relation to IPC arrangments within the Trust.

5. Policy Report

The Committee granted extensions to the following policies until 31 August 2018 and request for ratification by the Trust Board.

1.25 Food Waste Policy
4.27 Protected Mealtimes
1.19 Chaperoning Policy
4.32 Privacy and Dignity
4.41 Responding to Patient opinion
5.06 Waste policy
5.09 Environment Policy
5.18 Risk Markers Policy
5.25 New and Expectant mothers
R07 CS Gas Policy
R10 Teaching Physical Interventions to carers
1.04 Complimentary Therapies

1.70 Managing Allegations of Abuse
4.2 Volunteer policy
4.22 Children visiting MH & LD Hospitals
5.20 Health and Safety Audit procedures
1.55 Advanced Statements
4.4 Being Open – Duty of Candour
5.19 Violence and Aggression with Police Protocol
5.37 Pinpoints
5.38 Lockdown
4.33 Clinical Photography
IC9 Food Safety
5.14 Outdoor Activities

The Committee approved the following policies for 3 years and request for ratification by the Trust Board.
5.35 Medical Devices Policy
1.15 Dress and Appearance Policy
1.70 Managing Allegations against staff

6. Learning from Experience Report March/April 2018

The Committee received the Learning from Experience report detailing emerging issues, including learning and action taken following the feedback from Trust services.

7. 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.

8. Board Assurance Framework Q1 2018/19 Quality Objectives

The Board Assurance Framework (BAF) for 2018/19 aligns the Trust`s new strategic objectives to our quality priorities and key risks. The 2018/19 BAF provides describes the key control and assurances to ensure delivery of the seven strategic objectives. The paper details the strategic objectives and risks that are overseen by the Quality Committee.

9. OFSTED Feedback Unannounced Inspection Dragon Square

The report has not yet been received.

10. 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**.**

11. Next meeting:
Thursday 9 August 2018 at 2pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Laurie Wrench, Associate Director of Governance
09 February 2018

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REPORT TO TRUST BOARD)

Enclosure No:16

Date of Meeting:	21st June 2018		
Title of Report:	Freedom to Speak Up		
Presented by:	Alex Brett, Director of Workforce, OD and Communications		
Author:	Alex Brett, Director of Workforce, OD and Communications		
Executive Lead Name:	Alex Brett, Director of Workforce, OD and Communications	Approved by Exec	☐

Executive Summary:	Purpose of report	
NHS Improvement and the National Guardian's Office have recently published refreshed guidance setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement, entitled *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts, May 2018.* This report sets out a brief update regarding the Freedom to Speak Up approach, considerations for the Board arising from the new guidance and proposals for strengthening the Trust approach as a result.	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☐

Seen at:	• SLT ☐ Execs ☐	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	N/A		
Resource Implications: Funding Source:	Management Time N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	All staff are actively encouraged to access the abovementioned mechanisms to raise concerns and can do so either electronically, in writing or where requested via telephone/face to face meeting.		

Recommendations:	• **Note** and **receive** the report for information • **Support** the proposed next steps • **Receive** an update report quarterly

Freedom to Speak Up

1. Introduction

As a Trust we are fully committed to supporting staff to raise any issues or concerns they have ensuring that they are all taken seriously, investigated where appropriate, actions taken where required and any lessons learnt are shared across the organisation. Effective speaking up arrangements helps us to protect patients and improve the experience of our staff. Having a healthy speaking up culture is evidence of a well-led trust.

The Trust has introduced a number of mechanisms to date to support staff to raise their concerns including; the Dear Caroline initiative, and a review of the Trust's formal Raising Concerns Policy (formerly Whistleblowing Policy). The Trust also operates a Resolution of Grievance and Dispute procedure which supports staff to raise issues regarding their working arrangements. We have recently re-appointed to the Freedom to Speak up Guardian role, which will provide additional capacity to undertake the role and strengthen this organisationally through building a network of champions.

The Board currently receives a Being Open report quarterly which provides a combined report of the abovementioned mechanisms reporting on their collective activity providing details regarding the themes, trends and patterns for assurance at Trust Board.

2. New Guidance

NHS Improvement and the National Guardian's Office have recently published refreshed guidance setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement, entitled *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts, May 2018.*

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guidance is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

A self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve and it is proposed that the Board undertakes this at its next Board Development session in July 18. Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

3. Outline of the guidance

3.1 Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They

can provide evidence that they have a ***leadership strategy and development programme*** that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

3.2 Leaders have a structured approach to FTSU

There is a ***clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.*** There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

3.3 Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. ***Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.*** Senior leaders model speaking up by acknowledging mistakes and making improvements. ***The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.***

3.4 Leaders are clear about their role and responsibilities

The trust has a ***named executive and a named non-executive director*** responsible for speaking up and both are clear about their role and responsibility. ***They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.*** Other senior leaders support the FTSU Guardian as required.

3.5 Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the ***FTSU Guardian has ready access to applicable sources of data to enable them to triangulate*** speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

3.6 Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process

- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. Boards should consider inviting workers who speak up to present their experience in person.

3.7 Leaders engage with all relevant stakeholders

A ***diverse range of workers' views are sought, heard and acted on to shape the culture*** of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan. The organisation is ***open and transparent about speaking up internally and externally.*** Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. ***Discussion of FTSU matters regularly takes place in the public section of the board meetings*** (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere. Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, ***senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians.*** Senior leaders request external improvement support when required.

3.8 Leaders are focused on learning and continual improvement

Senior leaders ***use speaking up as an opportunity for learning*** that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- **the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured**
- **workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome**
- **investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.**

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

4. Individual Responsibilities

The Guidance outlines refreshed and strengthened specific roles and responsibilities for:

- **The Chair and Chief Executive**
- **Executive Lead for FTSU**
- **Non-Executive Lead for FTSU**
- **Director of Workforce, OD and Communications**
- **Medical Director and Director of Nursing**

5. Next Steps

It is proposed that the Trust will:

- Continue to utilise all four mechanisms to support staff to raise concerns and issues
- Support the ongoing development of an open and transparent culture through a refreshed and strengthened approach to Freedom to Speak Up through the Guardian role and development of Freedom to Speak Up Champions.
- Complete the self-assessment at the July Board Development session and develop an action plan to strengthen the approach, being clear on the Board, Executive and Non-Executive roles and responsibilities
- Continue to strengthen communication to the wider Trust to help promote speaking up to managers, professional leads, trade union representatives as well as the more formal routes that are available.

6. Recommendations

It is recommended that the Trust Board

- **Note** and **receive** the report for information
- **Support** the proposed next steps
- **Receive** an update report quarterly

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REPORT TO TRUST BOARD (CLOSED)

Enclosure No:17

Date of Meeting:	21st June 2018		
Title of Report:	Update on Integrated Locality Working (Directorate Restructure)		
Presented by:	Jonathan O'Brien, Executive Director of Operations		
Author:	Nicky Griffiths, Project Manager Jonathan O'Brien, Executive Director of Operations		
Executive Lead Name:	Caroline Donovan, Chief Executive	Approved by Exec	☒

Executive Summary:	Purpose of report	
The paper provides the Trust Board with an update on the transformation journey that is underway to restructure the Trust's Clinical Directorates. This is following Trust Board approval, on the 18th April 2018, for the case 'Realignment of Operational Directorates - Integrated Locality Working'. The paper is intended to update the Trust Board on progress against the planned implementation timetable, governance arrangements, engagement and feedback, risk review and progress on supporting corporate activity from finance, governance, performance and workforce.	Approval	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☒ Date: 12th June & 18th June 2018.	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	N/A		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	Note progress to date.		

1. Introduction

An initial business case for the 'Realignment of Operational Directorates' was submitted to Trust Board on the 25th January 2018. The 'Integrated Locality Working Project' was outlined in this paper, describing an ambition to align leadership, management and clinical staff in a way that would allow the Trust to support integrated, locality based, out of hospital services, working across footprints for 30-70k patients.

A further business case that built on this proposal and gave updates on preferred options, revised phased approach, proposed governance arrangements and updates from a Finance, Performance and Digital and Workforce perspective was then submitted to Trust Board on 18th April 2018 for approval to progress to implementation. This Business Case, 'Realignment of Operational Directorates - Integrated Locality Working' gained approval.

This paper provides an update on the transformation journey that is underway following Board approval of the locality working project on the 18th April 2018 and the associated restructure of clinical directorates.

2. Planned Implementation

Key to the success of the project is to have a phased approach to implementation.

2.1 Phase 1 – Clinical Directors, Associate Directors (HOD's), Deputy Director of Operations

Phase 1 commenced on Monday 30th April 2018 through formal consultation and appointment of the Clinical Directors and Associate Directors is now taking place. Interviews are taking place for the Deputy Director of Operations post on Thursday 5th July 2018.

It is therefore anticipated that Phase 1 will be completed by Friday 6th July 2018.

2.2 Phase 2 – Configuration of Trust-wide Professional Heads

Phase 2 commenced on Monday 4th June 2018 through formal consultation. The consultation is live at the present time.

It is anticipated that Phase 2 will be completed by 16th July 2018.

2.3 Phase 3 - Appointment of Associate Clinical Directors, Service Managers, Matron/Quality Leads and AHP & Psychology

Phase 3 is in the planning stages and is scheduled to commence by 9th July 2018 and be concluded by Friday 31st August 2018.

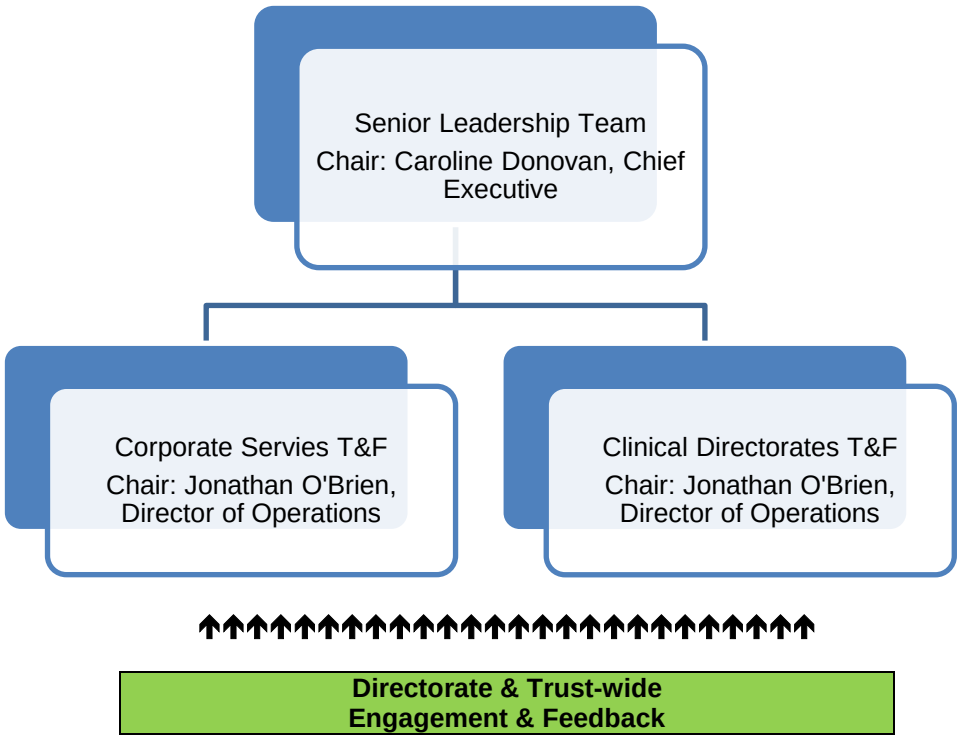
The clinical and managerial appointments for the new configuration of four Directorates will be concluded at this point and from September 2018 the Trust will report and operate from a four Directorate structure.

3. Governance Arrangements

From the Senior Leadership Team - two task and finish groups have been established, both of which are chaired by the Trust's Director of Operations. The groups are underway and have been established to oversee the governance arrangements for the process. They provide a forum for discussion and 'confirm and challenge', allowing a place for the development of the process in a meaningful and engaging way.

- **Corporate Services Task & Finish Group (CSG**) - representation at a fortnightly meeting from Workforce, Communications, Finance, Performance & Digital, Estates and Nursing, Quality and Governance.

- **Clinical Directorates Task & Finish Group (CDG) -** representation from current Heads of Directorate and Clinical Directors.



4. Completed Engagement & Feedback

The Trust has specifically developed a website - Integrated Locality Working Project. http://localities.wpengine.com/

This is a stand-alone website whereby staff can learn about the project aims and provide comments and feedback. It includes information on the new structure, governance arrangements and a calendar of events. It also includes a Frequently Asked Questions (FAQ) page so that staff can see if their queries are addressed in this section without having to submit individual questions. Individual questions however can be submitted if preferred via a 'Hearing your Voice' form available within the website. The clinical lead for the project collates the questions posed via the website and the Task and Finish groups will support the formulation of answers. The Director of Operations has oversight and final sign off for responses as Executive Lead for the project.

The website to date has received a total of 28 'Hearing your Voice' forms, 22 of these were anonymous submissions.

Feedback submitted by current Directorate (if known)	Nature of comment/question
Substance Misuse (9)	• Commissioning/Tendering concerns • Support for current HOD/CD • Loss of expertise and skill when brought into a wider specialist directorate.
Adult Community (2)	• Change in role/concerns around generic working • Website issues / carification
CYP (13)	• Fidelity to national policy and guidance • Consultation

	• Commissioning • CQC rating maintenance
Unknown (4)	• Governance arrangements • Organisational structure • Evidence base for MCP working • Website issues / maintenance

4.1 Directorate Engagement Sessions

In total, 12 engagement sessions (2 per existing Directorate) have now been delivered, led by the project Clinical Lead and the current Heads of Directorate with support from the HR Team. These sessions have given a dedicated opportunity for clinical teams and staff within the directorates to give their valued contributions and comments to the transformation process. All of the feedback from these sessions has been collected and fed through into the Task and Finish Groups. Staff have been invited to attend sessions outside of their own directorate to increase opportunities for engagement.

As requested by clinical staff during these sessions, further directorate engagement sessions will continue to be held throughout the process, giving teams timely updates on the transformation process and continuing to give them an opportunity to engage, feedback and comment. The second round will run in July and August 2018 and a third round when the new Directorates have been formed in September and October 2018.

Attendance at the engagement sessions varied across the Directorates. Whilst the Substance Misuse Directorate have submitted the most comments and questions to the website, there was limited staff attendance at the engagement sessions facilitated for that Directorate. In light of this an offer has been made to that directorate for the Project Clinical Lead to attend other forums/meetings that may be useful to the Directorate.

The inpatient directorate sessions also received limited attendance and no identifiable feedback forms have been completed on the website by that directorate. It may be that it is anticipated that in the inpatient areas, little will change. It is acknowledged however that lower attendance at the sessions could also have been impacted on by staffing levels and the maintenance of service delivery at ward level. This has highlighted a need to further engage with this Directorate in a more robust and meaningful way and this is currently being planned.

Both CYP sessions were well attended and they have also been the biggest subscribers to the website via the 'Hearing your Voice' forms submitted. On the suggestion from a CYP engagement session, the Project Clinical Lead has agreed to do a rolling programme of engagement sessions that will run throughout the restructure phases - keeping teams updated and continuing to provide a forum and opportunity for discussion and feedback.

Adult Community, NOAP and Learning Disability Directorates had well attended sessions and despite not subscribing heavily to the feedback forms on the website have, submitted regular contributions and feedback to the Task and Finish Groups.

Directorate	Attendance across 2 sessions
Substance Misuse	**15**
Adult Inpatient	**7**
Adult Community	**42**
Neuro and Old Age Psychiatry	**30**
Learning Disability	**35**
Children & Young People	**53**
Total	**182**

The main themes received from the sessions overall in terms of feedback mirror those which have been received via the website:

- Impact on service users - positively in a reduction in unnecessary barriers around transition and services being located 'closer to home', but concern that skill set of staff may be 'diluted' and

they would be required to work 'generically' with a loss of role identity/expertise. Reassurance has been provided on these points.
- The size and scale of the new 'Specialist Directorate'.
- Wide support for an overarching Acute Services and Inpatient Care.
- Potential for a lack of focus and expertise in future commissioning and tendering negotiations.
- Requests to have more detail about the structure and the localities - at team level and at an individual level once the new Directorates are formed.
- How the transformation process can be influenced by clinical staff at team level.
- Queries around bases / estates.
- Staff wanted to understand more about new roles and how the restructure may present new opportunities for personal development and career progression.
- Professional structure proposals were well received.

5. Future Engagement Plans

The professional network groups will continue to be provided with regular opportunities for update, engagement, comment and feedback- all of which are chaired / led by one of the Executive Team.

- Senior Operational Team (SOT) – Chaired by Dir. Of Operations
- Senior Medical Team (SMT) – Chaired by Medical Director
- Professional Leadership Advisory Group (PLAG) - Chaired by Medical Director
- Directorates from HoD's and CDs at their regular Directorate Board meetings
- Professional Network Groups including-
    - Nurse Network – Chaired by Director of Nursing and Quality
    - AHP Leads Meeting – Chaired by Director of Nursing and Quality
    - Social Care Forum – Chaired by Director of Nursing and Quality
    - Leadership Academy – Chaired on rotation by an Executive Director

The Clinical Task & Finish groups will continue to operate fortnightly as the regular forum for feedback and development of both clinical structures and corporate services in line with locality working.

In addition, '*Towards Outstanding*' engagement sessions will be established and facilitated through the Organisational Development Team to support commencement and transition in Phase 3. Again, all feedback from these sessions will feed into the Task and Finish groups and into SLT.

The Organisational Development Team is in the process of recruiting extra resource into the team that was agreed within business case.

6. Raising Concerns

As would be expected, some comments and queries have also been raised outside of the engagement sessions or the website. The project team have taken the approach that staff raising concerns about the restructure should be listened to, have their questions answered in a timely manner and positively encouraged to engage with the process.

The Chief Executive Officer and the Executive Director of Operations have received communications from individuals directly and in response, individuals and peer groups have had bespoke meetings arranged to discuss any concerns and issues raised.

The Trust's current procedures for expressing and raising concerns, for example through 'Dear Caroline', will continue to support the locality working project group to better understand any concerns people may have and enable timely responses to questions and comments about the proposals to be given.

Three 'Dear Caroline' submissions have been received by the Chief Executive Officer since the locality working project commenced in relation to how the directorates will be re-structured. These

have all related to CYP service provision and delivery and have all been responded to in a timely manner.

7. Corporate Services

7.1 Finance

The Trust is required to deliver a £2.8m (3%) Cost Improvement Programme for 2018/19, of which the restructure is expected to deliver a proportion.

The proposed change to the leadership and management structure in Phases 1 – 3 is estimated to drive an element of recurrent efficiencies. However, once HODs, Professional Leads and Service managers are appointed, Directorates will be expected to work up transformation programmes on an ongoing basis, which will drive improvements and efficiencies.

Upon completion of Phases 1 to 3, detailed work will be undertaken to consolidate and transact efficiencies achieved and planning will begin for those to be delivered within the new Directorates.

In readiness for the switch to financial reporting in the new structure in September 2018 (month 5):

- Finance has worked in association with other corporate departments to agree a cost centre hierarchy for clinical directorates that is consistent and can be used for benchmarking purposes. This is detailed in **Appendix 1**.
- Finance has identified a number of pooled budgets of medics, psychologists and administrative staff. Work has commenced to agree appropriate alignment with the new Directorates and budgets.
- Work has commenced to agree the appropriate apportionment methodologies that will be used for non-pay (drugs, estates, travel) to new Directorates.

7.2 Workforce

Details of workforce implications and impact have been evaluated and are detailed within the Management of Change documents for Phase 1 and Phase 2.
Phases 3 and 4 and any associated MOC processes will follow in due course.

- **Phase 1** *in progress*: Heads of Directorate and Clinical Directors Management of change will begin formal consultation on 30th April 2018 with a completion date of 6th July 2018.

- **Phase 2** *in progress*: Professional Heads Management of Change began formal consultation on 4th June 2018 with a completion date of 16th July 2018

- **Phase 3:** Associate Clinical Directors, Service Managers, AHP & Psychology Leads and Matron / Quality Leads. Formal consultation will begin on 9th July 2018 with a completion date of Friday 31st August 2018.

- **Service Improvement & Transformation** to commence 3rd September 2018

Detailed updates to the ESR and TRAC workforce systems are taking place as the new Directorate structures are developed through Phases 1 to 3.

7.3 Information & Performance

There is currently no impact on Information and Performance reporting, but work has commenced on preparation for the configuration of the Trust in a four Directorate structure. There will be an impact on reporting to create new locality look up tables, build locality description into data marts and align all scripts to localities. This will require additional resource.

For reporting purposes it will be necessary to assess the impact of the system change, reconfigure the data warehouse / data marts and develop the suite of reports to support the new locality leadership and team structure. This can only commence once the system change has been completed.

An estimation regarding timescales and additional resource required will be able to be provided once the change requirements have been defined. It will also impact on BAU.

There will be an impact on SLA and PLICS reporting mid financial year and there may be a gap in reporting depending on the scale of the team changes. This will need to be negotiated with commissioners.

There will also be a requirement of validation of locality reports and any new reports by Directorates. In a change to the original schedule, performance reporting for the new structure will now commence on 1st September rather than 1st July 2018. This is in response to feedback from the Clinical Directorates Task and Finish Group, who reported concerns that a two month transition period would be prudent following the appointment of new Associate Directors and Clinical Directors. The new Associate Directors and Clinical Directors will now have a period following appointment up to the 1st September 2018 where they will appoint to the positions in their new structure, whilst the Trust continues to operate on a six Directorate basis.

There will be a need to ensure any potential data quality issues are resolved prior to the reconfiguration. For example, ensuring referrals are attached to the correct teams, closing down of referrals and out-coming historic activity in advance.

It will be necessary to provide post implementation support, data quality validation and issue resolution for following implementation of changes.

It is expected that locality working will impact on the requirement for mobile devices which will be defined at the detailed costing phase.

7.4 Estates & Facilities

There is no significant Estate & Facilities work to be completed during Phases 1 to 3 of the restructure, however it is recognised that from September, the new Directorates will need to draw on support in relation to their transformation plans.

8. Risks and Mitigations

The Corporate Services Task and Finish Group and the Clinical Directorates Task and Finish Group are recording, monitoring and reviewing any risks identified as regards the project on the project action log.

At Directorate level, the HODs and CD's will also record, review and monitor any risks pertinent to their local areas on their directorate level registers.

All committees of the board have been asked to add the restructure programme to the current risk register for each committee, as appropriate, to provide assurance and ensure risks are appropriately managed and mitigated. These are detailed below and reviewed at each committee.

Business Development Committee

There is a risk to the sustainability of New Care Models due to insufficient capacity and capability for change, particularly within the clinical and operational teams with a consequence of not fully contributing to the new care models and therefore not realising the full potential of integration – residual score of 16 - owned by Director of Strategy.

People & Culture Development Committee

There is a risk that staff engagement scores, turnover and retention for the Trust will be impacted on as a result of the change and transition to implement the integrated locality working structure – residual score of 12 – owned by Director of Workforce.

Quality Committee

There is a risk that during reorganisation the Trust could fail to improve patient safety and deliver high quality services, resulting in less than optimal care, reputational harm and increased scrutiny – residual score of 12 – owned by Medical Director.

9. Summary

In the time period since the Trust Board approved the restructure of Operational Directorates in April 2018, a significant amount of work has been completed to ensure that the restructure us delivered in the planned timescale, with the Trust operating on the basis of four Clinical Directorates from September 2018. The programme of work is currently on schedule, however it should be noted that there is a significant amount of work to be completed in July and August 2018 (Phase 3) in order to meet the timetable.

10. Recommendations

The Trust Board is asked to:

- Receive the report.
- Note the significant progress and work completed by all teams between April and June 2018.
- Receive a further update on progress in July 2018.

Appendix 1 – Budget Hierarchy