North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON Thursday 23rd May 2019, 10.00AM,
BOARDROOM, LAWTON HOUSE, BELLRINGER ROAD, TRENTHAM, STOKE-ON-TRENT, STAFFORDSHIRE, 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 – 25th April 2019** *To APPROVE the minutes of the meeting held on 25th April2019*	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 recognise 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 Richard Bagnall, Registered Nurses Acute & Urgent Care* To be introduced by the Chief Executive and presented by the Chair.	Verbal

9.	**PATIENT STORY – THEA COSTA'S STORY** *To RECEIVE a Patient Story from Thea Costa to be introduced by Maria Nelligan, Executive Director of Nursing & Quality*	Verbal
	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 Service User and Carer Council*	Assurance Verbal
12.	**PERSON CENTREDNESS FRAMEWORK PRESENTATION** *To RECEIVE the Person Centredness Framework Presentation from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Presentation
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
13	**REDUCING THE RISK OF SUICIDE AND SELF HARM IN PEOPLE WITH A LEARNING DISABILITY : HEALTH SERVICE JOURNAL (HSJ) AWARD PRESENTATION SUMMARY** *To RECEIVE the Health Service Journal Award Presentation Summary from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 5
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
14	**NURSE STAFFING MONTHLY REPORT (March 2019)** *To APPROVE the Nurse Staffing Monthly Report presented by Maria Nelligan, Executive Director of Nursing & Quality*	Approval Enclosure 6
15.	**SAFEGUARDING ANNUAL REPORT** *To APPROVE the Safeguarding Annual Report presented by Maria Nelligan, Executive Director of Nursing & Quality*	Approval Enclosure 7
16.	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) REPORT QUARTER 4 2018/19** *To APPROVE the Director of Infection Prevention and Control Quarter 4 Report presented by Maria Nelligan, Executive Director of Nursing & Quality*	Approval Enclosure 8
16a	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) ANNUAL REPORT** *To APPROVE the Director of Infection Prevention and Control Annual Report presented by Maria Nelligan, Executive Director of Nursing & Quality*	Approval Enclosure 9

17.	**MORTALITY SURVEILLANCE QUARTER 4 REPORT 2018/19** *To APPROVE the Mortality Surveillance Quarter 4 Report 2018/19 presented by Dr Buki Adeyemo, Executive Medical Director*	Approval Enclosure 10
18.	**SERIOUS INCIDENTS QUARTER 3 & 4 REPORT** *To APPROVE the Serious Incidents Q3 and Q4 Report presented by Dr Buki Adeyemo, Executive Medical Director*	Approval Enclosure 11 & 12
19	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK ENHANCED REPORT (PQMF) – Month 12** *To APPROVE the Month 12 Performance Report presented by Lorraine Hooper, Executive Director of Finance, Performance and Estates*	Approval Enclosure 13
20.	**ASSURANCE REPORT FOR QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held on the 9th May 2019 from Patrick Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 14
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
21	**BEING OPEN QUARTER 4 - 2018/19 REPORT** *To RECEIVE the Being Open Quarter 4 – 2018/19 Report from Linda Holland, Director of Workforce, Organisational Development and Inclusion*	Assurance Enclosure 15
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
22.	**FINANCE REPORT – MONTH 12 (2018/19)** *To APPROVE for discussion the Month 12 Financial position presented by Lorraine Hooper, Executive Director of Finance, Performance and Estate*	Approval Enclosure 16
23.	**ASSURANCE REPORT FOR FINANCE, PERFORMANCE AND ESTATES COMMITTEE** *To RECEIVE the Finance, Performance and Estates Committee Assurance report from the meeting held on the 9th May 2019 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 17
24.	**ASSURANCE REPORT FOR PRIMARY CARE COMMITTEE** *To RECEIVE the Primary Care Committee Assurance report from the meeting held on the 10th May 2019 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 18
25	**ASSURANCE REPORT FOR THE EXTRAORDINARY AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from the Extraordinary meeting held on the 24th April 2019 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 19
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	

26	**ASSURANCE REPORT FOR PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** *To RECEIVE the People and Culture Development Committee Assurance report from the meeting held on the 13th May 2019 from Janet Dawson, Chair/Non-Executive Director*	Assurance Enclosure 20
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
27	**No items for discussion**	
	CONSENT AGENDA ITEMS	
28	**TOGETHER WE ARE BETTER – APRIL 2019 UPDATE** *To RECEIVE for information the Together We're Better April 2019 Update from Peter Axon, Chief Executive Officer*	Information Enclosure 21
	ANY OTHER BUSINESS	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 27th June 2019 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 RELATING TO AGENDA ITEMS	Note
	SERIOUS INCIDENTS	Assurance
	PERFORMANCE	Approve
	ESTATES	Assurance
	WORKFORCE AND AGENCY	Assurance
	ANY OTHER BUSINESS	

TRUST BOARD

Minutes of the Open Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 25th April 2019 At 10:00am in the Boardroom, Lawton House, Bellringer Road, Trentham, Stoke-on-Trent, Staffordshire, ST4 8HH

Present:

Chairman:

David Rogers
Chair

Directors:

Dr Keith Tattum
GP Associate

Maria Nelligan
Executive Director of Nursing and Quality

Tony Gadsby
Vice Chair / Non Executive

Janet Dawson
Non-Executive Director

Joan Walley
Non-Executive Director

Peter Axon
Chief Executive

Lorraine Hooper
Director of Finance, Performance and Estates

Russell Andrews
Associate Non-Executive

Chris Bird
Director of Partnerships and Strategy

Linda Holland
Director of Workforce, Organisational Development and Inclusion

Patrick Sullivan
Non-Executive Director

Dr Buki Adeyemo
Executive Medical Director

Jonathan O'Brien
Executive Director of Operations

In attendance:

Laurie Wrench
Associate Director of Governance

Lisa Wilkinson
Corporate Governance Manager (minutes)

Wendy Dutton
Chair Service User Carer Council

Jenny Harvey
Union Representative

Members of the public:
Tracey Flannigan – Registered Service Manager Specialist Children's Short Breaks Service

Retirees
None

The meeting commenced at 10:00am.

81/2019	**Apologies for Absence** Joe McCrea, Associate Director of Communications,	**Action**

82/2019	**Declaration of Interest relating to agenda items** No declarations of interest.	
83/2019	**Minutes of the Open Agenda – 28th March 2019** The minutes of the open session of the meeting held on 28th March 2019 were approved subject to: Amendment requested to Page 21 – **Assurance Report from Primary Care Committee** should read: The Clinical Director advised that Moorcroft Medical Centre were reminded to enter into a PCN with a further three neighbouring GP Practices; Hanley, Bucknall and Bentilee.	
84/2019	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***30/2019 – Minutes of the Open Agenda – 24th January 2019 – BiA Telephone Lines –*** *Actioned* ***49/2019 – Assurance Report from the Finance, Performance and Digital Committee –*** *Key Digital Developments Paper to come to Trust Board 25th April 2019. Agenda item.* *5**0/2019 – Staff Survey Results** – Action Plan to come to Trust Board 25th April 2019. Agenda item.* ***69/2019 – Enhanced Performance Quality Management Framework Month 10*** *- Stretch target for first and second treatment. Actioned*	
85/2019	**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. **A WARM AND GENEROUS WELCOME** Peter Axon introduced his first Chief Executives Report to the Board. Peter began by recognising and expressing his sincere thanks to all his new colleagues at all levels of Combined Healthcare for the kind, warm and generous welcome they had given me. Peter highlighted that when he applied to be Chief Executive, he spent some time researching how the Trust performed, the strengths of its people and its services and added how impressed he was with how truly outstanding Combined Healthcare appeared to be after his Stakeholder Panel and interview. Peter went on to say that in the short time he had managed to spend with the Trust, managers, frontline staff and partners he had been amazed at the amount of energy, positivity and quality he	

had encountered. The Trust journey over the last 5 years is truly inspirational and it is clear that staff are proud to be part of this transformation.

LOCAL SYSTEM UPDATE

The Planning documents for 2019/2020 at an organisation and system level were submitted to NHS Improvement in early April 2019. The Trust is progressing various programmes of work to achieve the operational, clinical and financial objectives described within these plans. Most notably for Combined Healthcare, is the launch of the CAMHS Trailblazer pilot. Our financial discussions with Commissioners at the point of this Trust Board meeting remain ongoing for this financial year. We are committed to ensuring a sustainable final agreement for Mental Health and Learning Disability services whilst recognising and where possible influencing, the wider system financial challenges.

In addition to in year programmes of work, we are also eager to support the creation of the longer term direction for the STP, including the evolution of the North Staffordshire Alliance Board, utilising the principles of Integrated Care Partnerships as referenced within the NHS Long Term Plan.

There is not yet a contract in place for 2019/2020 but a detailed conversation will take place during closed board today.

Joan Walley shared her concern of Stoke-on-Trent Council not having full information of the joined up work we want to do.

Chris Bird advised the leaders of Stoke-on-Trent Council have articulated their willingness to work in close collaboration with the Trust as part of which Chris has set up a conversation with the Deputy Director regarding how we can take this forward sharing a greater understanding of ours and the Council's direction of travel and planning arrangements for 2019/2020. Chris advised there will be a report going to the Trust's Executive Meeting on the 7th May regarding the city councils financial plan.

MARIA NELLIGAN TO LEAVE COMBINED

Maria Nelligan our Director of Nursing and Quality will be leaving the Trust to take up a new opportunity closer to home.

Maria has been appointed as Director of Nursing and Quality at Lancashire Care NHS Foundation Trust which provides Mental Health & Community services across Lancashire, Cumbria and Merseyside.

Whilst we are very sad to see Maria leave, we are extremely proud that she has been appointed to the role. This opportunity also allows Maria to continue working in the Mental Health sector of the NHS and support Lancashire Care NHS Foundation Trust with its improvement and transformation. This also removes the significant commute from Liverpool each day that she has been doing since 2015.

Maria has been an extremely highly valued member of the Trust Board and Executive Team and has made a significant contribution to obtaining

	our recent Outstanding rating from the CQC. Although we will greatly miss her, we wish her every success in the future. We won't be losing her quite yet and I'll keep you updated with plans for her replacement in due course. Appointments are underway for Executive vacancies which will be substantive appointments and will be discussed with NHSI. Joan Walley talked about job specifications including sustainable development goals and the expertise and capacity to inform on the health and wellbeing agenda. The NHS nationally are looking for leading organisations to take this agenda forward and to feed into Boards. Peter agreed Non-Executives will be involved in the appointments and these items will be included in the specifications. ***Received***	**PA**
86/2019	**Chair's Report** David Rogers updated the Board. The Department of Health and Social Care have not yet shared their finances and expectations even though we have now passed the end of the financial year and to memory this has not happened before. There are prospects of better, closer working relationships with UHNM and David reported that he had recently met with the Chair and there was a commitment on their part, to our delight, to work more closely with the Trust and other providers to transform things in a way that will help the hospital and the community. Jonathan O'Brien asked if the Trust was going to progress to having a formal Board to Board with UHNM. David confirmed this would be an excellent idea and will be on the agenda. ***Noted***	
87/2019	**Staff Retirements** There were no staff retirements present today. ***Noted***	
88/2019	**REACH Recognition Team Award** **Specialist Children's Short Breaks Service** The Specialist Children's Short Breaks Service has been selected to receive the REACH Team Award for meeting Ofsted requirements, achieving improved effectiveness status and improving outcomes for	

	children. The service provides overnight short breaks for children/young people 5-19 years old with a severe learning disability and other complex needs**.** During the stays the children and young people have the opportunity to have fun with peers completing activities inside and outside the unit, the staff-support them to gain independence and reach their full potential. Caring, positive relationships are developed between staff and children and their families. We aim to meet both health and social care needs. The service provides parents with the opportunity to take a break from their caring role, recharge their batteries and spend quality time with siblings. This helps to prevent family breakdown and reduces the number of looked after children. Improvements have been made in line with the 9 Ofsted quality standards. All children and young people accessing the service have benefitted through: Improved communication following children's preferred communication methods, increased opportunities for creative play, creating an environment more appealing to children and provided a vibrant, accessible outdoor play area, strengthening multi agency working, collaborative working with schools, ensuring safe recruitment and improved staffing levels, developing better informed, child centred, accessible support plans and increasing the knowledge of staff. The service has gained an 'improved effectiveness' rating. The children and young people are achieving better positive outcomes in education, health and social care. The service is still to be fully re inspected and are aiming to achieve a 'good' rating. All the improvements/good practice needs to be embedded into the day to day practice of the service. Janet Dawson asked if the team had noticed any change in the wellbeing of staff following the inspection. Tracey advised it was difficult at first as there were lots of changes and expectations but you can now see a real difference in the feel of the increased service, children have managed to go out on visits every day and staff now have a different mindset and increased positive morale. Workload has increased but staff can now see the benefits all round. Tony Gadsby asked in respect of OFSTED have any formal connections with OFSTED been agreed at the Darwin Centre. Tracey advised this had not been thought about but was a good valid point. Tony noted the team covers a range of ages and asked how much of a challenge it was when caring for the age range of 5 years to 18.5 years. Tracey advised this is still work in progress and the team have looked at compatible groups for the children and often rotate groups in terms of scheduling	

	breaks. The team has also asked parents to put requests in for holidays to prevent ad hoc stays to avoid those challenges. The service has the use of one bungalow which has two ends to it so there is the ability to split the bungalow to meet different needs. Wendy Dutton commented what the team is doing is brilliant and suggested the kind of work being undertaken by the team could be transferable particularly with older people with dementia i.e. pictorial one page items. Patrick Sullivan asked if there was anything the Board could do to help what the team are trying to achieve, if there were any blocks or challenges the Board could help with. Tracey advised the Trust has been very supportive with changes and finances but as previously mentioned staffing budgets is something that the team has difficulty with but that is something we are looking at. We have costed a business case and we are now part of safer staffing reporting. Dr Tattum added over the years many children from his practice had used the service and the service has always been good and could see improvement. The importance of the respite care cannot be underestimated. One lady described the service as stepping stones across a flooded river, as the needs of her child were overwhelming. Dr Tattum pointed out to the Board this service was as near as we can get to minimal input for maximum benefit. This is a superb cost efficient service. Tracey and the team were thanked on behalf of staff and parents. ***Received***	
89/2019	**PATIENT STORY – JACKIE AND MATTHEWS STORY – ASSESSMENT AND TREATMENT UNIT** Maria Nelligan, Director of Nursing and Quality told the story of Jackie and Matthew. Matthew is 20 years of age and has a diagnosis of autism and moderate learning disabilities. Matthew lived in a residential school specialising in working with people with autism and learning disabilities prior to hospital admission. Matthews's family live in Wolverhampton. Matthew has skills around sporting activities enjoying skating, running, using a trampoline and basketball. He has a lot of sensory needs and often engages in activities that provide sensory feedback, whistling, bouncing a ball, humming, rocking, hand flapping and flicking his hands in front of his eyes, water play; however he can easily become over stimulated and relies on staff support to manage his anxieties effectively by ending activities and directing to low stimulus environments. Matthew appears to respond better to short burst activities. Matthew regularly sees his parents and has a sister too who visits when possible.	

Prior to admission Matthews placement broke down due to high levels of challenging behaviours displayed by Matthew which included physical aggression towards staff, self-harming behaviours – banging his head against floors and walls, punching himself to the face, damage to property, stripping naked, and absconding. Matthews's parents also struggled with these behaviours during home visits. An urgent assessment was requested by the community team who then requested an inpatient bed which in turn resulted to admission to assessment and treatment unit on 19 May 2018. Matthew is supported by the nursing team through a positive behavioural approach and has daily positive engagement with his immediate support staff. Matthew continues to require support to manage anxieties and agitation associated with Autism Spectrum Disorder through effective communication, sensory diet, positive behavioural support and use of prn medication.

On admission Matthew was not able to demonstrate capacity to understand treatment or detention. He was initially admitted under Section 2 of the MHA and then was regraded to Section 3 of the MHA.

What have we done? - MDT

- Individualised environment
- Person centred approach – getting to know Matthew's likes and dislikes
- Structured predictable day around Matthew's preferences
- Physical health needs – assessment from the dentist, identification of ingrowing toe nail – working with the acute liaison nurse to support reasonable adjustments from the university hospital for a consultation
- Staff rotating regularly to prevent burnout and reduce over-reliance on familiar staff
- Behavioural analysis – identification of sensory function for behaviours of concern
- Positive Behavioural Support plan agreed with parents and staff team – key themes around structured day, supporting Matthew to manage his levels of stimulation (not over or under-stimulated), consistent approach from staff.

Matthew is now planning to transition to a rehabilitation service. This will offer Matthew more opportunities to access the community and outdoor areas, whilst a suitable community placement is identified.

Due to the complexity of Matthew's needs it has been difficult to identify a provider that is able to meet his needs within the community. However, it does appear that due to improvements and reduced risk this is now much more likely.

It is anticipated Matthew will move on the 1st May 2019, he is currently in the middle of a two week transition; staff are supporting him in his new home and will ensure he is offered similar activities and those are enhanced. He is moving to the private sector (Huntercombe) we wish

	him luck and hope his placement goes well. Maria advised there is a complexity of people coming into our Assessment & Treatment Unit we currently have patients who are 3/1 and 5/1 we have had conversations with our CCG colleagues regarding the need to have a different provision in the county to support people like Matthew with autism. We have someone moving to Northumberland Tyne and Wear which is long distance but they do have an autism team. Assessment & Treatment is not set up to deliver ongoing support of this level of complexity. Jonathan O'Brien noted this was a positive story but highlighted what we have seen with Assessment & Treatment generally because of work around transforming care is a significant shift in cohort and complexity. The environment has changed and we need to recognise this. The two patients we have at the moment, that we have just described, have really brought this to a head. The Trust would like to have open discussions with CCGs around what the future is for the unit in terms of its function and environment. There is money within the Capital Plan over the next two years to substantially refurbish the unit. The environment is essential to underpin what we are trying to provide in terms of care. An internal group is being formed to address these issues and take forward. Maria Nelligan noted there was no one available to attend today from the team as they could not be released due to the staffing demand. Patrick Sullivan asked if there was any scope around partnerships with the voluntary sector. Maria said there was not, the resources around developing complex placements is sitting with the CCG, this used to sit with the Trust. Patrick added sometimes we need to build a place and put the team around it. Jonathan O'Brien added when we assess patients at Assessment and Treatment we are often waiting for bespoke provision to be set up. The Trust is are very reliant on the private sector which are expensive this is part of the discussions we need to have with CCGs locally David Rogers added there is the argument regarding avoiding out of area placements. Maria Nelligan commented that we the Trust is under pressure to discharge people but is beholden to the CCG. Dr Tattum asked, as a digital exemplar, if there is any role in technology in improving quality of care, safety controlling and reducing the costs. Dr Adeyemo highlighted it is already there but this is very similar to what has happened with dementia, there is a lack of understanding from the CCG in terms of need and we have been trying to raise awareness. We need the environment that facilitates and the understanding of the individual needs that we can transfer into the community are limited. Joan Walley highlighted if we are really looking at this we need to look at it in a wider strategic way and it requires a lot of partnership work with	

	local authorities as well. We need to avoid duplication of services. We as a Board need to look at more collaboration with the voluntary sector and look at it strategically. Chris Bird highlighted we are bringing forward a review of the local authority financial plans for 2019/2020, giving horizon scan of potential challenges. We are developing and refreshing the partnership strategy which will consider our relationships with the voluntary sector. Tony Gadsby added if we are to talk to the CCG regarding taking more complex patients at Assessment and Treatment we need to consider the facility as we have considered undertaking work before as the unit would not be suitable structurally. Maria Nelligan agreed there would need to be a new built purpose build but we still also need an Assessment & Treatment Unit it is not one replacing the other we still need both. Jenny Harvey added the worry is the sustainability of moving Matthew out to another provider, working with level of staff who are not specialists and not paid at the same level. People like Matthew then end up bouncing backwards and forwards in their lifetime. Maria confirmed that in Matthews case he will have registered practitioners supporting him.	
90/2019	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no members of the public present.	
91/2019	**SERVICE USER AND CARER COUNCIL** Wendy Dutton, Chair of the Service User Carer Council provided a verbal update. The Service User Care Council formally elected a Vice Chair, Sue Tams who is a wonderful volunteer with NHS management experience who sits on lots of charities. Observe and Act Training and Volunteer Mentor Training is ongoing. There is a Kings Fund paper looking at care and outcomes from service user carer perspective. One concern has been raised and discussed by the Council is that people are being discharged without any obvious planning for the event. Patients think they are going for an appointment to discuss their ongoing care and then are being discharged. Alternate months the Service User Carer Council undertake an educational workshop therefore we are looking to open this invite to people to have an open and honest conversation about discharge and ensuring expectations are reasonable. Dr Tattum commented this reflects his experience. People who have been under long term care have attended a routine review and then have been discharged it is not the fact they have been discharged but more the way it has been presented. Dr Adeyemo noted this discussion as	

	being timely as at the last away day for senior medics one of the items we focused on was care planning. Maria Nelligan and Dr Adeyemo have delivered mini workshops around MDT working. These two items will now be brought together enhance what we are trying to do reflecting on the issues identified with discharge planning. ***Noted***	
92/2019	**DIGITAL TRANSFER REPORT** Chris Bird, Director of Partnerships and Strategy provided an update. The paper provided an update on the key digital developments across the Trust including: • Lorenzo Digital Exemplar • HIS Service Review • Electronic Document Transfer • Cyber Security • Lorenzo Roll-Out The report includes an update on the actions to deliver each of the projects above which have all reached an advanced stage of maturity. The paper was a precursor to a refresh of the Digital Strategy which will follow in June 2019. This will reframe the strategic direction of travel for the Trust to strengthen alignment to the commitments in The NHS Long Term Plan. Chris highlighted North Staffordshire Combined is one of only four Trusts nationally (the only Mental Health Trust) to achieve Lorenzo digital exemplar status which gives us the ability to work in partnership with DXC. The aim is to develop digital maturity. We will progress this through the development of the online portal. This has been aligned to the CAMHS Trailblazer project and we have to provide regular updates to NHS Digital. Joan Walley noted the report focussed on the technicalities and asked about the creative opportunities the digital strategy gives us. Joan suggested we could link with Ruth Chambers, Clinical Lead for Technology Enabled Care Services, Stoke-on-Trent CCG, around the work she is undertaking. Chris Bird confirmed Ruth will be involved in discussions which will all fit around the strategic direction of travel and an update on this will be included in the digital strategy. Russell Andrews asked if he should be concerned that the status of some of the projects were rated red or yellow. Chris Bird advised there are a few risks that do not come through as well as they should through the rating. i.e. in relation to Docman we are behind where we said we should be, there is a national requirement in the joint planning	

	requirement that all discharge summaries would be complete by 2018. There are a set of reasons why nationally this has not been delivered. This was a particular concern raised by the Local Medical Council. The timeline referenced is the 20th April 2019 the revised go live date is the 3rd May 2019. The review of HIS is essentially the support we receive from a hosted function. There is a review that is ongoing and the outcome of the review is reliant on the views of the Midlands Partnership Foundation Trust (MPFT), we want to be more strident as our view should be our view and if there is a gap from the baseline provision and what we need going forward we need to progress a conversation around that. Peter Axon added when the strategy comes back we need to reflect on how this benefits clinicians and patients. ***Received***	
93/2019	**NURSE STAFFING MONTHLY REPORT (February 2019)** Maria Nelligan, Executive Director of Quality and Nursing presented the report. The paper outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during February 2019 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during February 2019 was 79% for registered staff and 103% for care staff on day shifts and 74% and 112% 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 Managers supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. There were no incidents related to ward nurse staffing reported during February 2019. Staff prioritise patient experience and direct patient care. During February there were 3 occasions when patient activity had to be cancelled and could not be rescheduled and 5 occasions when patient activities were shortened; this amounted to 3 hours of total activity time being cancelled and had minimal impact on patient experience and direct patient care. In order to maintain safer staffing the following actions were taken by the Ward Manager during February 2019: • 133 staff breaks were cancelled (equivalent to approximately 3% of breaks). Any time accrued due to missed breaks is taken back with agreement of the Ward Manager. • There were 5 occasions reported during February when a staff	

	supervision session had to be cancelled to support safe staffing levels. • A total of two mandatory training sessions and one staff Performance Development Review (PDR) had to be cancelled to support safe staffing levels during February 2019. Safe staffing reporting continued to highlight challenges in staffing wards during February 2018; the Trust did however experience an increase in its fill rate of registered nursing shifts during February 2018. We continue to see a significant number of RN vacancies being filled by newly qualified RNs and the Trust continues to employ a number of strategies with the support of the HR and communication teams to attract RNs during this national shortage. The Trust is participating in the NHSI Retention Support Programme. A project team visit has been completed and learning shared, this has been incorporated into the Trust Recruitment and Retention Action Plan. There have been significant challenges in staffing Assessment and Treatment recently which has had an impact. Jenny Harvey commented that breaks not taken at 3% seemed low but asked if there were certain areas where that is a worry, particularly with staff undertaking longer shifts and is the Trust still looking at the flexibility of its offering and is there more we can do? Could the Trust tailor its work to what people want? Maria advised the Trust has introduced the new shift system long and short days but this has been implemented for a while so perhaps it would be timely to look at how that feels for people and if there are any ideas of how that can look differently and obtain feedback from staff. Maria will look into this. Tony Gadsby asked for Dragon Square to be added to the matrix going forward. Maria advised this would be included in the Safer Staffing Annual Review that is coming to Board May 2019. Amendment required to the report page 4 Item 5.5 does not identify what it is and Maria will ensure this is changed. ***Approved / Received***	**MN**
94/2019	**ENHANCED PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 11** Lorraine Hooper, Director of Finance, Performance and Estates highlighted the following: IAPT - 16.0% at M11 from 10.8% at M10. There are a number of clients who choose not to commence therapy in line with national waiting standards or who DNA their treatment appointment and then request a further appointment. The Service Specification indicates a more engaging approach to client commencement to treatment which clinically	

	the service adheres to. CPA Review - 93.6% at M11 from 91.6% at M10**.** CPA review for Acute Services & Urgent Care was 75.0% at M11 from 14.3% at M10, Patrick Sullivan queried if this was accurate as it seemed low. Lorraine Hooper will look into this. ***Approved / Received***	**LHoo**
95/2019	**DATA SECURITY AND PROTECTION TOOLKIT ANNUAL DECLARATION** Chris Bird, Director of Partnerships and Strategy presented the report. The Data Security and Protection Toolkit replaces the Information Toolkit and is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. The Trust successfully completed its assessment in compliance with the national deadline of 31st March 2019 and submitted 100 pieces of evidence across 40 lines of enquiry over the 10 domains. In each instance, the Trust declared it had met the assurance threshold required. The IG Team will develop an IG Improvement Plan pending national feedback which will feed into the planned refresh of the Digital Strategy. ***Received***	
96/2019	**MONTH 11 FINANCE REPORT** Lorraine Hooper, Director of Finance, Performance and Estates presented the report. The Board were asked to take the report as read as Lorraine was in a position to provide a verbal update on the Month 12 position. Draft accounts were submitted yesterday. Lorraine reported a 2018/19 surplus of £3,576k. Final accounts will be summited in June 2019 The Board were asked to delegate the sign off of the final set of accounts and opinion from external audit to the Audit Committee due to take place on the 24th May 2019 ahead of submission on the 28th May 2019. • The cash position of the Trust as at 31st March 2019 with a balance of £9,132k; which is £1,793k better than plan. • 2018/19 capital expenditure is £1,618k compared to planned capital expenditure of £2,185k. Patrick Sullivan noted the residential placement budget seemed to have	

	increased from £544K to £734K, Patrick asked if there are growing problems with this budget. Jonathan O'Brien advised discussions are taking place with the Stoke-on-Trent Council as this relates to the Section 75 contract. Meetings are taking place with Paul Edmondson-Jones, Director of Adult Social Care monthly. We have come to an arrangement regarding risk share which will be for one year only for 2019/2020 and a 50/50 risk share. We will be taking a long term view at what the contract should look like to see where we can minimise overspends on that budget and we are sticking to the criteria for entitlement for patients. There is a genuine gap in what we are being paid and what is being spent and we with the Council have come to the conclusion that the budget is insufficient. Our last Section 75 arrangement was agreed in 2011 which is why we are looking at a refresh. Joan Walley asked if this included children. Jonathan confirmed this was adults only. ***Received / Approved***	
97/2019	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & ESTATES COMMITTEE** Tony Gadsby, Non-Executive, presented the report for assurance from the meeting that took place on the 11th April 2019; highlighting the following: **Cost Improvement Programme (CIP)** The Committee received an update for Cost Improvement for M11 and were concerned that the total identified was significantly short of the target. CIP achievement to M11 was £1,269k, giving an adverse variance of £1,190k. The recurrent shortfall is forecast to be £981k, which has been 'risk adjusted' to reflect an element of uncertainty for schemes not yet worked up fully. 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. The committee noted that the focus was on working up schemes to deliver the 2019/20 target. **Estates Update** The Associate Director of Estates provided an update on key capital projects, allocated in the Capital plan for 2019/20. For the most part, the Committee were assured around the ability to deliver the Capital Programme, but requested further specific assurance around the ability to deliver the Assessment and Treatment Refurbishment within the year, as a business case has not yet been approved by Business Development Committee or Trust Board. **Terms of Reference:** The Committee agreed the revised terms of reference for the Finance,	

	Performance and Estates Committee. It was agreed that Business Development Committee should retain Investment Expenditure Limit approvals. Tony commented that the Committee requires three Board members to attend but currently there is one and this is being addressed. Tony also asked for it to be noted and acknowledged that there had been a very smooth transition between Suzanne Robinson leaving and Lorraine Hooper joining the Trust. ***Ratified / Received***	
98/2019	**REGISTER OF BOARD MEMBERS DECLARATIONS** Laurie Wrench, Associate Director of Governance presented the report. The report provided an update of current Board members interests given the change in membership since the last report. It is the Trust Board's responsibility to ensure the Trust operates its services in an open and transparent way. In line with the Code of Conduct and Accountability for NHS Board members and the Trust's Standards of Business Conduct Policy this information is published on the website and available for public view. ***Received***	
99/2019	**SELF CERTIFICATION G6 AND FT4 (PROVIDER LICENSE)** Laurie Wrench, Associate Director of Governance presented the report. Although NHS Trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. 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 2019 and FT4 by the 30th June 2019.	

	Tony Gadsby asked how Non-Executives would know if they were not conforming to the terms of the license during the year. Laurie Wrench will look into this and provide response at next meeting. ***Ratified / Received***	**LW**
100/2019	**ASSURANCE REPORT FROM BUSINESS DEVELOPMENT COMMITTEE** Joan Walley, Non-Executive Director presented the report for assurance from the meeting that took place on the 11th April 2019. Joan asked the report to be taken as read but highlighted that the Terms of Reference were agreed at the Committee and asked for approval of those from the Board. It was noted the paper was made available in the Open Board Agenda when this is usually discussed within the Closed Session it was suggested going forward there could be split report one for Open Board and tenders to be discussed in Closed Board. ***Approved / Received***	
101/2019	**STAFF SURVEY UPDATE** Linda Holland, Director of Workforce, Organisational Development and Inclusion presented the report highlighting the following: The Staff Survey responses this year have been grouped into 10 Themes: 1. Equality, Diversity and Inclusion 2. Health and Wellbeing 3. Immediate Managers 4. Morale 5. Quality of Appraisals 6. Quality of Care 7. Safe Environment – Bullying and Harassment 8. Safe Environment – Violence 9. Safety Culture 10. Staff Engagement The detailed nature of the new team reports mean that where there are less than 11 responses from a department, the scores are not shown to protect anonymity. This is especially the case when looking at some Corporate areas where departments contain less than 11 staff completing the questionnaire. In these instances we have to look at the overall themes, rather than specific questions, to identify areas to address. Our plan for 2019/20 is:	

	1. Through Staff Survey leads in each locality, a more intentionally detailed framework action plan will be produced owned and actioned 2. Identify and manage this through the naming of locality leads for staff survey 3. Establish a timeline of regular meetings and support to leads enabling them to share best practice 4. Enable dedicated time for directorates to have their Staff Survey plans to be heard and discussed at PCD 5. Strengthen Communications about Staff Survey "You said we did" now and throughout the year Jenny Harvey noted ownership by directors is good, the issue with the staff survey is that it is obsessed with benchmarking, i.e. if work is making staff unwell this is something the Trust should be doing better regardless of benchmarking. Linda advised a piece of work is underway as this is one of our objectives. Maria Nelligan highlighted the impact caring for people in distress has on carers themselves, the Trust implemented Swartz rounds acknowledging this and we are looking to roll out to more than one site at a time. It is part of one of the tools we can use in having a wellbeing strategy and approach to staff. Janet Dawson felt as part of the plans it would be helpful if we have an insight into the questions we did not ask. People might feel differently now we have a CQC rating of outstanding. We ask the questions once a year but it's how you feel today, next week and the week after tapping into the health of the organisation. Janet asked what our target is in terms of participation. Linda advised there is no target just an improvement on response rate each year. Janet felt this was perhaps something that we needed to think about further in the People and Culture Development Committee. Russell Andrews acknowledged the successful equality and diversity figure but noted the detail around revising PDR deadlines for June when all managers should have PDR's completed by June and in practice this seems out of sync. Linda advised that PDR documentation has been added to LMS and we are trying to streamline the process and language and therefore work is ongoing. We are ahead of that timescale the key is to ensure one is ahead of the other. ***Received***	
102/2019	**OPERATIONAL PLAN 2019/2020** Chris Bird, Director of Partnerships and Strategy presented the report for information. The Operational Plan 2019/20 has been produced as a collective effort from across the Trust's Executive Team and outlines the approach to activity, quality, workforce and financial planning for 2019/20.	

	This is the final version of the Operational Plan 2019/20 and is fully reflective of national guidance, regulator feedback of an initial submission in February 2019 and local comments from Trust Board. This will be published on the website as a standalone item and an easy read version is being produced. Jonathan O'Brien asked to what extend it mattered if we have a financial section as it may not be where we land. Chris advised the submission date of 4th April 2019 is as it was on 4th April 2019 there is no requirement at this stage to submit a revised plan. At intervals through the year we will be bringing back updates that will give us the opportunity to update through the year. ***Received***	
103/2019	**TOGETHER WE ARE BETTER – MARCH 2019 UPDATE** Peter Axon, Chief Executive circulated the report for information only.	
104/2019	**Any Other Business** **Staff Side Meeting with Sir Neil MacKay (STP)** Jenny Harvey highlighted that trade unions have still not met with Sir Neil McKay following cancellation of the meeting back in February 2019. Jenny confirmed there seemed to be a struggle to be engaged in the consultation. Peter Axon agreed to relay this message to Simon Whitehouse, STP Director and Neil MacKay, STP Chair.	**PA**
105/2019	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 23rd May 2019 at 10.00am, in the Boardroom, Lawton House, Bellringer Road, Trentham, Stoke-on-Trent, Staffordshire, ST4 8HH	
106/2019	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 12.31pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

Action	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
1	22-Nov-18	247/18	Person Centredness Framework Maria Nelligan will bring a progress back to Board in 6 months.	Maria Nelligan	23-May-19	Presentation
2	25-Apr-19	85/19	CEO Update - New appointments Joan Walley talked about job specifications including sustainable development goals and the expertise and capacity to inform on the health and wellbeing agenda. The NHS nationally are looking for leading organisations to take this agenda forward and to feed into Boards. Peter agreed Non-Executives will be involved in the appointments and these items will be included in the specifications.	Peter Axon	23-May-19	Job descriptions reflect the sustainability agenda and interivew processes in the final stages of being set up and will include the ability to address the sustainability agenda.
3	25-Apr-19	93/19	Nurse Staffing Monthly Report February 2019 Maria to look at obtaining feedback from staff around the new shift system and flexible working patterns and see if there are any ideas on how this could look differently.	Maria Nelligan	23-May-19	A survey monkey is being devised to go out to inpatient staff and results from this feedback will come to July Trust Board.
4	25-Apr-19	94/19	Enhanced Performance and Quality Management Framework Report (PQMF) Month 11 CPA review for Acute Services & Urgent Care is 75.0% at M11 from 14.3% at M10 Patrick Sullivan queried if this was accurate as it seemed low. Lorraine Hooper will look into this.	Lorraine Hooper	23-May-19	There is ongoing work to ensure that metrics are aligned to relevant services. Given the timing of the cycle of business the outcome of this work will be reflected from Quarter 1.
5	25-Apr-19	99/19	Self Certification G6 and FT4 (Provider License) Tony Gadsby asked how Non Executives would know if they are not conforming to the terms of the licnse during the year. Laurie Wrench will look into this and provide an update at the next meeting.	Laurie Wrench	23-May-19	Non-Exec Directors assurance regarding comforming to the requirements of the Provider License for is provided through the arrangements with External Audit in terms of the statement of assurance of the annual accounts, annual governance statement and quality account. Internal Audit provide assurance to the Executive team throughout the year that systems and processes are robust and identify areas of concern for action. Additonally, External Audit require the DoF and Chair of Audit Committee to declare compliance with management arrangements of how assurance is delivered.

Board Action Monitoring Schedule (Open Section)

Action	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
6	25-Apr-19	104/19	Any Other Business - Trade Unions and STP Jenny Harvey noted that Trade Unions planned meeting with Sir Neil MacKay in February was cancelled has not been rearranged and there seems to be difficultieswith regards to engagement between the STP and Trade Unions. Peter Axon will relay this message to Simon Whitehouse and Sir Neil MacKay.	Peter Axon	23-May-19	Correspondence sent to STP Prog Director requesting better engagement between unions and STP work programmes.
1	28-Mar-19	68/19	Nurse Staffing Monthly Report January 2019 - We have commenced the review for the Safer Staffing review which will come to the June Board which will provide an updated position.	Maria Nelligan	27-Jun-19	

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REPORT TO OPEN TRUST BOARD

Enclosure No: 4

Date of Meeting:	23rd May 2019		
Title of Report:	CEO Board Report		
Presented by:	Peter Axon, Chief Executive		
Author:	Peter Axon, Chief Executive		
Executive Lead Name:	Peter Axon, 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 ☐ • Primary Care Integration Programme Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Includes support for Muslim members of staff during Ramandan		
STP Alignment / Implications:	Includes local system update		
Recommendations:	To receive for information		
Version	Name/group	Date issued	
1.0	Peter Axon		

North Staffordshire Combined Healthcare NHS Trust

Chief Executive's Report to the Trust Board
23rd May 2019

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. A MONTH OF MEETS, GREETS AND PARTNERSHIPS

Throughout the past month, a large part of my time has been spent meeting and greeting a whole range of frontline teams, local stakeholders and partners.

Our Chair, David Rogers, and I met with NHS Improvement to review a variety of topics, and it was a really positive meeting. They complimented us on our Outstanding status and noted that we are performing well across many areas. We looked at the challenges the Trust faces and had an open and frank discussion about what we're doing to address them.

I met with Paul Edmondson-Jones MBE, Director of Social Care, Health Integration and Wellbeing and Peter Tomlin, Assistant Director of Adult Social Care, both from Stoke-on-Trent Council. The Trust has a long-standing and strong relationship with the council, so I was looking forward to introducing myself to Paul and Peter in order to continue our partnership work. It was a very productive meeting – we were all clear on how we intend to move forward to improve seamless care for our communities, utilising local mechanisms such as multi-disciplinary teams. We also touched on how we can work to evolve the North Staffordshire Alliance Board to focus on delivering more service improvements.

Our colleagues and friends at Midlands Partnership Foundation Trust (MPFT) and its predecessor NHS Trusts have been one of our most important partners over many years. As the two providers of mental health services across Staffordshire and Stoke-on-Trent, it is particularly important that we are able to work together in the most beneficial and productive way possible for the benefit of service users and their families across the communities we serve. It was a pleasure, therefore, to be able to have a really valuable chat with the Chief Executive of MPFT, Neil Carr. Having recently taken over community physical health services, Neil described to me the various service developments planned over coming months. We also discussed how we continue to work collaboratively to ensure equity of mental health provision across the county and how we maximise our support for acute health services. We also agreed to bring executive teams together very soon to co-develop narrative to support the Mental Health and Learning Disabilities elements of the the long term STP plan due for submission in the Autumn.

Supporting the development of the Primary Care across North Staffordshire and Stoke-on-Trent is at the heart of our long-term strategy and at the core of our vision to be outstanding in all we do and how we do it. The North Staffordshire and Stoke-on-Trent Alliance is essential to success in this regard, and so it was equally pleasurable to sit down with Mike Pyrah, Independent Chair of the Alliance Board. Mike is passionate about system-wide "population health" management to ensure that we maximise the clinical benefit derived from the limited resources available to us. This provider-led approach is at the heart of how

we plan to take our partnership forward with secondary, primary and social care partners over coming months.

2. LOCAL SYSTEM UPDATE

It was a pleasure to chair my first stocktake as Senior Responsible Owner for the STP Mental Health Workstream and gladdening to hear a ringing vote of confidence in the progress made thus far by the Workstream which is led on behalf of the STP by our Director of Operations, Jonathan O'Brien, and has had the Combined Healthcare Chief Executive as its SRO to date. We know, of course, that we have faced – and will continue to face – really significant and deep-rooted challenges as we work together to build a sustainable future not just for mental health services, but for the entire Staffordshire and Stoke-on-Trent health and care economy. I would be the last person to underestimate the scale of the challenge we face.

But, as we do so, it is heartening that there is common recognition across all of our partners that the Workstream is building on strong foundations of honesty, imagination and a willingness to work together on behalf of the communities and people we are here to serve.

Regarding our 2019/20 operational and financial plans, we are on the verge of finalising contractual agreements with our main commissioner (Staffordshire CCGs). The process for this year has been difficult given the system financial challenges facing Staffordshire. As mentioned above, our ambition is to ensure a focus on Mental Health and Learning Disabilities within the STPs long term plan.

3. OUR 4TH ANNUAL NURSING CONFERENCE

Our brilliant nursing staff came together this month for our 4th Annual Nursing Conference. Held in Keele Hall on Keele University's campus, the setting was no doubt nostalgic for many who will have graduated from our Official University partner. The conference was the perfect chance to celebrate the breadth and depth of the superb work our nurses do, and a time to say thank you.

Hosted by Maria Nelligan, Executive Director of Nursing & Quality, the theme of this year's conference was "the uniqueness of nursing" within mental health and learning disabilities healthcare.

Keynote speakers included some prestigious figures, including: Steven Pryjmachuk, Professor, Mental Health Nursing at the University of Manchester; Jim Blair, Clinical Lead Health Improvement at NHS England, Associate Professor Intellectual (Learning) Disabilities at Kingston University and St George's University of London, as well as our very own Ann Cox, Consultant Nurse & Clinical Lead, CAMHS, and Non-Medical Prescribing Trust Lead; and Christopher Fieldhouse, Consultant Nurse, Dual Diagnosis.

The event also celebrated 100 years of Learning Disability Nursing, where Jackie Shapland and Kieran Uttley from our Learning Disability services launched our Learning Disability Champion initiative.

The day concluded with an awards ceremony, which included the winning poster presentation, which celebrated nurse-led research.

4. OUR AWARDS SUCCESS CONTINUES

We were proud to host Positive Practice's Children & Young People's Mental Health Awards. This is the second year the awards have been held, which give us all the chance to give our thanks and support to those who work in CAMHS services across the country.

There is no greater priority in the NHS than supporting and caring for our young people and their mental health and wellbeing. As an NHS CAMHS Trailblazer with the leading reputation of our children's mental health services, we were delighted to be the host of the awards evening, which was held in Stoke-on-Trent.

Not only were we highly commended for the Inpatient Care award for The Darwin Centre, as well as Liaison and Intensive Support Service for The Hub, but we won the Partnership Working/Co-Production award. Chloe Jackson, one of the young volunteers on our CAMHS Trailblazer project, has been absolutely invaluable in her input into the project, so winning Champion of the Year was so well deserved.

Our Estates Team had two reasons to celebrate last week, when they won two awards at the Partnerships Bulletin Partnership Awards 2019. They took home The Public Sector Team of the Year Gold Award for how they worked together and managed to maintain services whilst going through major management of change with the Estates team, dealing with the collapse of Carillion and delivering the Trust's biggest capital project to the key parameters of time, cost and scope.

Secondly, they won the Silver Award for Best Operational Project for Harplands Hospital. This was a joint award to both the Trust Estates team and Imagile Professional Services for the way that they work so well together for their partnership working on the PFI and particularly for dealing with the collapse of Carillion as a provider of services on that contract.

Congratulations to everyone involved in this string of continued successes.

5. RAMADAN MUBARAK

The month of Ramadan began on the evening on Sunday 5 May and will end the evening of Tuesday 4 June. Ramadan involves periods of fasting for Muslims, which means abstaining from food, drink (including water) and smoking from sunrise to sunset. While fasting is an important part of Ramadan, it is also a time of self-reflection and self-evaluation for Muslims.

One of the ways in which we can support our Muslim staff is by providing a private space where they can pray or reflect. We have had the Oasis Room at Harplands Hospital and the Harmony Room at Dragon Square for a number of years. This year, for the first time, we have created “The Sanctuary” – a room at our Trust Headquarters in Lawton House. These spaces are not just for Muslim members of staff, but can be used throughout the year by all and any staff simply wishing to benefit from a quiet, reflective space.

To mark the start of Ramadan, our Combinations Podcast featured three of our Muslim colleagues talking with our Diversity and Inclusion Lead, Lesley Faux, about what Ramadan means to them and how their co-workers can support them and learn more during this period. It has proved to be one of our most popular podcasts to date. You can listen to it at https://soundcloud.com/nhscombinations/ramadan-mubarak

6. SUBSTANCE MISUSE COMMERCIAL SUCCESS CONTINUES

Many congratulations are due to our Substance Misuse Team – lead provider for the Stoke Community Drug and Alcohol Service – who recently were part of the successful bid team to Public Health England led by the Stoke-on-Trent City Council Commissioners for Adult Social Care, Health Integration and Wellbeing.

The successful bid was awarded just under £400,000 for a three-pronged project.

- Dedicated alcohol access:
- Breakfast club for rough sleepers:
- Maximise engagement:

This is a great example of the power of collaborative working across our health and care partners.

7. BUILDING RESILIENCE THROUGH STAFF NETWORKS

Staff networks can be a really effective voice for Combined, supporting all colleagues to create more inclusive environments where all employees, that want to, can progress.

They offer support to employees from different groups, are an effective mechanism of workforce engagement that can provide insight into unseen barriers and devise practical, creative and commercially viable solutions to help address the systemic challenges faced by certain groups.

The Trust has recently launched its BAME, LGBT and Neurodiversity Staff Networks. We are also keen to support the establishment of other networks where there is demand. Each Network will set its own terms of reference and agree how it will operate and keep in touch with its members.

Our Staff Networks will each have a direct route to a Trust Board member. It was great to be able to pop into a fantastic event this month, put on by the Trust to celebrate the National Day for Staff Networks.

8. BUILDING OUR NEW EXECUTIVE TEAM

We have begun the process of appointing three new Executive Team Members. These will all be permanent appointments and are:

- Assistant Chief Executive
- Director of Nursing and Quality
- Director of Workforce, Organisational Development and Inclusion.

With the recent fantastic news about Combined becoming officially an Outstanding Trust – and with a strong reputation both for the quality AND the compassion of our services and our people – I know we will be a really attractive prospect for potential applicants. We being supported by a high-quality and experienced Executive Search company – Gatenby Sanderson.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 5

Date of Meeting:	23rd May 2019		
Title of Report:	Reducing the risk of suicide and self-harm in people with a learning disability: Health Service Journal (HSJ) Award Presentation Summary		
Presented by:	Dr Buki Adeyemo (Medical Director)		
Author:	Dr Ruth Richards (Principal Clinical Psychologist) Kerri Mason R and D Lead		
Executive Lead Name:	Dr Buki Adeyemo (Medical Director)	Approved by Exec	☒

Executive Summary:	Purpose of report	
In 2016, Combined developed a local suicide strategy and signed up the local multi-agency Zero Suicide ambition. With further investment in risk assessment and clinical interventions for self-harm and suicide, staff were supported to attend the 'Connecting with People' training programme, which included both suicide response and self-harm prevention. It was identified that the tools and strategies used within the training were not accessible to the learning disability population. Of note: • The Learning Disability team identified a need that people with learning disability would need additional support in engaging in assessment and interventions; • Adapted and simplified the 'Connecting the People' SAFETool resource, making it accessible, relevant and helpful to people with a Learning Disability; • Adaption of the SAFETool increased confidence in staff and facilitated an open conversation around self-harm and suicide to empower feelings of connectedness with wider social networks; • Presentation delivered at the Health Service Journal (HSJ) Award Ceremony, on the 9th May 2019, for the Innovation in Learning Disability Safety Award; • Feedback from the HSJ panel was positive, acknowledging that the innovation was important and that the passion for service user care and adaptations for people with learning disabilities was evident.	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 ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐		

Risk / legal implications: Risk Register Reference	No legal or risk implications identified	
Resource Implications: Funding Source:	No resource implications identified at this time	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	The innovation aims to ensure inclusive assessments and interventions in self-harm and suicide for people with Learning Disability	
STP Alignment / Implications:	No STP implications	
Recommendations:	To receive for assurance	
Version	Name/group	Date issued

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Reducing the risk of suicide and self-harm in people with a learning disability: Summary

Overview

In 2016, Combined developed a local suicide strategy and led on the sign up of partners to the local multi-agency Zero Suicide ambition. To support further investment in risk assessment and clinical interventions for self-harm and suicide, staff were supported to attend the 'Connecting with People' training programme, which included suicide response and self-harm prevention training. The Learning Disability team attending the training identified that tools and strategies used were not accessible to our learning disability population**.**

Research into this area is very limited, with most research excluding people with a learning disability. Addressing the risk of suicide with adults with learning disabilities in the community team has been an ongoing challenge for services, with a similar picture nationally – as there is very little guidance and no adapted measures.

Concept

The Learning Disability team identified a need that people with learning disability would need additional support in engaging in self-harm and suicide assessments and interventions, and therefore adapted the 'Connecting with People' SAFETool resource. The resource was co-produced with service users and adapted, in line with the Accessible Information Standards, to utilise easy-read language and visual representation.

Impact

Outcomes have been very encouraging and have demonstrated; a reduction in risk factors and psychological distress with increase in well-being. Adaption of the SAFETool increased confidence in staff and facilitated an open conversation around self-harm and suicide to empower feelings of connectedness with wider social networks:

"I feel I can be more and honest about suicide" – ***Service User***

Further feedback from the suicide prevention forum reported that the adapted measure would be useful across child neuropsychology and acute adult mental health service.

The project was nominated for a Health Service Journal, Innovation in Learning Disability Safety, Award. A nomination presentation was delivered at the Health Service Journal (HSJ) Award Ceremony, on the 9th May 2019. Feedback from the HSJ panel was positive, acknowledging that the innovation was important and that the passion for service user care and adaptations for people with learning disabilities was evident. It was felt that presenters; Felicity Watkin (Assistant psychologist), Dr Ruth Richards (Principal Clinical Psychologist) and Phil Emery (Community Learning disability nurse) were eloquent and explained the innovation well.

Wider Applications

There is a plan to disseminate across the organisation and integrate into Combined's Electronic patient record system.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 6

Date of Meeting:	23rd May 2019		
Title of Report:	March 2019 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Alastair Forrester, Head of Nursing & Professional Practice		
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 March 2019 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during March 2019 was 82% for registered staff and 93% for care staff on day shifts and 76% and 104% respectively on night shifts. Overall a 90% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Managers 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 ☒ Execs ☒ Date: Execs - 7th May 2019 SLT– 14th May 2019	Document Version No.	Final v3
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: 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). See wider D&I Guidance	None		
STP Alignment / Implications:	None		
Recommendations:	To receive the report for approval		

Version	Name/group	Date issued
Final v1	Executive Meeting	7th May 2019
Final v3	Quality Committee	9th May 2019
	Trust Board	23rd May 2019

1 Introduction

This report details the ward daily staffing levels during the month of March 2019 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to NHS Digital. Additionally from April 2018 Care Hours per Patient Day (CHPPD) have also been required to be reported to NHS Digital. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours (appendix 1).

2 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. Additionally a mid-year review was reported to Board in November 2018. Recommendations relating to Safer Staffing Reviews are progressed and monitored through the Safer Staffing Group.

3 Trust Performance

During March 2019 the Trust achieved a staffing fill rate of 82% for registered staff and 93% for care staff on day shifts and 76% and 104% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 90% was achieved. This has decreased from an overall fill-rate of 94% in February 2019.

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 sets out the actions and recommendations from staffing reviews.

4 Care Hours per Patient Day (CHPPD)

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

means of consistently recording, reporting and monitoring staff deployment. The CHPPD:

- 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 12 incidents related to ward nurse staffing reported during March 2019. Eight incidents were due to a significant increase in staffing levels at the Assessment and Treatment Unit and related to an increase in patient acuity, 7 incidents of these incidents were due to a staffing shortfall during night shifts and 1 incident related to day shifts. The unit was supported by the Site Manager.

There were two reports of staffing shortfalls at the Darwin Centre, both related to the non-availability of a second Registered Nurse during the day shift.

Ward 6 and PICU both reported one incident of staffing shortfall, resulting in additional support being provided by the Site Manager.

None of the above occurrences resulted in a patient safety incident.

5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During March 2019 a total of 26 hours of patient activity had to be cancelled as a result of staffing shortfalls, due to the nature of these activities they could not be rescheduled.

5.3 Impact on Staff Experience

In order to maintain safer staffing the following actions were taken by the Ward Manager during March 2019:

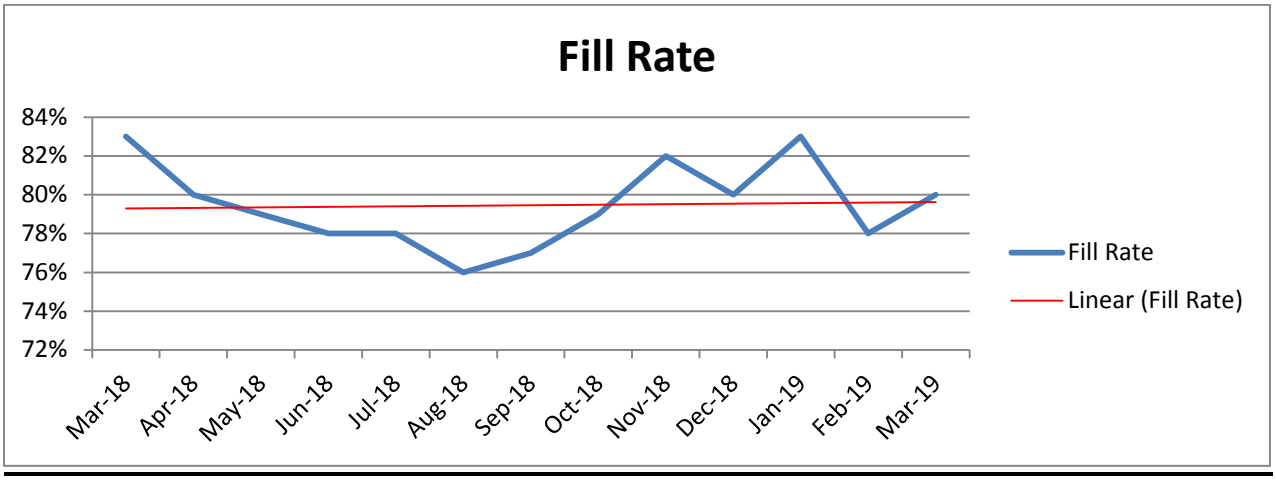
- 148 staff breaks were cancelled (equivalent to approximately 3% of breaks). Any time accrued due to missed breaks is taken back with agreement of the Ward Manager.
- There were 6 occasions reported during March when staff supervision sessions had to be cancelled to support safe staffing levels.
- A total of 7 mandatory training sessions and 2 staff Performance Development Reviews (PDR) had to be cancelled to support safe staffing levels during March 2019.

5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. There was also a total of 448 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 210 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 5.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels. There were 24 occasions (47.5 hours in total) when additional support was provided by members of the multi-disciplinary team to maintain safe staffing levels.

5.5 RN Staffing Fill Rate & Recruitment

In line with the national picture, RN recruitment remains challenging. The RN 12 month fill rate increased in March 2018 and the graph below demonstrates a slight upward trend (linear fill rate) over the past 12 months. The Trust is continuing to work proactively to recruit to these vacancies.



The Trust is participating in the NHSI Retention Support Programme and this has informed the Trust Recruitment and Retention Action Plan which details the actions that are being taken by the Trust to attract and retain registered nurses. This Action plan was previously reviewed by the Board in April 2018. These include recruitment incentives such as refer a friend, continued professional development offer, housing and flexible hours. These incentives are included in all RN job adverts.

Health Education England has recently identified funding to support Trusts with Return to Practice campaigns. These campaigns target former registered nurses who have left practice and allowed their nurse registration to lapse by providing academic and placement support to enable them to re-register with the NMC. The Head of Nursing & Professional Practice is working with the Trust Recruitment Lead and local Health Education Institutes to progress this campaign.

The newly qualified nurses who commenced with the Trust in September 2018 continue to be supported by a robust preceptorship programme; this programme has been refined and strengthened annually since 2016 and the Trust continues to maintain an excellent retention rate with the preceptorship cohorts.

The nursing career pathway has been strengthened and 4 Trainee Nursing Associates and a further 2 Trainee Advanced Nurse Practitioners commenced their training in September 2018. These are academic programmes which run alongside significant work based and placement learning. The Trust is currently in the process of recruiting a further 4 Trainee Nursing Associates for the March 2019 intake and over the next few weeks will begin to identify trainees for the September 2019 intake.

The education programme to support CPD and career progression for all RNs has also been strengthened. Additionally, a potential increase in Band 6 RNs is being considered. It is anticipated that career pathways will be further enriched as Directorates begin to finalise their workforce plans for 2019/20.

A recent advertising campaign for the recruitment of Registered Nurses has resulted in the recruitment of 24 newly qualified RN’s who will be commencing with the Trust from September 2019 onwards.

6. Summary

Safe staffing reporting continued to highlight challenges in staffing wards during March 2018; the Trust did however experience an increase in its fill rate of registered nursing shifts during March 2018. We continue to see a significant number of RN vacancies being filled by newly qualified RNs and the Trust continues to employ a number of strategies with the support of the HR and communication teams to attract RNs during this national shortage.

The Trust is participating in the NHSI Retention Support Programme. A project team visit has been completed and learning shared, this has been incorporated into the Trust Recruitment and Retention Action Plan.

7. Recommendations

The Trust Board is asked to:

- Receive the report for approval
- Note the challenges with recruitment and mitigations and action plan in place
- Note the challenge in filling shifts in March
- Be assured that safe staffing levels have been maintained.

Appendix 1 March 2018 Safer Staffing

	Registered Nurses						Care Staff						Registered Nurse		Care Staff		Total Nursing Staffing		
Date	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Fill Rate (%)	Night Fill Rate (%)	Day Fill Rate (%)	Night Fill Rate (%)	Overall RN %	Overall Care Staff %	Overall Staffing
Ward 1	1320.00	1320.00	1265.72	344.10	344.10	391.20	1162.50	1162.50	723.13	666.00	999.00	1003.40	95.9%	113.7%	62.2%	100.4%	99.6%	79.9%	88.4%
Ward 2	1320.00	1320.00	1015.25	688.20	688.20	457.25	1534.50	1534.50	1331.40	999.00	999.00	1031.95	76.9%	66.4%	86.8%	103.3%	73.3%	93.3%	84.5%
Ward 3	1320.00	1328.00	1110.47	688.20	688.20	400.20	1162.50	1204.00	1411.70	666.00	666.00	900.05	83.6%	58.2%	117.3%	135.1%	74.9%	123.6%	98.4%
Ward 4	1477.50	1477.50	1201.97	344.10	344.10	345.00	1162.50	1162.50	1376.82	1032.30	1032.30	1022.50	81.4%	100.3%	118.4%	99.1%	84.9%	109.3%	98.3%
Ward 5	1320.00	1320.00	991.00	688.20	688.20	400.50	1162.50	1446.00	1536.07	688.20	921.30	1087.05	75.1%	58.2%	106.2%	118.0%	69.3%	110.8%	91.8%
Ward 6	1320.00	1320.00	905.17	688.20	688.20	377.40	1348.50	1767.00	1949.93	688.20	1032.30	1344.90	68.6%	54.8%	110.4%	130.3%	63.9%	117.7%	95.2%
Ward 7	1320.00	1320.00	827.75	344.10	344.10	344.10	1162.50	1486.50	1789.53	1032.30	1309.80	1173.10	62.7%	100.0%	120.4%	89.6%	70.4%	105.9%	92.7%
Assessment & Treatment	948.00	948.00	1321.92	688.20	688.20	524.40	1534.50	3739.80	2385.40	688.20	2608.50	2332.45	139.4%	76.2%	63.8%	89.4%	112.8%	74.3%	82.2%
Darwin Centre	1320.00	1320.00	1008.37	688.20	688.20	344.10	1162.50	1162.50	1346.75	688.20	688.20	964.10	76.4%	50.0%	115.8%	140.1%	67.3%	124.9%	94.9%
Edward Myers	948.00	948.00	881.47	344.10	344.10	355.20	790.50	790.50	736.98	688.20	688.20	625.10	93.0%	103.2%	93.2%	90.8%	95.7%	92.1%	93.8%
Florence House	555.00	555.00	562.00	332.32	332.32	332.22	930.00	930.00	647.25	332.32	332.32	332.22	101.3%	100.0%	69.6%	100.0%	100.8%	77.6%	87.2%
Summers View	930.00	930.00	532.75	332.32	332.32	333.22	930.00	930.00	1032.45	664.64	664.64	641.50	57.3%	100.3%	111.0%	96.5%	68.6%	105.0%	88.9%
PICU	994.50	994.50	737.20	688.20	688.20	614.10	837.00	1363.50	1100.95	688.20	777.00	797.90	74.1%	89.2%	80.7%	102.7%	80.3%	88.7%	85.0%
Totals	15093.00	15101.00	12361.02	6858.44	6858.44	5218.88	14880.00	18679.30	17368.37	9521.76	12718.56	13256.22	81.86%	76.09%	92.98%	104.23%	80.06%	97.54%	90.34%
Dragon Square	1087.50	1087.50	851.25	310.00	310.00	300.83	1162.50	1162.50	783.75	300.00	300.00	320.00	78.3%	97.0%	67.4%	106.7%	82.4%	75.5%	78.9%

Date	Total Hours Per Day	Patients	CHPPD	Safe staffing was maintained by	RN Vacancies	HCSW Vacancies	Bed occupancy	Movement
Ward 1	3705.95	406.00	9.13	Nurses working additional unplanned hours, altering skill mix and the support of the wider MDT.	-3.08	4.79	93%	↑
Ward 2	4142.85	509.00	8.14	Nurses working additional unplanned hours, altering skill mix and the support of the wider MDT.	3.94	4.09	66%	↑
Ward 3	4084.92	537.00	7.61	Nurses working additional unplanned hours, altering skill mix.	2.02	0.5	74%	↓
Ward 4	4450.45	410.00	10.85	Nurses working additional unplanned hours, altering skill mix and the support of the wider MDT.	2.24	2.28	89%	↓
Ward 5	4538.95	418.00	10.86	Nurses working additional unplanned hours, altering skill mix.	5.29	1.81	96%	↓
Ward 6	5064.90	453.00	11.18	Nurses working additional unplanned hours, altering skill mix.	5.11	-0.93	97%	↑
Ward 7	4567.48	624.00	7.32	Nurses working additional unplanned hours, altering skill mix and the support of the wider MDT.	3.25	6.08	103%	↑
Assessment & Treatment	6818.67	155.00	43.99	Nurses working additional unplanned hours, altering skill mix.	1.96	-1.12	83%	↑
Darwin Centre	4022.07	292.00	13.77	Nurses working additional unplanned hours, altering skill mix.	5.96	1.54	76%	↓
Edward Myers	2598.75	267.00	9.73	Nurses working additional unplanned hours, altering skill mix.	3.08	1.82	72%	↓
Florence House	2024.18	171.00	11.84	Nurses working additional unplanned hours, altering skill mix.	-0.12	-0.33	100%	↑
Summers View	2674.42	259.00	10.33	Nurses working additional unplanned hours, altering skill mix.	3.59	2.2	103%	↓
PICU	3407.65	115.00	29.63	Nurses working additional unplanned hours, altering skill mix and the support of the wider MDT.	3	1.8	92%	↑
Totals	52101.23	4616.00	11.29		36.24	24.53		
Dragon Square	2255.83	151.00	14.94	Nurses working additional unplanned hours, altering skill mix.	-0.59	0.00	80%	↔

Appendix 2 Staffing Issues

- At the end of March 2018, there were 36.24 WTE RN vacancies in in-patient areas. This is an increase of 0.96 WTE from the February position. A majority of these vacancies continue to be within Wards 5 & 6 and the Darwin Centre. Our overall vacancy figure does continue to show a positive reduction throughout this financial year, demonstrating that we have not only been able to successfully recruit new Registered Nurses but, we have also retained a large proportion of these nurses. We continue to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- At the end of March 2018, there were 24.53 WTE HCSW vacancies reported within in-patient wards. This is a decrease of 1.47 WTE from February 2019. A majority of these vacant posts are within wards 1, 2, & 7 and have also been created in November 2018 following the transaction of Safer Staffing establishment recommendations from the April 2018 Annual Safer Staffing report. We are continuing to actively recruit to these posts. We are also enhancing the opportunities for HCSW's to join the Trust as part of an apprenticeship programme.

- RN day shift cover remained challenging during March 2018; the most significant increases continue to be within the Assessment & Treatment Unit where acuity remains high and a 40% increase in clinically required staffing has been required since mid-January 2019. The impact of this increase continues to be felt across all inpatient and some community areas. The MDT, Directorate Management and Executive Team are working closely with CCG colleagues to support the unit to manage these challenges.

- Ward teams also continue to be supported by Quality Improvement Lead Nurses, Nurse Practitioners and a Site Manager who is further supported by an On-Call Manager out of hours.

- RN night shift cover remained challenging during March 2018. Predominantly within the Assessment and Treatment Unit due to the ongoing requirement for a 40% increase in night staffing establishment as a result of patient acuity.

- 7 wards experienced an increase in occupancy and 5 wards had a decrease in occupancy during March 2018. Occupancy remains particularly high within the older persons and neuropsychiatry wards (Wards 5, 6 and 7).

- Staffing data for Dragon Square Specialist Children's Short Breaks Service is included in this report for information purpose and is reported independently of the main report. This is due to the nature of the service and will ensure reliability of data reporting for our inpatient areas.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 7

Date of Meeting:	23RD May 2019		
Title of Report:	Safeguarding Annual Report 2018-19		
Presented by:	Amy Davidson, Head of Safeguarding		
Author:	Amy Davidson, Head of Safeguarding		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:	Purpose of report	
The Safeguarding Annual Report 2018-2019 provides assurance on safeguarding activity throughout the Trust. This includes referral rates, training, audit and case reviews. The scope of the report is the portfolio of the Safeguarding Team and includes Safeguarding Children, Safeguarding Adults, Prevent and Domestic Abuse.	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☒
Seen at: SLT ☒ Execs ☒ Date: 14TH May 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐	
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒	
Risk / legal implications: Risk Register Reference	None	
Resource Implications: Funding Source:	None	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None	
STP Alignment / Implications:	N/A	
Recommendations:	For approval	

Version	Name/group	Date issued
V1	M Nelligan/ Safeguarding Group	02/05/2019
V2	Execs	07/05/2019
	Quality Committee	09/05/2019
	SLT	14/05/2019

Contents

1. Introduction

The purpose of this report is to outline the safeguarding work within the Trust for the period of April 2018 to March 2019, evidencing how we are making a positive difference and providing assurance of compliance to the Trust Board and partners.

1.1 Safeguarding Adults

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

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

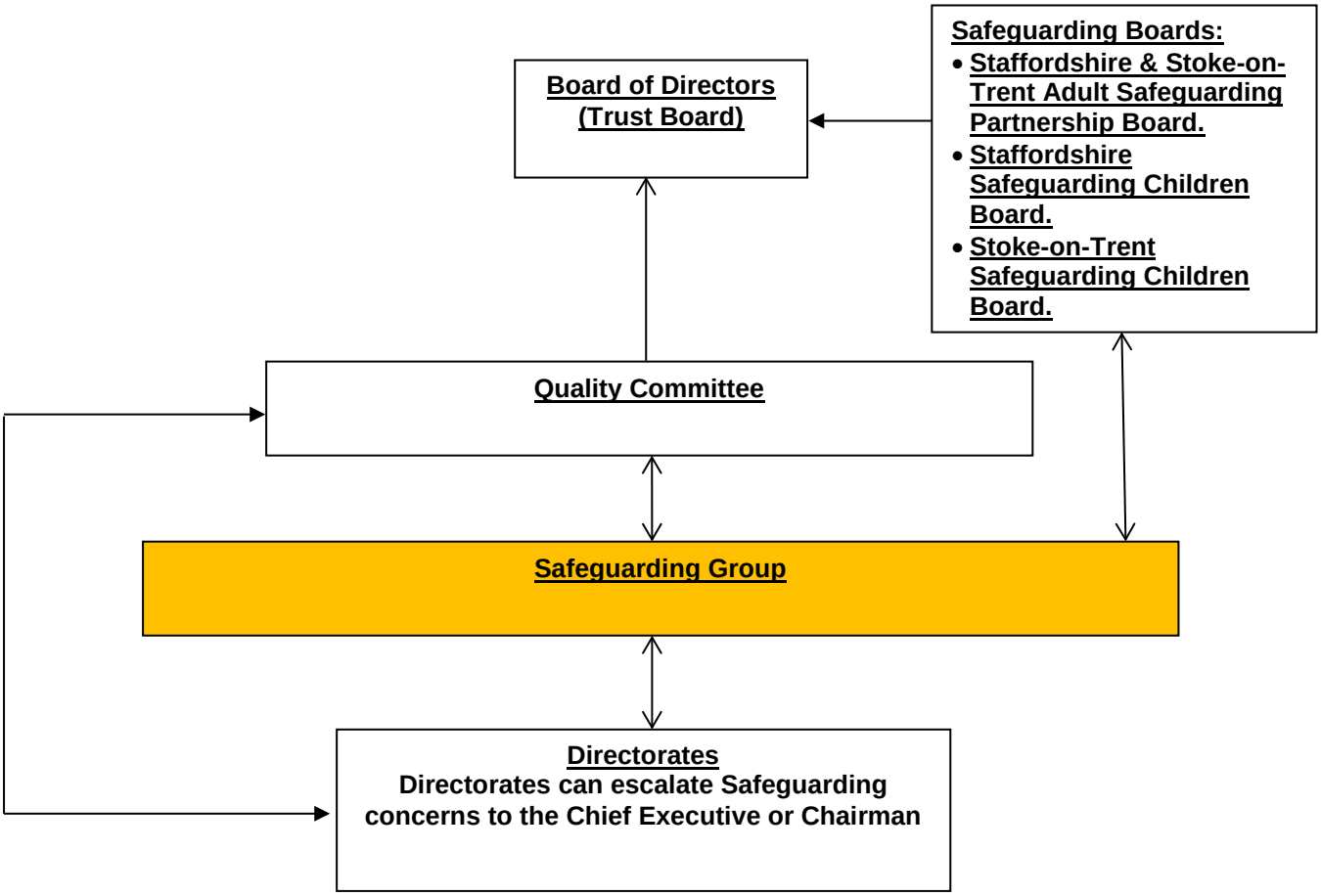
1.2 Safeguarding Children

The majority of parents manage their mental health and parenting responsibilities well and care for their children appropriately, however, some parents may need extra help and support, particularly at times when a parent's difficulties may become harder to manage, or at times of transition in children's lives.

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

North Staffordshire Combined Healthcare NHS Trust (NSCHT) is committed to ensuring the safety of all children who come in to contact with our services, either directly or through parents/guardians. We work within the legal framework of the Children Act (1989) and the Children Act (2004) and Working Together to Safeguard Children (2018).

2. Accountability Framework



2.1 Quality Committee

The Trust's Assurance Framework includes reports from the Executive Safeguarding Lead to the Quality Committee. Guidance documents and new or updated policies receive agreement and approval via this committee prior to submission to the Trust Board. Policy documents reviewed and currently proceeding through ratification process during 2018-2019 include the Prevent Policy, Domestic Abuse Policy and Sexual Safety and Responding to Sexual Violence Policy.

2.2 NSCHT Safeguarding Group

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

2.3 Executive Lead: Executive Director of Nursing and Quality

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

2.4 Safeguarding Team

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

The Safeguarding Team currently includes a Head of Safeguarding (Named Nurse), Named Doctor, Senior Safeguarding Practitioner, Safeguarding Team Coordinator and Safeguarding Administration Assistant.

2.5 All NSCHT Staff

The Trust embraces the belief that “safeguarding is everyone’s responsibility” and that effective safeguarding practice depends upon the collective contribution of all staff, patients, relatives and carers. Policies and procedures are accessible to staff electronically on the Trust intranet and are reviewed in line with the Trust schedule or as a result of significant legislative changes. Staff complete mandatory internal safeguarding training in relation to both child and adult safeguarding with level 1 and 2 adult and child safeguarding training delivered as eLearning and child safeguarding level 3 training delivered face to face. In addition to mandatory training, the Trust also commissions one-day specialist training in both domestic abuse and sexual violence. Additional topic specific training is available to staff, as appropriate to their role, through the various Safeguarding Boards.

Safeguarding supervision is available to all members of staff both on an individual basis and as a team. Teams are encouraged to incorporate safeguarding supervision into their regular meeting schedules and there is also both telephone and face to face supervision available on an as required basis for individual cases.

3. Partnership Working

3.1 Safeguarding Adults

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

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

The SSASPB brings together lead officers from all agencies concerned with the wellbeing and safeguarding of adults. As part of this multi-agency working, policies and procedures are developed to protect adults from abuse, training is provided and assurances sought from partner agencies regarding the quality of safeguarding activity both within organisations and across the wider community.

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

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

3.2 SSASPB Approved Strategic Priorities

The SSASPB strategic priorities for 2016-2018 were:

i) Transition from children to adult services
ii) Leadership in the Independent Care Sector
iii) Engagement with service users, communities and safeguarding partners

During 2018-2019 the Trust worked to improve the transition from CAMHS to adult services and the organisational changes to locality working further strengthened the support of this transition process.

The Community Home Liaison Team supported individuals residing within residential and nursing homes and as part of their role liaised with staff in homes to improve outcomes for adults with care and support needs and participated in developing leadership within the independent care sector by sharing best practice.

During 2018/19 the SSASPB reviewed its strategic priorities and agreed the following as strategic priorities for 2019-2021:

i) Financial and material abuse
ii) Leadership in the independent care sector
iii) Engagement with service users, communities and safeguarding partners.

In order to support these priorities NSCHT provides training and advice on all adult safeguarding concerns including financial abuse.

Frontline services work with care homes, where appropriate, to improve partnership working and engage with leaders in the independent care sector in order to improve outcomes for service users.

NSCHT seeks to engage with service users and carers through a variety of mediums including surveys, forums and patient advice and liaison services.

Adult safeguarding mental health expertise and leadership is also delivered within a multi-agency setting as part of the specialist safeguarding practitioner's role in the multi-agency safeguarding hub (MASH) with the aim of improving partnership working.

NSCHT also remain committed to partnership working through active participation in the various sub groups affiliated with the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and sharing of both learning lessons and examples of good practice.

3.3 Safeguarding Children

NSCHT was an active member of both the Staffordshire and Stoke-on-Trent Safeguarding Children's Boards and sub groups; the Executive Director of Nursing & Quality has represented NSCHT at Board level during 2018-2019.

On the 1 April 2019 following national changes to safeguarding children and young people, which are outlined in Working Together (2018), the two local children's Safeguarding Boards merged to form the Stoke-on-Trent and Staffordshire Local Safeguarding Children Board. These changes have taken place in order to further enhance and co-ordinate local multi-agency working to safeguard and protect children in Staffordshire and Stoke-on-Trent. NSCHT is a committed partner to this new partnership arrangement and maintains a commitment to active involvement in safeguarding children and young people as part of the new structure moving forwards.

As a result of these changes to the local Safeguarding Children Boards there is an ongoing review of sub groups. This is in order to explore the most effective way of streamlining the current sub groups to reflect the joint Board whilst maintaining a focus on the distinctive needs of different geographical areas within the Board's remit.

4. Inspections

4.1 External Inspections

During 2018/19 there was an external inspection by the Care Quality Commission, of which safeguarding forms part of the safe domain. This inspection consisted of visits to numerous core services over a period of time and culminated in a well led inspection and resulted in NSCHT being rated as 'Outstanding' overall. Whilst the inspection and correlating report was not focused on safeguarding, positive reference was made in the report to staff's awareness of how to keep patients safe and report incidents, including abuse.

5. Audit

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

5.1 External audits

i) Adult Safeguarding Self-Assessment Audit

This self-assessment has been changed to a biannual audit and was completed in March 2019. Upon completion of the audit there was one area of potential enhancement identified for NSCHT. This was an opportunity to strengthen the recording of the involvement of advocacy services in order to provide assurance that advocacy is appropriately utilised in safeguarding concerns that do not meet the criteria under The Care Act to progress to a formal Section 42 enquiry, but may be dealt with under other processes.

ii) Adult Safeguarding Case File Audit

The SSASPB performance sub group meet bi monthly and review case files for people that have required safeguarding support in their lives. This is a multi-agency approach and all partners involved in the care contribute. NSCHT proactively engages in this quality assurance process and learning from these reviews is disseminated across the organisation via the safeguarding quarterly meeting and through safeguarding supervision with both individuals and teams.

iii) Section 11 Audit

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

This audit was last completed in January 2017. The audit is due for completion during 2019. This audit has not yet been requested by the newly formed Stoke on Trent and Staffordshire Local Safeguarding Children Board, therefore outcomes from this will be reported in the 2019-2020 Annual Report.

5.2 Internal Audits

i) Adult Safeguarding

During Quarter 3 an audit of adult safeguarding referrals on the inpatient wards at Harplands Hospital was completed. The findings from this audit indicated that there was good evidence of staff knowledge regarding adult safeguarding risks and timely referrals. The audit also identified areas of development which were:

- embedding the adult safeguarding processes into care plans and discharge planning in order to ensure the safeguarding process is person centered, the person's views and wishes are heard and the plan is outcome focused
- supporting staff to develop the skills and knowledge to utilise safeguarding functions within the electronic care records system

The commencement of adult safeguarding level 3 training in April 2019 will further enhance frontline staff's knowledge and confidence as it places a strong emphasis on the six principles of adult safeguarding, making safeguarding personal and how this dovetails with other ongoing care processes, such as care plans and CPA reviews.

ii) Children

An internal audit, focused upon the recording of child safeguarding concerns within the electronic care records, was also undertaken during 2018-2019. Areas of good practice included the recognition of children within the families of adults accessing services. This audit has however identified further areas of work which need to be addressed with the electronic care records. There appears to be an underuse of existing safeguarding alert functions within the system and the lack of a defined section of the electronic records dedicated to safeguarding means that information is recorded within other sections of the electronic records such a clinical notes. As a result this information is not easily accessible to clinicians either in relation to clinical work or for audit and assurance purposes. The Named Doctor and Head of Safeguarding are working with the Lorenzo (electronic patient records) Team in order to streamline the process.

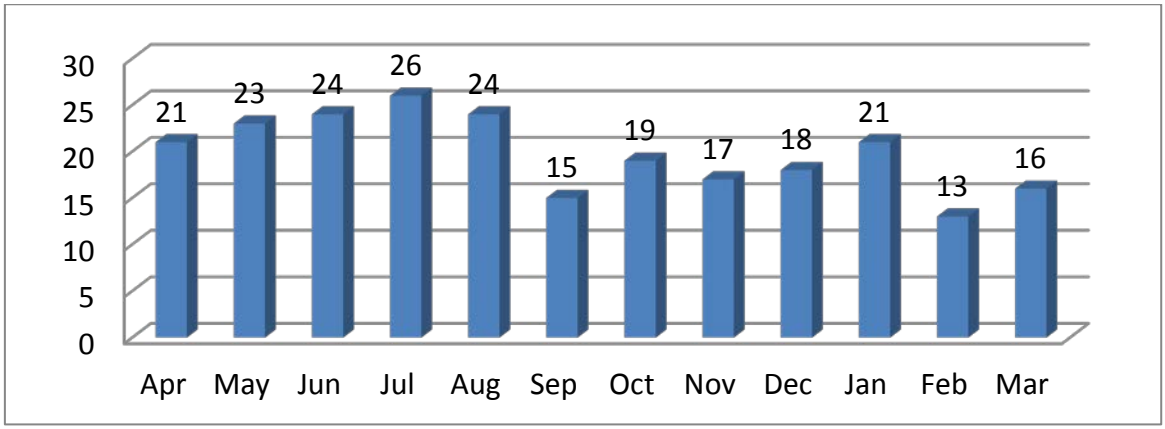
6. Performance

6.1 NSCHT Incident Reporting and Safeguarding

i) Safeguarding Adults

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

Total Number of Adult Referrals during 2018-2019: 237



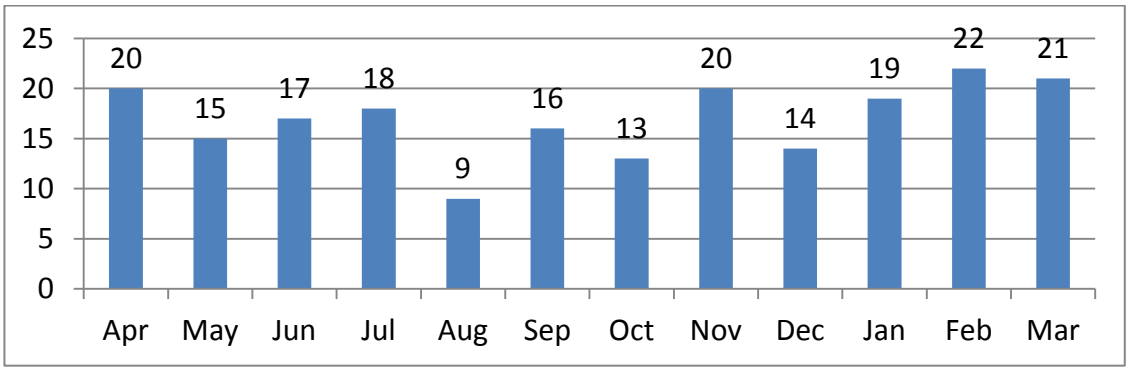
All referrals are reviewed on a weekly basis by the Incident Review Group, this provides cross directorate oversight of all incidents allowing incidents, not previously identified under Safeguarding, to be identified and acted upon appropriately.

The number of referrals (237) represents an increase from 2017/18 (185). This may be explained, in part, as a result of a number of initiatives by the Safeguarding Team to raise the profile of safeguarding within NSCHT, such as re-launching safeguarding supervision and encouraging spoke placements for students within the Trust. As a result staff knowledge, awareness and confidence in making referrals for adult safeguarding concerns has been increased.

ii) Safeguarding Children

The table below shows the total of number of child safeguarding referrals which have been made by Trust staff over the last 12 months:

Number of Child Protection Referrals 2018 - 2019**:** 204



Prior to organisational restructure on the 1st October 2018, the Adult Directorate and Children & Young People's Directorate generated the majority of child protection referrals for NSCHT. This demonstrates that both the children's and adults' workforce recognises and acts upon child safeguarding concerns.

Following the organisational restructuring there has been a spread of referrals across all directorates. As these directorates now include both child and adult services this indicates a good understanding from staff of their responsibilities to child safeguarding, whether they work directly with children or their parents/carers.

The number of referrals this year (204) is an increase in referrals from 2017/18 (144). The reasons described above for the increase in adult safeguarding referrals also apply to child safeguarding referrals and therefore may explain, in part, the increase.

6.2 Multi-Agency Safeguarding Hub (MASH)

Multi-Agency Safeguarding Hub (MASH) is the co-location of partner agencies for the purpose of information exchange. The MASH provides a confidential environment where information is shared according to its proportionality, necessity and relevance in a timely manner with appropriate services to safeguard children and adults at risk of abuse. This supports a timely appropriate multi-agency assessment of risk in relation to Child and Adult Protection concerns.

As part of NSCHT's commitment to multi-agency working, lateral checks are completed on behalf of partner agencies within the MASH when concerns are raised in order to assist with early risk assessment and aid the planning of potential support in order to keep adults and children protected from abuse and neglect. In 2018-2019 the safeguarding team completed 15,891 lateral checks, this results in a significant workload for the administrators within the Team.

In addition to NSCHT's responsibility to ensure that people who come into contact with our services are safe from harm, the areas where the Trust has Section 75 (NHS Act 2006) responsibilities requires the Trust to carry out adult safeguarding enquiries for adults with a mental health need between the ages of 18 and 65 where the abuse or suspected abuse occurred. The Trust had this responsibility for both Stoke on Trent or Staffordshire until October 2018 when Section 75 Agreement with Staffordshire Local Authority ceased and all adult safeguarding responsibilities for Staffordshire were transferred back to Staffordshire Local Authority. This means that whilst the Local Authority may still require NSCHT staff to undertake enquiries on their behalf in relation to adult safeguarding, where mental health needs are identified as the primary concern, overall responsibility and management of the safeguarding enquiry remains with the Local Authority.

For service users over the age of 65 and for service users with a learning disability of all ages, enquiries are led by their respective Local Authority team.

7. Training

7.1 Mandatory Safeguarding Training

Safeguarding training for both adults and children is mandatory for all Trust staff to ensure that they are equipped with the essential knowledge and skills to recognise and report abuse. Training is provided in accordance with the Intercollegiate Document; Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Intercollegiate Document (2019) which provides clarity on the levels of training required, by role, within health services.

Level 1 and 2 training is delivered via e-learning and, as mentioned previously in the report, is a live package that is periodically reviewed and updated in order to reflect legislation, national and local guidance, best practice and learning opportunities identified from both external and internal audit.

Level 3 safeguarding training is delivered face to face. Level 3 child safeguarding training continues to be delivered on a regular basis following the successful completion of a three year programme to ensure that all professionally registered staff receive training appropriate to their role in line with the Intercollegiate Document. As the table below illustrates, performance against both the Trust and external targets has been good. Currently, two sessions are offered per month and additional bespoke training sessions are arranged with teams if required.

Following the publication of the Intercollegiate Document; Adult Safeguarding: Roles and Competencies for Health Care Staff in August 2018, a face to face level 3 training

package has been developed by the safeguarding team and commences delivery in April 2019.

The table outlines the training figures for Mandatory Safeguarding Training by directorate as at year end 2018 – 19. Each directorate is responsible for supporting their staff to attend mandatory training and each directorate reports monthly on mandatory training to the Senior Leadership Team. The Safeguarding Team are responsible for ensuring there are enough training places made available to achieve compliance. During 2018-2019 level 1 and 2 sessions were delivered via e-learning.

Directorate	**L1/2 Children % Compliance**	**L3 Safeguarding Children % Compliance**
Acute Urgent Care	97%	92%
Specialist	97%	95%
North Staffordshire	95%	95%
Stoke-on-Trent	95%	93%
Corporate	87%	n/a
Trust Overall Compliance	**94%**	**94%**
Trust Compliance Target	**85%**	**85%**

Level 3 training overall has reached the 94%. This is beyond the Trust target of 85% for year three of the three year plan. The Clinical Commissioning Group currently has a 90% target for compliance and therefore the Trust is currently performing above target for these requirements.

7.2 Local Safeguarding Children Board (LSCB) Level 3 Safeguarding Training

The Head of Safeguarding contributes to the delivery of training for both Stoke-on-Trent and Staffordshire Local Safeguarding Boards. The Head of Safeguarding delivers Level 3 Parental Mental Health and Learning from Serious Case Reviews training for both of the Children's Safeguarding Boards. This training has been delivered during 2018-19 and will continue to be delivered during 2019-20.

In addition to this, NSCHT staff are encouraged to access Local Safeguarding Children Board training at level 3 and 4, as appropriate to their role, in order to facilitate multi-agency learning and areas of specialist knowledge. The recording of training completed with the Local Safeguarding Children Boards is updated by individuals sending certificates of attendance to the training department for Staffordshire and by email confirmation forwarded by the Safeguarding Team for Stoke-on-Trent.

8. Prevent

Prevent is one of the four strands of the Governments Counter Terrorism Strategy called Contest. NSCHT are active partners within the Prevent programme. Prevent gained a statutory footing in July 2015 giving staff a legal duty to report any concerns. The

Safeguarding Team are active members of monthly Channel meetings for both Staffordshire and Stoke-on-Trent the West Midlands Regional Prevent Forum and the Stoke-on-Trent Prevent Board. The Head of Safeguarding attends the Board.

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

8.1 Prevent/WRAP Training

Prevent training was developed in order to increase staff awareness of radicalisation and what to do if they had concerns. WRAP is a 'workshop to raise awareness of Prevent'; within NSCHT the two training sessions are combined for all staff. The Prevent/WRAP training aims to give professional members of our community the skills to identify individuals who show signs of vulnerability, identify what they are vulnerable to, and support those individuals so that they do not become exploited and drawn into terrorism by persons or groups supporting violent extremism or acts of terrorism.

The training looks at the background of crime, social processes, the history of terrorism, susceptibility, narratives used by radical groups or individuals and recognising, understanding and referring vulnerable people. Prevent training is delivered via eLearning using the Home Office approved package. During 2018-2019 this training moved from once only to three yearly in line with the NHS England Guidance for Mental Health Services in Exercising Duties to Safeguard People from the Risk of Radicalisation (2017). This transition has now been completed with overall Trust compliance rates remaining above the target of 85% at 88% at year end. This is demonstrated in the table below.

Breakdown of Directorate PREVENT Training Compliance (as at 31 March 2018):

Directorate	**% Compliance**
Acute Urgent Care	93%
Specialist	91%
North Staffordshire	90%
Stoke-on-Trent	89%
Corporate	87%
Trust Overall Compliance	**88%**
Trust Compliance Target	**85%**

8.2 Regional Multi-Agency Centre (RMAC)

The new Contest Strategy (2018) was published in June 2018; this places an emphasis on learning lessons from recent atrocities. It has been identified in the learning from several high profile attacks that the individuals who carried out these acts had been

previously known to security/counter terrorism services but deemed to be no longer of significant interest.

It has been identified that partner agencies may well have held information that would have informed this decision making but there were no mechanisms in place at the time for sharing information.

As a result of this, three pilot sites have been established nationally known as Regional Multi Agency Centres (RMAC). These pilots are East London, Manchester and the West Midlands. The purpose of RMACs are to enable security services to gather relevant information regarding individuals already known to them in order to further inform their decision making around whether to continue to monitor an individual or not.

NSCHT remains committed to playing an active role in reducing the risks presented by extremism as part of the Trusts wider safeguarding responsibilities and are involved in partnership working as part of the West Midlands site developing multi-agency working.

9. Domestic Abuse

Domestic abuse is now a category of abuse under the Care Act (2014), this enables adults at risk of domestic abuse with care and support needs to be supported under adult safeguarding procedures, this includes control and coercion, honour based violence and female genital mutilation.

This is particularly pertinent for the Trust as a provider of mental health and learning disability services, as it provides a framework for supporting individuals within services who experience domestic abuse and are unable to protect themselves as a result of their care and support needs. This is in addition to traditional criminal justice routes.

9.1 Domestic Abuse Policy

All NHS Trusts are required to have a Domestic Abuse Policy. NHS organisations should be working towards the recommendations of the Ending Violence towards Women and Girls Strategy (Home Office, 2016) and take into account NICE guidance such as Quality Standard116:Domestic Violence and Abuse and Public Health Guideline 50:Domestic Violence and Abuse: Multi-Agency Working (2014). The Trust has a Domestic Abuse Policy (Policy number 1.75) and provides stand-alone domestic abuse training as well as incorporating domestic abuse as a ‘golden thread’ through both child and adult safeguarding. The Trust is therefore compliant with this requirement. The policy is reviewed in line with Trust requirements and was last reviewed in June 2018.

9.2 Domestic Abuse Training

During 2018/19 the Trust commissioned the domestic abuse charity Women’s Aid to deliver Domestic Abuse and Sexual Violence training to frontline staff. This training has

been well received by staff and as a result the same training has been commissioned for 2019/20 to ensure continued staff knowledge and skills development.

Domestic abuse also forms a key element of both child and adult safeguarding training.

New Era commenced delivery of local specialist support services for both survivors and perpetrators of domestic abuse commissioned by the Safer City Partnership in October 2018; the Safeguarding Team has promoted these services through training, team safeguarding supervision and individual advice.

9.4 Multi Agency Risk Assessment Conferences (MARAC) Engagement

Locally Multi Agency Risk Assessment Conferences are held every fortnight and are a multi-agency response to individuals and their families experiencing domestic abuse. The Trust safeguarding team processes MARAC invitations on behalf of NSCHT to ensure that frontline practitioners are made aware of relevant referrals so that they can attend or provide a written report. A good practice guide of what happens at the meeting and what is expected of staff attending a MARAC conference has been developed for practitioners and is included with every invite. In addition to this individual support and supervision is provided by the Safeguarding Team.

MARAC services delivered within Stoke on Trent and North Staffordshire are currently under a multi-agency review led by Staffordshire Police in order to develop working practices that deliver the best use of resources and outcomes for those individuals requiring support.

10. Case Reviews

Learning from all types of case review is shared in a variety of ways; it is discussed at quarterly safeguarding meetings which includes directorate representation, incorporated into mandatory safeguarding training, safeguarding supervision and through the Trusts Learning Lessons Forum.

10.1 Safeguarding Adult Reviews

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

The Trust has contributed to two ongoing SARs and one new SAR during 2018/2019.

10.2 Domestic Homicide Reviews

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

There are currently five ongoing DHRs relating to service users who accessed the Trust's services.

10.3 Serious Case Reviews/Serious Child Safeguarding Reviews

Serious Case Reviews (SCR) are a statutory process undertaken when a child dies or experiences significant harm and abuse or neglect is suspected. The aim of these reviews is to identify learning and areas of improvement in order to improve services for children and young people and prevent future deaths or incidents of serious harm. Following the publication of Working Together to Safeguard Children (2018) in July 2018 this statutory process has been updated and re-titled Child Safeguarding Practice Reviews

The organisation has not been required to participate in any Serious Case Reviews or Child Safeguarding Practice Reviews during 2018/19.

10.4 Multi Agency Learning Reviews

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

The Trust was involved in one MALR during 2018-19. This was for Stoke on Trent Safeguarding Children Board following the death of a young person. This MALR is on-going at the time of this annual report.

11. Safeguarding Supervision

11.1 Safeguarding Supervision Strategy

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

<u>Level 1</u>
Staff can access safeguarding support and advice from their peers and line managers.

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

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

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

Level 5
Supervision for the Named Nurse is accessed from the Clinical Commissioning Group Designated Nurse for Adult Safeguarding and Designated Nurse for Safeguarding Children and the Named Doctor accesses regular supervision from the Designated Doctor.

Staff are made aware of the opportunity to seek safeguarding supervision during NSCHT safeguarding training, through the NSCHT supervision policy and information provided for staff on the intranet safeguarding page. Practitioners are also offered supervision when invited to a child protection conference, a MARAC conference or when involved in any other statutory safeguarding process such as a DHR or MALR.

11.2 Safeguarding Supervision Sessions

During 2018/19 seventeen teams received regular supervision from the Safeguarding Team. This is an increase from eleven during 2017/18. The number of safeguarding supervision sessions delivered has increased from 6 in Q1 to 24 in Q4.

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

The Head of Safeguarding, Named Doctor and Senior Safeguarding Practitioner regularly provide safeguarding advice on an individual basis both face to face and over the telephone. Telephone supervision has increased form 67 calls in Q1 to 110 in Q4. The Head of Safeguarding has also commenced 1:1 supervision with a practitioner to support with a particularly complex case.

The Head of Safeguarding received regular supervision from Clinical Commissioning Group Designated Lead for Adult Safeguarding and Designated Nurse for Safeguarding Children and the Named Doctor received regular supervision from the Clinical Commissioning Group Designated Doctor during 2018/19.

12. Local Authority Designated Officer (LADO)

12.1 Referrals

A referral is made to LADO when someone, in the course of their work, has allegedly harmed a child or behaved in a way which may deem them inappropriate to work with children. Referrals are received by the local authority who investigates concerns under the Children Act 1989. The Head of Safeguarding and Named Doctor are the named officers for Trust LADO referrals.

During 2018-19, there has been one LADO referral. This has been investigated and reviewed within the Trust policy and through Local Authority LADO processes.

13. Examples of Good Practice

13.1 Home Treatment Team

An example of good practice was displayed by a staff member at the Home Treatment Team. This staff member had assessed a service user who had a physical disability. The service user was experiencing a decline in their mental health following becoming aware that a person who presented a risk to them had identified where they were living. The Police were contacted by the service user, however they were unable to pursue a criminal justice route as no crime had been committed. The staff member made an adult safeguarding referral, with the service user's consent, on the grounds that their ongoing care and support needs due to physical disability meant they were unable to protect themselves from potential abuse. This resulted in a multi-agency co-ordination of actions which were taken to safeguard the individual. This a good example of involving the service user in safeguarding plans, thinking holistically about potential risk, remaining focused on the outcomes the adult with care and support needs wants and working creatively with third sector agencies to find solutions.

13.2 Child and Adolescent Mental Health Services (CAMHS) Community Team: Case 1

This case relates to a young person with an autistic spectrum disorder and a history of deliberate self-harm. Concerns were initially raised regarding this young person by Tier 4 CAMHS services. Separate concerns were also raised by Education.

The referral was subsequently reviewed by Children's Social Care following information received from other agencies around potential risk of sexual abuse in relation to the young person. As a result of the subsequent enquiries it was decided the young person should no longer reside in the family home. Following the proposed alternate living arrangements being identified, further concerns were raised by the Care Coordinator with Children's Social Care regarding the suitability of these.

The Safeguarding Team gave information and advice regarding the escalation policy to the Care Co-ordinator in order to escalate their concerns. This promoted an escalation to Stage 2 of the policy. Discussions took place between CAMHS and Children's Social Care Team Managers and a positive outcome was established. This resulted in the young person being placed in a residential placement as a medium term solution whilst a plan was formulated to look at longer term living arrangements for the young person.

13.3 Child and Adolescent Mental Health Services (CAMHS) Community Team: Case 2

This case relates to a young person living with a parent with significant mental health problems. The parent's difficulties were considered by clinical team to be adversely affecting the young person's presentation and the young person was expressing a desire to leave the family home. Children's Social Care involvement had been requested but following assessment a decision was made to continue with Early Help. CAMHS staff working with the young person felt that this did not sufficiently minimise risk as the identified protective factors, contributing to the rationale for remaining at an early help level, were felt not to provide a constant protective factor for the young person. This case was identified as part of team safeguarding supervision and advice was given on the use of the escalation policy to the CAMHS member of staff who then voiced their concerns in writing to Children's Social Care. As a result of this the young person's case was escalated to Children's Social Care Safeguarding and allocated a social worker in order to co-ordinate a package of support.

14. Sexual Safety

In response to the Care Quality Commission's report Sexual Safety on Mental Health Wards (2018) and as part of NSCHT's commitment to improving the provision of services, an action plan which maps our service provision against best practice and identifies potential improvements has been developed with a task and finish group identified to embed these changes.

The Head of Safeguarding has been identified as the Trust Lead for Sexual Safety and a Sexual Safety and Responding to Sexual Violence policy has been developed and is currently going through ratification processes. An action plan has also been produced and received by SLT.

15. Achievements & Priorities

15.1 Key Achievements 2018/19

In 2018/19 there have been a number of key achievements which are listed below:

- Contribution to MASH processes continues to increase with Safeguarding Team contributing daily to the Information Sharing Log to ensure agencies obtain the correct information in a timely way.
- NSCHT compliance for Level 3 Safeguarding Children Training has risen to 94% in the third year against a Trust target of 85% compliance.
- The three year child safeguarding level 3 training plan has been completed, this has resulted in a significant increase in numbers of staff receiving level 3 training. This provides assurance of an appropriately trained workforce for child safeguarding in line with identified standards of training contained within Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Intercollegiate Document (2019). This training will continue to be delivered in order to continue to ensure child safeguarding learning from child safeguarding practice reviews, best practice, changes to legislation and themes and trends in child safeguarding are shared with frontline staff.
- A programme of raising the profile of safeguarding supervision and encouraging teams across the organisation to access this has resulted in a significant increase in teams receiving supervision form 11 to 17 and sessions delivered have increased to 60 sessions throughout the year 2018-2019. This supervision aims to ensure practitioners are supported and key messages regarding safeguarding are disseminated. This positively influences both organisational culture and individual practitioner's confidence and professional practice.
- A training package for level 3 adult safeguarding for professionally qualified staff has been developed and a schedule of two sessions per month has been planned across 2019-2020. This will ensure that staff are receiving appropriate training in line with the Intercollegiate Document; Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).
- To strengthen the Trust response to domestic abuse and in line with NICE Quality Standard 116 Domestic Violence and Abuse (2016) a significant focus within the adult level 3 safeguarding training relates to routinely asking sensitive questions regarding domestic abuse and responding to subsequent disclosures.

15.2 Key Priorities 2019-20

As part of the Safeguarding Team's programme of continued improvement for 2019-2020 a number of key priorities have been identified. These include:

- An annual audit schedule is planned in order to link effectively with wider Trust agendas and to provide assurance of safeguarding practices within NSCHT.

- The delivery of level 3 adult safeguarding training will commence and participant feedback will be utilised to further develop and enhance the training package.

- Further development of mechanisms for engaging with frontline staff including the use of I.T to facilitate safeguarding surveys, a quarterly safeguarding bulletin and the development of Safeguarding Champions within clinical areas.

- Further work to be completed to explore the capability of electronic patient records to store safeguarding information in an easily accessible and auditable way.

- Safeguarding team supervision to be further embedded across the organisation in order to provide assurance with both the Intercollegiate Documents.

- To further strengthen training evaluation/follow up by exploring options for a post course follow up questionnaire. The aim of this will be to provide enhanced assurance around learning and influence the development of future training.

- Continued review of the resilience of the Safeguarding Team to represent NSCHT in an evolving safeguarding arena.

- The further development of directorate quarterly reports to increase assurance regarding safeguarding practice and ensuring that safeguarding is owned by directorates with support from the Safeguarding Team. These changes are being implemented in order to gain assurance around safeguarding activity and knowledge which is not captured by central reporting processes.

16. Conclusion

This year has seen the Safeguarding Team embed changes of leadership with both the Named Doctor and Head of Safeguarding coming into post just prior to April 2018.

The service has continued to deliver both internal and external training packages in line with national guidance, developing additional training packages to be delivered by the team and sourcing external specialist training.

Supervision has also continued to be a focus for the team in order to support practitioners in the organisation with what are often complex and emotionally demanding situations. The enhanced provision of supervision has supported staff around their decision making and in improving outcomes for both children and adults with care and support needs.

Supervision continues to be delivered on both an individual case by case basis and as a structured part of team supervision. It is planned to continue to increase participation with structured team supervision over the coming year to engage with a wider spread of teams across the Trust. This will provide an opportunity to develop both individual and team skills and knowledge through supportive discussion and challenge.

Active participation and involvement with the newly formed Stoke-on-Trent and Staffordshire Child Safeguarding Board and the Staffordshire and Stoke-on-Trent Safeguarding Adults Partnership Board ensures the visibility of the Trust in the wider safeguarding community and provide assurance that the Trust is fairly and appropriately represented in child safeguarding practice reviews, safeguarding adult reviews and domestic homicide reviews in addition to playing an active role in the development work of the various Boards.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 8

Date of Meeting:	23rd May 2019		
Title of Report:	Director of Infection Prevention & Control (DIPC) Q4, (January 2018 –March 2019) report		
Presented by:	Maria Nelligan, Director of IPC		
Author:	Chris McGinley, Head of IPC and PH		
Executive Lead Name:	Maria Nelligan. Director of IPC	Approved by Exec	☒

Executive Summary:	Purpose of report	
To provide the Board with assurance in relation to the IPC arrangements within the Trust. The report will also give an overview of the influenza situation, our external reporting responsibilities, confirmed Influenza activity and Influenza vaccine uptake, including the CQUIN requirements.	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 ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference			
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on protected characteristics in relation to the completion of this report.		
STP Alignment / Implications:	N/A		
Recommendations:	For approval		

Version	Name/group	Date issued
V1	IPC Group	Virtually
	Execs	07/05/19
	Quality Committee	09/05/19

1. Purpose of the report

This report is in line with the requirements set out in Winning Ways (DH, 2003) and the Health Act (2006) for the Director of Infection Prevention and Control (DIPC) to appraise the Board on a quarterly basis on the arrangements and activity within Infection, Prevention and Control (IPC). The report will update and provide assurances to the Board for quarter four (Q4) on IPC activity including influenza within the organisation. The Board will also be briefed on our position in relation to Health Care Acquired Infections (HCAIs) and relevant issues.

2. Health Care Acquired Infections (HCAI)

During the Q4 period there were no HCAIs within the Trust, including incidents of MRSA Bacteraemia or C-difficile.

MRSA screening continues to be implemented with a zero positive result for this quarter. Therefore no exceptions have been reported externally.

3. Incidents

No IPC incidents reported in Q4.

4. Influenza Activity

Only two inpatients at Combined have been symptomatic and those patients were reviewed and treated as required. Only one ward has been affected with seasonal influenza.

Communication with colleagues at UHNM and the wider community continued to maintain an accurate daily picture across the region.

The immunisation programme for 2018/19 commenced late September 2018 to the 31st March 2019. The Trust achieved 76% compliance for uptake of the Influenza vaccine for frontline staff. The denominator for this year has increased to over 1200 frontline staff, as a result vaccinators have had to vaccinate more staff to meet overall compliance. The programme has included:

- 'Jabathons' (24 hour access to the vaccine),
- Dial a jab, text a jab, tweet a jab
- Grand prize incentive of an IPad mini and a number of golden tickets worth £10 hidden in vaccine boxes
- We deliver 'to you' clinics

Frequently asked questions, declaration forms and other relevant information, including myth busting tips, were all available via the IPC pages on SID. The communication team also supported the "12 days of Fly for X-mas" for myth busting.

5. Outbreaks

From April 2017 we report to commissioners by exception only for outbreaks or incidents of avoidable cross infection incidence.

Influenza

Ward 7 - Confirmed Influenza A was detected in 2 patients, the first on 15/01/2019 and the second on 17/01/2019. Both patients were treated with Tamiflu. One member of staff also had Flu like symptoms; GP treated with Tamiflu but was not a confirmed influenza. All precautions implemented no further evidence of transmission.

Affected = x2 patients x1 staff member
Ward remained open

Norovirus

Ward 7 – Confirmed norovirus during February 2019. First symptoms identified on 30/01/2019 from a member of staff. First patients both identified as symptomatic on 01/02/2019 which was confirmed by laboratory testing which identified Norovirus GII. In total during the outbreak a further 5 patients and 13 members of staff displayed symptoms of either diarrhoea and/or vomiting. All precautions were taken; staff were excluded from work as per the outbreak policy until 48 hours symptom free. Enhanced cleaning started and continued for the duration of the outbreak. Ward closed from 05/02/2019 until 12/02/2019 after a full deep clean of the Ward.

Affected = x7 patients x13 staff members
Ward closed from 05/02/19 – 12/02/19

6. Infection Prevention & Control Group

The Infection Prevention and Control Group (IPCG) met bi-monthly, and the last meeting took place in March 2019. The chairs summary comprises:

- Annual Work Plan 2018/19 reviewed (appendix 1)
  - Items 8, 10 and 11 remain ongoing, work identified for 2019/2020.
  - Item 14 status changed from red to amber with ongoing work identified for 2019/2020.
  - Item 14 Closed status changed to green.
- Assurance Framework 2018/19. All criterion completed except 4.2.4 which remains open with ongoing work into 2019/2020.
- The IPC audit programme completed by end of Q4.
- Influenza Programme – the trust exceeded the national of 75% of frontline staff being vaccinated with a 76% uptake.

7. Recommendations

The Board is asked to note the DIPC Quarter 4 Report for 2018/19.

Appendix 1

Infection Prevention and Control (IPC) Group Work Programme 2018–2019
Chair: Maria Nelligan, Director of Infection Prevention & Control (DIPC)
Deputy Chair: Amanda Miskell, Deputy DIPC

(2018/19)
Our Vision - To be a high quality health and social care provider that continuously improves patient experience and deploys its resources intelligently and efficiently.

Our Quality Priorities - Key areas which evidence that we are delivering high quality care and treatment to those using our services in a way that is person-centred
•S - Our services will be consistently safe
•P - Our care will be personalised to the individual needs of our service users
•A - Our processes and structures will guarantee Access to services for service users and their carers
•R - Our focus will be on the recovery needs of those with mental illness

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
1	The Trust has a Work Programme / Assurance Framework in place. An annual and four quarterly (Q) reports are presented to the Board of Directors.	D/DIPC & IPC Group (IPCG) D/DIPC	Last annual report presented to Board of Directors in 2017 and published Q4 April 2018 Annual Report June 2018 Q1 August 2018 Q2 October 2018 Q3 February 2019	
2	Board level responsibility for IPC is clearly defined and there are clear guidelines on reporting corporate risk from the IPCG	D/DIPC	Annual and Quarterly reports Reporting by exception to CCGs where needed IPC Work Programme IPC Assurance Framework	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
3	There is an IPC Group which is directly accountable to the Chief Executive and the Trust Board. The Group endorses all IPC policies, procedures and guidance, and provides advice and support on the implementation of policies. The Group monitors the progress of the annual IPC Work Programme/Assurance Framework bi monthly	IPCG	IPCG Terms of Reference reviewed annually IPCG Agendas and Minutes IPC Policy and Standard Operating Procedures Audit Programme Performance reporting Strategy	
4	There is an appropriately constituted and functioning IPC team.	D/DIPC	Recruitment of two B6 staff for IPC (1.0 WTE) Annual and Quarterly Reports Consultant Nurse/Deputy DIPC 1-1s with DIPC Performance & Compliance Reporting	
5	Prevention and control of infection is considered as part of all service provision.	Head of Estates/Water Safety Support services/ Decontamination Lead Heads of Directorate	IPC is compulsory in all Service Level Agreements and External Contracts IPC is included in all Trust Job Descriptions Audit Programme and Review Inpatient and Community Safety metric Modern Matron/Senior Nurse Monthly review Procurement sign off for all medical devices New builds, refurbishment and change of purpose must have IPC sign off	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
6	Written policies, procedures and guidance for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance The IPC team also play a part in supporting other key stakeholders policies	Infection Prevention & Control Team	IPC Policy Review Work Plan Safety Metrics, Surveillance and Audit Reports Minutes of IPCG Assurance Framework Waste Water Safety Admission Discharge & Transfer policy Dress Code Policy Nutritional Policy Food Safety Tissue Viability Antimicrobial prescribing Medical photography Medical devices Cleaning and Decontamination Care of the deceased	Ongoing
7	There is an annual IPC Audit Programme	IPC team IPCG	Audit exceptions are reported to the Board via the IPCG chairs summary 2018/19 audit programme will increase compliance score to 90% from 85% to show a year on year improvement	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
8	Timely and effective specialist microbiological support is provided to the trust 24/7 in relation to individual patients and advice	Microbiologists IPC team	Written service level agreements / contracts are in place with the accredited microbiology Department (UHNM). This includes an agreement from PHE/UHNM that all exposure incidents are followed up as per national recommendations out of office hours. All alert organisms, blood stream infections, and other significant organisms including confirmed Influenza are reported via the nhs.net address at IPC Combined.	
9	Education and training in the prevention and control of infection is provided to **all frontline** staff on an annual basis This is supplemented by e learning for other staff Develop the role, knowledge and skills of staff in IPC Support a robust IPC clinical network across the organisation with Clinical Staff, Pharmacy, Modern Matrons, Support Services and Estates	IPC team D/DIPC	Training records & monitoring of attendance % bi monthly Local standard monitoring via audit Compliance reported to IPCG Audit and checklist programme in place which is efficient in terms of multi-disciplinary attendance	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
10	Incidents, transmission of infections and outbreaks are documented by the IPC team, reviewed by the IPCG and reported to the Board where required	IPC team D/DIPC	IPCG minutes Trust Board informed via Annual and Quarterly Reports Performance and exception reporting Post outbreak meeting reports Safeguarding reporting	
11	Antimicrobial Stewardship will adhere to the 5 year strategy, formulary, Regulation 12 and best practice	IPCG and Pharmacy	Pharmacy representation at IPCG and antibiotic reporting Current antibiotic formulary (community) in line with local surveillance for multi resistant organisms	
12	There is a programme to manage and monitor the potential and actual risks of Health Care Associated Infections (HCAI's) In unavoidable cases these are monitored, reviewed and reported to the Board A Sepsis recognition programme is in place in line with the detection of the deteriorating patient and national sepsis programme	All Trust Staff D/DIPC IPC team	IPC policies IPC audit programme Safety Thermometer Safety Matrix Quarterly and Annual Reports Cleaning Strategy IPC training Information for staff and service users Surveillance Sepsis is included in all training, sepsis cards have been distributed and sepsis 6 pathways introduced for CAMHS and adult areas Implementation of NEWS	
13	Reporting on HCAI's to Commissioners by exception and PHE where required (communicable diseases).	IPC team	Performance reporting DIPC's quarterly Reports PIRs, peer reviews and RCAs	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
14	Water Safety Plan & Group is included within the IPCG	Head of Estates and Support Services DIPC IPCG	Legionella Management update report to IPCG IPCG Minutes Quality Committee also informed All water safety incidents are reported to the IPC team and escalated to the DIPC where required.	

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 9

Date of Meeting:	23RD May 2019		
Title of Report:	Infection Prevention & Control (DIPC) Annual Report		
Presented by:	Maria Nelligan, Director of IPC		
Author:	Chris McGinley, Head of IPC and Physical Health (PH), Deputy DIPC		
Executive Lead Name:	Maria Nelligan, Director of IPC	Approved by Exec	☒

Executive Summary:		Purpose of report	
The Annual DIPC Report will assure the Board that the organisation is compliant with the Health & Social Care Act 2008 – Code of Practice on the prevention and control of infections and related guidance (2015). The cleanliness report for the year and the completed annual audit/work programme for 2018/2019 are also included. The new 2019-20 work programme is submitted for approval.		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 ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	The report must be made publically available as soon as is reasonably possible.		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	The report does not impact negatively on any person/group in terms of Equality & Diversity.		
STP Alignment / Implications:	None		
Recommendations:	Ask the Board to approve the annual DIPC report for 2018/2019, and the associated documents.		

Version	Name/group	Date issued
1	IPC Group	Virtually 03 May 2019
	Execs	07 May 2019
	Quality Committee	09 May 2019

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PROUD TO CARE

1. Introduction

The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from 01 April 2018 to 31 March 2019, and to highlight achievements and the progress made against the priorities outlined in the Infection Prevention and Control Group (IPCG) work programme 2018/2019. This is in line with The Health & Social Care Act 2008 – Code of Practice (2015) on the prevention & control of infections and related guidance (2015) which refers to the Department of Health Winning Ways document (2003), for the Director of Infection Prevention and Control (DIPC) to produce and release publicly an annual report. This document will now be referred to as "The Code".

High standards of infection prevention and control are crucial to ensure prevention of infection(s) in all health care facilities within the Trust. To support this, the IPC team have worked in collaboration with directorates and other corporate teams to continue the Trust's extensive efforts to prevent all avoidable infections and minimise the risk of resistant organisms across our Health & Social Care footprint.

Below is a brief summary of the IPC team activities and achievements, and how we continue to raise the profile of IPC within the Trust:

- **Meticillin Resistant Staphylococcus Aureus (MRSA)** - No preventable MRSA bacteraemia infections within our services
- **Clostridium difficile toxin (C.diff)** - One C.diff toxin apportioned for the year which was investigated. Following investigation the outcomes and actions identified were shared with relevant areas.
- **Healthcare Associated Infections (HCAIs)** – No cross infection cases in patients or staff.
- **Outbreaks** – One ward experienced 3 separate outbreaks of Influenza and Norovirus. All appropriate precautions and monitoring undertaken, no evidence of transmission.
- **Infection Prevention Society (IPS)** – Infection Prevention and Control Nurse Specialist presented at the Regional conference and the IPC team submitted poster presentations.
- **Mental Health IPS Special Interest Group**, the IPC team are active members of the national group.
- **West Midlands Antimicrobial Group**, the IPC team are active members of the group
- **Health Education West Midlands** the IPC team are key players in developing competencies for Mental Health (MH) and Learning Disabilities (LD) nurses.
- **Patient Led Assessments of the Care Environment (PLACE)** – The Trust maintained exceptionally high PLACE scores
- **Flu campaign** - Trust exceeded the national target of 75% for patient facing staff, achieving 76% uptake. This was supported with a campaign including prize incentives such as IPad & vouchers.
- **Group Membership** – The IPC team are members of and an active presence in multiple Trust groups. For example the mortality surveillance group, end of life task and finish group and incident review group.
- **Standardisation of equipment and consumables** – The IPC team continued the development of a Trust standardisation list for all areas.
- **Standard Operating Procedures (SOP)** – The IPC team continued the development of multiple SOPs to support Trust staff.
- **IPC Policies** – The IPC team have developed newly identified policies for IPC

- **Partnership and Collaborative Working** – The IPC team have maintained good working relations with multiple Trusts and organisations both locally and nationwide.
- **Audit** - Implementation and monitoring of Trust wide IPC audit and introduction of Monthly Modern Matron audit.
- **Surveillance** - Continued monitoring of Trust surveillance database for the monitoring of clients / service users with IPC and physical health issues
- **Service Level Agreements (SLA)** - Continued review and streamlining of multiple policy and service level agreements (SLA) throughout the Trust including palliative care management policy
- **Replacement Equipment Program** - Continued review of replacement equipment program e.g. Beds, hoists, and defibrillator machines
- **Intra Venous (IV) audit** – A single audit was undertaken as a scoping exercise of the existing use of intravenous support in the Trust to enable a review of the appropriateness of use within clinical areas.
- **Trials**
  - **IV equipment** – Trial started for non-ported and cannula and needle free devices at Edward Myers Centre. Outcome to be reported to IPC group in 2019/2020.
  - **Patient wipes** – trial outcome to be reported to IPC group in 2019/2020.
  - **Bladder scanner** - trial undertaken outcome reported to IPC group.
- **Safety Needles** - Change of anaphylaxis packs to include safety needles.
- **IPC Update** - Trust based IPC information updated for all areas which include information and campaigns from Public Health England and World Health Organisation.
- **Antimicrobial Guidelines** - IPC team work closely with the Pharmacy department in reviewing new antimicrobial guidelines as required.

2. Director of Infection Prevention and Control's (DIPC) reports to the Board of Directors

2.1 Frequency/nature of reporting

In addition to delivering the annual report, the DIPC delivers a quarterly report to the Board. During 2018/2019 the Board received reports in accordance with The Code, which highlighted areas of practice and development, including arrangements for IPC.

2.2 Decisions made by the Board of Directors

The approval and recommendations agreed by the Board following presentation of Quarterly and Annual Reports have been actioned accordingly**.**

3. Care Quality Commission and Health and Social care Act 2008

The Trust continues to meet its commitments to the Care Quality Commission (CQC) standards in relation to the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health, 2015) which contains the ten criterions that healthcare providers are assessed against.

CQC Regulation 12 and 15 shown below are also addressed within the Trust IPC assurance framework:

Regulation 12 – Safe care and treatment, "Providers must prevent and control the spread of infection. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare".

Section 2h – "Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated". When assessing risk, providers should consider the link between infection prevention and control, antimicrobial stewardship, how medicines are managed and cleanliness.

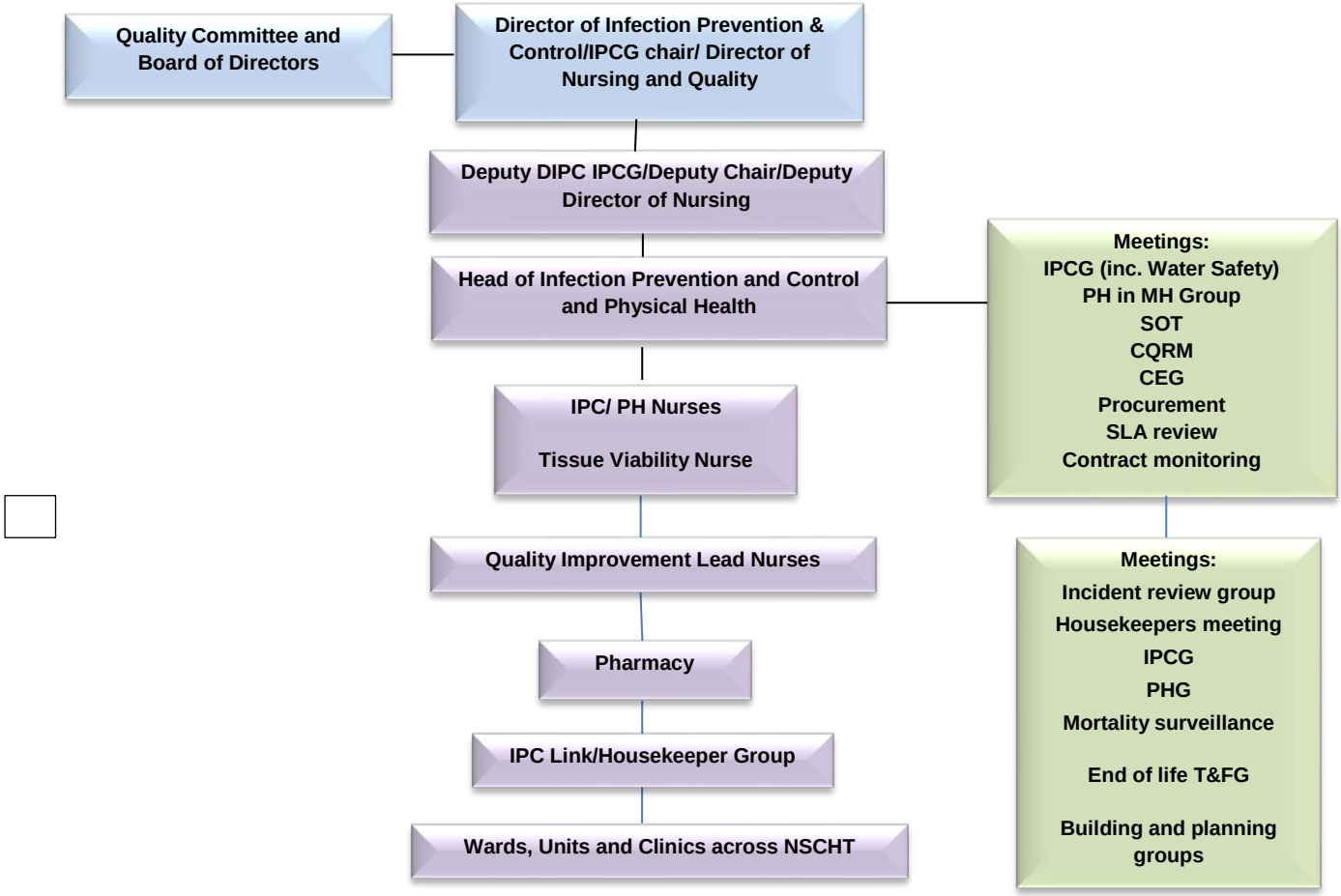
Regulation 15 – Premises and Equipment, "The intention of this regulation is to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly".

Section 15.2 – "The registrant must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used".

4. Infection Prevention and Control (IPC) governance arrangements

4.1 Arrangements

The IPC team have a high profile within clinical and support services across the Trust. The following diagram sets out the escalation process within the Trust, "Ward to Board".



4.2 Infection Prevention and Control Group (IPCG)

The IPCG reports directly to the Quality Committee, and is chaired by the DIPC. Meetings have taken place bi-monthly in the past year, and all services and directorates have been represented.

4.3 The IPC team (IPC team)

The DIPC is supported by the Deputy DIPC and the IPC/PH team which is led by the Head of IPC/PH, (1.0 WTE), supported by IPC nurses (1.4 WTE) and a Tissue Viability Nurse (0.2 WTE, through an SLA).

4.4 IPC/Housekeeper group

Facilities and Estates, including the housekeepers, throughout the trust are supported by the IPC team to deliver the IPC agenda corporately and locally. The IPC/Housekeeper group is well established and is coordinated by the Head of Facilities. This group meets on a monthly basis, and provides an opportunity to cascade and disseminate key IPC guidance to staff.

4.5 IPC and TV resources

The following resources are available to all staff and carers:

- The IPC team
- IPC policy/Standard Operating Procedures (SOPs) – which are reviewed in line with the IPCG work plan.
- An IPC web page – a direct link provided on the intranet home page, updated with new announcements, useful codes, links to all other relevant information. This page is regularly updated and any feedback on areas for development is actioned as required.
- Access to microbiology advice
- Standardisation lists for products and medical devices
- Information leaflets
- Regular stands and IPC promotions
- Coordinate trials of new products and processes for clinicians
- Safer Sharps
- Influenza vaccination
- Detailed training programme
- Sepsis cards
- TV nurse for advice and support

The IPC team have had extensive interactions with staff and service users throughout the year. Each episode involves contact, advice to staff and patients, where appropriate, and is documentation on Lorenzo. As the profile of the IPC team has risen there continues to be an increase in IPC and Tissue Viability contact, for advice and support.

4.6 Infection Prevention and Control strategy 2018 - 2020

The IPC strategy sets out the Trusts commitment to preventing and minimising the impact of infection and the on-going achievements from previous years to reduce avoidable healthcare-associated infection. The Board of Directors receives regular progress reports on the initiatives that are in place. The key objectives and plans for monitoring improvement are highlighted within the commitment which is supported by the IPCG work programme and assurance framework.

This strategy supports effective and meaningful infection prevention and control practice of all employees within the Trust. It will also ensure that effective measures for prevention and control of infection are integrated in to the Trust's core business planning and delivery.

The trust aims to prevent any risk of Healthcare Associated Infection (HCAI), throughout the diversity of settings within the Trust.

4.7 IPC Work Programme

The work of the IPCG is detailed in an annual work programme which is approved by the Board and reviewed at each IPCG meeting. Areas of concern are highlighted and escalated where required. Appendix 1**.**

4.8 Programme of Policy Review

All IPC policies are current and in line with the policy review programme which forms part of the IPCG work plan.

5. Refurbishments and New Builds

The IPC team provide advice and support during refurbishments and new builds across the Trust, including advice for community premises to ensure compliance with national guidance and the audit programme. The team have also supported and advised on tender properties.

6. Standardisation of Products

The IPC team have continued to review and standardise products, continually updating IPC information on Combined Access Tool (CAT).

Standardisation of IPC related items used within the Trust has been achieved in relation to equipment such as patient wipes, safety needles and devices, respiratory products and foot care products. The team continues its work to improve this as new guidance, evidence and products become available ensuring clients / service users and staff have access to the most appropriate, safe and cost effective resources.

7. Safe Systems for Sharps and Exposure Incidents

The IPC team review all incidents on the Ulysses system to reduce risk and promote good practice in relation to needle stick injuries (NSI). They also provide training and promotional materials to staff to support safer processes. Exposure incidents are potentially high risk, and preventative training and resources are provided on an ongoing basis to negate these risks. Venepuncture training includes safe system sharps.

8. Hand Decontamination

The IPC team continues to actively promote hand hygiene, via observational activities in the workplace, audit, Trust induction, mandatory training and at Trust events. Identified work with volunteers is being undertaken and will be ongoing through 2019/2020.

9. Education activity

9.1 Induction and Mandatory Training

The IPC team have facilitated 44 mandatory training sessions and have oversight of the e-learning package which is available to all staff. The team strive to improve compliance by

providing extra sessions, targeting low compliance areas and attending key clinical meetings. Specific bespoke training has been developed and delivered in relation to the introduction of venepuncture and ECG**.** The team continuously aims to improve their training by ensuring packages are current and in-line with the latest evidence and guidance available.

The IPC team also provide the foundations of physical health training and its accompanying competency document which includes the deteriorating patient, the correct use of the National Early Warning Score (NEWS), including Sepsis, use of the Lester tool, smoking cessation including use of Nicotine Replacement Therapy (NRT), tissue viability, falls and oxygen therapy training.

Our aim for 2019/20 is to continue to achieve a higher compliance rate, refresh training resources and delivery methods as well as offering new training sessions.

9.2 Continuing Professional Development of the IPC team

In addition to completion of organisational training requirements, the IPC team attends relevant local, national workshops and conferences, including national and regional Infection Prevention Society (IPS) conferences.

Two members of the team hold officer posts within their regional IPS groups. One is education officer and the other is deputy communications officer. The team present at conferences both regionally and nationally for the IPS and the Trust is hosting one of the West Midlands branch regional meetings early 2019/20.

The Antimicrobial Pharmacist undertakes additional training courses relating to antimicrobial management and IPC as part of their Continual Professional Development (CPD).

The Facilities Management team are members of the Association Healthcare cleaning professionals.

10. IPC standards reviews

10.1 Modern Matron Walkabouts

The IPC team/Facilities have oversight of the modern matron monthly walkabouts audits and provide advice and support as required.

10.2 IPC Audits

During 2018/2019 the Team carried out audits on all inpatient and community clinical areas. The results and the audit programme is available in appendix 2.

All Trust areas achieved above the compliance score of 90% with the exception of one community based service where some environmental issues were identified. The issues were raised immediately with estates and the environmental work continues in these premises which the IPC team is supporting.

Results are reported back to the Ward Manager, Modern Matron, Estates and Facilities managers, and the IPCG where areas of good practice are highlighted and appropriate actions regarding areas of concern is actioned and documented on the risk register if necessary.

The audit programme for 2019/1920 has been developed and will be implemented from April 2019.

11. Integrated Working and Support

The IPC team support investigations and reports for directorates, and patient safety and have undertaken several local investigations. The IPC team also supports Trust wide activities raising the Trusts profile e.g. a collaborative event in which Trust staff, including the IPC team/PH team prepared and cooked meals for over 200 members of the public at the local Young Men's Christian Association (YMCA).

12. Service User Involvement

There is service user representation on the IPCG, and always on PLACE visits. In the coming year we are hoping to involve our volunteers to become hand hygiene ambassadors, supporting the implementation of the new dress code policy and advocating appropriate hand hygiene across the trust. This will involve training which the IPC team will support.

13. Health Care Associated Infection (HCAI)

During 2018/2019 there were no cases of MRSA Blood Stream infections in the inpatient areas.

There was one case of Clostridium *difficile* Toxin infection

This performance demonstrates that excellent IPC standards are followed in inpatient services, and patients are not harmed unnecessarily by any HCAI's**.**

14. Outbreaks Inpatient Areas

All IPC incidents and outbreaks are routinely reported to the IPCG and the Board of Directors, ensuring relevant information and good practice is shared as well as the development of action plans where required. The focus of the IPC team is to prevent outbreaks and if they do occur, to support the area to reduce the impact of the outbreak on service users and staff. This is achieved by monitoring environmental cleaning standards, hand hygiene and by ensuring staff can identify a potential outbreak which is addressed during daily surveillance and training. In order to learn from experience post-outbreak meetings are held for inpatient areas within five working days of the end of an outbreak. These meetings may include; Clinical Service Managers, Modern Matrons; Ward Managers, Temporary Staffing, Occupational Health, Estates personnel and Facilities Managers from both the Trust and Serco.

For 2018/19 we have reported 3 outbreaks of infection 2 of which resulted in ward closures.

Details of Outbreaks per quarter;

Q1 – **Norovirus**

- Ward 7 had 4 cases of confirmed Norovirus in April 2018. Four patients confirmed Norovirus GII. All standard precautions taken including enhanced cleaning, good hand hygiene practice with liquid soap and water replacing alcohol gel.

  Affected = 4 patients Ward closed for total of 5 days 30/04/2018 – 04/05/2018

Q2 – No outbreaks

Q3 – No outbreaks

Q4 – **Influenza and Norovirus**

- **Influenza**
  Ward 7 - Confirmed Influenza A was detected in two patients, the first on 15/01/2019 and the second on 17/01/2019. Both patients were treated with Tamiflu. One member of staff also had Flu like symptoms; GP treated with Tamiflu but was not a confirmed influenza. All precautions implemented no further evidence of transmission.
  Affected = x2 patients x1 staff member. Ward remained open
- **Norovirus**
  Ward 7 - confirmed during February 2019. First symptoms identified on 30/01/2019 from a member of staff. First patients both identified as symptomatic on 01/02/2019 which was confirmed by laboratory testing which identified Norovirus GII. In total during the outbreak a further 5 patients and 13 members of staff displayed symptoms of either diarrhoea and/or vomiting. All precautions were taken; staff were excluded from work as per the outbreak policy until 48 hours symptom free. Enhanced cleaning started and continued for the duration of the outbreak. Ward closed from 05/02/2019 until 12/02/2019 after a full deep clean of the Ward.
  Affected = x7 patients x13 staff members. Ward closed for a total of 8 days from 05/02/19 – 12/02/19

In all incidences post outbreak meetings took place, and minutes noted at IPCG.

15. Tissue Viability

The Tissue Viability Service (TVS) is provided through an SLA. The Tissue Viability Specialist Nurse (TVSN) works 0.2 WTE (1 day per week) as part of the IPC/PH team with direct advice available on the day. At all other times advice is provided through the TVS triage system.

Inpatient MH services have shown an increase in the number of patients requiring support for tissue viability, which is inclusive of self-harm wounds, cuts, post-operative surgical sites and pressure damage management and treatment which has included pressure ulcers.

Education and support in the management of wound and pressure areas is included as part of the physical health training day. The TVN has started to develop the Tissue Viability policy which will be available for review by the IPC group by July 2019. Work incorporating standardisation of dressings has been completed.

16. Surveillance

Review of activity in relation to IPC is reviewed on a daily basis. The key items for the IPC/PH team are the surveillance and identified risks associated with invasive devices, pressure ulcers, wounds and the use of antimicrobials.

All patients admitted from other healthcare premises, with skin integrity complications, or invasive devices (including those patients being cannulated on the Edward Myers Unit are screened for MRSA, with their consent, as these patients are potentially at risk of infections, including blood stream infections (BSI's).

The IPC team support and collate all the information in relation to the above, including those who self-harm and/or inject.

16.1 Chest Infections

There was a slight rise in chest infections over the winter months through both Q3 and Q4. Some of these were possibly due to secondary infection following normal viral infections over the winter period including Round Structure Virus (RSV).

Q3 saw a significant rise in Urinary Tract Infections (UTIs). No specific infection control reason for the increase was identified and all patients were treated appropriately. To help prevent and minimise UTIs the IPC team promoted best practice including; good hygiene, hydration and the correct use of continence aids.

From the information below and the collaborative work with the pharmacy department, we can see an increase in antimicrobial prescribing Q2 and Q3 which mirrors the number of infections recorded.

Where appropriate, patients were transferred to acute services for acute medical treatment

16.2 Catheter Associated/Urinary Tract Infection (CAUTI)

UTIs contribute to a large proportion of antimicrobial prescribing. More recently these have been caused by gram negative organisms, E.coli and Klebseilla. The majority of these are totally resistant to commonly used antibiotics therefore it is imperative that we do all we can to prevent and minimise these by promoting best practice. This includes good hygiene, hydration and the correct use of continence aids.

The IPC team ensure NICE guidance EPIC 3 (2014) and CQC requirements with regards to Catheter Associated Urinary Tract Infections are followed. These are reported by exception, during 2018/19 there have been no CAUTIs that have developed from care within the Trust.

The team continues to deliver education and increase knowledge regarding urinary catheters as well as helping staff to identify the need for antibacterial/silver catheters where infection is recurring.

16.3 Peripheral Vascular Devices

Most patients on EMU admitted for alcohol detoxification are cannulated for the administration of *Pabrinex* and artificial hydration. A review of clinical practice and the SOP has been carried out, and a new SOP has been produced and a programme of standardising cannula packs, cannulas with safer devices, chlorhexidine decontamination of the skin and hub, and Aseptic Non Touch Technique (ANTT) has begun. Edward Myers Unit trialled the new packs in early 2018. The trial and evaluation of the new packs continues into 2019/2020 and will be reported to IPC group when completed.

The categories of infections identified via surveillance are summarised in the table (1).

Table 1.

Quarter		Q1	Q2	Q3	Q4	Total
Infection	Sepsis	1	2	1	0	4
	Chest infection	15	16	23	19	73
	Cellulitis	8	11	6	9	34
	Wound infection	7	12	8	6	33
Quarter		Q1	Q2	Q3	Q4	Total
Infection	Skin infection	5	5	3	0	13
	Gastrointestinal infection	9	1	0	2	12
	Urinary tract infection	6	7	20	4	37
	Bloodstream infection	0	0	0	0	0
	Eye	0	0	0	0	0
	Ear	1	0	1	0	2
	Nose	0	0	0	0	0
	Throat / mouth	5	2	0	0	7
	Multiple	4	2	4	3	13
Totals		**61**	**58**	**66**	**43**	**228**
Culture growth	None sent	33	37	31	28	129
	Mixed bacterial growth	5	6	10	3	24
	E.Coli	12	13	17	3	45
	ESBL	1	0	0	0	1
	Staphylococcus aureus	3	9	4	5	21
	MRSA	0	0	0	0	0
	MRSA colonisation	1	0	1	0	2
	Influenza	0	0	0	2	2
	Klebsiella	1	0	1	0	2
	Norovirus	5	0	0	2	7
	C.diff PCR	0	0	1	0	1
	C.diff Toxin	0	0	1	0	1
	Other	12	9	13	4	38
	Multiple	3	2	3	3	11
	Antibiotic treatment	63	74	76	40	253

17. Sepsis

Evidence suggests that some cases of sepsis are preventable, particularly in groups of people who are at the greatest risk. Though anyone can be affected, those at the extremities of life – the very young and the very old – are particularly at risk, along with people who are immunosuppressed and pregnant women. For these groups, measures to prevent infection and to recognise and treat infection promptly can prevent sepsis from developing.

The implementation of the SEPSIS assessment supports the clinical decision making process as to requirement for responsible referral and transfer to acute physical health services.

SEPSIS awareness and recognition is a key element of the IPC team Physical Health and Deteriorating Patient education programme. This is also supported by the use of the workplace competency document developed by the IPC team with Health Education England, West Midlands.

The IPCT/PH team implemented the National Early Warning Score (NEWS) in July 2017. In 2018 a review was undertaken and it is planned that NEWS2 will be implemented in the trust in 2019/2020.

In the community setting staff must adhere to policy if a patient is assessed visually as deteriorating from a physical health perspective they should call 999.

During 2018/2019, 4 cases of sepsis were identified;

- 2 cases on Ward 2
- 1 case on Ward 3
- 1 case on Ward 7

Patients were appropriately treated and the cause of sepsis investigated as per policy with all appropriate learning and actions taken.

18. Influenza Immunisation Activity

The immunisation programme for 2018/2019 commenced late September 2018, and to the 31st March 2019, our peer vaccinators 1040 have vaccinated patient facing staff. This meant that the Trust exceeded the national target of 75% with a Trust compliance of 76% uptake by frontline staff. The denominator for 2018/19 was increased and as a result vaccinators have had to vaccinate more staff to meet overall compliance. The programme included:

- Jabathons (24 hour access to the vaccine)
- Dial a jab, text a jab, tweet a jab
- Grand prize incentive of an IPad mini and a number of golden tickets worth £10 hidden in vaccine boxes
- We deliver to you
- Clinics
- Promotional videos on ‘youtube’
- Attendance at various combined conferences for Allied Health Care Professions (AHP) and none registered health care staff.

Frequently asked questions, declaration forms and other relevant information, including myth busting tips, were all available via the IPC pages on the Trust intranet. The communication team have also run the “12 days of Flu for Xmas” for myth busting.

This year there was 1591 staff within the Trust, of which;

- 1369 were identified as ‘frontline’. 1040 were vaccinated.
- 222 were identified as ‘Non-frontline’. 31 were vaccinated

The IPC / PH team submitted compliance data to Immform and NHSI with a 76% overall achievement and the CQUIN target of 75% was achieved by mid December 2018.

19. Antimicrobial (AM) Resistance (R) Stewardship

AMR has risen alarmingly over the last 40 years and the inappropriate use of antimicrobials is a key contributor. The consequences of AMR include increased treatment failure for common infections and decreased treatment options where antibiotics are vital. Antimicrobial stewardship is crucial in combating AMR and is an important element of the UK Five Year Antimicrobial Resistance Strategy.

The Code of Practice states that as a registered provider with the Care Quality Commission, the Trust has several specific responsibilities including the following:

- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Including; targeted training to ensure appropriate AMR stewardship, access to microbiology and advice on choice of therapy. Pharmacy played a pivotal role with clinical screening of prescriptions.

- Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic and referred to acute services as appropriate.

- The DIPC/appropriate other, have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions. Pharmacists challenge prescriptions which do not follow best practice.

- Having a 3 month review of antimicrobial prescribing decisions and Pharmacy clinically screen prescriptions in a timely fashion at ward level, providing targeted holistic patient care.

- Benchmarking should be used to demonstrate progress in antimicrobial stewardship the ongoing audits compare data trends from previous years to ensure improvements are made against criterion.

- Raise awareness of AMR through posters and displays throughout the Trust. This is highly targeted at specific events, such as European Antibiotic Awareness Day.

This will be the same for our NMP prescribing.

Antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials by:

• optimising therapy for individual patients;
• preventing overuse and misuse; and
• minimising the development of resistance at patient and community levels.

A patient safety alert from National Patient Safety Agency (NPSA) was jointly issued by Health Education England (HEE), NHS England (NHSE) and Public Health England (PHE) to highlight the challenge of AMR and to signpost the toolkits developed by PHE to support the NHS in improving antimicrobial stewardship in both primary and secondary care.

TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) was designed to be used by the whole primary care team within the GP practice or out-of-hours setting, as well as being relevant to mental health care settings

All our surveillance work along with pharmacy colleagues compares activity with the agreed AM formulary which is "The Antimicrobial Prescribing Guidelines in General Practice 2016 v1". This is being reviewed this summer and the D/DIPC is part of this review group across the health economy.

The IPC team working collaboratively with pharmacy colleagues and have been proactive in raising awareness in judicious prescribing of all antimicrobials across inpatient settings. AMR is also a standing item at the IPCG.

19.1 Inpatient Services antibiotics audit 2018/19

Since April 2012 the IPC team has monitored and responded where necessary, to every antimicrobial prescription with all our inpatients. This is a benchmark towards our commitment to the national antimicrobial strategy 2013 – 2018. The data is collated into 3 monthly reports**.**

2018 - Q2 saw the highest prescribing for UTI's which reflects the activity within the IPC team regarding dehydration and the numbers of multi resistant (ESBL) UTI's. Prescribing within Q3 shows an increase in respiratory infections compared to Q2 which may be expected.

In Q2 and Q3 – 100% compliance with the guidelines recommendations was achieved for all prescribing initiated within the Trust.

Improvements were made in documentation of infections and prescribing in patient notes in 2018/2019.

The Trust continued to use the antimicrobial prescribing guidelines for general practice for use within in-patient and community services. The in-patient audit criteria include the antimicrobial stewardship principles of TARGET.

20. Estates Department contribution to the IPC work programme

20.1 Legionella compliance with legislation

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

The Trust revised its Legionella policy and developed a comprehensive Water Safety Plan to ensure that appropriate systems and procedures are in place to minimise the risk of legionella within the Trust's hot and cold water systems. The policy describes the responsibility of the Trust to provide adequate resources to enable full implementation of the Codes of Practice as defined in the Health and Safety Executives document L8, The Control of Legionella Bacteria in Water Systems and for specific technical guidance, the NHS Estates Code of Practice HTM 04-01 and 'safe' water guidance notes, in order that they can properly control their water supply system. Under the new policy the Trust will not be looking to achieve compliance with Part C: Pseudomonas aeruginosa – advice for augmented care units, as the Trust has no augmented care units.

During 2018/19 the Water Safety Group responsibilities were incorporated into the Infection Prevention and Control Group.

Regular sampling and testing continued on a quarterly basis and the results were reported back to the IPCG.

20.2 Capital programme works

Refurbishment projects completed 2018/2019:

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

The Estates team continue to involve the lead for IPC in the planning and implementation of refurbishment and new build projects. Moving forward it will also involve the IPC team when addressing backlog maintenance.

Refurbishment projects this year include:

- The creation of a Psychiatric Intensive Care Unit (PICU) at Ward 1, Harplands Hospital.
    - 6 Bedrooms with en-suite facilities.
    - 1 Clinic room
    - 1 Therapies room
    - New kitchen servicing both Ward 1 & PICU
    - 2 New dining rooms
    - 1 Laundry room
    - 1 Seclusion suite
- Boiler replacement.
    - Darwin Children's Centre
    - The Bennett Centre
    - Greenfield Centre

21. Cleaning Services

During the last 12 months, the Trust has provided high standards of cleanliness/hygiene with well-maintained environments that are aesthetically pleasing and safe for patients, staff visitors and general public in all premises.

21.1 Monitoring arrangements for cleaning service

Throughout the twelve month period, the Support Services Management Team in partnership with Modern Matrons and Infection Prevention Control (IPC) have measured standards against the national standards of cleanliness using our professional monitoring package, Support Services Solutions Ltd.

Each area has been audited against the category of risk, in compliance with the National Specification for Cleanliness in the NHS and the Trust's Cleaning Strategy.

Quarterly Cleanliness reports are presented at the Trust's IPC committee.

21.2 Waste Management and Auditing

The waste audit system is designed to assess compliance with the requirements of Department of Health guidance document Safe Management of Healthcare Waste HTM 07-01 and to also ensure that waste segregation standards meet the requirements for waste handling and storage.

Waste auditing forms part of a planned programme of waste management and any issues or outstanding actions is followed up by IPC team and/or Facilities team. Where a new service is introduced, a full "Pre-acceptance" waste audit is carried out, as happened in relation to the new premises for substance misuse and needle exchange, to assess all types of waste and disposal methods. Thereafter audits are completed as part of the monthly matron's visits at all sites.

The Head of Estates has also undertaken an audit of the disposal of clinical waste with the contractor, at their incineration plant, in Wrexham.

Some of the actions from the 2018/2019 audit programmes have included addressing the following risks:

- Inappropriate waste disposal – packaging and paper towels disposed of in clinical waste bins
- Sharps bins temporary aperture closure not in place

22. Patient-led Assessment of the Care Environment (PLACE)

We achieved excellent PLACE scores in all of our areas and received very positive feedback from our patient assessors who have actively been engaged in the process.

We achieved scores well above the National average scores and the National average scores per Mental Health/Learning Disability sites in all domains.

This year's scores are a credit to all staff and clearly demonstrate the hard work and high standards that are being delivered and maintained within the organisation.

All assessments were completed by at least 50% representation from Health Watch, Sikh Community, Service User Care Council (SUCC) or Patient representative on each team. This year we had a total 14opatient assessors engaged in the PLACE assessments.

The management representation included Facilities, Estates, Clinical Leads and Infection Prevention and Control (IPC).

We were fortunate to use the same independent validator on all of our assessments; this proved to be invaluable and clearly demonstrates our commitment to ensure consistency across our organisation. It was noted the improvements that we had made since last year and commented on how we strive and take pride, in the delivery of our services to maintain/improve our PLACE standards.

Trust's overall score for 2018:

- Cleanliness - 99.47%
- Food and Hydration - 96.26%
- Organisation Food - 93.08%
- Ward Food - 99.47%
- Privacy, Dignity and Well-Being - 97.07 %
- Condition, Appearance and Maintenance. - 98.90 %
- Dementia - 91.99%
- Disability - 98.28%

Cleanliness: The cleanliness scores which included hand hygiene and equipment cleanliness are excellent. Dragon Square, Assessment & Treatment (A&T), Unit, Darwin Centre, Florence House and Summers View each scored 100%.

Food and Hydration: The Food and Hydration scores are excellent. There are three areas assessed in this domain.

- Food (which includes hydration)
- Organisation Food
- Ward Food

The A&T Unit, Darwin Centre, Florence House and Summers View each scored 100% in the ward food assessment.

Privacy and Dignity: The Privacy, Dignity and Wellbeing scores ranged between 93.10 % at Dragon Square and 100% at A&T Unit. The lack of observation panels with integrated blinds in all patient bedrooms at Dragon Square and Darwin had an impact on the scores achieved in this domain.

Condition, Appearance and Maintenance: The Condition, Appearance and Maintenance scores were excellent and demonstrate our commitment to maintain the areas with scores ranging between 97.80% and 100%. Florence scored 100%. This is a real credit to the Estates Team, PFI partners and our Hospital Cleanliness Technician (maintenance assistant).

Dementia: This section was assessed on WD 4, WD 5, WD 6, WD 7, the ECT area and the Communal areas on the Harplands site, with an overall Trust Score of 91.99% being achieved. This is a slight reduction on last year's score and reflects the changes to the questions this year.

Disability: As an organisation we achieved a score of 98.28%. The scores ranged between 92.31% at Dragon Square and 100% been achieved at the A&T Unit, Darwin Centre, Florence House and Summers View

Many favourable comments were received throughout the PLACE Assessments by our Patient Representatives and Independent Reviewer:

- **Florence House**
  'A well maintained bright, clean and modern building. The building is very accessible and the staff are very engaged and friendly. Particularly like the facility for gardening/vegetable beds in the external court yard'.
- **Dragon Square**
  'A clean and well maintained unit with very friendly and caring staff'.
- **A & T Unit**
  'The unit improves year on year. New furniture recently purchased was noted including the new areas created for social spaces in the unit'.
  'The decoration is much brighter which seems to have led to a much calmer environment for clients. The unit is a credit to all staff involved'.
- **Summer View**
  'A modern building that is a clean and well maintained where the staff produce the food to an excellent standard. There is a very calm atmosphere in the unit'.
  'The staff are well trained in their job roles and this reflects well on the service users who seem happy and well looked after'.
- **Darwin**
  'The unit has improved year on year. The unit is very clean and staff work hard to make the unit homely as at the same time insuring it's a safe place to be'.
  'The pictures are lovely and particularly like the picture on the external fence in the front garden'.
- **Harplands Hospital**
  'A well maintained building which is clean, bright and well light. Good decorative condition internally. Well maintained grounds externally'.
  'Patients are treated with dignity and respect; could see that the Trust is continually developing this site for and with patients'.
  'Visited the Tony Scott garden and this is a wonderful area for patients but would benefit from having a shaded area'.

23. Conclusion

Infection prevention and control remains a priority for the Trust. The IPCG and IPC team continue to maintain and improve on the application, conservation, and development of IPC standards. The Trust is committed to working towards excellence in IPC practice as a best provider.

This report highlights the partnership working and continuous drive for improvement throughout last year. The annual work programme for 2019/2020 is set out below for Board approval appendix 1.

24. Recommendations

The Board is asked to approve:

- The Infection Prevention and Control Annual Report for 2018/2019
- The IPC audit/work programmes for 2019/2020

25. Appendices

Appendix 1 – IPC team Annual Work plan 2018/2019

Appendix 2 - 2018/2019 End of Year Infection Prevention & Control Audit Programme Summary

Appendix 3 – Glossary of terms

Appendix 1

Infection Prevention and Control (IPC) Group Work Programme 2018–2019
Chair: Maria Nelligan, Director of Infection Prevention & Control (DIPC)
Deputy Chair: Amanda Miskell, Deputy DIPC

(2018/19)
Our Vision - To be a high quality health and social care provider that continuously improves patient experience and deploys its resources intelligently and efficiently.

Our Quality Priorities - Key areas which evidence that we are delivering high quality care and treatment to those using our services in a way that is person-centred
•S - Our services will be consistently safe
•P - Our care will be personalised to the individual needs of our service users
•A - Our processes and structures will guarantee Access to services for service users and their carers
•R - Our focus will be on the recovery needs of those with mental illness

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
1	The Trust has a Work Programme / Assurance Framework in place. An annual and four quarterly (Q) reports are presented to the Board of Directors.	D/DIPC & IPC Group (IPCG) D/DIPC	Last annual report presented to Board of Directors in 2017 and published Q4 April 2018 Annual Report June 2018 Q1 August 2018 Q2 October 2018 Q3 February 2019	
2	Board level responsibility for IPC is clearly defined and there are clear guidelines on reporting corporate risk from the IPCG	D/DIPC	Annual and Quarterly reports Reporting by exception to CCGs where needed IPC Work Programme IPC Assurance Framework	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
3	There is an IPC Group which is directly accountable to the Chief Executive and the Trust Board. The Group endorses all IPC policies, procedures and guidance, and provides advice and support on the implementation of policies. The Group monitors the progress of the annual IPC Work Programme/Assurance Framework bi monthly	IPCG	IPCG Terms of Reference reviewed annually IPCG Agendas and Minutes IPC Policy and Standard Operating Procedures Audit Programme Performance reporting Strategy	
4	There is an appropriately constituted and functioning IPC team.	D/DIPC	Recruitment of two B6 staff for IPC (1.0 WTE) Annual and Quarterly Reports Consultant Nurse/Deputy DIPC 1-1s with DIPC Performance & Compliance Reporting	
5	Prevention and control of infection is considered as part of all service provision.	Head of Estates/Water Safety Support services/ Decontamination Lead Heads of Directorate	IPC is compulsory in all Service Level Agreements and External Contracts IPC is included in all Trust Job Descriptions Audit Programme and Review Inpatient and Community Safety metric Modern Matron/Senior Nurse Monthly review Procurement sign off for all medical devices New builds, refurbishment and change of purpose must have IPC sign off	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
6	Written policies, procedures and guidance for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance The IPC team also play a part in supporting other key stakeholders policies	Infection Prevention & Control Team	IPC Policy Review Work Plan Safety Metrics, Surveillance and Audit Reports Minutes of IPCG Assurance Framework Waste Water Safety Admission Discharge & Transfer policy Dress Code Policy Nutritional Policy Food Safety Tissue Viability Antimicrobial prescribing Medical photography Medical devices Cleaning and Decontamination Care of the deceased	Ongoing
7	There is an annual IPC Audit Programme	IPC team IPCG	Audit exceptions are reported to the Board via the IPCG chairs summary 2018/19 audit programme will increase compliance score to 90% from 85% to show a year on year improvement	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
8	Timely and effective specialist microbiological support is provided to the trust 24/7 in relation to individual patients and advice	Microbiologists IPC team	Written service level agreements / contracts are in place with the accredited microbiology Department (UHNM). This includes an agreement from PHE/UHNM that all exposure incidents are followed up as per national recommendations out of office hours. All alert organisms, blood stream infections, and other significant organisms including confirmed Influenza are reported via the nhs.net address at IPC Combined.	
9	Education and training in the prevention and control of infection is provided to **all frontline** staff on an annual basis This is supplemented by e learning for other staff Develop the role, knowledge and skills of staff in IPC Support a robust IPC clinical network across the organisation with Clinical Staff, Pharmacy, Modern Matrons, Support Services and Estates	IPC team D/DIPC	Training records & monitoring of attendance % bi monthly Local standard monitoring via audit Compliance reported to IPCG Audit and checklist programme in place which is efficient in terms of multi-disciplinary attendance	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
10	Incidents, transmission of infections and outbreaks are documented by the IPC team, reviewed by the IPCG and reported to the Board where required	IPC team D/DIPC	IPCG minutes Trust Board informed via Annual and Quarterly Reports Performance and exception reporting Post outbreak meeting reports Safeguarding reporting	
11	Antimicrobial Stewardship will adhere to the 5 year strategy, formulary, Regulation 12 and best practice	IPCG and Pharmacy	Pharmacy representation at IPCG and antibiotic reporting Current antibiotic formulary (community) in line with local surveillance for multi resistant organisms	
12	There is a programme to manage and monitor the potential and actual risks of Health Care Associated Infections (HCAI's) In unavoidable cases these are monitored, reviewed and reported to the Board A Sepsis recognition programme is in place in line with the detection of the deteriorating patient and national sepsis programme	All Trust Staff D/DIPC IPC team	IPC policies IPC audit programme Safety Thermometer Safety Matrix Quarterly and Annual Reports Cleaning Strategy IPC training Information for staff and service users Surveillance Sepsis is included in all training, sepsis cards have been distributed and sepsis 6 pathways introduced for CAMHS and adult areas Implementation of NEWS	
13	Reporting on HCAI's to Commissioners by exception and PHE where required (communicable diseases).	IPC team	Performance reporting DIPC's quarterly Reports PIRs, peer reviews and RCAs	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
14	Water Safety Plan & Group is included within the IPCG	Head of Estates and Support Services DIPC IPCG	Legionella Management update report to IPCG IPCG Minutes Quality Committee also informed All water safety incidents are reported to the IPC team and escalated to the DIPC where required.	

Appendix 2

2018/2019 End of Year Infection Prevention & Control Audit Programme Summary

Infection Prevention & Control Audit Programme for 2018-2019 - 80609R-TW					
Percentage Complete			100%		
INPATIENT AREAS					
AREA	Completed	Date	2018/19 Audit Score	Last Audit	Column1
Ward 3	Pass	08/11/2018	97%	14/09/2017	93%
Ward 4	Pass	15/08/2018	98%	19/07/2017	93%
Ward 7	Pass	06/06/2018	97%	06/09/2017	93%
Ward 5	Pass	04/07/2018	98%	16/08/2017	93%
A & T / Telford	Pass	01/08/2018	99%	11/01/2017	95%
Summers View	Pass	27/07/2018	98%	26/07/2017	95%
Ward 1	Pass	19/09/2018	98%	05/01/2018	96%
Ward 2	Pass	02/07/2018	98%	15/06/2017	97%
Ward 6	Pass	26/11/2018	97%	14/09/2017	97%
Edward Myers	Pass	08/11/2018	99%	17/10/2017	97%
Dragon Square	Pass	23/11/2018	99%	24/08/2017	97%
ECT Suite	Pass	09/11/2018	100%	23/11/2017	98%
Darwin Centre	Pass	08/11/2018	99%	19/06/2017	98%
Florence House	Pass	21/11/2018	99%	10/11/2017	99%
OUTTPATIENT AREAS					
AREA	Completed	Date	2018/19 Audit Score	Last Audit	Column4
Broom Street	Pass	13/04/2018	99%	13/09/2017	83%
Hazelhurst Unit	Pass	20/12/2018	98%	08/12/2017	94%
Wood house (D and A)	Fail	19/12/2018	88%	12/01/2017	94%
The Ashcombe Centre	Pass	01/06/2018	96%	24/08/2017	95%
Memory Clinic	Pass	20/03/2019	99%	22/08/2017	95%
Lymebrook Centre	Pass	20/03/2019	99%	28/11/2017	96%
Roundwell Place (CAMHS)	Pass	03/08/2018	99%	27/11/2017	96%
Bennett Centre Neurorology Day Service	Pass	31/08/2018	97%	13/09/2017	97%
Furlong Court	Pass	28/11/2018	95%	30/11/2017	97%
One Recovery Stafford	Pass	16/11/2018	99%	19/10/2017	97%
Sutherland Centre	Pass	21/11/2018	99%	10/11/2017	97%
Greenfields Centre	Pass	07/03/2019	99%	15/08/2017	97%
One Recovery Leek	Pass	04/12/2018	97%	07/11/2017	98%
Parent & Baby Unit (CAMHS)	Pass	10/12/2018	99%	14/12/2017	98%
Blurton Community Centre	Pass	07/12/2018	98%	16/10/2017	99%
Dragon Square Day Centre both CAMHS / LD	Pass	23/11/2018	97%	19/12/2017	99%
Hope Centre (77A)	Pass	20/03/2019	99%	01/09/2017	99%
One Recovery Burton	Pass	14/12/2018	97%	25/10/2017	99%
One Recovery Newcastle	Pass	12/11/2018	90%	18/10/2017	99%
Stoke Heath HMP Market Drayton	Pass	07/11/2018	99%	02/10/2017	99%
The Eaves (Marrow House)	Pass	20/11/2018	96%	29/11/2017	99%

Only one area did not meet the required 90% pass rate with 88% achieved. The environmental issues were highlighted at the time and Estates informed of issues for action.

All other areas attained between 97% - 100% in the audit.

Appendix 3 IPC Work programme 2019-20

Infection Prevention and Control (IPC) Group Work Programme 2019–2020
Chair: Director of Infection Prevention & Control (DIPC)
Deputy Chair: Deputy DIPC

(2018/19)
Our Vision - To be Outstanding in all that we do and how we do it

Our Quality Priorities - Key areas which evidence that we are delivering high quality care and treatment to those using our services in a way that is person-centred
•S - Our services will be consistently Safe
•P - Our care will be personalised to the individual needs of our service users
•A - Our processes and structures will guarantee Access to services for service users and their carers
•R - Our focus will be on the recovery needs of those with mental illness

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
1	The Trust has a Work Programme / Assurance Framework in place. An annual and four quarterly (Q) reports are presented to the Board of Directors.	D/DIPC & IPC Group (IPCG) D/DIPC	Last annual report presented to Board of Directors in May 2019 and published 2018-19 Annual Report May 2019 Q1 August 2019 Q2 October 2019 Q3 February 2020 Q4 May 2020	
2	Board level responsibility for IPC is clearly defined and there are clear guidelines on reporting corporate risk from the IPCG	D/DIPC	Annual and Quarterly reports Reporting by exception to CCGs where needed	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
			IPC Work Programme IPC Assurance Framework	
2	There is an IPC Group which is directly accountable to the Chief Executive and the Trust Board. The Group endorses all IPC policies, procedures and guidance, and provides advice and support on the implementation of policies. The Group monitors the progress of the annual IPC Work Programme/Assurance Framework bi monthly	IPCG	IPCG Terms of Reference reviewed annually IPCG Agendas and Minutes IPC Policy and Standard Operating Procedures Audit Programme Performance reporting Strategy	
3	There is an appropriately constituted and functioning IPC team.	D/DIPC	Head of IPC & PH appointed April 2019 1.4 WTE IPC/PH Nurses Annual and Quarterly Reports Head of IPC & PH 1-1s with Deputy DIPC/DIPC Performance & Compliance Reporting	
4	Prevention and control of infection is considered as part of all service provision.	Head of Estates/Water Safety Support	IPC is compulsory in all Service Level Agreements and External Contracts IPC is included in all Trust Job Descriptions	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
		services/ Decontamination Lead Heads of Directorate	Audit Programme and Review Inpatient and Community Safety metric audits Modern Matron/Senior Nurse Monthly review Procurement sign off for all medical devices New builds, refurbishment and change of purpose must have IPC sign off	
5	Written policies, procedures and guidance for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance The IPCT also play a part in supporting other key stakeholders policies	Infection Prevention & Control Team	IPC Policy Review Work Plan Safety Metrics, Surveillance and Audit Reports Minutes of IPCG Assurance Framework Key Stakeholder Policies: • Waste • Water Safety • Admission Discharge & Transfer policy • Dress Code Policy • Nutritional Policy • Food Safety • Tissue Viability • Antimicrobial prescribing • Medical photography • Medical devices • Cleaning and Decontamination	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
			• Palliative Care	
6	The annual IPC Audit Programme is fully completed	IPCT IPCG	Audit exceptions are reported to the Board via the IPCG chairs summary 2019/20 audit programme will maintain compliance score to 90% from 85% to show a year on year improvement	
7	Timely and effective specialist microbiological support is provided to the trust 24/7 in relation to individual patients and advice	Microbiologists IPCT	Written service level agreements / contracts are in place with the accredited microbiology Department (UHNM). This includes an agreement from PHE/UHNM that all exposure incidents are followed up as per national recommendations out of office hours. All alert organisms, blood stream infections, and other significant organisms including confirmed Influenza are reported via the nhs.net address at IPC Combined.	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
8	Education and training in the prevention and control of infection is provided to **all frontline** staff on an annual basis This is supplemented by e learning for other staff Develop the role, knowledge and skills of staff in IPC Support a robust IPC clinical network across the organisation with Clinical Staff, Pharmacy, Modern Matrons, Support Services and Estates	IPCT D/DIPC	Training records & monitoring of attendance % bi monthly Local standard monitoring via audit Compliance reported to IPCG Audit and checklist programme in place which is efficient in terms of multi-disciplinary attendance	
9	Incidents, transmission of infections and outbreaks are documented by the IPCT, reviewed by the IPCG and reported to the Board where required	IPCT D/DIPC	IPCG minutes Trust Board informed via Annual and Quarterly Reports Performance and exception reporting Post outbreak meeting reports Safeguarding reporting	
10	Antimicrobial Stewardship will adhere to the 5 year strategy, formulary, Regulation 12 and best practice	IPCG and Pharmacy	Pharmacy representation at IPCG and antibiotic reporting Current antibiotic formulary (community) in line with local surveillance for multi resistant organisms	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
11	There is a programme to manage and monitor the potential and actual risks of Health Care Associated Infections (HCAI's) In unavoidable cases these are monitored, reviewed and reported to the Board A Sepsis recognition programme is in place in line with the detection of the deteriorating patient and national sepsis programme	All Trust Staff D/DIPC IPCT	IPC policies IPC audit programme Safety Matrix Quarterly and Annual Reports Cleaning Strategy IPC training Information for staff and service users Surveillance Sepsis is included in all training, sepsis cards have been distributed and sepsis 6 pathways introduced for CAMHS and adult areas Implementation of NEWS	
12	Reporting on HCAI's to Commissioners by exception and PHE where required (communicable diseases).	IPCT	Performance reporting DIPC's quarterly Reports PIRs, peer reviews and RCAs	
13	Head of IPC and PH is member of Water Safety Group who report IPCG	Head of Estates and Support Services Head of IPC & PH IPCG	Legionella Management update report to IPCG IPCG Minutes Quality Committee also informed All water safety incidents are reported to the IPCT and escalated to the DIPC where required.	
14	Develop and deliver an effective Influenza	IPCT/Team	Order vaccinations	

Item	Performance Indicator	Responsibility	Assurance & Progress	Status
	Vaccination Programme achieving 80% uptake at least by March 2020	prevent	Register with Inform Develop PGD Deliver training to peer vaccinators Set up a communication programme Deliver programme with new and purposeful initiatives. Report to SLT and NHSI as required	
15	Introduce NEWS 2 to in-patient areas	Head of IPC & PH	Agree format of NEWS 2 appropriate for MH Order NEWS 2 forms Roll out through training, QILNs and IPC Link Nurses	

Appendix 3

Glossary of Terms and Abbreviations

Allied Health Professionals - AHP

Antibiotic Formulary
A list of approved antibiotics based on evaluations of efficacy, safety, and cost-effectiveness of drugs based on population trends

Antimicrobials
Antimicrobials are substances which are used in the treatment of infection caused by bacteria, fungi or viruses

Antimicrobial Resistance - AMR

Aseptic Non Touch Technique – ANTT
Aseptic Non Touch Technique or ANTT is a tool used to prevent infections in healthcare settings

Assessment and Treatment – A&T

Assurance Framework
A system for informing their parties that a process of due diligence is in place to assure safety and quality exists within that setting

Audit
Audit is a quality improvement process that aims to improve service user care and outcomes by carrying out a systematic review and implementing change. This is not necessarily complex and in its simplest form shows compliance with a single protocol. Its value is in showing improvement or maintenance of a high standard. Once an audit has been completed and actions taken, repeating the audit will complete the audit cycle

Board
A Board (of Directors) is the executive body responsible for the operational management and conduct of an NHS Foundation Trust. It includes a non-executive chairman, non-executive directors, the chief executive and other executive directors. The Chairman and non-executive directors are in the majority on the Board

Care Quality Commission – CQC
The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations

Carers
Person who provides a substantial amount of care on a regular basis, and is not employed to do so by an agency or organisation. Carers are usually friends or relatives looking after someone at home who is elderly, ill or disabled

Catheter Associated Urinary Tract Infection – CAUTI
Catheter associated urinary tract infections comprise a large proportion of healthcare associated infections and can occur whether a person has either a short-term or a long term catheter

Clinical Commissioning Group – CCG

Clinical Commissioning Groups are groups of GP's that are responsible for designing and commissioning / buying local health and are services in England

Clostridium Difficile Toxin
This is a type of infectious diarrhoea caused by the bacteria Clostridium difficile

Combined Access Tool - CAT

Commissioning for Quality and Innovation - CQUIN

Continual Professional Development – CPD

Director of Infection Prevention and Control - DIPC
An individual with overall responsibility for infection control and accountable to the registered provider in NHS provider organisations

EMU – **Edward Myers Unit**

ESBL
Extended Spectrum Beta Lactamase

Healthcare
Healthcare includes all forms of care provided for individuals, whether relating to physical or mental health

Health Care Associated Infection - HCAI

Health Education England – HEE

Health Technical Memorandum - HTM

Health and Social Care Act 2008 - The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.
The guidance and standards used as Part of Regulation 12 and 15 in relation to the CQC standards health providers are assessed against

Infection
Where the body is invaded, by a harmful organism (pathogen), which causes disease or illness

IPC link practitioners
The Infection Prevention and Control Link Practitioner (IPCLP) will act as a resource and role model in their designated area of work and will liaise with the Trust's Infection Prevention and Control Team (IPC team). The role will help to create and maintain an environment that is safe for service users, visitors and staff

IPCG
Infection Prevention and Control Group

IPCN (S) - Infection Prevention and Control Nurse (Specialist)

IPC team - Infection Prevention and Control Team

IPS - Infection Prevention Society

IV - Intravenous

LD - Learning disabilities

MH - Mental Health

MMG - Medicines Management Group

MRSA - Meticillin Resistant Staphylococcus Aureus

MRSA Bacteraemia - Meticillin Resistant Staphylococcus Aureus infection which enters the patients' bloodstream

NSI – Needle Stick Injury

NEWS - National Early Warning Score

NHSE – National Health Service England

NPSA – National Patient Safety Agency

NRT – Nicotine Replacement Therapy

NSC - National Standards of Cleanliness

PH - Physical Health

PHE - Public Health England

PLACE - Patient Led Assessment of the Care Environment

Post Infection Review – PIR
A process which allows organisations to understand areas requiring improvement in the patient care pathway, and more importantly, identifies and targets actions to minimise the chance of recurrence for future patients for MRSA Bacteraemia

PICU – Psychiatric Intensive Care Unit

Root Cause Analysis - RCA
A process which allows organisations to understand areas requiring improvement in the patient care pathway, and more importantly, identifies and targets actions to minimise the chance of recurrence for future patients for Clostridium Difficle Toxin Positive cases

Sepsis - Sepsis is a potentially life-threatening condition caused by the body's response to an infection. The body normally releases chemicals into the bloodstream to fight an infection.

SID – Staff Information Desk

SLA - Service Level Agreement

Service User / patient

Anyone who uses, requests, applies for or benefits from health or local authority services

SUCC – Service Users Care Council

Standard Operating Procedure (SOP)
Standard operating procedures (SOPs) are written instructions intended to document how to perform a routine activity. Many Trusts rely on standard operating procedures to help ensure consistency and quality in their products.

Surveillance
Infection surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of infection prevention and control practice. Such surveillance can serve as an early warning system for impending multi resistance or increase in emergence of newer organisms, and allow the team to respond appropriately supporting the health care structure for our population

TVN (S) – Tissue Viability Nurse (specialist)

TVS - Tissue Viability Service

TARGET – Treat Antibiotic Responsibly, Guidance, Education, Tools

Transmission
Cross infection is the transfer of harmful microorganisms. Bacteria and viruses are among the most common. The spread of infections can occur between people, pieces of equipment, or within the body

UTI's – Urinary Tract Infection
An infection of the Urinary Tract that can be upper or lower and complicated or uncomplicated causing symptoms**.**

WTE – Whole Time Equivalent

YMCA – Young Men's Christian Association

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REPORT TO OPEN TRUST BOARD

Enclosure No: 10

Date of Meeting:	23RD May 2019		
Title of Report:	Quarter 4 Mortality Surveillance Report		
Presented by:	Dr Adeyemo. Executive Medical Director		
Author:	Jackie Wilshaw. Head of the Patient and Organisational Safety Team		
Executive Lead Name:	Dr Adeyemo. Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides the Trust with assurance as to the mortality surveillance process with regards to the scrutiny of people open to Trust services who have died of natural causes before the age of 75 years		Approval	☒
		Information	☐
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☒ Execs ☐ Date: 16th April 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Issues relating to Equality, Diversity and Inclusion were not identified during the MS process or the writing of this report		
STP Alignment / Implications:	N/A		
Recommendations:	For approval		

Version	Name/group	Date issued
1	CSIG	15 April 2019
1	SLT	16 April 2019
1	Quality Committee	09 May 2019

1. Introduction

In 2017 the National Quality Board published new guidance on learning from deaths. As a result there is a need to ensure that the Trust can be confident that all unexpected deaths are reported and investigated appropriately. Additionally, information contained within its databases must be accurate and comply with the Trust standard of transparency and accountability. This report is for the Q4 reporting period 2018/19 and provides information for the time frame January to March 2019.

2. Trust reporting and data collection

The table below shows the number of deaths reported monthly during Q4 (January to March 2019). These deaths will be reviewed by the mortality surveillance group following completion of the investigation process.

Month	Total number of deaths recorded on Lorenzo	Total number of deaths – out of service	Reported as SI	Open to services at the time of death- natural causes	Substance Misuse Deaths			LD deaths
					North Staffs	Stoke	Staffs	
Jan	24	12	5	7	2	5	1	0
Feb	17	7	5	5	0	3	0	1
Mar	17	1	8	8	1	0	2	1

NB. Substance Misuse deaths may be included in the Lorenzo column if the person is also open to mental health services.

During Q4 the mortality surveillance group reviewed the care of 24 people (meetings took place on 8th January 2019, 5th February 2019 and 5th March 2019). The analysis of these deaths is shown in the table below.

Meeting Date	Identifier	Death category	Level of care	Death occurred as a result of problems in healthcare	Duty of Candour applies	Domain
8th Jan 19	23247	UN2	Good care	No	No	Drugs & Alcohol
	23582	UN2	Good care	No	No	Drugs & Alcohol
	23817	EN1	Good Care	No	No	Physical Health
	23785	EN1	Good Care	No	No	Physical Health
	24402	UN1	Good Care	No	No	Physical Health
	24381	UN1	Excellent Care	No	No	Physical Health
	24372	UN2	Good Care	No	No	Physical Health & Drugs & Alcohol
	24214	EN1	Good Care	No	No	Physical Health & LD
	24695	EU	Good care	No	No	Drugs & Alcohol
	24971	EN1	Excellent Care	No	No	Physical Health
	19639	UN2	Good	No	No	Drugs & Alcohol
5th Feb 19	24403	UN1	Excellent care	No	No	Drugs & Alcohol
	25208	UN2	Good Care	No	No	Drugs & Alcohol
	18900	UN1	Good care	No	No	Physical health
5th Mar 19	24334	EN1	Good Care	No	No	Physical Health

	24208	EN1	Poor Care	No	No	Physical Health
	24217	EN1	Good Care	No	No	Physical Health & LD
	24583	UN1	Good care	No	No	Physical health
	24696	UN1	Good care	No	No	Physical health
	25079	EN1	Good Care	No	No	Physical Health
	24974	EN1	Good Care	No	No	Physical Health
	24772	EN1	Good Care	No	No	Physical Health & LD
	25568	EN1	Good Care	No	No	Physical Health
	19263	UN1	Good Care	No	No	Physical Health

The definitions for the death category are shown below:

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

There is no national guidance on the criteria for the level of care determination. However the mortality surveillance group considered that Good Care had been provided where there was evidence of the staff providing a good level of support, had responded quickly and appropriately to situations where deterioration in physical health was noted. Adequate Care is determined to be care where the basic standards of expected support are given. Poor Care is determined where the group consider that the actions of the clinicians did not meet the standards required by the Trust. In part these determinations are dependent upon the quality of the documentation contained within the mortality surveillance review tools and the electronic patient records. Feedback to the directorate/team on the quality of documentation is sent to the clinical teams in order to improve future entries in the patient records.

In case number 24208, the care was assessed as being poor as there was no evidence to demonstrate that the clinical team had completed the physical health monitoring, in line with anti-psychotic medication monitoring standards. The mortality surveillance group were informed that the clinical team had already recognised that they had not met the required standards in their initial review of this person's care. Action plans have been developed to address the issues identified. This action plan is linked to a Serious Incident review and the actions will be monitored through the SI action plan review process and the community safety matrix.

There were 3 reviews were the mortality surveillance group considered that Excellent Care had been given; this level of care was determined in part due to the quality of the clinical notes in recording both the clinical decision making but also it was considered that there was evidence of person-centred care and collaboration.

3. LeDeR

The Trust is required to report all deaths of people with Learning Disabilities to a national reviewing board based at the University of Bristol. The deaths are then allocated to regional offices for review. Since November 2017, the Trust has reported eight deaths for review under the LeDeR process. To date only one case has been fully reviewed. The person was found to

have received good care and no issues were raised for the Trust. However the remaining deaths are still in the review process and there has been no further information for the Trust. Therefore due to this delay in the external LeDeR process, the Trust made the decision to include the deaths of people with Learning Disabilities in the mortality surveillance process.

During Q4, the mortality surveillance group received 3 reports relating to the care of people with Learning Disabilities. In each case the deaths were recorded as expected and natural as the people were in receipt of palliative care and the care was determined to be good.

4. Conclusion

The Trust continues to monitor the deaths of people whose deaths are outside of the Serious Incident process. The monthly Mortality Surveillance Group receives and reviews investigations in order to provide assurance as to the quality of the care provided by the Trust. The group identifies any learning from the reviews and offers recommendations for practice when required. In the deaths reviewed during Q3, there were no evidence of deficits in the healthcare provided by the Trust which may be considered to have contributed to the death of any individuals.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 11

Date of Meeting:	23RD MAY 2019		
Title of Report:	Q3 Serious Incident Report		
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 the Trust with information relating to the nature and status of SI's currently open and the trend data for Q2 and Q3 2018/19. The report also includes information regarding themes, learning and change arising from Serious Incident investigations. There are 6 and 12 month updates to completed SI actions plans (Closing the loop) also the quarterly Duty of Candour report is included.	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 collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Consideration of Diversity and Inclusion issues is given during the SI investigation processes and the analysis provided in this report. There have been no issues raised with regards to D+I during these processes.		
STP Alignment / Implications:	None		
Recommendations:	To receive for approval		

Version	Name/Group	Date Issued
Version 1	CSIG	18/02/2019
Version 2	Quality Committee	Virtually 20 Feb 2019
Version 2	Trust Board	20 Feb 2019

1. Purpose of the report

This report provides assurance to the Quality Committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st October to 31st December 2018 (Quarter 3, 2018/19) and details the following:

- The status of SIs currently open and trend data for Q2 2018/19 and Q3 2018/19.
- Serious Incidents by category reported by quarter.
- Themes, learning and change arising from Serious Incident investigations.
- 6 and 12 month updates to completed SI actions plans (Closing the loop)
- The quarterly Duty of Candour report.

2. Serious Incidents Q2

SI investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. Investigations are completed for incidents where death, serious injury or occurrence has occurred. For the purposes of this report, investigations are not completed for those service users whose deaths are determined by HM Coroner to be the result of natural causes. The table below illustrates the total number of SIs reported by quarter for the period April 2017 to December 2018.

StEIS Incident category	Q1	Q2	Q3	Q4	Total 2017/18	Q1	Q2	Q3	Q4	Total 2018/19
Apparent/actual abuse	0	1	2	2	5	2	0	0		2
Unexpected potentially avoidable injury causing serious harm: this is subdivided as shown below										
Apparent/actual/suspected self-harm criteria meeting SI criteria	1	0	2	2	5	2	2	3		7
Slip, trip, fall	2	6	3	3	14	1	6	1		8
Unexpected/Potentially avoidable injury causing serious harm	0	0	0	0	0	3**	0	0		3
Disruptive, aggressive behaviour meeting SI criteria	0	0	0	0	0	1	1	0		2
Unexpected/Potentially avoidable serious assault	0	0	0	0	0	0	0	1		1
Under 18 admission	0	0	0	0	0	0	0	1		1
Incident demonstrating existing risk	0	0	0	0	0	0	0	1		1
Unexpected potentially avoidable death: This is subdivided as shown below										
Pending review	4	10	8	11	33	7	14	10		31
Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)	3	6	2	5	16	10	3	4		17
Total	10	23	17	23	73	26	26	21		73

** this included one incident where the harm occurred to a member of the public but the nature of StEIS does not allow for this in the reporting framework.

During Q3, 22 incidents were reported into StEIS and have undergone or are in the process of undergoing SI investigation.

The tables below shows the incidents reported in Q3 by team (Table 1) and by directorate (Table 2).

Table 1. Incidents by team

Team	October 18	November 18	December 18	Total
Ashcombe	1			1
CJMHT*/CDAS	1			1
Darwin Centre		1	1	2
Florence House	1			1
Greenfields*/Sutherland centre	1			1
Greenfields		1		1
Lymebrook	2			2
Lymebrook*/One Recovery(Newcastle)	1			1
One Recovery*/Lymebrook	1			1
One Recovery (Burton)	1	1		2
One Recovery (Leek)		1	1	2
Recovery + Resettlement	1	1		2
Ward 1		1		1
Ward 2		1		1
Ward 2*/Home Treatment Team		1		1
Ward 7		1		1
Grand total	10	9	2	21

*Denotes team allocated as lead for purpose of investigation

Table 2. Incidents by directorate

Directorate	October 18	November 18	December 18	Total
Acute and Urgent Care	4			4
North Staffordshire Community	5			5
Specialist Services	4	4	2	10
Stoke Community	1	1		2
Grand total	14	5	2	21

The main points to note are:

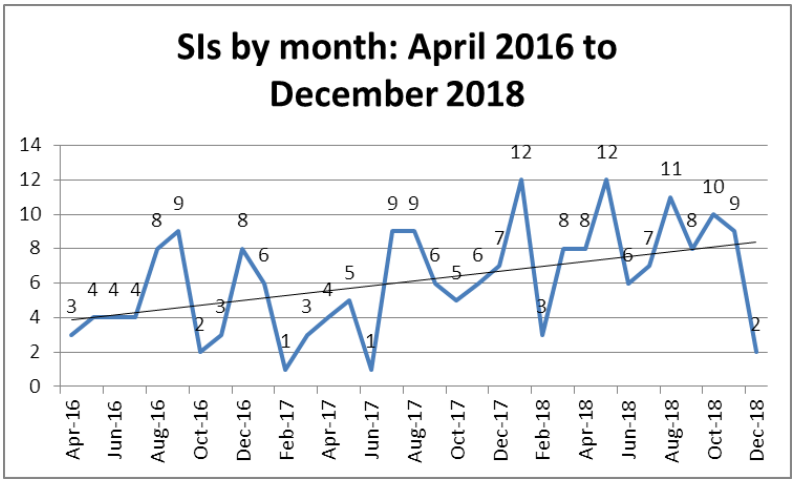
- There were 10 serious incidents reported for the Specialist Directorate.
    - There were 6 unexpected, potentially avoidable deaths, 2 incidents of serious self-harm, 1 incident where a person under the age of 18 was admitted to an adult ward and 1 incident involving a collapsible shower rail. The incident with the shower rail was later reported as a Never Event at the request of a Board executive, although the incident itself did not fully meet the criteria for a Never Event as the Trust demonstrated full compliance with Healthcare Technical Memorandum 66 in the testing and maintenance of collapsible shower rails. Nevertheless the Trust has

worked alongside another Trust, the rail manufacturer and a design engineer in order to learn from the event and to assist in the possible development of an improved design. This incident was also reported to NHS England. With regards to the incident where an under 18 year old was admitted to an adult ward, the person was claiming to be 17 years and 8 months however the correct age of the person was unable to be corroborated and potentially the person is older than 18 years.

- There were 5 incidents in North Staffordshire Community Services.
  - There were 4 unexpected/potentially avoidable deaths and 1 incident where a person was later charged with attempted murder.
- There were 4 incidents in Acute and Urgent Care Services.
  - There was 1 incident of serious self-harm by an inpatient on one of the adult wards, a fall resulting in fracture of an elderly person on one of the older person's wards.
  - The Trust was notified of the deaths of 2 people who had recently been discharged from adult inpatient wards: One death is likely to be determined to be suicide, however it is suspected that the other gentleman died from an accidental drug overdose
- There were 2 incidents in Stoke Community Services.
  - One person died as a result of electrocution, this is likely to be declared an accident at inquest and the SI will be downgraded to a natural cause death.
  - The second incident involved a person well known to services who set fire to her property. This person has been remanded into custody and is being supported through the prison health service.

3. Themes and Trends

The graph below shows the number of Serious Incidents reported monthly from April 2016 to December 2018. During this timeframe the trend line shows an increasing number of SIs.



The numbers of slip, trips, falls has reduced in Q3 with one fracture reported by ward 7. The total number of unexpected deaths has fallen slightly in Q3 with 15 deaths reported; however during Q3 the number of unexpected deaths within the Substance Misuse Services reduced with 4 out of the 11 reported deaths whereas in the previous quarter 10 out of 14 deaths were of people known to Substance Misuse Services.

During Q3 there have been 3 incidents of self-harm meeting the SI criteria relating to people receiving either 24 hour or enhanced support from clinical staff

4. Learning from Serious Incidents

4.1 Quarter 3 learning

Recommendations and learning from investigations are disseminated upon completion of the SI investigation. As in previous reports, elements relating to care planning and risk assessments remain an issue for the Trust. Inpatient and community teams are subject to regular (monthly) peer audits utilising the patient safety matrix tool however this is a relatively small sample size and therefore does not allow for widespread analysis of the quality of the risk assessments and care plans for each person under the care of the Trust. The quality of the care [plans and risk assessments is being followed up from an improvement perspective through the Ward Manager Task and Finish groups and the Community Team Managers Meeting.

Examples of the learning themes found from this quarter and the previous Q2 investigations are outlined below:

- Staff have been reminded through training and supervision that care plans should be SMART (specific, measurable, achievable, realistic and timely) and person centred.
- Service users should be encouraged to register with GPs for support with their physical health
- Improved letters to GPs following service user non-engagement with services. A new Standard Operating Policy was implemented by the Access Team to ensure that practitioners complete a detailed contact note, including the reason for discharge and a review of risks (historical and current) when the person is discharged.
- Inpatient Teams were also reminded to include the rationale for discharge in the notes, especially in cases where the service user does not agree with plan to discharge
- Substance Misuse teams were reminded to ensure that clinical notes also include any engagement strategies to support hard to engage patients. The teams were also asked to consider the need to access records from partner agencies in order to fully explore the care delivered.
- Substance Misuse services were advised to ensure that all clients with a history of opiate misuse are issued and trained in the use of take home Naloxone, and to consider if this training needs to be extended to probation and housing services.
- All entries in clinical notes by staff in training should be authorised by registered staff at the earliest opportunity
- It is well recognised that the period of transition of care between teams is a time of potential opportunity for poor/miscommunication and therefore extra care must be taken to ensure robust transfer pathways between areas.
- Staff have also been reminded of the need to ensure that the care reviews include a review of any specific psychosocial interventions offered.

4.3 SI Action Plan Analysis (previously known as Closing the Loop)

During 2018, a refresh of Trust processes to ensure that all recommendations identified as a result of Serious Incident (SI) investigations are embedded into clinical and operational practice was undertaken. The assurance process includes the following:

The following process has been established to provide the required assurance to CSIG:

- An overarching action plan has been developed which incorporates the recommendations and actions from completed SI investigations.
- The Head of the Patient and Organisational Safety meets with Team leaders to review action plans due in that quarter. This is followed by discussions with team members, selected at random, in relation to the actions to ensure that these were embedded; additionally, patient records or audits were also reviewed.
- To further strengthen the process, the Head of the Patient and Organisational Safety will meet with the Directorate Quality Improvement Lead Nurses to review the action plans and obtain assurance that the actions and learning are cascaded across the wider Teams/Directorates.
- Following the Trust restructure, the Head of the Patient and Organisational Safety attends the locality quality forums, where learning and actions plans form part of the standing items agenda, for discussion by the wider locality team leaders.
- The overarching action plan is reviewed on a monthly basis by Patient and Organisational Team (POST) and the relevant action plans (due for 6 or 12 monthly review post incident) is reviewed in order to ensure that the learning from investigations has been embedded into practice.
- CSIG will receive a quarterly report detailing progress
- In the event of actions not being completed/embedded into practice, immediate action will be taken by the directorates and the action review date will be further extended to 18 months in order for the embedding of learning to be evidenced. Furthermore the Head of POST works alongside the Quality Improvement Lead Nurses until all actions are completed. The action is given a blue final RAG rating when the Trust is able to demonstrate that recommendations/actions are embedded into practice.
- Assurance and any required escalation is through the Directorate quality forums and Quality Committee (via CSIG Quarterly Serious Incident reports).

The table in Appendix 1 contains the action plan reviews undertaken during Q3 2018/19. The action plans are RAG rated during the 6 monthly reviews. Actions are reviewed again at 12 months, if the action is demonstrated to be embedded into practice the action is RAG rated blue. If there is no evidence to support that actions are embedded in practice, the escalation procedures detailed above will be implemented. The six actions reviewed during Q3 were all evaluated as blue (ie embedded into practice).

5. Duty of Candour (Quarter 3 report)

The Trust continues to strive for open and transparent practice in our delivery of mental health and learning disability services. All reported incidents are scrutinised at the weekly meeting of the incident review group. This meeting is facilitated by P+OS Team and aims to provide secondary monitoring and identification of all incidents which may potentially meet the criteria as Duty of Candour (DoC) reportable incidents.

In the case of SIs, it is not always possible to immediately determine which, if any of the deaths under investigation meet the Duty of Candour requirements. However should any investigation identify causal links between patient harm and service delivered, the Duty of Candour process would be initiated and a letter outlining the issues sent to the patient or next of kin. The table below shows the incidents that were initially reported as potentially meeting the DoC requirements.

Month	Moderate and above incidents reported	Moderate and above incidents downgraded after review	Moderate and above incident. Managed via SI process	Moderate incident but does not meet DoC criteria	Incident meeting DoC requirement	Moderate and above incident. Managed through the MS process
Oct	40	29	9	1	1	0
Nov	29	22	6	0	0	1
Dec	24	22	1	1	0	0
total	93	73	16	2	1	1

During Q3, there was 1 incident at the Darwin Centre that met the criteria for reporting under the Duty of Candour requirements (self-harm, overdose), action taken as per DoC requirements by the directorate. The current ongoing SI investigations may determine that incidents meet the DoC criteria as part of the investigative process however the initial investigations do not indicate this at present.

6. Conclusion

- The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- The trend line shows that Serious Incidents have continued to increase during the timeframe April 2016 to December 2018.
- No specific care or service delivery themes have been identified during this time.
- The greatest number of Serious Incidents relate to unexpected/potentially avoidable deaths however SI investigations do not demonstrate that actions taken/omitted by clinical teams are a contributory factor in these incidents.
- The number of high impact harm falls has reduced during Q3 2018/19
- The learning from investigations, as outlined above, is cascaded across the Trust through a variety of governance processes: From the internal team and directorate processes across to full Trust cascade through the Learning Lessons framework. This is to ensure that the learning from investigations is not completed in isolation and that a positive learning culture is maintained, through supporting staff with the opportunity to reflect and share learning.

7. Appendix 1

KEY:

	Complete
	Embedded in practice
	Almost complete
	Incomplete

Action	Date completion progress note or 6 month review progress	RAG	12 month review progress	RAG
Once the DR officer has completed their risk assessment, if significant change to the level of risk is identified, the risk assessment should immediately be updated. The care co-ordinator will be informed of this entry and the care co-ordinator will make an assessment of the need to increase the level of input or to escalate to the HTT.	Sep-18 DR officer aware that risk assessment must be completed on change of circumstances, Audit completed by NN		Dec-18 Discussion with KL from the team- verbal assurance given that risk assessments are completed on change of circumstances. In addition this has been discussed at the directorate meetings for cascade across other teams	
HTT action - For all team members to document as part of the assessment process and in progress notes at each contact that there is clear rationale for decision making regarding Home Treatment vs hospital admission. GF action - The care co-ordinator to maintain contact with the HTT to inform a collaborative risk assessment.	07/09/2018- check with HTT Discussed with NN- assurance given. Discussed with JW - assurance given		Dec-18 Discussion with KL from the team evidenced assurance. Also noted PIPPA document no longer completed. Record keeping template in use.	
Centre Manager to introduce the use of the PIPPA document to the GF team with the need to commence the process pre admission which would then follow the patient through to discharge and engage all appropriate community personnel.	PIPA document no longer completed by community teams - discussed at team meetings CLOSE		Closed	

Effective care planning is a mandatory requirement for all staff.	07/09/2018 progress note: guidance discussed at team meeting - provided opportunity to discuss the role. Checked LSM for training GF majority of staff completed - 2 staff outstanding - email reminder sent		Dec-18 Discussion with team. Team leader responsible for ensuring all new staff complete the training; team leader aware of which new staff need to complete training. All other staff compliant.	
For all staff to have knowledge of the report and case discussion for the purpose of reflective practice. For GF – SI report to be discussed at the next Clinical Governance meeting being held on 1st February 2018. A review of the case will also be completed in the care co-ordinators next caseload management session.	SI report disseminated to GF staff- discussion with CC involved and open discussions with GF team. Team leader has improved understanding of governance process.		Dec-18 Discussion with team - reflective practice sessions ongoing. HHT/Access continue to hold reflection sessions post SI reports. The HHT/Access teams meet separately and jointly on a monthly basis in order to capture all staff. For GF - action plans reviewed at quality forum and cascaded to team via team meetings	
To ensure all staff are clear regarding their responsibilities under law, professional standards and Trust Policy as regards Safeguarding adults and children and the making of appropriate and timely referrals where potential for harm to others is reported, significantly where there are children in residence at the home address.	Safeguarding supervision on going only one member of staff still to completed L3 Safeguarding training (new member of staff)		Dec-18 Level 3 safeguarding checked on LMS - where people are outstanding these are people new to the team/trust. Team leaders aware of these and of people who are out of date and assurance given that staff are booked onto training sessions	

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REPORT TO OPEN TRUST BOARD

Enclosure No: 12

Date of Meeting:	23RD May 2019		
Title of Report:	Q4 Serious Incident Report		
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 the Trust with information relating to the nature and status of SI's currently open and the trend data for Q3 and Q4 2018/19. The report also includes information regarding themes, learning and change arising from Serious Incident investigations. There is also a review of previously completed SI actions plans (Closing the loop) and the quarterly Duty of Candour report is included.		Approval	☒
		Information	☐
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☒ Execs ☐ Date: 16th April 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services √ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. √ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. √ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Consideration of Diversity and Inclusion issues is given during the SI investigation processes and the analysis provided in this report. There have been no issues raised with regards to D+I during these processes.`		
STP Alignment / Implications:	N/A		
Recommendations:	For approval		
Version	Name/group	Date issued	

1. Purpose of the report

This report provides assurance to the Quality Committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st January to 31st March 2019 (Quarter 4, 2018/19) and details the following:

- The status of SIs currently open and trend data for Q3 2018/19 and Q4 2018/19.
- Serious Incidents by category reported by quarter.
- Themes, learning and change arising from Serious Incident investigations.
- Updates to completed SI actions plans (Closing the loop)
- The quarterly Duty of Candour report.

2. Serious Incidents Q4

SI investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. Investigations are completed for incidents where death, serious injury or occurrence has occurred. For the purposes of this report, investigations are not completed for those service users whose deaths are determined by HM Coroner to be the result of natural causes. The table below illustrates the total number of SIs reported by quarter for the period April 2017 to March 2019.

StEIS Incident category	Q1	Q2	Q3	Q4	Total 2017/18	Q1	Q2	Q3	Q4	Total 2018/19
Apparent/actual abuse	0	1	2	2	5	2	0	0	1	3
Unexpected potentially avoidable injury causing serious harm: this is subdivided as shown below										
Apparent/actual/suspected self-harm criteria meeting SI criteria	1	0	2	2	5	2	2	3	2	9
Slip, trip, fall	2	6	3	3	14	1	6	1	2	10
Unexpected/Potentially avoidable injury causing serious harm	0	0	0	0	0	3**	0	0	0	3
Disruptive, aggressive behaviour meeting SI criteria	0	0	0	0	0	1	1	0	0	2
Unexpected/Potentially avoidable serious assault	0	0	0	0	0	0	0	1	0	1
Under 18 admission	0	0	0	0	0	0	0	1	0	1
Incident demonstrating existing risk	0	0	0	0	0	0	0	1	0	1
Unexpected potentially avoidable death: This is subdivided as shown below										
Pending review	4	10	8	11	33	7	14	10	20	51
Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)	3	6	2	5	16	10	3	4	11	28
Total	10	23	17	23	73	26	26	21	36	109

** this included one incident where the harm occurred to a member of the public but the nature of StEIS does not allow for this in the reporting framework.

During Q4, 37 incidents were reported into StEIS. 1 incident was downgraded following review as it was determined to be a natural cause death and will be subject to the mortality surveillance process. Therefore 36 incidents have undergone or are in the process of undergoing SI investigation.

The tables below shows the incidents reported in Q4 by team (Table 1) and by directorate (Table 2).

Table 1. Incidents by team

Team	Jan-19	Feb-19	Mar-19	Grand total
Access Team			1	**1**
Acute Home Treatment			1	**1**
Assessment & Treatment		1		**1**
CAMHS Blurton	1			**1**
CDAS	4	2		**6**
CDAS*/Greenfield Centre		1		**1**
CDAS*/Sutherland Centre	1			**1**
CJMHT*/HVU			1	**1**
Healthy Minds		1		**1**
Home Treatment	1			**1**
Lymebrook		1		**1**
MH Liaison Team	1			**1**
MH Liaison Team*/IAPT NS			1	**1**
Neuro		1		**1**
NS Memory Clinic			1	**1**
One Recovery (Burton)			1	**1**
One Recovery (Stafford)			1	**1**
One Recovery Newcastle	1			**1**
One Recovery Stafford	1			**1**
One Recovery*/Greenfield			1	**1**
One Recovery*/Lymebrook	1			**1**
Parent & Baby Unit			1	**1**
PICU Harplands Hospital			1	**1**
Sutherland Centre	2	3	1	**6**
Ward 4, Harplands Hospital	1			**1**
Ward 7, Harplands Hospital	1			**1**
Grand Total	**15**	**10**	**11**	**36**

*Denotes team allocated as lead for purpose of investigation

Table 2. Incidents by directorate

Directorate	Jan-19	Feb-19	Mar-19	grand total
Acute & Urgent Care	4		4	**8**
North Staffs MH (Adult)		1		**1**
North Staffs MH (Adult)* Acute & Urgent Care			1	**1**
Spec (LD&CAMHS IP)		1		**1**
Spec (Neuro/Rehab)		1		**1**
Spec (Sub Mis)	6	2	2	**10**
Spec (Sub Mis)* North Staffs MH (Adult)	1			**1**
Spec (Sub Mis)* Stoke MH (Adult)	1	1	1	**3**
Stoke MH (Adult)	2	4	2	**8**
Stoke MH (CAMHS)	1			**1**
Stoke MH (Older Persons)			1	**1**
Grand Total	**15**	**10**	**11**	**36**

*Denotes Directorate allocated as lead for purpose of investigation

The main points to note are:

- There were 16 serious incidents reported for the Specialist Directorate.
    - There were 14 unexpected, potentially avoidable deaths of people known to Substance Misuse Services; of these 13 are classed as pending review. The final categorisation will be determined at a Coroner's Inquest. One person from this service is suspected of death by suicide.
    - One female was found deceased at home by members of staff from the Neuropsychiatry service. A police investigation is ongoing.
    - The final incident in this directorate relates to the unlawful detention of a person to the A+T unit in Learning Disabilities service. There was a misunderstanding between clinicians which resulted in the person being admitted to the unit before the final completion of the MHA documentation. This error was immediately recognised and rectified within the next working day. The MHA law team continue to work alongside teams, providing education, training and support in the management of the MHA. In addition the Trust is focusing on improving staff actions in specific areas; namely the management of Section 17 and the recording of mental capacity in relation to hospital admission.

- There were 8 serious incidents in the Acute and Urgent Care Directorate.
    - Two females sustained fractures as a result of a fall on two of the older person's wards (wards 4 and 7).
    - There were 2 deaths of people who had been in recent contact with the Home Treatment Team.
    - There were 2 deaths of people who had been in contact with the Mental Health Liaison Team
    - One person was found deceased; he had been in contact with the Access Team in the week prior to his death.

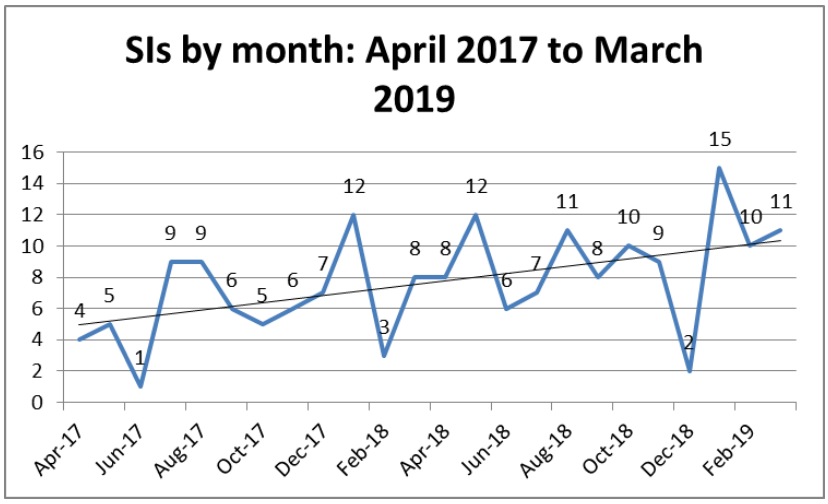
- One person was found deceased on the PICU. This incident is subject to investigation using the panel review methodology, which is being chaired by an external investigator.

- There were 10 serious incidents in the Stoke Community Directorate.
  - There were 8 unexpected, potentially avoidable deaths reported; 4 of these incidents related to the Sutherland Centre.
  - One female died after recently being discharged from the Parent and Baby unit.
  - One male was found deceased, he had previously been open to the North Staffs Memory Service (this service is hosted by Stoke Community Directorate).
  - One male was found deceased at home; he has been discharged from the Healthy Minds Service in the 3 months prior to his death.
  - There was one suspected death by suicide in the Child and Adolescent Mental Health Service. This death is being reviewed utilising the panel review methodology.

- There were 2 serious incidents in the North Staffordshire Community Directorate.
  - One death relates to a person who was known to the Lymebrook community team
  - One death relates to a person who was known to the Criminal Justice Mental Health Team and the High Volume Users team. Drug misuse is suspected.

3. Themes and Trends

The graph below shows the number of Serious Incidents reported monthly from April 2017 to March 2019. During this timeframe the trend line shows an increasing number of SIs.



The number of unexpected, potentially avoidable deaths has increased. There were 31 deaths reported during Q4 compared to 14 deaths in Q3. This increase is particularly noticeable with regards to the number of deaths reported by the Substance Misuse Directorate. In Q3 there were 4 unexpected deaths reported by the Directorate however in Q4, this has increased to 14 deaths reported.

During Q4, there has been another incident where the management of the Mental Health Act documentation has resulted in the unlawful detention of a person. The team quickly identified and rectified the error however there have been a number of incidents involving completion of the MHA process throughout 2018/19. This issue is being addressed by the MHA law team.

4. Learning from Serious Incidents

4.1 Quarter 4 learning

Recommendations and learning from investigations are disseminated upon completion of the SI investigation. As in previous reports, elements relating to care planning and risk assessments remain an issue for the Trust. Inpatient and community teams are subject to regular (monthly) peer audits utilising the patient safety matrix tool however this is a relatively small sample size and therefore does not allow for widespread analysis of the quality of the risk assessments and care plans for each person under the care of the Trust. The quality of the care plans and risk assessments is being followed up from an improvement perspective through the Ward Manager Task and Finish groups and the Community Team Managers Meeting.

Examples of the learning themes found from this quarter and the previous Q3 investigations are outlined below:

- The teams within Substance Misuse Services have met to discuss possible methods of improving engagement with clients who have complex chaotic lifestyles. This work is being developed by the Service Managers and Quality Improvement Nurses.
- Actions taken by the Lymebrook CMHT (Adult) to improve the use of Lorenzo; in particular this relates to the use of template documents
- The adult CMHTs have strengthened the operational process in relation to care coordinator absence.
- The Darwin centre recognised the need for an operational procedure to support staff should an under 18 year old require admission to an adult ward. This is currently in development.
- The Rehab and Resettlement team improved the staff knowledge for the care of people who significantly self–harm. The training included increased first-aid knowledge and the management of blood spillage following self-harm (cuts).
- The adult acute wards were reminded to request the clinical notes of people who are open to other Trust services where these services do not use Lorenzo.
- The inpatient and community Safety Matrix Tools have been updated to include questions to improve the quality of case note recording.
- The Trust has implemented an addition check to the monitoring requirements contained within HTM66 (collapsible shower rails): This check includes the lateral testing of the shower/curtain rails as well as vertical load testing.
- A workshop to support the development of improved multi-disciplinary team working was held. Clinical were reminded of the importance of escalating potential areas for concern to medical staff in a timely manner.

4.3 SI Action Plan Analysis (previously known as Closing the Loop)

During 2018 a refresh of Trust processes introduced an action to ensure that all recommendations identified as a result of Serious Incident (SI) investigations are embedded into clinical and operational practice.

During the Q4 review of ongoing action plans the following actions have been checked as being embedded into practice:

- Improvements in the quality of clinical record keeping is monitored through the safety matrix tools in use in the community and inpatient areas
- The assessment of falls risk and the use of the multifactorial risk assessment on the older person's wards has been implemented and maintained

However for the Q4 period, a review of the actions plans shows that there are still a number of areas to achieve full implementation/completion. These areas are outlined below:

- The Trust has agreed the funding for the training proposed for the care and treatment of people with a diagnosis of Personality Disorder. The training commissioned is the Structured Clinical Management Training and will initially be provided for ward 3 and an adult CMHT. The Trust is also in the process of commissioning the Certificate in DBT for 4 practitioners
- Recruitment into the psychology positions on the adult inpatient wards problematic however this is a national issue. Therefore a psychology recruitment strategy is in development in order to support the ongoing recruitment and retention of psychologists.

5. Duty of Candour (Quarter 4 report)

The Trust continues to strive for open and transparent practice in our delivery of mental health and learning disability services. All reported incidents are scrutinised at the weekly meeting of the incident review group. This meeting is facilitated by P+OS Team and aims to provide secondary monitoring and identification of all incidents which may potentially meet the criteria as Duty of Candour (DoC) reportable incidents.

There is a need to wait for investigations to take place before issues relating to Duty of Candour are identified. However should any investigation identify causal links between patient harm and service delivered, the Duty of Candour process is initiated and a letter outlining the issues sent to the patient or next of kin. The table below shows the incidents that were initially reported as potentially meeting the DoC requirements.

Month	Moderate and above incidents reported	Moderate and above incidents downgraded after review	Moderate and above incident. Managed via SI process	Moderate incident but does not meet DoC criteria	Incident meeting DoC requirement	Moderate and above incident. Managed through the MS process
Jan	33	15	16	2	0	0
Feb	29	18	6	3	0	2
Mar	33	20	9	4	0	0
total	**95**	**53**	**31**	**9**	**0**	**2**

During Q4, there were no incidents that met the criteria for reporting under the Duty of Candour requirements. The current ongoing SI investigations may determine that incidents meet the DoC criteria as part of the investigative process however the initial investigations do not indicate this at present.

6. Conclusion

- The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- The trend line shows that Serious Incidents have continued to increase during the timeframe April 2017 to March 2019. The Trust continues to review all incidents and reports in order to identify any themes arising from Serious Incidents investigations. No specific care or service delivery themes have been identified during this quarter.
- The greatest number of Serious Incidents relate to unexpected/potentially avoidable deaths however SI investigations do not demonstrate that actions taken/omitted by clinical teams are a contributory factor in these incidents.
- The learning from investigations, as outlined above, is cascaded across the Trust through a variety of governance processes: From the internal team and directorate processes across to full Trust cascade through the Learning Lessons framework. This is to ensure that the learning from investigations is not completed in isolation and that a positive learning culture is maintained, through supporting staff with the opportunity to reflect and share learning.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 13

Date of Meeting:	23rd May 2019		
Title of Report:	Performance & Quality Management Framework Month 12		
Presented by:	Lorraine Hooper, Director of Finance, Performance & Estates		
Author:	Vicky Boswell, Associate Director of Performance		
Executive Lead Name:	Lorraine Hooper, Director of Finance, Performance & Estates	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report provides an overview of performance for March 2019 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 on the supporting PQMF dashboard.	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☒ Execs ☐ Performance Review Date: 30th April 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance, Performance & Estates Committee ☒ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	In Month 12 there are 0 target related metric rated as Red and 0 metrics rated as Amber; all other indicators are within expected tolerances. All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	There are potential contractual penalties if the Trust is not able to meet reporting requirements or performance standards. A Data Quality Improvement Plan is agreed with commissioners to address data quality issues that may impact on performance.		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	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. A new diversity and inclusion report is being developed to monitor trust performance on closing service user and workforce equality data gaps.	
STP Alignment / Implications:	Reporting from Month 8 reflects the Locality restructuring in support of STP alignment. This will include a breakdown of activity and performance according to North Staffs and Stoke localities.	
Recommendations:	The committee is asked to • Approve the report as outlined • Note the Management action and committee oversight	
Version	Name/group	Date issued
1.1	Finance, Performance and Estates Committee	09.05.19

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD

Date of meeting:	23rd May 2019
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 12 2018/19**
Executive Lead:	Lorraine Hooper, Director of Finance, Performance & Digital
Prepared by:	Vicky Boswell, Associate Director of Performance
Presented by:	Lorraine Hooper, Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for March 2019 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.

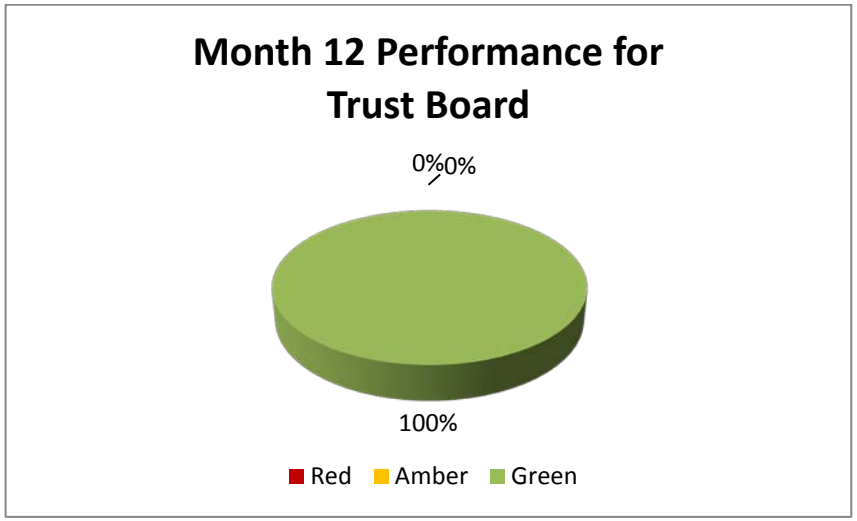
2 Executive Summary – Exception Reporting

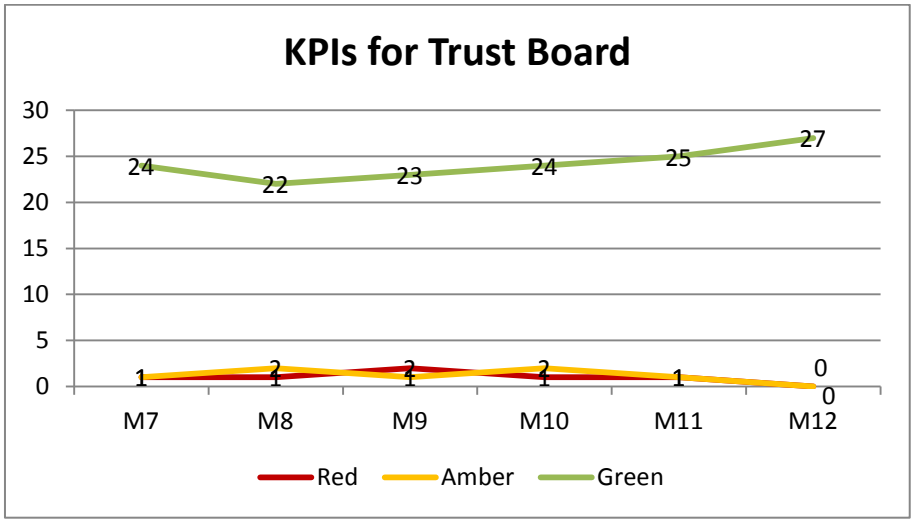
The following performance highlights should be noted:

- 97.0% of MH Liaison Team response to A&E referrals within 1 hour (target 95%)
- Mental health delayed transfers of care achieved 4.8% in M12 (target7.5%)
- 66.2% of IAPT service users are moving to recovery (target 50%).
- 98.9% of IAPT service users have been treated within 6 weeks and all service users (100%) have received treatment within 18 weeks (target 95%)
- 8.8% of IAPT service users wait no longer than 90 days between 1st and 2nd treatment (target <10%)
- 95.0% of service users on Care Programme Approach (CPA) for at least 12mnths have a formal review within 12mnths *NHSI* (target 95%)

Month 12 Performance:

In Month 12 all indicators are within expected tolerances.





3 Updated metrics and targets

The following measures and targets have been updated for Month 12:

- PALS & Complaints figures for February confirmed, provisional data received for March 2019
- Sickness absence percentage figures for M12 are provisional. Year to date sickness absence figures have been refreshed to reflect the updated 12 months rolling position.
- Employment status reporting methodology has been updated year to date to adopt the Model Hospital definition

4 Exceptions - Month 12

There are no exceptions to report to the Trust Board this month

5 Recommendations

The Trust Board is asked to:

- Receive the Trust reported performance, management action and committee oversight on the Month 12 position

Month: **March**
12
Key:-

PQMF Report

CCG	NHS Standard Contract Reporting
National	NHS Improvement metric
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%, 19/20-57%, 20/21-60%)	Monthly	53%	75.0%	75.0%	100.0%	75.0%	90.0%	87.5%	80.0%	72.2%	100.0%	91.7%	100.0%	80.0%
	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (North Staffordshire CCG) (Target 17/18-50%, 18/19-53%, 19/20-57%, 20/21-60%)	Monthly	53%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%
	Number of completed EIP pathways (North Staffordshire CCG)	Monthly	No Target	4.0	2.0	2.0	2.0	1.0	4.0	0.0	0.0	3.0	4.0	1.0	4.0
	Number of incomplete EIP pathways (North Staffordshire CCG)	Monthly	No Target	1.0	2.0	0.0	1.0	0.0	1.0	5.0	0.0	0.0	1.0	1.0	3.0
	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Stoke-on-Trent CCG) (Target 17/18-50%, 18/19-53%, 19/20-57%, 20/21-60%)	Monthly	53%	50.0%	66.6%	100.0%	66.6%	88.8%	100.0%	80.0%	88.9%	100.0%	87.5%	100.0%	63.6%
	Number of completed EIP pathways (Stoke-on-Trent CCG)	Monthly	No Target	2.0	4.0	2.0	4.0	8.0	4.0	4.0	8.0	7.0	7.0	7.0	4.0
	Number of incomplete EIP pathways (Stoke-on-Trent CCG)	Monthly	No Target	1.0	1.0	1.0	0.0	0.0	0.0	5.0	0.0	7.0	4.0	5.0	3.0
NHSI	CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (North Staffs and Stoke CCG)	Monthly/Quarterly	95%			100.0%			100.0%			100.0%			100.0%
	CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (North Staffs CCG)	Monthly/Quarterly	95%			100.0%			100.0%			100.0%			100.0%
	CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (Stoke CCG)	Monthly/Quarterly	95%			100.0%			100.0%			100.0%			100.0%
NHSI	CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (North Staffs and Stoke CCG)	Monthly/Quarterly	95%			100.0%			100.0%			100.0%			100.0%
	CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (North Staffs CCG)	Monthly/Quarterly	95%			100.0%			100.0%			100.0%			100.0%
	CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (Stoke CCG)	Monthly/Quarterly	95%			100.0%			100.0%			100.0%			100.0%
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention)	Monthly	92%	90.5%	86.8%	93.5%	93.9%	93.9%	91.7%	92.8%	90.1%	92.5%	90.8%	95.2%	94.5%
	Acute Services & Urgent Care									100.0%	100.0%	98.0%	99.5%	100.0%	99.6%
	North Staffordshire Community									89.2%	92.6%	94.9%	87.6%	95.3%	94.9%
	Specialist Care									84.5%	75.6%	88.7%	74.5%	86.3%	79.2%
	Stoke Community									89.2%	85.8%	87.6%	88.5%	92.3%	90.7%
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0
CCG	MH Liaison Team response to A&E referrals within 1 hour	Monthly	95%	94.8%	93.0%	98.0%	95.0%	97.9%	97.3%	96.7%	96.0%	95.0%	96.0%	95.0%	97.0%
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
National	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%
National/CCG	Overall safe staffing fill rate	Monthly	No Target	93.7%	93.4%	94.1%	93.7%	93.6%	93.4%	94.3%	94.2%	89.9%	92.8%	92.1%	88.0%
National	Mental health delayed transfers of care (target NHSI)	Monthly	7.5%	5.5%	9.1%	7.6%	7.8%	7.8%	5.9%	4.1%	2.1%	2.9%	3.5%	3.3%	4.8%
CCG	Emergency Readmission rate (30 days). Percentage of patients readmitted within 30 days of discharge.	Monthly	7.5%	6.0%	4.8%	4.8%	6.5%	7.5%	6.4%	6.4%	3.5%	6.3%	3.4%	5.2%	4.0%
NHSI	Total **bed days** patients have been Out of Area - In Month figures rather than Bed days for patients returning in month	Monthly	No target	10.0	0.0	28.0	4.0	64.0	3.0	2.0	3.0	17.0	33.0	57.0	33.0
Trust Measure	Adult	Monthly	No target	10.0	0.0	28.0	4.0	64.0	3.0	2.0	3.0	17.0	33.0	57.0	33.0
Trust Measure	Older Adult	Monthly	No target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0

	Metric	Frequency	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
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%	6.7%	0.0%	18.7%	2.7%	42.7%	2.0%	1.3%	2.0%	11.3%	22.0%	38.0%	22.0%
Trust Measure	Total patients Out of Area - In Month figures rather than Bed days for patients returning in month	Monthly	No target	3.0	0.0	6.0	2.0	5.0	2.0	2.0	1.0	1.0	2.0	3.0	3.0
Trust Measure	Adult	Monthly	No target	3.0	0.0	6.0	2.0	5.0	2.0	2.0	1.0	1.0	2.0	3.0	3.0
Trust Measure	Older Adult	Monthly	No target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Trust Measure	Total bed days - PICU	Monthly	No target	227.0	268.0	263.0	316.0	285.0	184.0	209.0	156.0	133.0	86.0	121.0	90.0
Trust Measure	Total patients - PICU	Monthly	No target	12.0	14.0	14.0	15.0	15.0	15.0	10.0	7.0	8.0	5.0	5.0	2.0
SAFE															
CCG	Number of patients 16/17 years old admitted to Adult Psychiatric wards	Monthly	0.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NHSI	Admission to adult facilities of U16s	Monthly	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CCG	Bed Occupancy (incl home leave) - Trust	Monthly	85%	90.7%	89.0%	87.8%	85.4%	89.7%	89.7%	80.4%	86.5%	82.5%	81.7%	85.9%	86.9%
CCG	Bed Occupancy (incl home leave) - Acute Services & Urgent Care - Adult Inpatient	Monthly	90%	89.7%	77.8%	89.5%	91.1%	89.7%	86.4%	76.1%	86.5%	79.0%	71.3%	74.3%	75.9%
CCG	Bed Occupancy (Including Home Leave)-Trust excluding Adult Inpatient	Monthly	85%	90.6%	94.9%	85.9%	79.6%	88.0%	90.4%	86.9%	86.0%	83.8%	84.3%	92.4%	93.1%
CCG	LD & CAMHS Inpatient - LD	Monthly	85%	79.7%	83.6%	90.6%	81.7%	80.3%	81.9%	83.3%	83.3%	94.6%	67.2%	77.0%	78.4%
CCG	Neuro & Rehab - Neuro	Monthly	85%	88.2%	102.0%	91.8%	93.1%	96.5%	99.1%	89.9%	99.1%	87.5%	91.0%	98.8%	95.9%
CCG	Acute Services & Urgent Care - Older Adult Inpatient	Monthly	85%	91.5%	95.9%	83.4%	78.4%	88.2%	96.9%	94.4%	88.2%	88.9%	90.0%	97.8%	97.0%
CCG	LD & CAMHS Inpatient - C&YP	Monthly	85%	98.7%	95.1%	85.1%	68.3%	84.7%	66.6%	66.5%	73.1%	61.0%	80.0%	74.3%	80.0%
CCG	IAPT: The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Quarterly	19% per annum (4.75% per quarter)			4.8%			4.6%			4.7%			4.9%
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%	71.7%	67.8%	70.3%	66.0%	60.3%	57.9%	66.7%	61.7%	64.8%	63.4%	66.2%
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%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.0%	98.6%	98.1%	98.8%	98.9%
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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CCG	IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment	Monthly	<10%	26.1%	17.9%	17.8%	15.1%	6.8%	4.4%	8.4%	12.1%	10.6%	10.8%	16.0%	8.8%
CCG	Place of Safety Assessments	Monthly	No Target	22.0	24.0	22.0	25.0	27.0	26.0	18.0	29.0	14.0	15.0	19.0	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%	96.5%	97.1%	97.0%	93.8%	93.4%	85.7%	84.8%	86.3%	91.6%	93.6%	95.0%
NHSI	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	100.0%	97.9%	98.7%	96.3%	96.4%	98.0%	97.1%	100.0%	96.2%	97.3%	97.1%	97.0%
Trust Measure/CCG	(ALL PATIENTS) The proportion of those receiving follow up within 7 days of discharge	Monthly	Internal-No Target CCG -90%	91.2%	85.2%	91.0%	80.2%	87.3%	83.5%	95.4%	88.8%	89.2%	96.1%	97.9%	92.3%
NHSI/CCG	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
National	Patient Safety Alerts not completed by deadline	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CCG	Mixed Sex Accommodation Breach	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0
CARING															
National	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	90.8%	84.9%	89.2%	89.8%	87.0%	77.0%	86.0%	87.0%	89.5%	79.8%	86.0%	89.0%
National	Staff Friends and Family Test - % recommended - care	Quarterly	No Target			73.0%			73.0%			N/A			N/A
National	Percentage of complaints responded to in line with timescale agreed with complainant	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
National	Written complaints rate	Quarterly	No Target			9.4%			10.0%			5.4%			9.3%
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
ORGANISATIONAL HEALTH															
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%	-45.0%	-39.0%	-23.0%	-12.9%	-2.0%	2.0%	1.0%	-3.0%	-7.0%	-4.0%	-3.0%	0.0%
National	Sickness Absence Percentage: Days lost	Monthly	4.95%	4.6%	4.4%	4.6%	4.6%	4.4%	4.3%	4.3%	4.5%	4.4%	4.3%	4.3%	4.3%
National	Staff Turnover (% FTE)	Monthly	>10%	0.6%	0.8%	0.5%	0.9%	1.2%	1.6%	0.5%	0.8%	1.2%	1.3%	0.8%	1.2%

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REPORT TO: Open Trust Board

Enclosure No: 14

Date of Meeting:	23 May 2019		
Title of Report:	Assurance report from the Quality Committee		
Presented by:	Patrick Sullivan, Chair of Quality Committee		
Author:	Sandra Storey, Associate Director Medical & Clinical Effectiveness		
Executive Lead Name:	Maria Nelligan - Director of Nursing & Quality Dr Buki Adeyemo, Medical Director	Approved by Exec	☐

Executive Summary:		Purpose of report	
The attached assurance report describes the business and outputs from the last meeting of the Quality Committee.		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 ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	To provide assurance to the Board on quality of services, issues of concern and remedial action being taken.		
Resource Implications: Funding Source:	None highlighted		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Non highlighted		
STP Alignment / Implications:	Nil as part of this report		
Recommendations:	Receive for assurance purposes and ratify policies highlighted.		

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Key points from the Quality Committee meeting held on 9 May 2019
For the Trust Board meeting on 23 May 2019

1. Introduction

This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee with items aligned to the Trust's SPAR objectives.

2. Patient Story – presentation

The committee watched a video presentation entitled "M and J's story".

Nurse Cath Todd-Jones noted that she had worked with J and his mum since 2010. They are a very good example of the work the team delivers and how they provide support in the best traditions of Community LD nursing and the importance of building a trusting therapeutic relationship.

In the video Mum spoke of how she was informed that her son had cerebral palsy and LD in a very insensitive way and said that this has stayed with her and affected her very deeply. For many years she just wanted to keep him safe and she could never think about his future without feeling scared and anxious. The LD team worked collaboratively and were able to provide a range of support and interventions that focused on promoting her son's development in a very holistic way. They also maintained wider multi-agency links to enhance support and over time have supported the family to accept additional support from other helpful agencies.

The great thing about their story is that through the long engagement with the service, staff have been able to see how their support has helped to shape J's progress through childhood and adolescence and his potential is very evident. Mum noted the journey and the support she received and commended the team for their work.

The committee noted once again, how powerful patient stories are. In this case, highlighting how important the first contact is in making a positive impression at the outset of a journey with services.

3. Reports received for review, information and/or approval

3a Reports:

- ✓ ***Learning from Experience Report – January & February 2019*** *(summary* report detailing patient related incidents / events and action and learning.
- ✓ ***Unannounced Visits Q4 2018/19*** (overview of areas visited, areas of good practice and recommendations to support on-going improvement – report approved).
- ✓ **CCQ, Healthwatch and Trust Visits Report Q4 2018/19** – summary of visits to teams and showcasing good practice – report approved).

- ✓ **PQMF M12 2018/19** (M12 dashboard and exception report in respect to contracted key performance indicators (KPIs). The committee discussed the 8 indicators that are underperforming and improvement actions being taken.

- ✓ **Quality Committee Risk Register 12+** (members discussed and agreed the risks contained within the Trust Risk Register which fall under the portfolio of the Quality Committee. An additional risk was suggested in relation to MH Law compliance and this will be communicated to the Risk Review Group).

- ✓ **Board Assurance Framework (BAF) 2019/20** (members received for information and assurance the refreshed BAF which aligns strategic objectives to the Trust's quality priorities and key strategic risks.

- ✓ **Equally Well** (briefing note detailing commitment to sign up to collaborative to support the physical health of people with mental illness).

- ✓ **Action plan for the delivery of the Citizens Jury for Mental Health 2016-19** (Reviewed and approved).

- ✓ **Safeguarding Report Q4 2018/19** (summary report approved by the committee detailing activity during this reporting period).

- ✓ **Safeguarding Annual report 2018/19** (summary of the work undertaken by the Safeguarding Team. The team were commended for their achievements in raising the profile of safeguarding over the course of the year, particularly in respect to the training provided and support given to front-line staff).

- ✓ **Eliminating Mixed Sex Accommodation** (Annual declaration of compliance was approved).

- ✓ **Draft Autism Strategy** (members were advised that this was developed following a review of key national policy documents. The committee approved the strategy with the plan to identify key leads for further development in partnership with service users, carers and key stakeholders).

- ✓ **Director of Infection Prevention and Control Q4 2018/19** (the committee approved the summary report detailing performance during Q4).

- ✓ **Director of Infection Prevention and Control Annual Report 2018/19** (this report provided assurance to the Committee that the organisation is compliant with the Health & Social Care Act 2008. Cleanliness report and the completed annual audit/work programme also detailed. Report approved).

- ✓ **Directorate Clinical Dashboard / Balance Scorecards** (these reports were also discussed in detail at Performance meetings. Areas of good practice highlighted and areas of continued improvement noted. At the next Committee meeting members will receive the quarterly report looking back on Cost Improvement Programmes detailing any negative impact on quality of service and remedial action).

- ✓ **Clinical Effectiveness Report** (summary of the outputs from the Medicines Optimisation Group, Research & Development Group, Mental Health Law Governance Group, Clinical Records and Systems Design Group and the Clinical Effectiveness Group).

- ✓ **National Confidential Inquiry into Suicide and Safety (NCISH) – March 2019** (overview of data received for information by the Committee. Benchmarks data to support teams with quality improvement).

- ✓ **Serious Incident Report Q4 2018/19** (the Committee discussed the report detailing the nature and status of incidents and trend data for Q3 and Q4).

- ✓ **Mortality Surveillance Q4 2018/19** - Provided assurance on the process in place for the scrutiny of people open to Trust services that have died of natural causes.

- ✓ **Safe Staffing Reports January – March 2019** (assurance of safe staffing levels in place in line with National Quality Board requirements, report reviewed and approved).

- ✓ **Quality Committee Terms of Reference** (following the Committee's review of its effectiveness in March 2019, the Terms of Reference were refreshed. They will be finalised at the next committee meeting.

- ✓ **Quality Account 2018/19** – First draft of the Quality Account received by the committee. The document will be further refreshed following feedback from key stakeholders. The committee will receive the next iteration virtually for review and approval given the timing of the next committee meeting. Assurance given that the Quality Account will be published on time in accordance with the Project Plan.

3b **Policy report** – the recommendations supported by the Committee for ratification of policies by the Trust Board for 3 years, or otherwise, are noted as follows:

Policy No.	Name	Recommendation
4.43	Prevent Policy	Approve 3 years
New Policy	Sexual Safety and Responding to Sexual Violence Policy	Approve 3 years
1.14a	Supervision Policy	Approve 3 years
3.43	Serious Placement Issues Policy	3 Month Extension

4. Next meeting:
11th July 2019

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director

Sandra Storey Associate Director Medical and Clinical Effectiveness
16 May 2019

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REPORT TO OPEN TRUST BOARD

Enclosure No: 15

Date of Meeting:	23rd May 2019		
Title of Report:	Being Open Report		
Presented by:	Kerry Smith, Associate Director of Workforce		
Author:	Kerry Smith, Associate Director of Workforce		
Executive Lead Name:	Linda Holland, Director of Workforce, OD and Inclusion	Approved by Exec	☒

Executive Summary:	Purpose of report	
The Being Open report provides a combined report of Dear Caroline, FTSU, Raising Concerns and Grievances submissions, reporting on their collective activity providing details regarding the themes, trends and patterns for assurance at Trust Board. It provides a full summary of activity covering a 12 month period for January to December 2018 and a detailed quarterly review for the period of January to 2019. Combined Being Open key themes – April 2018 to March 2019 Top three themes: - Policies, Procedures and Processes - Quality and Safety - Other Combined Being key themes (quarter) – January to March 2019 Top themes: - Employment, Bullying, Etc. - Other - Staffing Levels <u>Next Steps</u> 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 development and embedding of the Trust Values and supporting Behaviours Framework • Continuation of the Freedom to Speak Up Guardian (FTSU) role including further embedding and development of a range of Freedom to Speak Up Champions to further support the FSSU role.	Approval	☐
	Information	☒
	Discussion	☒
	Assurance	☒

Seen at:	SLT X Execs ☐ Date: 14th May 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services X		

	3. Inspire and implement innovation and research. X 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. X 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐
Risk / legal implications: Risk Register Reference	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). See wider D&I Guidance	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.
STP Alignment / Implications:	N/A
Recommendations:	• Receive the report for assurance • Support the proposed next steps • Receive an update report quarterly

Version	Name/group	Date issued

Being Open Report:
An Evaluation and Analysis of Dear Caroline, Freedom to Speak up, Grievance and Raising Concerns activity (April 2018 to March 2019)

1. Introduction

As a Trust we are committed to supporting staff to raise concerns they may have, ensuring that they are taken seriously, investigated where appropriate, actions taken where required and any lessons learnt are shared across the organisation.

The Trust has introduced a number of mechanisms to support staff to raise their concerns including; the Dear Caroline initiative, the appointment of the Freedom to Speak up Guardian and a review of the Trust's formal Raising Concerns Policy (formerly the Whistleblowing Policy). The Trust also operates a Resolution of Grievance and Dispute procedure which supports staff to raise issues regarding their working arrangements. A brief synopsis of each mechanism is provided in appendix 1.

The Being Open report provides a combined report of the abovementioned mechanisms and provides an elevated synopsis highlighting key themes, trends and patterns for assurance at Trust Board. It provides a full summary of activity covering a 12 month period for April 2018 – March 2019 and a detailed quarterly review for the period of January 2019 – March 2019. Furthermore, to allow greater comparison and review the high level themes developed by the National Freedom to Speak Up Guardian (FTSU) have been adopted and allocated to all submissions across each of the abovementioned mechanisms. Further detailed break downs are available.

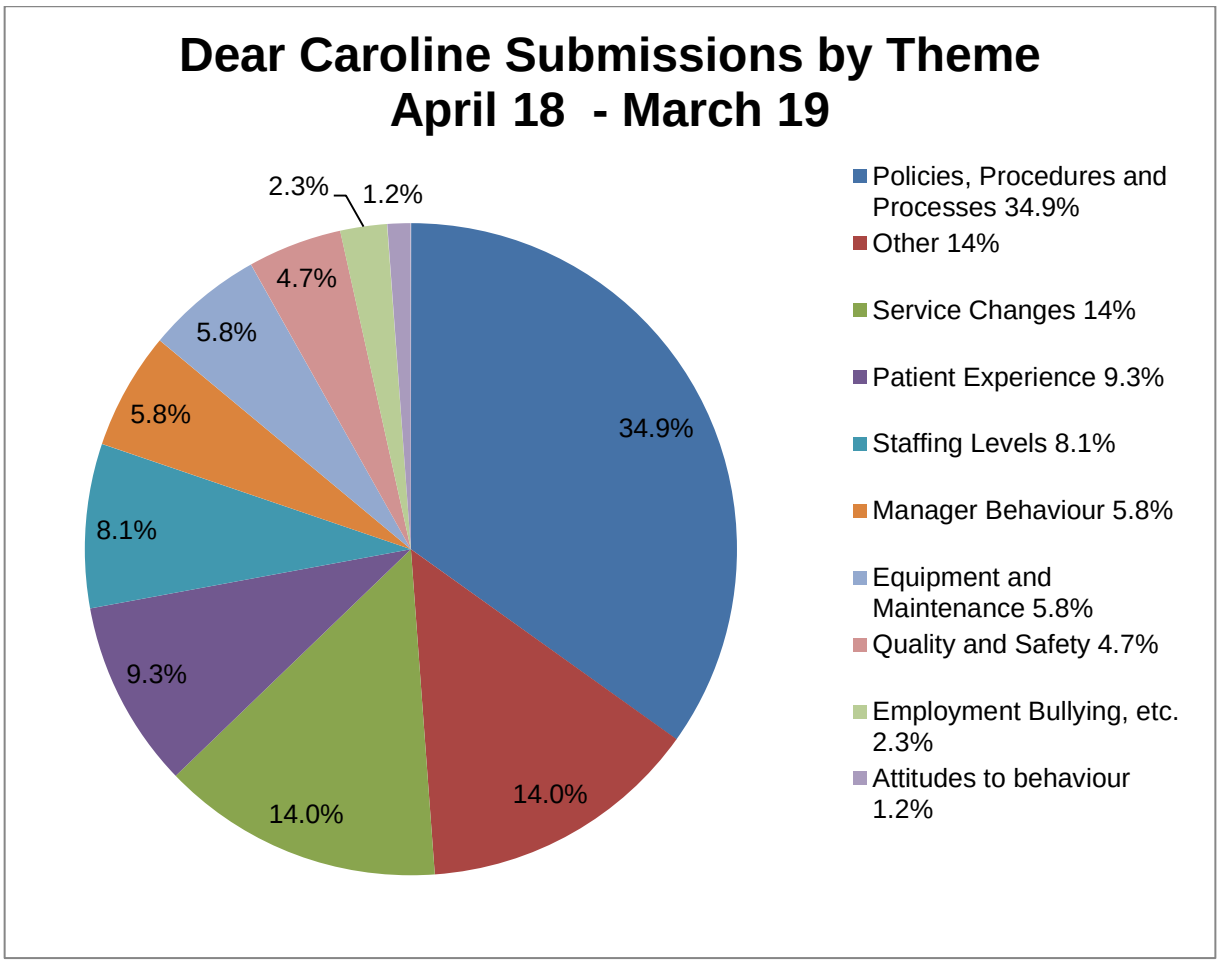
The high level themes recommended by the National FTSU Guardian include:

- Attitudes and Behaviours
- Equipment and Maintenance
- Staffing Levels
- Policies, Procedures and Processes
- Quality and Safety
- Patient Experience
- Performance Capability
- Service Changes
- Other
- Employment Bullying, etc.
- Manager Behaviour
- Work Relationships

2. Summary of activity and themes (12 month – April 2018 – March 2019)

2.1 Dear Caroline (DC) Activity

Between April 2018 – March 2019, a total of 87 DC submissions have been received and 7 submissions between January - March 2019. The pie chart below details themes by percentage over the 12 month period.

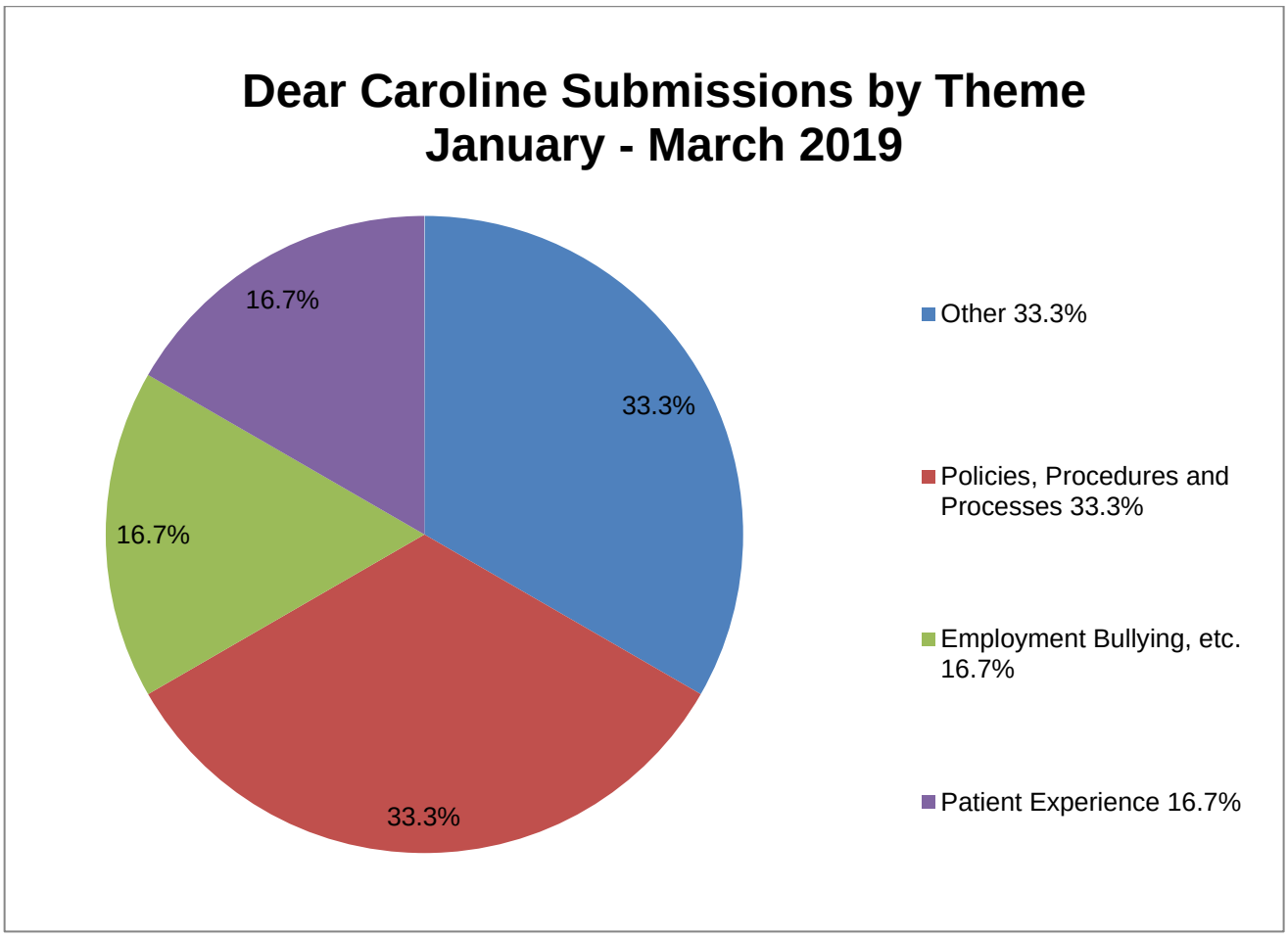


Over the 12 month period the top three themes include Policies, Procedures and Processes (33.9%, 28 submissions), Service Changes (14% - 10 submissions) and Other (14% - 10 submissions).

Repeat themes relating to Policies, Procedures and Processes include car parking and parking fines at the Harplands site, E-rostering concerns, Lorenzo concerns, a variety of workforce reward and recognition suggestions, flexible/agile working opportunities and concerns/suggestions regarding the Trust Smoke Free initiative. Submissions relating to service changes relate in the main to the recent locality restructure and include concerns regarding CAMHs, Inpatients, Psychology and Substance Misuse Services and general estate matters relating to the Harpland site facilities.

Submissions which fall into the 'Other' theme include matters regarding general communications, Dear Caroline and CEO Blog.

The pie chart below details themes by percentage for the quarter January – March 2019.



Between January – March 2019, the most common matters raised are with regards to Policies, Procedures, and Processes (33%, 2 submissions) and relate to suggestions regarding flexible/agile working.

Submissions classified as 'Other' (33% - 2 submissions) include concerns regarding car parking and rest rooms facilitates at the Harplands site.

Employment Bullying, etc. (16.7% - 1 submission) relates to the perceived style of a member of the Senior Leadership Team.

Patient Experience (16.7% - 1 submission) relates to the impact of the CQC Celebration for Service Users in that the Gym was not accessible for a time.

2.2 Freedom to Speak Up Guardian Activity

From April 2018 March 2019 a total of 23 concerns have been received by the Freedom to Speak Up Guardian (FYSU) and 12 submissions between January – March 2019. The submissions relate in the main to Stoke Community Directorate (10 concerns), Acute and Urgent Care Directorate (7 concerns) and the North Staffordshire Directorate (5 concerns).

The highest three reported themes include:

- Working Demands (7 concerns)
  Five of the seven concerns related to the management of individual practitioners caseloads.

- Quality and Safety (4 concerns)
  All four concerns were a sub theme and linked to case load management.

- Bullying and Harassment (4 concerns)
  All concerns directly linked to one case.

The Annual Freedom to Speak Up Report (1st April – 31st March 2019) provides a more detailed position with regards to this initiative. Including further analysis of the activity and proactive steps taken to address concerns and themes.

2.4 Raising Concerns Activity

From April 2018 – March 2019, 6 submissions have been received in total and no submissions for the period January – March 2019. Previous submissions relate to the use of the Meridian tool within the Community Directorate Teams; the Locality Restructure and service redesign with regards to CAMHs Service provision; service provision of ASD within the North Staffs Community Directorate; Staff Attitude and Service capacity at the Sutherland Centre and an individual Service User's concern regarding their experience whilst being an inpatient within the Acute and Urgent Care Directorate.

All submissions have been reviewed and actions taken where required.

2.4 Grievance and Dispute Activity

From April 2018 – March 2019 a total of 4 grievances were raised and no submissions during the period January – March 2019.

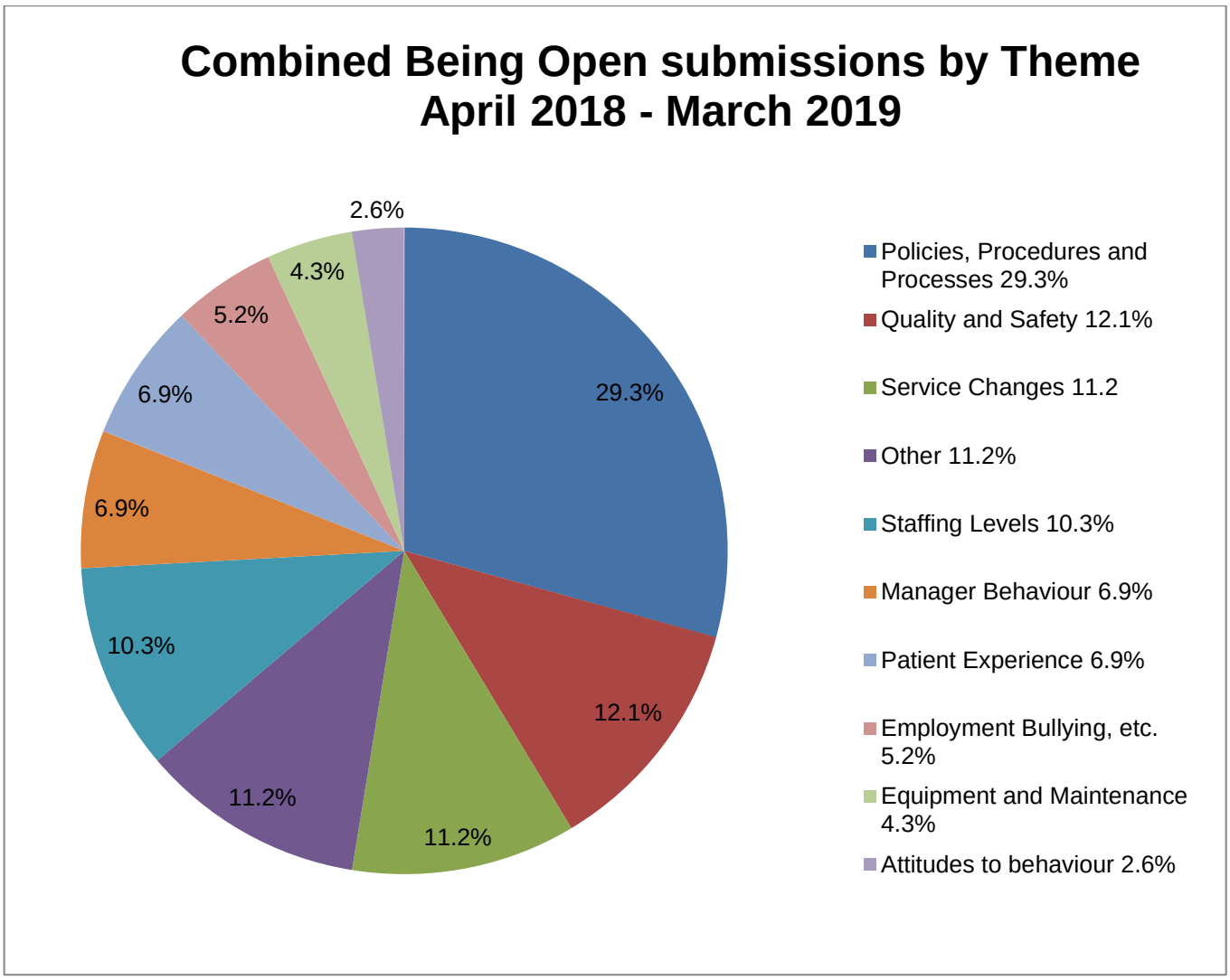
Overall, grievances raised relate in the main to the Corporate function (Estates Team with 3 submissions and a collective Grievance in the former Learning Disability Directorate) and have an overarching classification of Manager Behaviour theme pertaining to a TUPE process, a request to take on additional duties/manager behavior and a contract dispute. All matters are closed.

3. Combined Being Open Key Themes

3.1 High level: 12 month theme analysis

In order to assess the themes that emerge from Dear Caroline, FTSU, Grievances and Raising Concerns each submission is assigned a summary category where possible for further evaluation. Please note the submissions have been categorised to allow analysis against the recommended FTSU Guardian national themes. Furthermore, all submissions (where possible) have been reallocated in line with the new locality restructure.

It is important to note the submissions have been categorised based on the primary concern and some of the submissions are multi-faceted. The chart below shows the distribution of submissions, with further detail provided below for the top 3 reasons which include Policies, Procedures and Processes (29.3%), Quality and Safety (12.1%) and Service Changes (11.2%).



3.1.1 Policies, Procedures and Processes (29.3% - 34 submissions)

The concerns categorised as Policies, Procedures and Processes relate to a number of areas within the Trust and predominately refer to Trust wide and Corporate issues.

Repeat submissions have been made regarding Trust Policies including suggestions about service improvement, Lorenzo, E-rostering, LMS, Trac recruitment, Dress Code, No Smoking Policy and Flexible Working Policy.

3.1.2 Quality and Safety (12.1% - 13 submissions)

Submissions have been received concerning staffing levels within the Inpatient and Community Services, a lack of ASD Service within the Trust, concerns with regards to the Access Service and a concern regarding patient's experience within an inpatient setting.

3.1.3 Other (11.2% - 11 submissions)

This category combines a variety of submissions including Cycle to Work suggestions, CEO Blog, Dear Caroline initiative, Christmas incentives, Trust Communications, Recruitment and Retention incentives and general Harplands estate matters including café opening times, car parking and rest room facilities at the Harplands site.

3.1.4 Service Changes (11.2% - 11 submissions)

A number of submissions have been received concerning the Locality Restructure and supporting management of change process, concerns regarding Care Coordination, Psychology Services, and planned changes within CAMHs. Matters also raised regarding service changes to the Section 75 service provision and the Substance Misuse service. It should be noted that the majority of the submissions relate to quarters one and two.

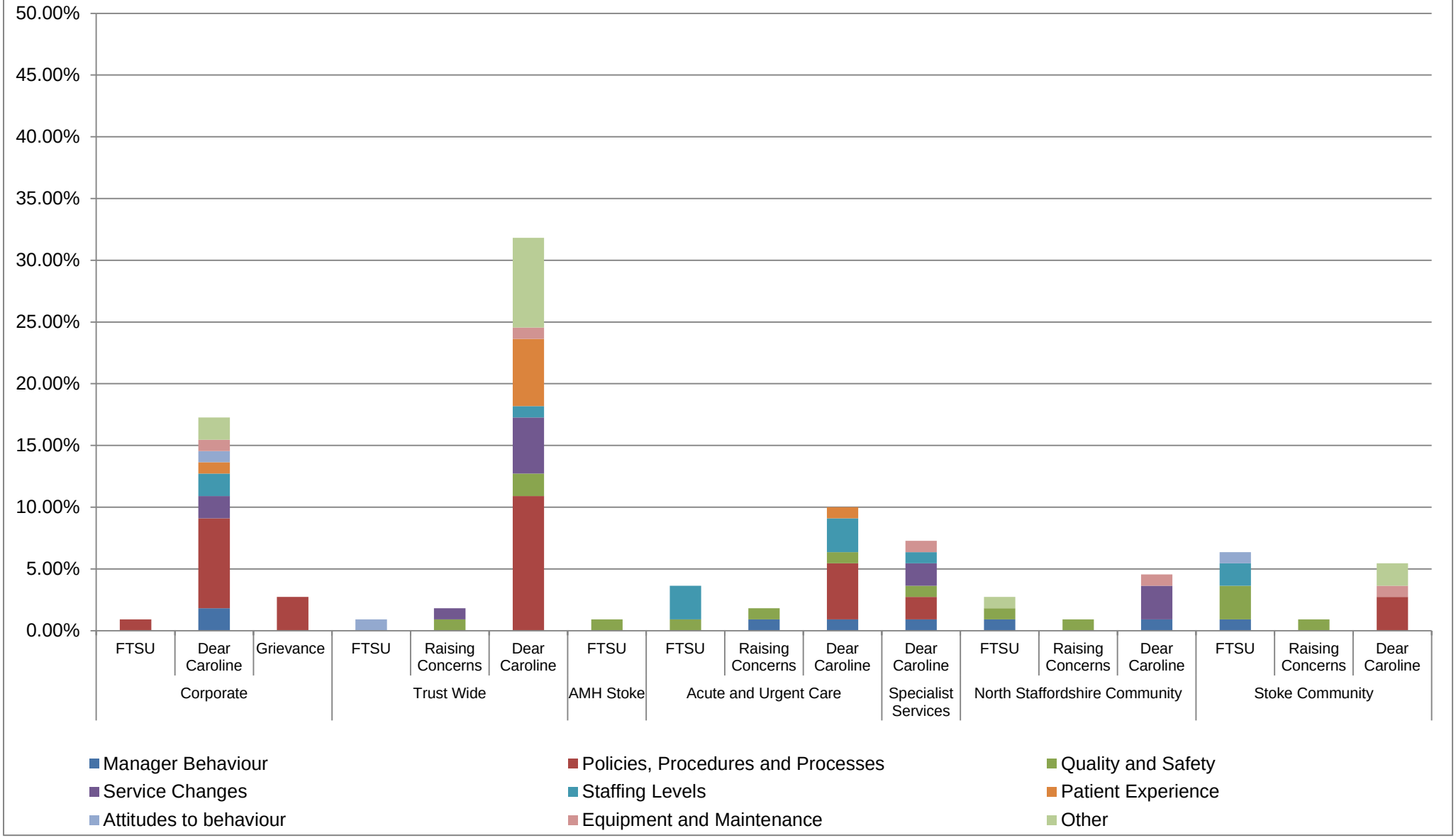
3.2 High Level: Directorate Themes and activity (April 2018 – March 2019)

For all Directorates/areas, the graph below details themes including Dear Caroline (DC), FTSU, Raising Concerns (RC) and Grievance (Gri) themes. Key themes include Service Changes which feature throughout Corporate, Trust wide, Specialist Services and North Staffs Community. Many of the submissions are linked to the Locality Restructure and Trust wide system developments including Lorenzo, Learning Management System (LMS) and Trac.

Staffing Levels feature within the Acute and Urgent Care Directorate although it should be noted that many submissions were received prior to the increase in Safer Staffing numbers which were agreed in October 2018 and continue to be actively recruited. The Stoke Community Directorate and Specialist Services Directorate also feature Staffing Levels which need to be monitored.

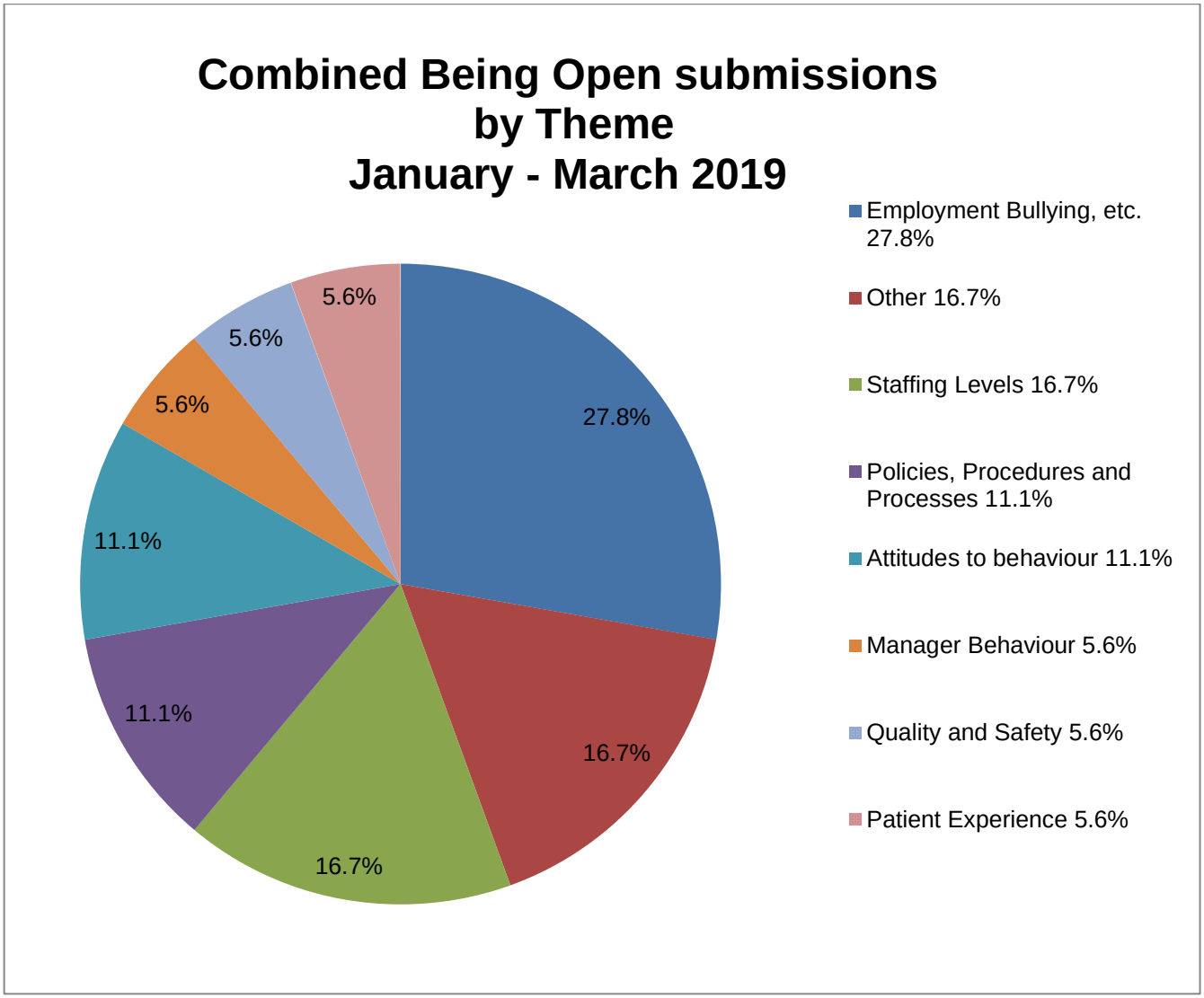
The Quality and Safety theme features across all Directorates and the submissions vary in content. Repeat submissions are linked with the potential impact of the Locality Restructure with a specific focus on Substance Misuse and CAMHs services and the use of the Meridian Tool within the Community Teams.

Openness Report - All Submissions by Theme, Type and Directorate
April 2018 - March 2019



3.2.1 Being Open Combined High Level Quarterly Theme Update (January – March 2019)

Following the last Being Open report submissions for DC's have significantly decreased whilst Grievance and Raising Concerns submissions remain static. However, FTSU submissions have significantly increased when compared to the same time frame in 2017. Themes continue to be varied as previously highlighted.



3.2.1 Employment Bullying, Etc. (27.8% - 5 submissions)

Submissions in the main have been made via the FTSU mechanism. Four submissions are interconnected and relate to one case. One DC relates to the perceived leadership style of a senior colleague within the Trust.

3.2.2 Other (16.7% - 3 submissions)

All submissions relate to the Harplands site, two matters concern the car parking arrangements and one matter concerns the rest room facilities.

3.2.3 Staffing Levels (16.7% - 3 submissions)

All submissions relate to perceived work demands and have been received via the FTSU mechanism. One concern for a Community Team and two concerns regarding Inpatient Wards.

4. Being Open Mechanisms – Impact review

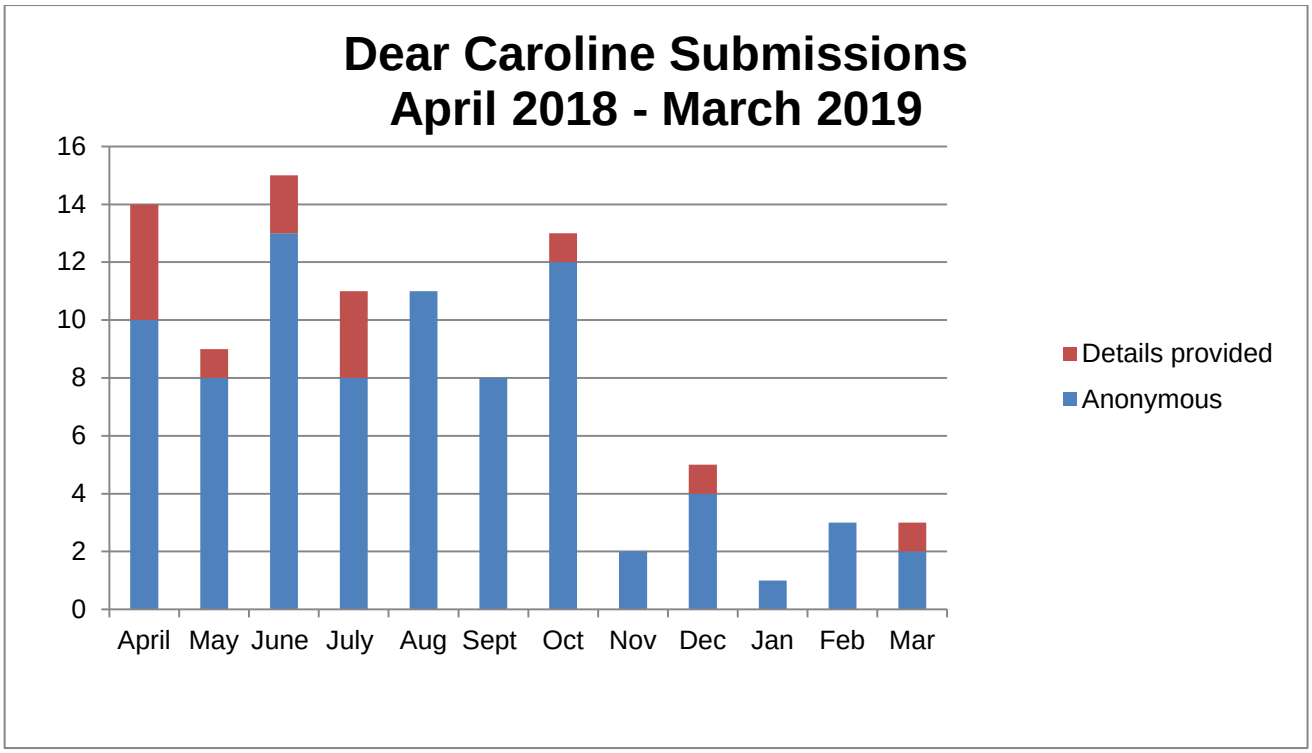
4.1 Dear Caroline Impact

In order to provide further detail, context and assurance regarding issues raised via the Dear Caroline initiative, each of the submissions received (which do not specifically identify any Trust colleagues) including those received since the last report are accessible via the link below:

Jan – June 2018 http://sid/news/DC/Pages/January-to-June-20180228-1636.aspx
July – Dec 2018 http://cat.combined.nhs.uk/being-open/dear-caroline/july-to-december-2018/
Jan – June 2019 http://cat.combined.nhs.uk/being-open/dear-peter/dear-caroline-archive/january-to-june-2019/

The Dear Caroline website provides staff with an anonymous channel to raise concerns. Between April 2018 – March 2019, 87 submissions have been received against a position of 54 submissions for the same period in the previous 12 months (April – March 2018).

Feedback has been received from a range of areas and regular submissions are being made. The bar chart below shows the number of submissions made by month over a rolling 12 month period. The most recent quarter (January – March 2019) has seen a significant reduction in the number of submissions at 7 in comparison from the previous two quarters, 20 submissions received (July – Sept) and 38 submissions received (Oct – Dec).



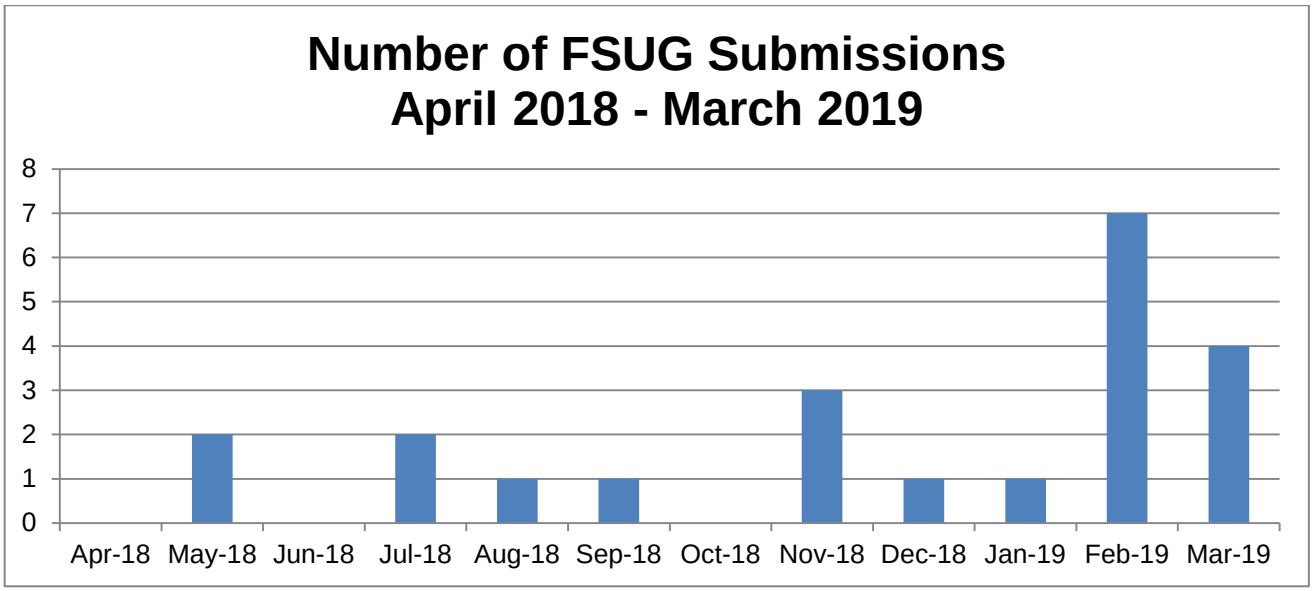
The majority of submissions (86%) continue to be submitted anonymously; and some submissions have raised concerns with regards to whether the mechanism is entirely anonymous. That said it

should be noted that 14% of the submissions received are choosing to leave their contact details which is encouraging. Where a submission has a named contact, feedback is directly provided.

Moving forwards from April 2019 the Dear Caroline mechanism will be renamed Dear Peter and will continue in its current format.

4.2 Freedom to Speak Up Guardian Impact

22 concerns have been raised during April 2018 – March 2019 which is significantly higher than the same period in 2018 where 2 concerns were raised. 12 submissions were raised in the last quarter.



It should be noted that a considerable effort has been made to raise the profile of the FTSU Guardian role across the Trust role and developments such as the appointment of the FTSU Champions may well have led to an increase in submissions.

4.3 Raising Concerns Impact

No concerns have been raised via this method in the last quarter.

A total of six concerns have been raised via this method over the 12 month period and include an allegation of bullying and harassment, service changes and the introduction of the Meridian Tool. This is consistent when compared to six submissions raised for the previous 12 months.

By the very nature that concerns relate to a danger or illegality that has a public interest aspect it would be of great concern if many issues were being raised via this method. However it is important for the Trust not to be complacent with regards to this matter.

4.4 Grievances Impact

Four concerns have been raised via this method between April 2018 – March 2019 and none between January – March 2019. This level of activity is a consistent when compared to the same period in 2017 where six grievances were also raised.

The Resolution of Grievance and Disputes procedure provides a clear informal and formal process for all Trust colleagues to raise serious concerns regarding their working arrangements. By the very

nature that concerns relate in many cases to a matter which may not be able to be resolved informally it would be of great concern if many issues were being raised via this method. It should also be noted that the HR Advisory Team support individuals to resolve grievance matters informally wherever possible, which this activity does not account for.

All grievance matters are handled in accordance with the Trusts procedure and reviewed, investigated and action taken where required.

4.5 Summary of combined mechanisms impact

In summary, for the time period April 2018 – March 2019, there has been an increase in FTSU submissions and a decrease in quarter 4 of Dear Caroline submissions. Raising Concerns and Grievance activity remains broadly consistent. All mechanisms will continue to be publicised internally using a variety of media.

4.6 Actions taken in response to submissions

As part of the collective submissions received there have been numerous actions taken to address issues or where Dear Caroline, Raising Concern, FTSU and Grievance submissions have supported ongoing work. These have included some of the following:

- Car parking system at the Harplands site revised and additional communications published.
- Further recognition of long service event held and process amended based on suggestions received
- Team development sessions held for Access and Home Treatment and CYP Team
- Clarification of the Dear Caroline process and timely publication of responses
- Amendment of the Establishment Control Process
- Commissioning of a number of investigations
- Development of Values and Behaviours Framework
- Developments linked to the Trusts Digital approach
- Review of staffing in identified areas where raising concerns were raised
- Enhanced OD/Counselling support offered to teams raising concerns
- Changes made to Lorenzo processes/service developments
- Streamlining of recruitment and selection/Trac process and additional training sessions provided
- Developments to the REACH Awards ceremony and process
- Development of policies such as the Dress Code Policy.
- Development of the LMS
- A refresh of the FTSU approach including the Trust Board undertaking a self-assessment at a recent Board Development session and supporting action plan which is in development; dedicated pages on the Trust's intranet; the introduction of 10 FTSU Champions across the organization; commissioning of regional FTSU training for the champions and also the development of a FTSU protocol which is currently in consultation.
- Feedback from the being open submissions led to changes being made as part of the Locality Restructure and consultation.

In general terms, the themes received to date are broadly consistent with other sources of information such as the Staff Survey and action plans and initiatives have been launched to address the issues. Examples include commissioning of further cohorts of the People Management Programme.

Detailed Staff Survey analysis has been undertaken and a separate full report given and supporting action plan developed which will continue to be monitored and reviewed at the Trust's People

Culture and Development Committee along with the quarterly Friends and Family pulse check survey results.

5. Conclusion

In conclusion, the Dear Caroline initiative continues to be used by our staff as an effective mechanism and means for staff to raise issues/concerns regarding the quality and effectiveness of our services, with 87 submissions received from April 2018 – March 2019. It continues to provide a mechanism for staff to raise concerns anonymously if they prefer. Whilst the majority of submissions, 86% have been submitted anonymously, some staff are choosing to leave their contact details which is encouraging.

Furthermore, it continues to provide an additional direct source of information, enabling the Executive Team to be connected to current frontline issues and concerns from a staff perspective and provides a useful pointer for further review and/or action. From April 2019 the Dear Caroline process will be renamed and branded to Dear Peter and continue as a means of raising concerns. A high level summary of each submission continues to be published on CAT, along with each of the Dear Peter submissions – published in a 'you said, we did' format.

Although the FTSU Guardian role and initiative is relatively new in comparison, it is encouraging that staff are accessing the Guardian to raise issues or concerns across the majority of Directorates. Further developments are expected with regards to this role as directed by the National FTSU Guardia, the CQC and our recently appointed FTSU Guardian.

Both the Raising Concerns process and Grievance and Disputes procedure continue to be used on an adhoc basis by staff to raise serious matters and concerns.

In order to support the abovementioned mechanisms, trust wide communications will continue to be undertaken on a regular basis to raise awareness and reinforce the importance of each of the mechanisms.

Each of the submissions and actions are regularly reviewed and progress is also monitored to provide assurance that concerns and appropriate actions are being undertaken in a timely manner.

The Being Open report will continue to report on a quarterly basis. With a view to sharing submissions in one comprehensive report and adopting a transparent and open approach to all concerns and themes raised.

6. 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 further development and embedding of the Trust Values and supporting Behaviours Framework
- Continuation of the Freedom to Speak Up Guardian role including further embedding of the approach and development of a range of Freedom to Speak Up Champions to further support the FTSU Guardians role.

7. Recommendations

It is recommended that the Trust Board

- Receive the report for assurance
- Support the proposed next steps
- Receive an update report quarterly

Appendix One

Synopsis of Being Open Mechanisms

- **Dear Caroline (DC)**
  The Dear Caroline website (www.dearcaroline.org.uk) was launched within the Trust in February 2015 in order to provide staff with an additional mechanism to raise concerns in an anonymous way. All Dear Caroline's are received by the Trust's Chief Executive and shared with the Executive Team. The Clinical Directorates/ Heads of Directorates are also advised of any Dear Caroline's which concern their respective Directorates. Summary analysis of the submissions is undertaken on a regular basis and presented at Trust Board.

- **The Freedom to Speak Up Guardian (FTSU)**
  Following Francis's recommendations the NHS contract 2016/2017 specified that NHS Trusts should have nominated a Freedom to Speak Up Guardian (FSUG) by 1 October 2016. This position is currently held by Zoe Grant. The purpose of the FSUG is to work alongside the leadership team to support a more open and transparent place to work, where all colleagues are actively encouraged and enabled to speak up safely. The Freedom To Speak Up Guardian has adopted the recommended national recording system and core activity themes.

- **The Raising Concerns Policy**
  This policy (formerly the Whistleblowing Policy) is used when someone who works for the Trust raises a concern about a possible fraud, crime, malpractice, danger or other serious risk that could threaten clients/patients, colleagues, the public or the organisation's reputation. The Raising Concerns process is used when an individual has a concern about a danger or illegality that has a public interest aspect to it.

  Our workforce is supported and empowered to raise issues and concerns early and will always be involved in helping to resolve them. Our staff are our best early warning system and they are integral in ensuring that problems are identified and addressed early, before they have a chance to escalate into something potentially very serious.

  This procedure has been developed to support members of staff to bring genuine concerns to the attention of appropriate people within the Trust, who can then take the relevant action. This includes bringing the matter to the immediate attention of a suitable person outside the normal line of management. No member of staff will be penalised for disclosing genuine concerns about any form of malpractice. Individuals raising concerns under this *procedure have legislative protection from such victimisation, as set out in Public Interest Disclosure Act 1998.* A database of concerns raised under this procedure is maintained by Associate Director of Governance and is reported to the Quality Committee for monitoring.

- **Resolution of Grievance and Dispute procedure**
  A grievance may arise when a member of staff or group of staff wishes to resolve a complaint about their working arrangements, which may include:

  - Duties
  - Conditions of Employment
  - Working Conditions

- Working Procedures
- Working Practices

It is clearly in the interests of the Trust and its managers to resolve problems before they develop into major difficulties/disputes. This procedure provides an appropriate mechanism for those individual employees or group of employees to resolve their complaint, which they may have been unable to resolve through informal means.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 16

Date of Meeting:	23RD MAY 2019		
Title of Report:	Finance Position M12		
Presented by:	Lorraine Hooper – Executive Director of Finance, Performance and Estates		
Author:	Mike Newton – Deputy Director of Finance		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance and Estates	Approved by Exec	☒

Executive Summary:	Purpose of report	
The Report summarises the financial position as at March 2019.	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☒

Seen at:	SLT X Execs ☐ Date: 14TH May 2019	Document Version No.	

Committee Approval / Review

- Quality Committee ☐
- Finance & Performance Committee X
- Audit Committee ☐
- People, Culture & Development Committee ☒
- Charitable Funds Committee ☐
- Business Development Committee ☐
- Primary Care Committee ☐

Strategic Objectives
(please indicate)

1. To enhance service user and carer collaboration. ☐
2. To provide the highest quality, safe and effective services ☐
3. Inspire and implement innovation and research. ☐
4. Embed an open and learning culture that enables continual improvement. ☐
5. Attract, develop and retain the best people. ☐
6. Maximise and use our resources effectively. X
7. Take a lead role in partnership working and integration. ☐

Risk / legal implications: Risk Register Reference	Ref 1035 – references trust top 3 risk around delivery of cost improvement
Resource Implications: Funding Source:	The trust financial position is monitored on a monthly basis as part of the organisational financial control framework. Deviations to plan are monitored and managed to ensure delivery of trust control total.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report;
STP Alignment / Implications:	Part of the aggregate STP reported financial position
Recommendations:	The Trust Board is asked to Note: • The reported 2018/19 surplus of £3,576k against a planned surplus of £2,023k. This is a favourable variance to plan of £1,553k

	• The 2018/19 CIP achievement:
	  o Achievement of £2,699k; an adverse variance of £96k to plan;
	  o The reported recurrent value of schemes transacted at £1,813k, 65% of target. This includes £451k which will be transacted during 2019/20 due to a timing difference.
	• The cash position of the Trust as at 31st March 2019 with a balance of £9,132k; £1,793k better than plan;
	• Total agency expenditure of £1,987k in line with the agency cap.
	• 2018/19 capital expenditure at £1,618k compared to planned capital expenditure of £2,185k;
	• Use of resource rating of 1 against a plan of 1.
	
	Approve:
	• The month 12 position reported to NHSI.
	• M12 expenditure on Agency of £1,987k against a ceiling of £1,987k; breakeven against the agency ceiling;
	• M12 Use of Resources Rating of 1;
	• Price cap breaches for Medics and off-framework use at M12.
	
	Approve:
	• M12 expenditure on Agency of £1,987k reported to NHSI;

Version	Name/group	Date issued

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Financial Overview as at 31st March 2019

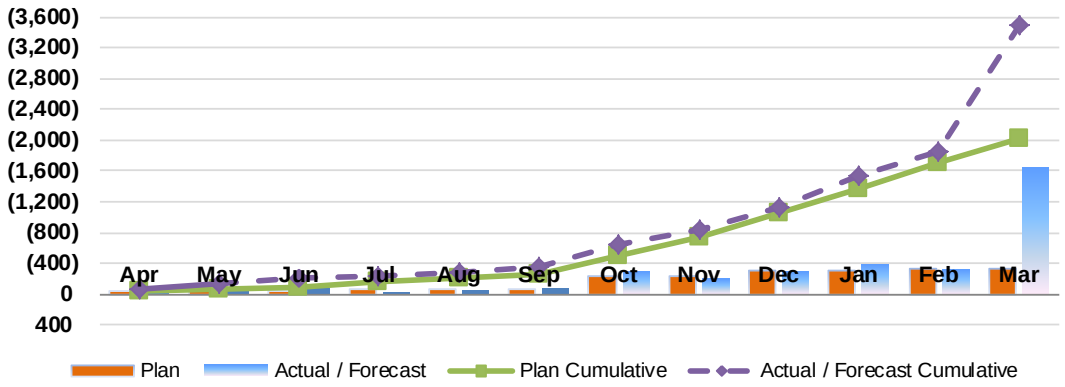
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(2,023)	(3,576)	(1,553)	(77)	G

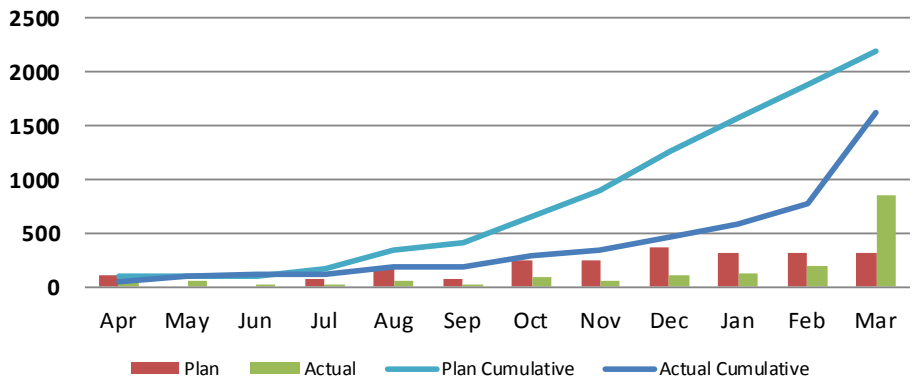
Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	2,185	1,618	(567)	(26)	R

Retained (Surplus) / Deficit Run Rate 2018/19



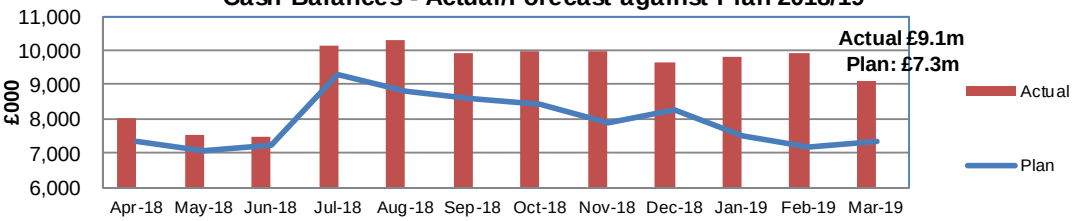
Net Capital Expenditure - Plan / Forecast 2018/19



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	7,339	9,132	1,793	24	G

Cash Balances - Actual/Forecast against Plan 2018/19



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	2,214	2,371	157	7	(931)	R
Corporate	581	328	(253)	(44)	(51)	R
Total	2,795	2,699	(96)	(3)	(982)	R

Use of Resource	Plan	Actual
Overall Risk Rating	**1**	**1**
Liquidity Ratio	1	1
Capital Servicing Capacity	3	1
I& E Margin	1	1
I&E Margin Variance to Plan	1	1
Agency Spend	1	1

Introduction:

The Trust's original 2018/19 financial plan was to deliver a trading position of £0.720m surplus. The trust accepted the Control Total from NHS Improvement (NHSI) of £1.423m surplus which included £0.703m from the Provider Sustainability Funding (PSF).

2018/19 Agreed Improvement to Control

NSCHT Trust Board agreed at month 7 to improve the 2018/19 forecast outturn position by £0.2m, increasing the trading surplus for 2018/19 to £0.920m. This allowed the trust to attract an additional £0.4m PSF, to deliver an overall control surplus of £2.023m.

- Trusts that agreed to improve beyond the control surplus attracted a pound for pound additional incentive payment.
- Trusts that overachieved against control also receive a share of any remaining national PSF funding at the end of the financial year. In 2018/19 NSCHT received £1,521k of the PSF Incentive Scheme, comprising of:
    - £32k £ for £ surplus improvement
    - £64k Agenda for Change cost pressure funding
    - £949k General Distribution
    - £476k Bonus PSF funding

	2018/19 Plan Control £'000	Agreed Forecast Improvement £'000	2018/19 Forecast Outturn £'000	Further Surplus Improvement £'000	AfC Cost Pressure Fuding £'000	General Distribution PSF Funding £'000	Bonus PSF Funding £'000	2018/19 Outturn £'000
Trading Surplus	(720)	(200)	(920)	(32)				(952)
Provider Sustainabillity Funding	(703)	(400)	(1,103)	(32)	(64)	(949)	(476)	(2,624)
(Surplus)/Deficit	**(1,423)**	**(600)**	**(2,023)**	**(64)**	**(64)**	**(949)**	**(476)**	**(3,576)**

1. Income & Expenditure (I&E) Performance

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

- During month 12, the trust had an in month trading position of £1k deficit against a plan of £195k surplus; **giving an adverse variance of £196k**. After Provider Sustainability Funding (PSF) at £1,649k for month 12 including the bonus share, and losses arising from transfers by absorption, the Trust has a surplus for the year of £953k; **giving a favourable variance of £630k**.

- £695k relating to losses arising from transfers by Absorption is the transfer of the Staffordshire County Council Section 75 Pensions (LGPS) to the Local Authority during the year. Through discussions with External Audit and guidance in the DHSC Group Accounting Manual 2018-19 this transfer is required to be shown as a technical accounting adjustment in arriving at the Surplus/Deficit for the year as reported in the Trust's draft accounts. There is no cash impact and no deficit to the Trust.

- To arrive at the final performance against control total, the surplus is adjusted for the losses arising from transfers by Absorption £695k, Net impairment of £93k and the non-cash element of LGPS Pension (£16k) to give the Adjusted Financial Performance for 2018/19 of £3,576k, **a favourable variance of £1,553k to the control total.**

		Month 12			Final Outturn		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(87,142)	(8,085)	(7,849)	235	(87,142)	(86,489)	653
Pay	62,661	4,327	5,826	1,500	62,661	61,818	(843)
Non Pay	20,797	3,329	1,767	(1,562)	20,797	21,028	231
EBITDA	**(3,684)**	**(429)**	**(256)**	**173**	**(3,684)**	**(3,644)**	**41**
Other Non-Op Costs	2,764	234	257	23	2,764	2,769	5
Trading Surplus	**(920)**	**(195)**	**1**	**196**	**(920)**	**(875)**	**45**
Provider Sustainability Funding	(1,103)	(128)	(1,649)	(1,521)	(1,103)	(2,624)	(1,521)
(Surplus)/Deficit for the year	**(2,023)**	**(323)**	**(1,648)**	**(1,325)**	**(2,023)**	**(3,499)**	**(1,476)**
(Gains)/losses arising from transfer by Absorption	0	0	695	695	0	695	695
(Surplus)/Deficit for the year for Continuing Operations	**(2,023)**	**(323)**	**(953)**	**(630)**	**(2,023)**	**(2,804)**	**(781)**
Add Back for Control Total Purposes							
(Gains)/losses arising from transfer by Absorption	0	0	(695)	(695)	0	(695)	(695)
Impairments	0	0	(93)	(93)	0	(93)	(93)
Non Cash element of on-SOFP pension costs	0	0	16	16	0	16	16
Adjusted Financial Performance (Control)	**(2,023)**	**(323)**	**(1,725)**	**(1,402)**	**(2,023)**	**(3,576)**	**(1,553)**

2. 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. Variance to plan to date relates to 2017/18 quarter 4 under performance of CQUIN (which was confirmed in June 2018) under performance in quarter 1 for CQUIN and anticipated under performance in quarter 4 for CQUIN for 2018/19.

- Specialised Services under performed by £463k due to a reduction in activity at the Darwin Centre as a result of lower length of stay for service users.

- OATs income over performed during the year by £50k due to out of area patients in A&T.

		Month 12			Final Outturn		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(37,935)	(3,314)	(3,246)	68	(37,935)	(37,859)	77
NHS North Staffordshire CCG	(25,691)	(2,245)	(2,200)	45	(25,691)	(25,640)	51
Specialised Services	(3,260)	(275)	(209)	66	(3,260)	(2,797)	463
Stoke-on-Trent CC s75	(3,999)	(333)	(333)	(0)	(3,999)	(3,999)	(0)
Staffordshire CC s75	(527)	(0)	0	0	(527)	(528)	(1)
Stoke-on-Trent Public Health	(2,108)	(333)	(333)	(0)	(2,108)	(1,994)	114
Staffordshire Public Health	(613)	(51)	(51)	0	(613)	(613)	0
ADS/One Recovery	(1,461)	(122)	(122)	0	(1,461)	(1,461)	0
Associates	(735)	(124)	(138)	(13)	(735)	(742)	(7)
OATS	(1,042)	(191)	(152)	39	(1,042)	(1,092)	(50)
Department of Health	(840)	(70)	(70)	0	(840)	(840)	0
Private Patients	0	0	(4)	(4)	0	(15)	(15)
Total Clinical Income	**(78,212)**	**(7,058)**	**(6,858)**	**200**	**(78,212)**	**(77,579)**	**633**
Other Income	(8,930)	(1,027)	(991)	36	(8,930)	(8,910)	20
Total Income	**(87,142)**	**(8,085)**	**(7,849)**	**235**	**(87,142)**	**(86,489)**	**653**
Provider Sustainability Funding	(1,103)	(128)	(1,649)	(1,521)	(1,103)	(2,624)	(1,521)
Total Income Incl. PSF	**(88,245)**	**(8,213)**	**(9,498)**	**(1,286)**	**(88,245)**	**(89,113)**	**(868)**

3. Expenditure

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

- Underspend of £843k on pay is due to vacancies across the trust, partially covered by temporary staffing.
  - Agency costs at £1,987k are **in line with the agency ceiling of £1,987k.**
- Non-Pay over spend of 231k mainly due to residential payments, premises costs and consultancy.
- Unwinding of discount rate £5k relates to the provisions of dilapidations and injury benefits.
- Over recovery of income of £58k on investment revenue is mainly due to the Trust holding a higher bank balance than in previous years and so receiving higher bank interest.

		Month 12			Final Outturn		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	7,549	504	791	287	7,549	6,876	(673)
Nursing	29,808	2,014	2,734	719	29,808	29,213	(595)
Other Clinical	14,269	814	1,084	270	14,269	12,862	(1,407)
Non-Clinical	10,815	971	958	(12)	10,815	10,657	(159)
Apprenticeship Lewy	214	18	19	1	214	223	9
Agency	6	6	240	234	6	1,987	1,981
Total Pay	**62,661**	**4,327**	**5,826**	**1,500**	**62,661**	**61,818**	**(843)**
Drugs & Clinical Supplies	2,443	264	318	55	2,443	2,701	258
Establishment Costs	1,694	145	238	93	1,694	1,550	(144)
Information Technology	973	316	257	(58)	973	974	0
Premises Costs	2,311	209	329	120	2,311	2,795	484
Private Finance Initiative	4,349	365	360	(5)	4,349	4,311	(37)
Services Received	3,903	458	585	126	3,903	4,169	266
Residential Payments	1,760	147	(287)	(434)	1,760	2,102	342
Consultancy & Prof Fees	153	(6)	55	61	153	459	306
External Audit Fees	65	5	5	(0)	65	62	(3)
Legal Fees	0	0	0	0	0	0	0
Unacheived CIP	(97)	1,095	0	(1,095)	(97)	0	97
Other	3,243	333	(93)	(426)	3,243	1,905	(1,338)
Total Non-Pay	**20,797**	**3,329**	**1,767**	**(1,562)**	**20,797**	**21,028**	**231**
Finance Costs	1,239	103	103	0	1,239	1,239	0
Local Government Pension Scheme	0	0	0	0	0	0	0
Unwinding of Discount Rate	0	0	(5)	(5)	0	(5)	(5)
Change in Discount Rate	0	0	(9)	(9)	0	(9)	(9)
Dividends Payable on PDC	592	53	0	(53)	592	553	(39)
Investment Revenue	(14)	(1)	(22)	(20)	(14)	(72)	(58)
Fixed Asset Impairment	0	0	93	93	0	93	93
Depreciation (excludes IFRIC 12)	947	79	97	18	947	971	24
Total Non-op. Costs	**2,764**	**234**	**257**	**23**	**2,764**	**2,769**	**5**
Total Expenditure	**86,222**	**7,890**	**7,850**	**(40)**	**86,222**	**85,614**	**(608)**

Agency Breakdown		
Agency Type	**Outturn (£000)**	**%**
Medical	1,420	71%
Nursing	39	2%
Other Clinical	422	21%
Non Clinical	107	5%
Total	**1,987**	**100%**

4. Directorate Summary

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

	Pay			Non Pay			Income			Total		
Table 4: YTD Expenditure	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Acute Services & Urgent Care	13,730	14,050	319	1,028	708	(320)	(462)	(418)	44	14,297	14,340	43
North Staffordshire Community	9,011	8,565	(446)	1,021	1,153	131	(1,776)	(1,809)	(33)	8,256	7,908	(348)
Specialist Care	15,871	15,257	(614)	2,451	2,684	233	(2,334)	(2,191)	142	15,989	15,750	(239)
Stoke Community	12,083	11,443	(641)	3,764	4,161	397	(942)	(978)	(37)	14,905	14,625	(281)
Moorcroft Medical Practice	592	656	65	223	92	(131)	(814)	(674)	140	0	74	74
Corporate	11,373	11,847	474	15,074	15,000	(75)	(81,918)	(83,042)	(1,124)	(55,470)	(56,195)	(725)
Trustwide	0	0	0	0	0	0	0	0	0	0	0	0
Total	**62,661**	**61,818**	**(843)**	**23,561**	**23,797**	**235**	**(88,245)**	**(89,113)**	**(868)**	**(2,023)**	**(3,499)**	**(1,476)**

- The clinical directorates are underspent on pay due to vacancies partially offset with bank and agency.
- Adverse variances on non-pay are due to overspends on residential payments (Stoke-on- Trent section 75).
- The residential placement budgets over spent £342k. The Trust and Stoke-on-Trent City Council are working closely to design a sustainable service model for 2019/20, and risk share arrangement which will be factored into the new contract.

5. Cost Improvement Programme

The Trust target for the year is £2,795k, as reported to NHSI. This takes into account the requirement to deliver a £2,023k control surplus for 2018/19. The table below shows the achievement by Directorate for the year. At M12, the trust is reporting achievement of £2,699k against a plan of £2,795k, resulting in an under achievement of £96k. Of CIP delivered, 42% is recurrent.

		YTD M12			Forecast		
CIP Delivery	Annual CIP Target 2018/19	Plan	Transacted	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Position
	£'000	£'000	£'000	£'000		£'000	£'000
Clinical							
Acute Services & Urgent Care	538	538	859	322	160%	442	442
North Staffordshire Community	458	458	379	(78)	83%	127	127
Specialist Care	533	533	609	76	114%	266	266
Stoke Community	685	685	523	(162)	76%	188	188
Total Clinical	**2,214**	**2,214**	**2,371**	**157**	**107%**	**1,023**	**1,023**
Corporate							
CEO	15	15	15	0	100%	15	15
Finance, Performance & Digital	43	43	60	17	140%	60	60
MACE	9	9	14	4	144%	14	14
Operations	6	6	6	0	100%	6	6
Quality & Nursing	41	41	30	(10)	74%	42	42
Strategy	11	11	11	0	100%	11	11
Trustwide	384	384	133	(251)	35%	133	133
Workforce & OD	72	72	60	(13)	82%	60	60
Total Corporate	**581**	**581**	**328**	**(253)**	**57%**	**340**	**340**
Total	**2,795**	**2,795**	**2,699**	**(96)**	**97%**	**1,363**	**1,363**

	Target	**2,795**
	Variance	**(1,432)**

- The year-end position for 2018/19 is £2,699k (97%), which represents an in year shortfall against the annual target of £96k.
- Recurrent transacted CIP are £1,363k (49%), a shortfall of £1,432k. £451k of schemes were included in the M11 forecast but will not be transacted until 2019/20 due to a timing difference (section 3.1). After adjusting, the recurrent value of 18/19 CIP programme is £1.813m and £981k short of plan.

3.1 Cost Improvement Programme Transacted 2018/19

The table below articulates the schemes to be transacted in 2019/20 compared to what was originally forecast. The shortfall in recurrent CIP in 2018/19 is simply a timing difference and will be transacted in 2019/20.

Recurrent Schemes (2018/19 Impact)	2018/19 Forecast (£000)	To be transacted in 2019/20 (£000)	Variance (£000)	Deliverability RAG
Recurrently Transacted at M12	1,363	1,363		
Schemes to be transacted (timing difference)				
Lymbrook	23	23	0	OK
OOA Gainshare	163	238	-75	Awaiting signed contract
Community Redesign	75	0	75	Removed
Restructure	163	163	0	OK
Printer Procurement	27	27	0	OK
Total Recurrent Forecast	**1,814**	**1,814**	**0**	
CIP Target	2,795	2,795		
2019/20 Actual (Surplus) / Shortfall	**982**	**981**		

6. Statement of Financial Position

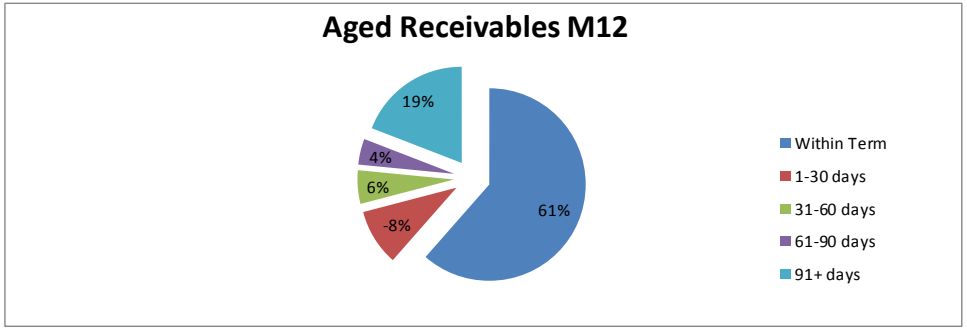
Table 6 below shows the Statement Financial Position of the Trust.

Table 6: SOFP	31/03/2018 £'000	31/01/2019 £'000	28/02/2019 £'000	31/03/2019 £'000
Non-Current Assets				
Property, Plant and Equipment - PFI	16,185	16,203	16,177	16,736
Property, Plant and Equipment	14,841	14,633	14,775	15,142
Intangible Assets	277	256	250	255
NCA Trade and Other Receivables	608	0	0	0
Other Financial Assets	1,089	1,089	1,089	321
Total Non-Current Assets	**33,000**	**32,181**	**32,291**	**32,454**
Current Assets				
Inventories	79	71	105	89
Trade and Other Receivables	7,347	7,136	7,287	8,787
Cash and Cash Equivalents	6,633	9,801	9,912	9,132
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**14,058**	**17,007**	**17,304**	**18,008**
Current Liabilities				
Trade and Other Payables	(7,166)	(8,388)	(8,407)	(8,294)
Provisions	(621)	(482)	(602)	(386)
Borrowings	(633)	(635)	(635)	(635)
Total Current Liabilities	**(8,420)**	**(9,504)**	**(9,644)**	**(9,316)**
Net Current Assets / (Liabilities)	**5,639**	**7,503**	**7,660**	**8,693**
Total Assets less Current Liabilities	**38,639**	**39,684**	**39,951**	**41,146**
Non Current Liabilities				
Provisions	(458)	(458)	(458)	(555)
Borrowings	(11,557)	(11,027)	(10,974)	(10,921)
Total Non-Current Liabilities	**(12,015)**	**(11,485)**	**(11,432)**	**(11,476)**
Total Assets Employed	**26,624**	**28,200**	**28,520**	**29,670**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,775	7,775	7,787
Retained Earnings reserve	7,943	9,392	9,712	11,440
Other Reserves (LGPS)	1,089	1,089	1,089	321
Revaluation Reserve	9,944	9,944	9,944	10,122
Total Taxpayers' Equity	**26,624**	**28,200**	**28,520**	**29,670**

Current receivables are £8,787k, of which:

- £4,969k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter.
- £3,818k is trade receivables; based on invoices raised and awaiting payment of invoice. (£2,895k within terms).
- Invoices overdue by more than 31 days are 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	823	(22)	103	70	298	1,272
Receivables NHS	2,072	(424)	161	134	603	2,546
Payables Non NHS	1,111	11	0	0	5	1,127
Payables NHS	273	112	109	95	8	597



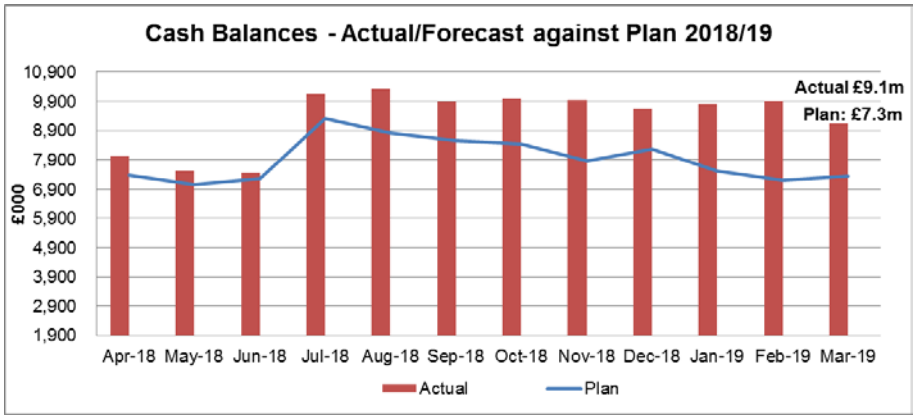
7. Cash Flow Statement

The Trust cash position at 31st March 2019 is £9,132k, **£1.793m higher than planned.** This is as a result of additional surplus and PSF agreed at M7 as well as slippage on the Capital Programme.

The 2018/19 PSF bonus of £1.521m is not included in the 2019/20 planned cash flow submitted to NHSI on 4th April as the trust was not notified prior to submission. This will therefore improve the trusts cash flow forecast compared to the current plan.

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	928	(281)	159	2,909	408	(177)	392	206	(73)	468	491	190	**5,619**
Net Inflows/(Outflow) from Investing Activities	676	(60)	(8)	(6)	(54)	(6)	(87)	(54)	(105)	(118)	(185)	(825)	**(834)**
Net Inflows/(Outflow) from Financing Activities	(193)	(193)	(203)	(203)	(203)	(230)	(204)	(199)	(111)	(209)	(195)	(145)	**(2,286)**
Net Increase/(Decrease)	**1,411**	**(533)**	**(52)**	**2,701**	**150**	**(413)**	**101**	**(47)**	**(289)**	**141**	**111**	**(780)**	**2,498**
Opening Cash & Cash Equivalents	**6,633**	**8,044**	**7,511**	**7,459**	**10,160**	**10,310**	**9,897**	**9,998**	**9,950**	**9,661**	**9,801**	**9,912**	**6,633**
Closing Cash & Cash Equivalents	**8,044**	**7,511**	**7,459**	**10,160**	**10,310**	**9,897**	**9,998**	**9,950**	**9,661**	**9,801**	**9,912**	**9,132**	**9,132**
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	**(678)**	**(456)**	**(204)**	**(853)**	**(1,485)**	**(1,329)**	**(1,553)**	**(2,077)**	**(1,398)**	**(2,278)**	**(2,708)**	**(1,793)**	**(1,793)**



8. 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		
Capital Expenditure	**Annual Plan £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Learning Disability Facilities	400	100	0	(100)
Mental Health Crisis Care Centre	1,000	827	329	(498)
Information Technology Replacement Programme	108	108	118	10
Backlog Maintenance	150	150	301	151
Reduced Ligature Risks	250	250	245	(5)
Equipment Replacement Programme	50	50	83	33
Psychiatric Intensive Care Unit	0	100	131	31
Darwin	0	0	(1)	(1)
Generator	0	0	33	33
Garden Redesign CYP Short Breaks	0	0	47	47
Pharmacy Temperature Monitoring System	0	0	37	37
ICT	0	0	108	108
Dragon Square CCTV	0	0	8	8
Lymebrook Lifts	0	0	12	12
A&T Swipe Access	0	0	9	9
Ward 5 Lobby	0	0	15	15
Contingency	100	473	0	(473)
Sub Total Gross Capital Expenditure	**2,058**	**2,058**	**1,477**	**(581)**
Wifi	127	127	129	2
Pharmacy Infrastructure Investment		12	12	0
Total Gross Capital Expenditure	**2,185**	**2,197**	**1,618**	**(579)**

- It was agreed by the Business Development Committee and Trust Board to support the re-phasing of the MH Crisis Care Centre Project. This results in planned expenditure in 2018/19 reducing by £500k, revising the Capital expenditure forecast to £1,685k. The explains the majority of the underutilisation in year.

- Actual Capital Expenditure at month 12 is £1,618k, against the revised forecast of £1,685k, **£67k lower than forecast.**

9. Use of Resource Metrics

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

Table 9: Use of Resource	Year to Date Plan	Year to Date Actual	RAG Rating
Liquidity Ratio (days)			
Working Capital Balance (£000)		8,604	
Annual Operating Expenses (£000)		82,845	
Liquidity Ratio days		38	
Liquidity Ratio Metric	1	1	
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		6,261	
Annual Debt Service (£000)		2,424	
Capital Servicing Capacity (times)		2.58	
Capital Servicing Capacity Metric	3	1	
I&E Margin			
Normalised Surplus/(Deficit) (£000)		3,576	
Total Income (£000)		89,113	
I&E Margin		4.0%	
I&E Margin Rating	1	1	
I&E Margin Variance from Plan			
I&E Margin Variance		1.6%	
I&E Margin Variance From Plan	1	1	
Agency Spend			
Providers Cap (£000)		1,987	
Agency Spend (£000)		1,987	
Agency %		(0%)	
Agency Spend Metric	1	1	
Use of Resource	1	1	

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

10. Better Payment Practice Code

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

During month 12, the Trust has achieved the 95% target in terms of the total number of invoices paid, and has over-achieved against the 95% target for the total value of invoices paid. Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

The overall results for the year show an under-achievement on total number of invoices paid at 91% and an over-achievement on value of invoices paid at 96%.

	2017/18			2018/19 Month 12			2018/19 Total		
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	61	1,042	1,103	625	10,935	11,560
Total Paid within Target	575	9,527	10,102	61	990	1,051	581	9,914	10,495
% Number of Invoices Paid	87%	87%	87%	100%	95%	95%	93%	91%	91%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-8%**	**-8%**	**-8%**	**5%**	**0%**	**0%**	**-2%**	**-4%**	**-4%**
Value of Invoices									
Total Value Paid (£000s)	7,164	33,211	40,375	530	4,267	4,797	6,449	35,113	41,562
Total Value Paid within Target (£000s)	6,258	31,653	37,911	530	4,103	4,633	6,100	33,819	39,919
% Value of Invoices Paid	87%	95%	94%	100%	96%	97%	95%	96%	96%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-8%**	**0%**	**-1%**	**5%**	**1%**	**2%**	**0%**	**1%**	**1%**

11. Recommendations

The Trust Board are asked to:

Note:

- The reported 2018/19 adjusted retained surplus of £3,576k against a planned surplus of £2,023k. **This is a favourable variance to plan of £1,553k, driven primarily by the bonus PSF funding.**

- The M12 CIP achievement:
  - Achievement of £2,699k; **an adverse variance of £96k to plan**
  - The reported recurrent value of schemes transacted at £1,813k, **65% of target**. This includes £451k of schemes which will be transacted in 2019/20 due to a timing difference.

- The cash position of the Trust as at 31st March 2019 with a **balance of £9,132k**; £1,793k better than plan.

- Total Agency expenditure of £1,987k in line with the agency cap of £1,987k.

- Capital expenditure at £1,618k compared to planned capital expenditure of £2,197k and a revised forecast of £1,685k;

- Use of resource rating of **1** against a plan of 1.

Approve:

- The month 12 position reported to NHSI.

NHS
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REPORT TO OPEN TRUST BOARD

Enclosure No: 17

Date of Meeting:	23RD May 2019		
Title of Report:	Finance, Performance and Estates Committee Assurance Report		
Presented by:	Tony Gadsby Chair/Non-Executive Director		
Author:	Mike Newton – Deputy Director of Finance		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance and Estates	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper details the items discussed at the Finance, Performance and Estates Committee meeting on the 10th May 2019. The meeting was quorate with minutes approved from the previous meeting on the 11th April 2019. Progress was reviewed and actions confirmed from previous meetings.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services X 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. X 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Oversees the risk relevant to the Finance, Performance and Estates 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). See wider D&I Guidance	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
STP Alignment / Implications:	The Trust Financial performance feed into the overall STP Financial Position.		

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.	
Version	Name/group	Date issued

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board
23rd May 2019

Finance, Performance and Estates Committee Report to the Trust Board – 23rd May 2019.

This paper details the items discussed at the Finance, Performance and Estates Committee meeting on the 10th May 2019. The meeting was quorate with minutes approved from the previous meeting on the 11th April 2019. Progress was reviewed and actions confirmed from previous meetings.

Executive Director of Finance, Performance and Estates Update

The following updates were given by the Director of Finance, Performance and Estates;

- **Update on the 2019/20 Contract Discussions –** Following the agreement at Trust Board on 25th April, the trust outlined in writing to the CCG a clear final negotiated position, indicating that formal dispute resolution would be required if a resolution cannot be reached. Following this correspondence and meetings between organisational board members, the CCG have agreed to underwrite the £2.6m.

- **Engagement, Values and Outcome Framework Pilot –** The Trust has been selected as one of four pilot sites, to trial a new value framework, designed to support trusts to drive efficiencies using internal Patient Level Information Costing Systems (PLICS.) This is expected to feed into the trust cost improvement plan for 2019/20.

- **Changes to the Performance Management Framework** – The Trust is preparing to launch a new performance management framework, which moves towards monitoring performance using Statistical Process Control (SPC.) Training will be provided and the framework will feature as part of the Trust Board Development session in May 2019.

- **Other Updates –** The Director of Finance also updated on Finance, Performance and Estates Objectives for 2019/20 and the merger of NHS Improvement with NHS England, which has entered more formal working arrangements from 1st April 2019. There are currently no changes to reporting requirements or arrangements.

Finance

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for 2019/20. The final outturn position was £96k behind plan, which includes non-recurrent CIP. The recurrent value of transacted schemes as at 31st March 2019 was £1.363m, which excludes £451k of schemes that will be transacted in 2019/20 due to a timing difference. After adjusting for the 2018/19 schemes transacted in 2019/20, the final 2018/19 recurrent CIP position will be a £981k shortfall.

The committee received an update around the approach to cost improvement for 2019/20 and the progress to date against the £2.5m target. The trust has identified £1.75m (70%) for 2019/20 and £1.65m (66%) recurrently. The Director of Finance and Director of Operations outlined the actions to close the gap, to be supported by a Trust PMO. The trust also plans to develop a multiyear programme, to deliver £5m recurrently by 2020/21.

The Committee were assured that there was sufficient focus being placed on Cost Improvement, they were not assured around delivery of 2019/20 programme. The committee also requested a phasing profile to be presented at the next committee for identified schemes.

- **Agency Report**

The committee received an update on the expenditure on agency for 2019/20, which was utilised within the ceiling. The committee noted the increase in Agency run rate over the last 3 months, which is being primarily driven by Primary Care, following the integration in December 2018.

The committee outlined a need for further application of Trust Agency controls in primary care that are consistent with those exercised in other areas of the trust. The committee also noted that at the current level of expenditure, the Trust would breach the Agency ceiling in Month 1.

Activity and Performance

- **Measuring for Improvement – Performance Report**

The committee received a draft performance report, presented using the new performance framework. The committee were supportive of the approach but highlighted a need for training to ensure staff at all levels could interpret Statistical Process Control (SPC) measures and understand where appropriate is appropriate.

Other:

- **Additional Assurance Reports:**

The Committee received additional assurance reports as follows:

- Finance Position M12
- PQMF M12
- Estates Update
- Activity Report M12
- Finance, Performance and Digital Risk Register
- Working Capital
- Partnerships and Contracts
- Cycle of Business 2019/20

- Finance, Performance and Estates Monitoring Schedule

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 OPEN TRUST BOARD

Enclosure No: 18

Date of Meeting:	23RD May 2019		
Title of Report:	Primary Care Committee Assurance Report		
Presented by:	Tony Gadsby, Chair, Primary Care Committee		
Author:	Chris Bird, Executive Director of Partnerships and Strategy		
Executive Lead Name:	Chris Bird, Executive Director of Partnerships and Strategy	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report is presented to the Trust Board as an Assurance Report for the Primary Care Committee held on 10 May 2019.		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 ☐ • Primary Care Committee ☒		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	1103, 1204 & 1205		
Resource Implications: Funding Source:	None directly arising from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None directly arising from this report		
STP Alignment / Implications:	None directly arising from this report		
Recommendations:	The Trust Board are invited to: i) Note the contents of this report		

Version	Name/group	Date issued

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board
Primary Care Committee
10th May 2019

Introduction

This paper details the issues discussed at the Primary Care Committee on 10th May 2019. The meeting was quorate with minutes approved, subject to minor amends, from the previous meeting on 21st March 2019. Progress was reviewed and actions confirmed from previous meeting.

Action Items

The meeting received updates against the several actions that had been carried forward from previous meetings and noted that all but three were now either completed or included on the agenda for the 10th May 2019 meeting.

Of the three remaining items, two have a future date of 20th June 2019 for completion. The residual items relates to clarity on the arrangements for clinical indemnity following publication of the new GP Contract and will be subject to a briefing note published to Committee members later this month.

Clinical Model

The meeting received an update report from the Clinical Director on a range of metrics related to the introduction of a new clinical model. In summary:

- Patients continue to experience greater access to primary care advice and treatment
- A comparison of two time periods (04.12 – 04.04) 12 months apart shows a 28% increase in appointments with a clinician – drilling down, this represents a 20% increase in GP appointments and a 41% increase in Advanced Nurse Practitioner appointments
- The practice is continuing to increase Allied Health Professional capacity responding to urgent, same-day appointments so that GPs can spend more time on complex patients who benefit from continuity of care

The Primary Care Team continue to engage with other interested parties to explore expansion opportunities and/or opportunities to promote the benefits & experience of working with the new clinical model. This has included presentations at two NHS E events to an audience of c200 GPs & Practice staff from across the pan-Staffordshire geography. It is hoped this will encourage more lines of enquiry to the Team.

The Trust Board previously ratified a decision for the Practice to join the Hanley Primary Care Network – this is made up of additional practices including Bentilee, Bucknall and Hanley. The Team are now also able to advise that North Staffordshire Combined Healthcare will be providing PCN support to the new group; this support will focus particularly on financial management and employment services.

As a verbal update to the report, the DoPS advised that a new Primary Care Task & Finish Group had been established which brought together colleagues from across a range of functions to bring a dedicated focus on a range of 'snagging issues' which require further work. The Committee agreed to receive a separate report on the progress of the T&F Group at its next meeting.

The Committee received the report

Workforce

The meeting received an update on Primary Care workforce issues:

- The DoPS has received support for a proposal to establish the Primary Care Team following the departure of the Programme Director – Integration. This will be rolled out over the next 4 – 6 weeks
- 2 GPs have agreed to use an extra session to lead quality improvement initiatives which will support QOF/QIF achievement
- 3 new Allied Health Professionals have been appointed – an Urgent Care Practitioner and two Advanced Nurse Practitioners – this will release the capacity of the Physician Associate to spend more time on working with patients who have long-term conditions
- Discussions are underway with Associate Director colleagues regarding a possible secondment of an experienced Community Psychiatric Nurse to run a pilot for a first contact mental health professional to enhance the primary care offering

The Committee received the report.

Finance

The Committee received the Month 12 Finance Report which shows an adverse position of £74k.

The main driver is an under-recovery of income forecast to outturn at £140k linked to an under-performance of QOF points referenced elsewhere in this report. The under-recovery of income was offset by an underspend on expenditure of £66k linked to staff vacancies, the subsequent cost of agency cover and premises costs which has been difficult to forecast accurately.

The Committee had an extensive discussion on the drivers of the financial position and how the key variables, notably QOF, agency spend and premises costs, might be subject to improved forecasting during the 2019/20 year. The Committee also noted that an over-spend of £74k meant that other services across the Trust would need to bear the impact and this could not tolerated as we move into the new financial year. Consequently, the Chair requested a new risk related to financial performance be added to the Committee risk register.

The Committee agreed to undertake a specific review of the forward finances to produce a "Best Case" "Forecast" and "Worst Case" for the full year with known mitigations based on the format produced for the Trust's overall position. L Hooper to take this forward as soon as is practical as it is important to ascertain the financial risk of Primary Care activity on the Trust's overall position given the £74k overspend in a quarter. It is not sufficient to note the risk is added to the register as it does not identify the action.

The Committee received the report.

Performance

The Committee received the Month 12 Performance report and considered the update on the nature of the performance metrics and performance against them. An overview of the performance report is included below:

- QOF achievement was 94% - 512 / 545 points – this represents a 3% reduction on performance in 2017/18
- QIF achievement was 76% - 62 / 81 points - this represents a 4% reduction on performance in 2017/18
- The common denominator in both areas is services relating to Diabetes which equates for 56% of the shortfall. It was agreed that a QOF Plan will be developed and a clinical lead identified at Practice level who will coordinate all Diabetes related services

- The Practice has achieved all the metrics under the Prescribing Incentive Scheme and is awaiting confirmation from the CCG of the financial position which works on a 3 month timelag.
- 3 informal complaints were received during M12 and all were resolved successfully within the target two-week time period
- Friends and Family Test outcomes continue to be very positive with 93% of 113 respondents declaring 'Extremely Likely' (82%) or 'Likely' (9%) to recommend the service
- DNA rates for nurse appointments have remained consistent with previous months at 17% whilst DNA rates for GP appointments have reduced from an average of 13% to just over 5%

The DoPS explained that he was facilitating a meeting between representatives from AQuA, CCG and Trust colleagues to identify opportunities for improving performance reporting.

The Committee received the report.

Risks

The Committee received an update on items relating to Primary Care Services on the Trust risk framework and recommended a new risk re financial performance be included. No other changes were proposed.

Strategy

The Committee agreed to generate a full Board discussion on the current policy of not actively promoting our Primary Care offering to GPs. The Chair advocated that we should review this policy in the light of the move to Integrated Care Hubs and PCNs.

Recommendation

The Trust Board is asked to:

1) Note the contents of this report

Chris Bird, Director of Partnerships & Strategy

On behalf of Tony Gadsby, Chair

14th May 2019

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REPORT TO OPEN TRUST BOARD

Enclosure No: 19

Date of Meeting:	23RD May 2019		
Title of Report:	Extraordinary Audit Committee Assurance Report		
Presented by:	Tony Gadsby Chair/Non-Executive Director		
Author:	Mike Newton – Deputy Director of Finance		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance and Estates	Approved by Exec	☒

Executive Summary:		Purpose of report	
An extraordinary Audit Committee was held on the 24th April to approve submission of the draft accounts, following delegated authority from Trust Board.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee • Audit Committee X • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services X 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. X 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Oversees the risk relevant to the Audit 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). See wider D&I Guidance	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
STP Alignment / Implications:	The Trust Financial performance feed into the overall STP Financial Position. The Digital priorities include support in delivery of STP Digital Programme; Integrated Care Record.		

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.	
Version	Name/group	Date issued

Assurance Report to the Trust Board
23rd May 2019

Extraordinary Audit Committee Report to the Trust Board – 23rd May 2019.

An extraordinary Audit Committee was held on the 24th April to approve submission of the draft accounts, following delegated authority from Trust Board.

Annual Accounts 2018/19

The draft annual accounts were presented which showed an accounting surplus of £2.804m and a control surplus of £3.576m, which includes certain items which are added back for control purposes.

The difference between control surplus and accounting surplus primarily results from de-recognition of an overall net pension asset of £0.695m from the balance sheet, following the loss of the Staffordshire S.75 contract. This is a technical adjustment and there is no cash impact to the Trust.

The Committee also were presented with a number of Key financial performance highlights for 2018/19, including a 14% reduction in Consultancy and 25% reduction in Agency expenditure compared to 2017/18.

The committee also received a full assessment of the Going Concern as part of the papers, which provided a proposal to prepare accounts on a going concern basis. The committee agreed this would need to be reviewed in light of 2019/20 contract discussions.

The Committee approved submission of the draft accounts.

Draft Governance Statement 2018/19

The committee received a first draft of the Governance statement for 2018/19 and agreed to feedback any comments outside the meeting.

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
Acting Chair of Audit Committee

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REPORT TO Open Trust Board

Enclosure No: 20

Date of Meeting:	23rd May 2019		
Title of Report:	People, Culture & Development Committee Summary		
Presented by:	Janet Dawson, Non-Executive Director		
Author:	Janet Dawson, Non-Executive Director		
Executive Lead Name:	Linda Holland, Director of Workforce, OD, Inclusion & Communications	Approved by Exec	☒

Executive Summary:	Purpose of report	
A summary of the People, Culture & Development Committee meeting held on Monday 13th May 2019 and chaired by Mrs Janet Dawson. The minutes from the meeting have been appended for clarity and detail.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date: N/A	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	*The Committee reviewed the following risks, which all have mitigating plans in place to address the concerns:* *12 There is a risk that there is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increased pressure upon existing staff.* *868 There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSI.* *900 There is a risk that the Trust does not provide inclusive service that recognises the diverse nature of our service users, therefore services may*		

	not be accessible or of sufficient quality and the Trust may not be responsive to the diversity & the inclusion needs of our local communities. *901 There is a risk that the Trust does not have an inclusive and diverse workforce as reflected in the WRES, thus impacting on our ability to support the needs of diverse communities and ability to attract and retain staff* *1072 There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that they fulfil requirements or their professional responsibilities and as a result may not feel supported in practice.* Compliance at M11 is 88%.	
Resource Implications: Funding Source:		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	The Committee plays a significant role in actions and assurance related to Diversity and Inclusion and the oversight of the Public Sector Equality Duty under the Equalities Act. This duty requires the Trust to • Eliminate unlawful discrimination • Advance equality of opportunity • Foster good relations	
STP Alignment / Implications:	N/A	
Recommendations:	The Board are asked to approve the policy extensions for ratification and receive the summary for assurance purposes.	
Version	Name/group	Date issued

People Culture and Development Committee, Summary to the Trust Board

Monday 13 May 2019, 9.30 to 12.31

Mrs Dawson chaired the meeting. The minutes of the meeting are appended to this summary.

Staff Story

Step On is a service delivered through a Centre of Excellence that works across Staffordshire to assist those living with mental illness to gain or retain work. It's been in existence for some six years and has had over 700 referrals for its services. It now covers both our Trust and MPFT working collaboratively to support people at an individual level with all aspects of job search and maintain support once people are in role if required. Step On works with other agencies to co-ordinate a range of services to support job seekers and works with employers to remove barriers to getting their clients into work. Of their referrals they have placed some 200 individuals including around 10 into the Trust and more into bank roles.

Some assistance is required with improved access to our vacancies and our target should be to become an exemplar in this area, leading by example with our own vacancies and including Step On in our employee brand offering. It was also felt that there were potential opportunities to learn from the experience of the Step On team to help our own people with anxiety and experiencing stress to manage to remain at work or return to work and this will be taken forward. Support has also been offered for their Fidelity Review in September.

The staff story element of this was provided via a video showcasing success stories from people now in work and showing the impact on their lives and confidence that this brings. The team is a great example of working with our values to produce excellent outcomes.

Strategic items

Director of Workforce update – the areas covered are set out in the minutes. Highlights not mentioned elsewhere are:

- Executive roles under recruitment with a closing date of 23 May, Nursing & Quality, Assistant CEO and Workforce, OD & Inclusion Director posts
- Recognising Staff Networks May 3rd 2019 and further work on employee networks to improve inclusion and diversity
- Progress being made on the actions plans from the staff survey

Board Assurance, workforce and OD risks – Q4 BAF showed a relatively positive position over the year with any areas still amber or red with actions plans to address. The 2019/20 BAF metrics were approved for objectives 4 (continuous learning) and 5 (attract, retain and develop talented people).

The workforce and OD risks are detailed in the minutes. In summary all remain under tight scrutiny particularly the linked risk of high vacancy levels and agency overspend.

Workforce performance

The details of the workforce metrics are contained in the minutes and Trust wide we are on track. Although the performance against the target is good, the issue remains of repeat offenders on failure to complete statutory and mandatory training and interventions are being made on an individual basis such as barring other training requests until statutory and mandatory training is completed.

Nicky Griffiths presented the metrics from Acute and Urgent Care & Specialist Services. Her comments reflected the issue we heard about at Board with resources being absorbed by a few cases where multiple staff members are required to support individuals with complex needs. While this issue is being managed at SLT level it was interesting to hear the impact at a service delivery level including reluctance of staff to take bank roles. Recruitment for Healthcare Support Workers has filled 18 of 24 vacancies but Registered Nurse vacancies remain. This is being addressed by the cross directorate nurse recruitment currently being undertaken.

Delivering our Resourcing Ambitions

The team has delivered an excellent turnaround over the last 8 weeks, and improved candidate and hiring manager experience and resourcing outcomes. A review of band 5/6 staff nurse vacancies has been undertaken, and the Trust is making all attempts to encourage recruitment into this area. Our Employee brand is also being reviewed to allow for greater optimisation of our Outstanding rating and allow us to have a greater impact in the job market. Network meetings will commence to allow us to tap into what our people think and why they work at the Trust to build into external messaging.

It was noted that flexibility is an incredibly powerful recruitment tool. However, it does require flexibility from us to deliver it to our people. Finding ways to move this forward within the Working Time Directive will take time and effort and we should look at what has been achieved elsewhere in this area. E-rostering should assist with this; however the Trust is not at that point yet. It was noted that some Trusts that have implemented flexible working arrangements have moved to three-monthly rotas.

The Committee approved a proposal to reduce time for approvals to hire from 5 weeks to 10 days for like for like recruitment within establishment, retaining appropriate governance but streamlining the process. This had already been approved by the SLT.

Being Open

The collective activity for the four employee concern feedback channels (FTSU, Dear Caroline, Raising Concerns and Grievances) for 2018 was reviewed and the Committee was assured regarding the use of these mechanisms and that trends were identified across all through the Being Open

report to aid feedback and resolution. The procurement of MOOD to manage these submissions would improve the feedback loop to people as would the appointment of further FTSU champions across the Trust. It was also noted that Mrs Dawson as chair of the PCDC would have an independent role in supporting FTSU.

Gender Pay Gap

Following our request to have further granularity on the gender pay gap, the Committee had a presentation with helpful graphical representation of the metrics underpinning the gap of 14.8% an improvement over the prior year. Despite only 22.6% of our workforce being male, there is a higher proportion of women paid at the lower quartile for their role and a higher proportion of men at upper quartile which produces the gap. This is particularly true for pay including bonuses as these bonuses relate to consultants only. Building on this work, the Committee has requested more analysis by banding to help us monitor the effectiveness of interventions to close the gap.

PEOPLE, CULTURE & DEVELOPMENT COMMITTEE
Monday 11th March 2019, 9.30 –12:31pm
BOARDROOM, TRUST HQ, TRENTHAM

BUSINESS MEETING

PRESENT:

Janet Dawson, Non-Executive Director, Chair
Patrick Sullivan, Non-Executive Director, Vice-Chair
Linda Holland, Director of Workforce, OD, Inclusion & Communications
Dr Buki Adeyemo, Medical Director (left at 10.10am)

IN ATTENDANCE:
Kerry Smith, Associate Director of Workforce
Laurie Wrench, Associate Director of Governance
Joe McCrea, Associate Director of Communications (from 9.50am)
Jenny Harvey, Staff Side Chair, Unison
Jane Rook, Associate Director of Organisational Development
Nicky Griffiths, Associate Director of Acute & Urgent Care & Specialist Services (Item 10)(Left at 11.02am)
Jasmine Sherratt, Occupational Therapist, Step On Team, Lead for South Staffs (Staff Story) (Left at 9.55am)
Jennifer Hawkins, North Staffs Step-On Lead (Staff Story) (Left at 9.55am)
Cherie Cuthbertson, Resourcing and Retention Lead, (Item 13)
Lesley Faux, Inclusion & Diversity Lead (Item 16)
Gaynor Pearce, PA – Notes

APOLOGIES:
Jonathan O'Brien, Director of Operations
Hilda Johnson & Phil Leese, SUCC/Healthwatch Representative
Zoe Grant, Freedom to Speak Up Guardian

Mrs Dawson welcomed those present to the meeting.

056/2019	STAFF STORY Mrs Hawkins, North Staffs Step-On Lead provided an overview of the Step-On IPS service that works across the county to help equip clients with the skills to move into paid employment. The team started in 2013, and has grown over the years to 12 staff members. The focus is on the individual, through providing access to job-clubs, CV building skills, and interview coaching. The team works to reduce the barriers faced by individuals returning to or remaining in work and works with local employers including ourselves to source employment for those experiencing mental health issues. The team also works very closely with the Job Centre to review benefits and other support for job seekers. The service is inspected every 3 years, with the next inspection due in September 2019, and they are a centre of excellence. The team works alongside HR to review potential Trust vacancies and has had a number of recent successes including appointment to substantive roles in the Trust. The team has had some 700 referrals with 200 successful job outcomes including ten with the Trust. The team then presented a powerful video of the work that they undertake with stories from those who have been successful and are now being engaged as peer support workers. It was noted that the introduction of TRAC had made access to vacancies more difficult which need to be resolved. Mrs Dawson felt as a Trust we should be an exemplar in this area and ensure that we add Step On to our employer brand.	

	Ms Harvey stated that she was interested to learn if there was anything that could be used or learned to help keep our own staff experiencing mental health issues in work? Actions: • Review previous BAF targets for Step On objectives. • Ensure interaction with all hard to reach groups, with assurance that we are a diverse employer. • Link with MPFT and UHNM also. • Meet with the recruitment team to review the TRAC operating system. Action: • Ms Harvey to meet with the Step-On team to review resources and potential support for staff. Mr Sullivan queried whether there was anything else that the Trust could be doing to assist the team? Other than the job alerts noted above, it was further noted that the team would receive their Fidelity Review in September and Board level representation was key for the team to carry on as a Centre of Excellence, the team asked for Board support. Mrs Wrench confirmed that she was happy to support the team. *Received*	 LW JR JH/JS JH/JS JH LW
057/2019	APOLOGIES The following apologies were noted from: Jonathan O'Brien, Director of Operations/Interim Director of Leadership and Workforce Hilda Johnson & Phil Leese, SUCC/Healthwatch Representative Zoe Grant, Freedom to Speak Up Guardian *Noted*	
058/2019	MINUTES OF PREVIOUS MEETINGS HELD ON 11th MARCH 2019 The minutes of the previous meeting were amended as follows: Page 3, 026/2019, paragraph 12, Mr Sullivan was aware that there had been problems with the Board picking up and needed to review how these could be picked up in future. Page 8, 034/2019, paragraph 3 – to read Mrs Dawson asked how confident the Trust was to reach the mitigated target by 29th March, Mrs Smith stated that the timescales were tight. The minutes were then agreed as a true and accurate record. *Approved*	
059/2019	MATTERS ARISING The actions were reviewed and the monitoring schedule was updated accordingly. 001/2019 Staff Story – Mrs Smith suggested reviewing a potential nomination for PICU as the forthcoming HPMA awards. *Update 15.01.2019 – Details of the HPMA categories sent to Mrs Smith, Mr McCrea and Mrs Rook.* *Update 11.03.2019 Being worked up at present – retain on schedule.* *Update 13.05.2019 Complete – Remove from schedule.* 006/2019 Committee Effectiveness – AQuA Well Led Development Review Action Plan – Meeting required outside of the Committee meeting to discuss the resolution of some of the issues raised from the questionnaires. *Update 11.03.2019 Discussion held, Mr Sullivan stated that the Committee Effectiveness action had*	

	been reviewed and with the increasing assurance on both BAF and risk, plus with a new Chair in place this may well now develop in a different way. *Retain on schedule.* *Update 13.05.2019 Mrs Wrench to send the November report to Mrs Dawson, this has been actioned. Remove from schedule.* 020/2019 Policies Extensions were approved until the end of March 2019 on the following policies: • 1.76 Job Planning Policy (policy is drafted, requires approval at JNCC, LMC and BMA) • 3.09 Freedom to Speak Up Policy • 3.32 Performance Development Review – (was awaiting clear guidance from NHS England) Extensions had been approved at the September PCD meeting until the end of December 2018 for the following policies, these were further extended until the end of March 2019: • 3.36 Supporting Staff Policy – expired 30.09.2018 - extended • 3.39 Medical Appraisal Policy – expired 30.09.2018, JLNC was postponed and could not be ratified, it will come to the March 2019 meeting – extended Update 11.03.2019 Agenda item *Update 13.05.2019 Agenda item. Remove from schedule.* 026a/2019 Staff Story OD support required for the Greenfields Centre *Update 13.05.2019 – There is an ongoing issue of OD support and demand for the team currently, and this will be added as a risk to the register.* 026b/2019 Staff Story Dr Adeyemo offered to review the request for laptops and dongles and to expedite the ordering process. Update 13.05.2019 The laptops requested were collated following the message to staff regarding additional devices from SLT/Execs, these laptops were then in included as part of the Capital Programme and a business case produced. This was signed off in February and the laptops have been ordered but not yet delivered, Greenfields will be prioritised for delivery. *Update 13.05.2019 – Not to be removed from schedule until Dr Adeyemo has confirmed that the centre has taken delivery of the IT equipment* 026c/2019 Staff Story The Executive team were invited to shadow the work of the centre on either a Monday or Friday which are their busiest days, and then report back to Board. Update 13.05.2019 Dr Adeyemo visited the Greenfields Centre on April 2nd. Remove from schedule. 026d/2019 Staff Story Story Mrs Smith will review demand and capacity at the Greenfields Centre with her HR Business Partner *Update 13.05.2019 - This will be continued to be monitored as part of ongoing work. Remove from schedule.* 026e/2019 Staff Story Mrs Wrench to feedback to Mrs Grant on the positive response to the identified issues. *Update 13.05.2019 – complete, remove from schedule.* 026f/2019 Staff Story Mr Sullivan commented that there had been problems with Board picking up relevant issues and how this will be reviewed in future. *Update 13.05.2019 – This will be monitored at Quality Committee, remove from schedule.* 034a/2019 Workforce & OD Risks 1111 There is a risk that staff engagement scores, turnover and retention for the Trust will be impacted as a result of the change and transition to implement the integrated locality working structure. Phase 4	

	is underway within the Directorates, with the majority of clinical leads now appointed. 58% return rate for the staff survey (highest in the West Midlands). Query to reduce this score following the Staff Survey results review, conversation required between Mrs Rook and Mrs Wrench. *Update 13.05.2019 – complete, remove from schedule.* 034b/2019 Workforce & OD Risks Mr Sullivan commented that the risks ratings appeared correct, but that stress/anxiety and MSK reasons for absence needed to be discussed further at SLT. To be added as a standing item to PCD under Health & Wellbeing. *Update 13.05.2019 – Standing agenda item. Remove from schedule.* 036a/2019 Workforce Metrics Ms Harvey commented that it would be interesting to review the number breakdown between long and short term sickness to establish if this is typical of an organisation. Stress and anecdotally supporting staff is often a combination of both work and home related stress and it would be interesting to see what Staff Counselling see this as. Staff can manage a busy work life, however if home-life is less positive this can have a detrimental effect. Update 13.05.2019 – this continues to be work in progress. 036b/2019 Workforce Metrics A deep-dive with BP's is required around stress absence as the new locality structure settles. Mrs Dawson commented that there was no indication of numbers involved on the metrics which made it difficult to understand the size of the issues reported. Mrs Smith to review. *Update 13.05.2019 – this continues to be work in progress.* 040/2019 Diversity & Inclusion Strategy Mrs Dawson praised the strategy and queried what the public saw? Mr McCrea stated that this would be via podcasts, and bite-size chunks, but agreed that perhaps a once page information sheet on the website would be beneficial. *Update 13.05.2019 – completed, remove from schedule* 050/2019 Policies The following policies had been extended at the January meeting until the end of March, further extensions for a further 3 months was requested on the following policies: • 3.09 Freedom to Speak Up Policy (Should have been presented to JNCC on 28th February 2019, however this meeting was cancelled). • 3.32 Performance Development Review (This policy remains under review as per the national A4C Pay changes). • 3.39 Medical Appraisal Policy (This policy was extended for a further 6 months). *Update 13.05.2019 Consent Agenda item.* *Noted*	
060/2019	ITEMS REFERRED FROM OTHER COMMITTEES No items were referred from other Committees.	
	STRATEGIC	
061/2019	DIRECTOR OF WORKFORCE UPDATE Ms Holland updated the Committee on the following: • CQC Celebration Event 29th March 2019 – this was a great success and Ms Holland gave thanks for the support the OD and Comms team had provided in support of this event • CAMHS Trailblazers • Dragons' Den • International Nurse Day & Conference with Keele University	

	• Recognising Staff Networks May 3rd 2019 – with a commitment to establish more networks • Award Winners – in both the Finance and Estates teams • Recruitment for Director posts – the Trust was currently out to national advert for the Nursing & Quality, Assistant CEO and Workforce, OD & Inclusion Director posts. The closing date for these posts is 23rd May, with interviews likely to be held during the first and second weeks of July • Successful consultant appointment to the Stoke Heath consultant post, made on May 9th 2019 • The TNA process has been undertaken and allocations have been made • STP is still not quite there on the financial position. Mr O'Brien is heavily involved in the Mental Health Sprint work. The STP is also gearing up for public and workforce engagement, we are connecting with this through the Comms & Engagement work stream, although the Trust is not necessarily directly involved • The STP OD & System Work Stream remains active with focus on the High Potential Scheme, details of which will be presented to the Committee at a later date, it was noted that we are one of six pilot sites • Staff Survey – the high level actions have been received from Directorates, these will now shared at other forums, and Champions will now be identified *Received*	
062/2019	BOARD ASSURANCE FRAMEWORK (BAF) Mrs Wrench presented the Q4 2018/19 update to the Committee, finishing the year in a relatively positive position. Mrs Wrench highlighted the areas that have ended the year in amber or red RAG ratings, and spoke of the successes. Action plans are in place to review these areas. Mrs Dawson commented that the "Embed and optimise full benefits of TRAC" was red RAG rated and she queried why? Mrs Wrench stated that there had been teething problems in the implementation of TRAC, but that support is now in the system and this is improving – a paper follows to detail the issues and highlight the solutions. Mrs Wrench also presented the Q1 2019/20 BAF, specifically under objectives 4 & 5, outlining key controls identified for the Committee. Mrs Wrench highlighted the key areas. Mrs Dawson asked for confirmation that the Committee was content with the people objectives it was being asked to monitor. No objections were raised by the Committee. *Received*	
063/2019	WORKFORCE & OD RISKS Mrs Wrench presented the risks to the Committee. All risks were reviewed and noted and in particular: *12 There is a risk that there is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increased pressure upon existing staff.* The committee noted; progress against the action plan continues, including rolling recruitment of bank staff, consolidated recruitment campaigns for Directorates, improvements to timeliness of recruitment process and the provision of temporary funding for additional resource within the recruitment team until the end of March 2019. It was noted that this is the only risk with a rating of 16. *868 There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSI.* The YTD agency spend to M11 is £1747k against an agency ceiling of £1810k, giving an underspend of £63k. A review of agency posts is underway with plans being developed to recruit substantively where possible. We have recruited to a consultant post which should now impact favourably.	

	900 There is a risk that the Trust does not provide inclusive service that recognises the diverse nature of our service users, therefore services may not be accessible or of sufficient quality and the Trust may not be responsive to the diversity & the inclusion needs of our local communities. The Trust is working to introduce AcessAble to support people with physical and mental disabilities in feeling able to access Trust services, by providing clear text and photographic information about what to expect (such as layout, amenities etc.) Work to engage local communities continues with relationships with NORSACA, CCMA, Stoke Gurdwara and City Central Mosque, Older Peoples' LGBT Group, Trans Staffordshire Support Group and others continuing to be developed. *901 There is a risk that the Trust does not have an inclusive and diverse workforce as reflected in the WRES, thus impacting on our ability to support the needs of diverse communities and ability to attract and retain staff.* In mitigation the WRES report and action is closely monitored by the PCD and the Inclusion Council has been established. *1072 There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that they fulfil requirements or their professional responsibilities and as a result may not feel supported in practice.* Compliance at M11 is 88%. PCD will actively monitor compliance with AD's and Business Partners on a regular basis, and a score reduction is to be considered once M12 compliance is known. It was noted that OD support for front line teams needs to be added to the risk register, as there are limited resources within the OD team to provide the level of support required. Mrs Wrench to liaise with Ms Stubbs to ensure this is added to the register. *Received*	LW
	WORKFORCE PERFORMANCE	
064/2019	PERFORMANCE REPORT Ms Holland presented the PQMF for M12: Stat/Mand training is at 98% and is well above the target of 95%, and the Trust is at 87% for staff appraisal against a target of 85%. It was noted that the cycle for PDR will commence again shortly and compliance may fall initially. Agency use has decreased in M12 to 18.2% from 20.6% at M11. The Trust agency ceiling was increased in M11to recognise primary care integration, which has been reflected in the change in target. The vacancy rate has decreased to 12.2% at M12 from 12.5% at M11, and the Trust vacancy rate decreases to 8.6% taking into account the posts that have recently been brought into establishment, have been recruited to or are part of a transformation scheme not yet transacted. Clinical Supervision is improving, and teams have undertaken a lot of work to ensure recording occurs in a timely manner. *Received*	
065/2018	WORKFORCE METRICS Mrs Nicky Griffiths was in attendance at the meeting to review the Directorate metrics by exception. Mrs Smith presented Month 12 metrics to the Committee. Trust Wide – it was noted that the report format will be altering over the next few months to provide a greater detail to the metrics. Sickness remains under 5% and the validated data for M12 will be distributed. Three complex employee relations cases are ongoing currently and these are impacting on	

	the stress/anxiety metrics. Cascade PDRs need to commence, stat/mand training remains excellent, however there are some staff members who need to prioritise their training compliance especially in light of the revised contract implications. It was noted that in terms of IPR we are now in the 6 month CQC reporting window, and staff needed to be mindful of this. Reported vacancies are impacted by a number of issues, specifically with inpatient areas and TUPE's. Turnover is now a major focus and intelligence is needed at a far greater level. DBS fast track on-boarding ensures staff without a valid DBS assessment are risk assessed for their roles. Mrs Nicky Griffiths presented the metrics for Acute & Urgent Care: 18 HCSW's have been recruited into the 24 vacancies held by the Directorate, and the balance is being reviewed, registered nursing continues to be an issue with new recruits commencing in the Autumn. Stress/anxiety/depression continues to be a major reason for absence, however high acuity on the wards impacts on staff wellbeing, and there have also been a couple of major incidents on PICU which can be once in a lifetime events but have significant impacts. The acuity on A&T and Telford means that staff are often pulled into those areas to assist when demand increases, and staff are reticent to pick up bank shifts in case they are scheduled to these areas. This will be reviewed in greater detail at SLT. Completion of incident reports is encouraged; these are picked up thematically to review areas of concern and trends. The discharge pathways are then out of the Directorates gift to control. Supervision targets for M11 & M12 were not met, work has been undertaken to review competence in the reporting and filtering techniques and should now address this deficit. LMS has helped the Directorate immensely allowing staff to complete training 24/7, block training dates for May & July however have been booked over school holidays, and this has been highlighted and reported back. It was noted that the two STP schemes which are the expansion of PICU to 6 beds and the High User Service will require further recruitment and resourcing from the Trust. Mrs Dawson queried how it "felt" in the team? Mrs Griffiths stated that it felt tight, that the staff felt unable to manage exceptional circumstances as the team only ever felt staffed to a base level. There has been patient damage on Ward 2, and the inpatient population has been challenging. Dr Singh a locum on Ward 2 is now in place; he is embedded in team, and takes ownership for the ward. Acute services are moving into the Crisis Care Centre under one leadership pathway that is ageless, and the team are excited about this. The CQC ratings on the Older Persons' Wards has been difficult for staff to understand as they feel that they are offering an outstanding service, in particular Ward 4 has award winning attributes. No-one was in attendance to provide an update for the Specialist Services. *Received*	
066/2019	HEALTH & WELLBEING Mrs Smith provided the Committee with an update on Health & Wellbeing; and a strategy is being compiled. For the last 2 years this metric has been aligned to a CQUIN, for flu vaccine, reduction of salt and fat in staff food, and staff engagement scores. The CQUIN for staff engagement scores has not been met this time. It was noted that "Thriving at Work", the Stevenson/Farmer report is now impacting on lots of initiatives, and whilst not NHS specific, the team are working through the document to ensure the Trust aligns to it. Agenda item at the July meeting. Received	GEP
067/2019	WORKFORCE & STP PLAN Mrs Smith updated the Committee on the workforce & STP plans. There is a requirement to complete a collaborative plan with the STP, however following the significant Directorate transformation; these will be coming on line in the next few weeks. There will be further iterations of the plans moving forward, and contracting negotiations with the CCGs are still being worked through. Challenges remain the same with Band 5/6 nurses and medics, and the Trust is reviewing new ways of working and	

	looking to grow our own in future. The plans will be monitored on a quarterly basis at SLT. *Noted*	
068/2019	DELIVERING OUR RESOURCING AMBITIONS Mrs Cuthbertson presented the paper to the Committee. The team are now working in real-time, which is an excellent turnaround over the last 8 weeks, and improves the candidate's experience. A review of band 5/6 staff nurse vacancies has been undertaken, and the Trust is making all attempts to encourage recruitment into this area. Branding is also being reviewed to allow for greater optimisation, and allow us to have a greater voice in the job market, this will continued to be worked on during the summer months. Network meetings will commence to establish why staff would want to work at the Trust, resulting in a consistent message for potential candidates. It was noted that flexibility is an incredibly powerful recruitment tool. However, Mrs Harvey commented that we are not necessarily a flexible Trust and to implement this may require costs, as staff currently fit around the service and not the other way around. The Trust needs a jigsaw of shifts and ways of accommodating the legalities of working time directives while still being able to offer flexibility, choice and autonomy. E-rostering should assist with this; however the Trust is not at that point yet. It was noted that some Trusts that have implemented flexible working arrangements have moved to three-monthly rotas. Mrs Dawson queried whether measuring "difficult to fill" and standard roles against two separate KPI's may help to reflect more accurately the working being done and to allow focus on harder to fill roles. This was reported as work in progress now the backlog had been addressed. *Received* STREAMLINING TIME TO HIRE – Establishment Control and Authorisation Mrs Cuthbertson presented the paper to the Committee which seeks to reduce the Stage 3 vacancy process from up to 5 weeks to 10 days to approve. The change will maintain appropriate governance but remove approval for clinical roles which are a like for like replacement, requisitions that outline there is existing service budget to support the request, and all Safer Staffing posts as agreed in the Safer Staffing plan. *Approved* STREAMLINING OUR RECRUITMENT PROCESS - Management of Internal Movers Mrs Cuthbertson presented the paper to the Committee that outlined the time to hire internal staff. It was also noted that KPI's are being introduced from the TRAC system, and these will put in place over the next 3-4 weeks to monitor compliance. Mrs Dawson congratulated the team on the progress made and welcomed the work on employee brand provided there was a good and demonstrable Employee Value Proposition (EVP) to back it up and that enabled everyone to deliver a consistent and well-articulated message to our people. *Approved*	
	DISCUSSION	
069/2019	BEING OPEN Mrs Smith presented the Q4 report to the Committee, based on 12 months of activity that combines Dear Caroline, FTSU, Raising Concerns and Grievance submissions.	

	The top three combined Being Open key themes for April 2018 – March 2019 were Policies, Procedures and Processes, Quality & Safety and Other; in comparison to the Q4 submissions that were Employment, Bullying etc., Other and Staffing Levels. It was noted that as the numbers were relatively small, figures in the pie chart detail would add granularity to the data. It was noted that staff were clear about the four channels of raising concerns. Mr McCrea commented MOOD had been procured for 2 years which would help the processes. The Comms team has been successful in advertising the various channels of communication for raising concerns. Staff Network groups will have champions, with parameters around the role, they may also need to deal with challenging situations; and the Trust needs to ensure that we provide the necessary support for them. We also need to start to encourage solutions to the problems and issues raised via Being Open. *Received*	
070/2019	GUARDIAN OF SAFE WORKING CARE – QUARTERLY REPORT Dr Adeyemo presented the quarterly report to the Committee, providing assurance to the Board on Junior Doctor working hours. No exceptions have been reported from January to March 2019, there are a couple of housekeeping issues regarding timeliness of the rota but these are being addressed. Mrs Dawson queried if the issues raised in the executive summary had been addressed? Mrs Smith clarified that this was around the rota flexibility, and technical issues getting the rota on the website, there should also be no issues with the log-ins. *Received*	
071/2019	GENDER PAY GAP UPDATE Mrs Rook confirmed that the gender pay data had been submitted in line with the submission date of March 31st 2019, this was a legal requirement now in its' second year.. Mrs Faux outlined the data capture, which shows a slight improvement in gender equality from 15.6% to 14.8% year on year, and the median gender pay gap also fell from 4.5% to 3.6%. As a largely a female organisation with 79% of our employees female, it was helpful to see the distribution of pay by quartile and by gender. The distribution of higher pay to males was in part explained by a more men in consultant roles and fewer men in care assistance roles. It was noted that support is given to women to apply for more senior roles and that we were attracting more men into caring and nursing roles so the impact on this would come through over time. Bonus pay is part of the measurement and the higher instance of higher bonus pay for men related just to consultants in the form of Clinical Excellence Awards (CEA), and the gender gap metric had therefore increased in slightly in 2018. CEA is a national scheme and individuals put themselves forward for this award, and those at the very top can be awarded significant amounts which then skew the data from a small demographic group. It was noted that the Trust's CEA policy is being reviewed to ensure award equality is paramount, and staff were encouraged to apply whilst being offered support to submit their application if required. Flexibility in senior posts may encourage more women into the more senior consultant roles. More analysis around banding was requested. Mrs Faux to prepare this for the July meeting. *Received*	LF
072/2019	EMPLOYEE RELATIONS UPDATE Mrs Smith presented the report to the Committee which covered activity from Q1-Q4 2018/19 and was	

	based on the status of activity as at 30th April 2019. There had been 19 disciplinary cases, with a high number in the Stoke Directorate and Acute & Urgent Care. There were no major themes, but were more random in nature. The Trust has tried to move away from suspending staff, and of the 7 that were suspended, 6 have been redeployed temporarily elsewhere into the Trust as an alternative to suspension. Only 2 BAME individuals, (11% of staff) have been subjected to proceedings which is a reduction in last year's 40% metric. The average length of time for a disciplinary investigation from commissioning to handover of the final report is 85 calendar days, however, this does not take into account the time taken to arrange and rearrange hearings due to lack of staff availability. Two investigations are awaiting disciplinary hearings; one has been postponed at the advice of Occupational Health. The Trust-wide rolling average sickness absence at the end of 2018/19 is 4.95%. Four formal grievances were lodged in 2018/19 (stage 2 or above). The Committee reviewed the report noting that there needs to be a focussed effort into the investigation timescales, and these need to reduce significantly. *Noted*	
073/2019	FREEDOM TO SPEAK UP (FTSU) GUARDIAN ACTION PLAN Mrs Wrench presented the action plan to the Committee for information prior to submission at Trust Board, the action plan came out of a Board Development session and benchmarked against national guidelines, It was noted that FTSU is now a regular item on Directorate meetings and that Mrs Dawson has an independent board role for FTSU. *Received*	
	CONSENT AGENDA ITEMS	
074/2019	POLICIES The following policies had previously been extended at the March meeting: • 1.76 Job Planning & CEA extended until the July meeting • 3.09 Freedom to Speak Up Policy/Protocol - agreed • 3.32 Performance Development Review – this is in hand, extend until July 2019 • 3.39 Medical Appraisal Policy - extended until the end of July 2019 *Approved*	
075/2019	PCD REPORTING GROUPS for information • Strategic Education & Learning Group (SEAL) – April 24th 2019 The meeting had discussed the whole career pathway, and it was noted that Trust had almost met the apprenticeship target (achieved 33 staff), and the levy now needs to be viewed as the training budget moving forward; the more good news stories that we can communicate about apprenticeships can only promote the provision. Appropriation of training funds was also discussed as this currently only equates to approximately £30 per head. • Joint Negotiating Consulting Committee (JNCC) – April 17th 2019 • Professional Leads Advisory Group (PLAG) – March 21st 2019 It was noted that this meeting is being refreshed, and the ToR and meeting frequency have been reviewed for efficiency. • Joint Local Negotiating Committee (JLNC) – 11th April 2019 • Inclusion Council – 3rd April 2019 – The meeting had been shown the "Inclusion starts with I" video, this will now be adopted by the Trust, with details of what inclusion means to staff in the workplace. A key discussion took place around broadening out the remit, whilst maintaining the focus. The Staff Networks event should assist with this, and the CEO will now look to chair these meetings where possible moving forward.	

	Received	
076/2019	ANY OTHER BUSINESS No other business was discussed	
079/2019	CYCLE OF BUSINESS *Noted for information*	
080/2019	ATTENDANCE MONITOR *Noted for information*	
081/2019	DATE AND TIME OF NEXT MEETING	
	Monday 15th July 2019 9.30am, Boardroom, Lawton House Deadline for papers – 8th July 2019 The meeting closed at 12:31	

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 21

Date of Meeting:	23rd May 2019		
Title of Report:	Together We're Better Update		
Presented by:	Peter Axon, CEO		
Author:			
Executive Lead Name:	Peter Axon, CEO	Approved by Exec	☐

Executive Summary:	Purpose of report	
Attached is the Together We're Better Update for April 2019.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ o People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	Nil		
Resource Implications: Funding Source:	Nil Nil		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Nil		
STP Alignment / Implications:	Nil		
Recommendations:	To receive for information		

Version	Name/group	Date issued

Together We're Better Update

March/April 2019

Introduction

With the arrival of the new 2019/20 financial year, the importance of the next 12 months cannot be underestimated.

The pace has continued to build during 2018/19 and we've been pleased with the progress made as a health and care partnership over this time.

It is in 2019/20, however that the work to deliver tangible transformational change properly gets underway with the launch of our 12-week period of public, workforce and stakeholder involvement taking place across Staffordshire and Stoke-on-Trent following the local elections.

This will be a very busy period that will see us talking with and listening to people in each part of the county – with the feedback helping to shape the development of any proposals going forwards. More information on our involvement plans can be found below. Alongside this later this year, we will publishing our Five Year Plan for Staffordshire and Stoke-on-Trent that responds to the priorities and challenges set out in the NHS Long Term Plan.

One of the areas where we've made great strides over the past 12 months has been in the way we work together as a partnership and this was flagged by the Care Quality Commission (CQC) in its report into the provision of older peoples' services in Stoke-on-Trent.

That energy is being directed towards developing a Five Year Plan that is ambitious, but realistic and provides a 'single line of sight' for how we will develop into a fully integrated health and care system – one that learns from the development of the plan originally published in 2016 and includes feedback from local people, partners and stakeholders.

We also need to get a firmer grip on the serious financial challenges that are facing the area. It's no secret the financial situation in Staffordshire and Stoke-on-Trent is far from where we would wish it to be. This is clearly not acceptable and needs to be addressed more decisively in 2019/20. The reality of the position in which we find ourselves is fully accepted within the partnership and the onus collectively falls on us to tackle this challenge head on.

That does not mean, however that our ambitions should be limited. The work being carried out by our clinically-led programmes to deliver transformational change within the system will continue to play an essential role in the development of our Five Year Plan and achieving our vision of 'Working with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work'.

Finally, on a piece of really positive news, we're delighted that North Staffordshire Combined Healthcare NHS Trust has been rated overall 'Outstanding' by the CQC – one of just two specialist mental health trusts in the country to have achieved this rating. Mental health is a top priority for Together We're Better and we applaud Combined Healthcare for receiving such a positive accolade.

Sir Neil McKay
Chairman

Simon Whitehouse
Director

Our journey towards public and workforce involvement

We will be holding a 12-week public conversation across Staffordshire and Stoke-on-Trent following the local elections that focusses on the following areas:

1. Simplifying urgent and emergency care
2. Developing a new vision for health and care in Staffordshire and Stoke-on-Trent
3. Reviewing Community Hospitals in South Staffordshire
4. Identifying additional priorities that will deliver clinical and financial stability.

As part of this, the following face-to-face public involvement events are to be held across Staffordshire and Stoke-on-Trent:

Date	Time	Location	Book
Monday 3 June	7pm-9.30pm (registration from 6.30pm)	Tirol Suite, SnowDome, River Drive, Tamworth, B79 7ND	Click here
Thursday 6 June	7pm-9.30pm (registration from 6.30pm)	Entrust, Riverway Centre, Riverway, Stafford, ST16 3TH	Click here
Wednesday 12 June	1pm-3.30pm (registration from 12.30pm)	Leek Cricket Club, Macclesfield Road, Leek, ST13 8SG	Click here
Thursday 13 June	10am-12.30pm (registration from 9.30am)	Kingfisher Room, Blurton Community Hub, Ingestre Square, Stoke-on-Trent, ST3 3JT	Click here
Tuesday 18 June	7pm-9.30pm (registration from 6.30pm)	Aquarius Ballroom, Victoria Shopping Park, Victoria Street, Cannock, WS12 1BT	Click here
Wednesday 26 June	1pm-3.30pm (registration from 12.30pm)	C J Bayley Suite, Port Vale Football Club, Hamil Road, Stoke-on-Trent, ST6 1AW	Click here
Tuesday 2 July	1pm-3.30pm (registration from 12.30pm)	Garrick Room, George Hotel, Bird Street, Lichfield, WS13 6PR	Click here
Thursday 4 July	7pm-9.30pm (registration from 6.30pm)	Windsor Room, Stoke Town Hall, Glebe Street, Stoke-on-Trent, ST4 1HP	Click here
Thursday 11 July	10am-12.30pm (registration from 9.30am)	Tom Bradbury Suite, Pirelli Stadium, Princess Way, Burton-on-Trent, DE14 0AR	Click here
Monday 15 July	7pm-9.30pm (registration from 6.30pm)	North Staffordshire Medical Institute, Hartshill Road, Newcastle-under-Lyme, ST4 7NY	Click here
Wednesday 17 July	2pm-4.30pm (registration from 1.30pm)	Bourne Room, Wombourne Civic Centre, Gravel Hill, Wombourne, WV5 9HA	Click here

Public roadshows will also be held across the county in areas of high footfall, such as shopping centres, supermarkets, leisure centres and libraries. More details on where these roadshows will be held will be available shortly.

Alongside this, staff roadshows will take place in key health and care locations and focus groups held with community and voluntary sector groups and organisations. We will be

actively meeting with a range of voluntary/community sector organisations, patient networks and protected characteristics groups, while people will be able to share their views by completing a survey (both online and hard copy).

We are working on updating our Case for Change document, first published in March 2016 while a public facing Issues Paper is being developed as part of our pre-consultation that will provide further detail and background information. In addition, we are continuing discussions with NHS England about the assurance process to make sure we are following national guidance and best practice.

In the run up to the launch of the 12-week pre-consultation, our NHS and local government partners have been holding conversations with staff using a workforce involvement toolkit that supports consistent messages and helps staff to give early feedback.

We held a workshop event in Stoke-on-Trent in March involving about 20 representatives from Healthwatch, the local voluntary and community sector, patient groups and local government, who provided valuable feedback on our plans for public involvement.

Furthermore, we're continuing to hold face-to-face sessions with our Local Representatives group, whose insight is helping to refine our pre-consultation plans. Members of this group come from all walks of life, including existing Patient Participation Groups, Healthwatch members, local community advocates and other roles.

You can find out more information about our involvement plans on our website www.twbstaffsandstoke.org.uk.

Key highlights from the March 2019 Health and Care Transformation Board meeting

- **Development of Primary Care Networks.** The Board received a clinically led presentation and held an interactive session on the progress towards establishing Primary Care Networks by June 2019. There is recognition of the need for a stronger role for primary care at scale, which will require a new operating model serving larger populations and delivering a wider range of services. The system leaders offered their 'pledge of support' towards the development of the networks.
- **Population Health Management.** Jane Moore, Director of Strategy, Planning and Performance in the CCGs provided an update on work to develop Population Health Management capability. This work is led by the Prevention programme, with strong links to the Digital programme. Work is starting with the two councils on how we can use Population Health Management to best address the issues across the system.
- **Integrated Care System (ICS):** Simon Whitehouse, Director, shared the latest progress in developing an Integrated Care System in line with the national ambition by 2021. Ongoing discussions are happening with Chairs and Chief Executives, with a collective commitment to co-production and the need for this work to link to the development of Population Health Management, Primary Care Networks, Alliance Boards and Strategic Commissioning. The Board recognised the need to accelerate the development of our ICS locally to enable us to meet our financial, quality and performance challenges. As this work progresses, we will be seeking the views of partners, the public and staff in how we best achieve the benefits of integrated care through the services we deliver to local people
- **Case for Change:** The latest iteration of the Case for Change was approved by the Board. This is an essential part of our pre-work as we build towards a Pre-Consultation Business Case, providing a snapshot of the challenges faced in the

system and why change is necessary. The Case for Change was submitted to NHS England at the end of March, ahead of the Strategic Sense Check process.

Risk summary

Progress continues to be made in the majority of areas. The Prevention programme has revised their projects to ensure a good focus on addressing health inequalities and supporting health and wellbeing, while the Children and Young People programme is continuing to develop projects to ensure children and young peoples' services play a prominent part in Together We're Better's work. Planned Care and Cancer has recently completed a re-alignment of its projects and is now focused on delivery.

Risks that remain red-rated after mitigation (15 and above) are considered by the Together We're Better Health and Care Transformation Board on a quarterly basis. There are currently seven risks which remain red after residual action/mitigation, these are:

Digital

- Risk that other programmes will look to source their own solutions for helping to facilitate collaborative working, due to the delay in providing an Integrated Care Record (ICR)
- There is a risk that funding will not be available to deliver the ICR.

Maternity, Children and Young People

- Lack of Estates across Pan Staffordshire to accommodate clinics or transform into community hubs or high charging to use rooms
- Activity restricted at Walsall Health Care NHS Trust, Royal Wolverhampton Hospitals NHS Trust, Dudley Group Foundation Trust and the Good Hope Hospital site of Heart of England Foundation Trust.

Mental Health

- Availability of funding to expand Psychiatric Liaison at County Hospital in Stafford and Queen's Hospital in Burton (affecting two mental health projects)
- Cost pressures on partners remain a risk as further austerity measures impact on commissioners and providers.

Pre-Consultation Business Care (PCBC)

- There is a degree of uncertainty around preparedness of Planned Care and Cancer to be in a state of readiness for the PCBC due to the Board being in the early stages of development.

Update from Together We're Better's work programmes

Urgent and Emergency Care

- The system across Staffordshire and Stoke-on-Trent is working well together to understand the issues in respect of urgent care and to effectively plan and deliver against its commitments - it has been commended by NHS Improvement and NHS England for the strong progress made and the system governance arrangements in comparison to winter 2017/18
- The hard work of partners and frontline staff across Staffordshire and Stoke-on-Trent has led to this improved performance, including an improved four-hour A&E performance against the same period 12 months ago and zero 12-hour trolley breaches reported between November and January this year
- One example of partnership working is a successful two-week pilot project involving West Midlands Ambulance Service, University Hospitals of North Midlands NHS Trust (UHNM) and Midlands Partnership NHS Foundation Trust – the two-week pilot was

aimed at patients identified by ambulance crews as not needing to go to A&E, but still requiring some form of urgent support
- Paramedics were able to call a dedicated phone line to assess the patient's needs, identify if they were known to the service and determine what community services could be provided to support them at home, if this was appropriate
- The pilot tested what alternative services are available and if paramedics are able to handover patients in a timely manner – the initial findings were very positive, with a significant number of people involved having been able to receive support in the community rather than being conveyed to hospital
- There have been improvements in the number of patients streamed into primary care at UHNM's Royal Stoke University Hospital
- A base Clinical Assessment Service (CAS) is live in Staffordshire and Stoke-on-Trent, meaning that patients calling NHS111 between 10am-6pm Monday to Friday will be able to access clinical support over the phone if clinically required
- Significant work is taking place with the Enhanced Primary and Community Care (EPCC) programme to align priorities, resources and plans where appropriate across the two programmes to support a fully integrated urgent and emergency care system, including work around long term conditions, care homes, frailty and integrated urgent care
- The programme has been working in alliance with EPCC on the 'sprint' initiative to identify services which can be transformed rapidly during 2019/20
- A system wide plan is in operation to reduce medically fit for discharges at County Hospital in Stafford.

Planned Care and Cancer programme
- A refreshed governance structure for the programme has been established, with revised terms of reference and Programme Board membership
- Leads have been confirmed for Specialty Focus (Mark Seaton), Diagnostic Redesign (Sharon King) and Outpatient, Day Case Provision and Theatre Utilisation (Mary Ridout)
- The funding has been allocated to ensure robust systems and processes are in place to enable achievement of national cancer standards, core requirements and objectives
- Project scoping meetings are being arranged with project leads to identify milestones, objectives and deliverables.
- Following the £1.15m transformation funding awarded by the West Midlands Cancer Alliance (WMCA), a Transformation Plan has been submitted to WMCA
- The Eye Health capacity review plan has been submitted to NHS England
- University Hospitals of North Midlands NHS Trust has received funding for equipment for pathology sample tracking that will help to reduce reporting times
- A process has been embedded to ensure all women at moderate risk of familial cancer are automatically recalled for surveillance
- A detailed plan for lung cancer low dose CT screening has been completed and a project manager appointed
- Development work for the implementation of a best practice pathway for lung and prostate cancers has been completed
- A process has been embedded to ensure holistic needs assessments are completed for 80% of patients with a cancer diagnosis
- The programme is meeting with Keele University to discuss the roll out of the First Contact Practitioner (FCP) model and the developing Innovation Partnership for musculoskeletal (MSK) triage services, including FCPs across Staffordshire and Stoke-on-Trent
- The programme has been working on the 'sprint' initiative to identify services which can be transformed rapidly during 2019/20.

Prevention programme

- Karen Bryson has moved from her role as Programme Director to work with the Ministry of Wellbeing full time – Andrew Donaldson, Head of Strategy at Staffordshire County Council, has been appointed as the new Programme Director
- The Ministry of Wellbeing will now be delivered independently to the programme in its capacity as a Community Interest Company
- This change has allowed the programme to review its current delivery structure, governance and outcomes
- To support this wholescale review, a task and finish group has been created, made up of key programme representatives, that is meeting every three weeks over a four-month period to agree a refreshed Prevention programme.

Mental Health programme

- The confirmation of Peter Axon as the new Senior Responsible Officer for the programme in place of Caroline Donovan has been actioned by Together We're Better's Executive leadership
- Peter joined North Staffordshire Combined Healthcare NHS Trust on 1 April as its new Chief Executive, taking over from Caroline who is taking up a new opportunity as Chief Executive at Lancashire Care Foundation NHS Trust
- The programme is to connect with GPs through the new Primary Care Networks regarding the delivery of physical health checks to ensure value for money
- The project lead for Integrating Physical and Mental Health (Jane Munton-Davies) is now a member of the Enhanced Primary and Community Care programme to ensure links around Integrated Community Team developments
- A business case for the implementation of the Intensive Outreach/Home Treatment service for children and young people in North Staffordshire has been completed and is under consideration dependent on commissioning intentions response
- The programme is on track to launch the 'trailblazer' programme in North Staffordshire and Stoke-on-Trent in April to establish child and adolescent mental health service (CAMHS) support in schools
- Further bids are being prepared in the summer for Wave 2 of the trailblazer programme, starting in September
- A bid has been submitted to Public Health England for additional resources to support the delivery of actions set out in the Suicide Prevention Plan, particularly around workforce and primary care training; with a decision due in March
- Work will take place to establish what crisis care services are in place and identifying any differences in provision across the patch, with further work focusing on mental health liaison arrangements in place at County Hospital in Stafford and Burton Hospital to ensure appropriate levels of service are in place
- A crisis care project group is being established to engage with stakeholders and develop and deliver project plans
- The Psychiatric Intensive Care Unit located at Harplands Hospital in Stoke-on-Trent is to expand to six beds from May 2019.

Enhanced Primary and Community Care (EPCC) programme

- A bid for a cohort of eight GP practices to undertake the Productive General Practice (PGP) Quick Start programme has been successful and the programme has now commenced for practices in the south and east of the county
- A further cohort of eight practices to undertake the programme was also approved for North Staffordshire and Stoke-on-Trent and this work has commenced
- PGP Quick Start is an on-site, hands-on, short term support package for practices that forms part of NHS England's Time for Care programme, designed to help practice teams manage their workload, adopt and spread innovations that free-up clinical time for care

- The first cohort of Advanced Clinical Practitioners has completed their work, funded by Health Education England
- The programme is delighted that more than 20 students who attended Keele University's recent annual career conference expressed interest in commencing their nursing career in General Practice
- A Locality Development Programme is underway to support networks of practices to work together, with the initial 'diagnostic' phase understanding the readiness of practices to work at scale and identify a programme of support tailored to the needs of each geographical area
- Regarding the development of Primary Care Networks (PCNs) within Staffordshire and Stoke-on-Trent, a steering group has been established and will be chaired by the EPCC Clinical Lead; this group will monitor progress on the delivery and formation of PCNs, and the development of the primary care strategy
- A shared governance group has been formed to ensure the operational delivery of end of life protocols across Staffordshire and Stoke-on-Trent.

Maternity, Children and Young People programme

- Mary Barlow has taken over from Alex Birch as Strategic Lead for Maternity – thanks very much to Alex for all her hard work
- Each Local Maternity Service is required to carry out an audit of the number of women on a Continuity of Carer pathway – work is taking place in relation to the specifics of how this will be measured and this will involve comparative work with surrounding services
- A Continuity of Carer Midwife and Lead Midwife for Transformation have been appointed and started in April
- The Maternity programme attended the Better Births Three Years On event in March; the notable theme of which was Continuity of Carer
- An in-depth midwifery staffing assessment called Birthrate Plus has now concluded at University Hospitals of North Midlands NHS Trust and the final report should be available by April
- The children and young people programme has welcomed Jacqui Ashdown, Stoke-on-Trent City Council, who has taken up the role of Programme Director
- The following priorities have been identified by a children and young people task and finish group:
  - Reducing inappropriate demand in children's health and social care services with a focus on the most vulnerable (looked after children, children in need of protection)
  - Embed a preventative approach with a focus on early years, positive parenting and early interventions
  - Work across the system to improve the pathways and transition points for children with complex health needs
- The children and young people team will be engaging with children, young people and parents and with wider partners and stakeholders to confirm its priorities and identify leads for each priority and project plan.

Workforce programme

- The programme is working with and supporting a number of Together We're Better programmes on workforce planning – including Maternity, Children and Young People on the continuity of carer model; Enhanced Primary and Community Care on Integrated Community Teams; and Urgent and Emergency Care on Urgent Treatment Centre modelling
- Following an apprenticeship levy event involving 40 businesses, a number of applications have been received from providers and these will be considered by the Programme Board

- More than 20 applications for the rotational apprenticeship scheme were received, with 10 apprentices being recruited to take part in a robust training programme, rotating between providers over a two-year period
- The scheme has been developed to help increase the supply of our future workforce, improve the quality of care and service provision for service users, and embed integrated working and joined up service provision in our future workforce
- A steering group has been set up to take forward the system-wide domiciliary care workforce and recommendations, with priority activity currently being converted into an action plan to address the key workforce challenges in recruitment, retention, career progression, future workforce supply
- The programme has developed a retention framework and roadmap to include best practice schemes and case studies from partner organisations
- Schemes such as 'transfer window', 'itchy feet conversations' and retirement schemes are being developed to pilot within partner organisations
- Careers Hub information web pages will soon be going live on Together We're Better's website and an STP careers service offer is being developed with partners to retain the workforce in Staffordshire and Stoke-on-Trent
- NHS provider organisations (University Hospitals of North Midlands NHS Trust, Midlands Partnership NHS Foundation Trust and North Staffordshire Combined Healthcare NHS Trust) have met with suppliers to consider collaborative bank solutions and approach for Staffordshire and Stoke-on-Trent – trusts are signed up to work together to find the right collaborative approach locally
- A system-wide workforce database is currently in development with testing taking place over the coming weeks; the database will help support understanding of the local health and social care workforce as a whole system and support integrated workforce planning across the programme
- A Health and Care Graduate pathway has been developed with partners to improve the entry of young people into health and social care careers, with the plan to have the first cohort in place by September 2019.

Digital programme

- Bids from two prospective suppliers were received for the replacement Integrated Care Record (ICR) 2 project
- The procurement evaluation is progressing in line with the project plan, with a planned contract due to be awarded in the latter half of June
- The benefits of the ICR include:
  - Patients avoiding having to repeat information to different health and care professionals
  - Patients avoiding having to undergo unnecessary duplication of tests – leading to fewer delays in receiving the right care
  - Empowering patients to have greater control of their care by enabling them to view their patient record online
  - Enabling health and care professionals to be able to access an individual's record wherever they are based
- Due to their dependency on ICR2, a number of programme workstreams are currently on hold, including Business Intelligence and Analytics and the Information Sharing Agreement workstream, and these will be re-activated again from June.

Estates programme

- Outline business cases have been submitted to NHS England's Project Appraisal Unit (PAU) for the development of a new medical centre in Longton South and the Greenwood House Health Centre development
- The programme is working with colleagues at NHS England and PAU to ensure the most efficient running of the process to get to the quickest outcomes

- Governance arrangements are in place for the health and care campus project on the Outwoods site at Queen's Hospital in Burton – the programme is supporting with next steps
- A development appraisal is being prepared for the Burntwood North project
- A Development Plan has been produced to capture progress on identified projects and disposals and identify possible future options
- A system-wide delivery plan is being developed following feedback received on the Estates Workbook, with support from Estates leads from NHS provider organisations
- The programme is continuing to support other Together We're Better programmes on project work.

Organisational Development and Leadership programme

- The programme is continuing to develop the High Potential Scheme (HPS) locally, following a successful application to the NHS Leadership Academy to become a pilot site
- The aim of the HPS will be to identify, support and develop the most talented individuals providing NHS-funded care, in order to help them succeed in the most senior roles within local health and care services
- The scheme will ensure the NHS has a stronger and more diverse cohort of aspirant leaders who will progress to senior executive roles by:
  - Identifying those people with the greatest potential to progress to senior executive roles and provide them with the support and development necessary to enable the acceleration and achievement of this
  - Recruiting and developing cohorts of high potential leaders that are diverse and inclusive, and ensuring the scheme itself models inclusive leadership in its content, design, process and operations
  - Establishing a valid, reliable and inclusive framework for identifying and assessing 'high potential'
  - Tracking the careers of high potential participants during and after the scheme
- The HPS pilot is due to get underway in June, with an initial cohort of 20 people
- A total of 36 people took part in the latest cohort of the BAME (Black, Asian and minority ethnic) Leadership Programme
- Feedback has continued to be extremely positive, with more than 50 existing and aspiring leaders from the BAME community having now taken part in the programme.